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COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Reference: Health Practitioner Regulation (Consequential Amendments) Bill 2010

FRIDAY, 30 APRIL 2010

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Friday, 30 April 2010

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

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

Senators in attendance: Senators Adams, Boyce, Moore and Siewert

Terms of reference for the inquiry:

To inquire into and report on:

Health Practitioner Regulation (Consequential Amendments) Bill 2010

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BENNETT, Ms Carol, Executive Director, Consumers Health Forum of Australia

WISE, Miss Anna, Senior Policy Manager, Consumers Health Forum of Australia

CHAIR (Senator Moore)—This morning's hearing of the Senate Community Affairs Legislation Committee is into the impact of the Health Practitioner Regulation (Consequential Amendments) Bill 2010. I welcome representatives from the Consumers Health Forum. You are experienced witnesses and you have information on parliamentary privilege and the protection of witnesses and evidence. The committee has your submission. Thank you very much. I invite either or both of you to make an opening statement. At the end of that process we will go to questions.

Ms Bennett—I would like to start by outlining the importance of the national registration and accreditation scheme for Australia's health consumers and then make some comments on the Health Practitioner Regulation (Consequential Amendments) Bill, which is before us, and other matters that have been raised in submissions to this inquiry.

As a consumer if I want a service—whether it is from a lawyer, a builder, an architect, an IT provider or a gardener—I will want to know certain things about them. I want to know if they are qualified to do the job. I want to know their record of achievement. I want to know if they have appropriate insurance in the instance that anything goes wrong. I want to know if there are appropriate complaints mechanisms in place to deal with any potential issues and if there is some form of quality assurance or a commitment to improve based on feedback. Currently if I want someone to be my doctor I will know where they practice from, I will know what their charges are, although not always, and I will know that they are registered to practise medicine in one jurisdiction. I will not know about their qualifications and credentials, their levels of accreditation, their levels of specialty practice, their limitations on practice and any complaints that have been upheld against them. These are really important facts for health consumers to know and I believe they should have a right to know. Certainly, the consumers we have consulted with believe they have a right to know these things.

Beyond removing some of the gaps in this information and providing informed choice for consumers, the national registration and accreditation scheme can generate confidence by consumers if it delivers on its guiding principles, and we strongly support them. The safety of the public is paramount. High-quality health care must be protected and advanced, governance should be accountable and processes should be transparent. CHF argues that everyone has the right to safe, good quality health care and there must be a high-quality national registration and accreditation scheme for the health professions to help improve patient care and safety.

The CHF has undertaken extensive consultations with health consumers, including hosting a national workshop. We have also been a member of the professions reference group, which was put together during the design of the scheme. We undertook a funded project to consult with health consumers on the scheme throughout 2008-09. We found that consumers want national consistency—they want to know that there is registration and accreditation of health professionals that is consistent across jurisdictions and disciplines; better information—they want provision of information about registration, accreditation, area of specialty and limitations on practice through a public register; safety and quality assurance—they want links between accreditation and registration so that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered and links between quality assurance, education and training processes and registration requirements with analysis of complaints ensuring a continuous quality improvement process for health care; and mandatory reporting by health professionals of reportable conduct, particularly where the public is at risk.

They want transparency and accountability, a genuine independent consumer or community reference point beyond professionals and bureaucrats in both accreditation and complaints processes, a public interest assessor to provide an additional level of scrutiny for accreditation and registration decisions and an independent complaints process, including a one-stop shop, to raise concerns, lodge complaints and access information. Consumer participation is also very important. The opportunity for consumers to contribute to the scheme through community members on the national boards is seen as being a very positive thing.

I would like to talk for a moment about the role of the public interest assessor. While CHF considers that the introduction of the national registration and accreditation scheme represents a big win for health consumers with many potential benefits, we remained concerned about the removal of the public interest assessor. CHF

strongly supported the inclusion of the public interest assessor role in the exposure draft of bill B and was disappointed to note its removal from the final version.

The Australian Health Workforce Ministerial Council argued that, in the final version of the legislation, the increased role of the state and territory health complaints bodies and the strengthened and formalised role of community members on national boards removed the need for the public interest assessor role. CHF, however, is concerned that removal of this role has reduced the rigour of the national registration and accreditation scheme arrangements and the processes in place to protect consumers' health and safety.

In relation to ministerial reserve powers, as with the role of the public interest assessor, CHF supports the notion of providing a ministerial council with reserve powers to intervene should the situation require it. This system would provide an additional level of decision making to safeguard consumers from any decisions that may impact on patient health and safety. We note other stakeholders' comments that there should be some transparency around the decisions of the ministerial council and that a public interest test should be applied to any of its decisions. In general, the CHF considers that these measures would not be unreasonable.

In conclusion, overall CHF supports the passage of the bill as a key part of the introduction of the national registration and accreditation scheme. The degree to which this bill and the scheme itself achieve what consumers want will be entirely dependent on the degree to which implementation actually involves and engages not just the professionals but consumers. After all, the system is for them. CHF stands ready to work to ensure the implementation is as good as it can be given the limitations of the initial process.

CHAIR—Thank you, Ms Bennett. Miss Wise, do you have any comments you would like to add?

Miss Wise—No.

Senator SIEWERT—Overall you are obviously happy with the approach of the scheme.

Ms Bennett—Yes.

Senator SIEWERT—Your main concern at this stage appears to be with the public interest assessor. With the way the process is rolling out now, you have obviously still got concerns but is there anything specific that has occurred that would highlight or aggravate your concerns in terms of the public interest assessor?

Ms Bennett—From our perspective, we want to see that the role of the community members on those boards is as robust as it can be and that those members are given an opportunity to engage with each other and to represent broader community and consumer issues beyond just being an individual appointment and that there are safeguards in place that would ensure that in the instance that there is required to be an additional level of checking or safety assurance—and this would be exceptional—that is actually happening.

The public interest assessor role, for us, just provided that additional level of check and balance that would ensure that, in the event that it was required, there was an independent process that would protect the public safety. It remains to be seen how the scheme is actually implemented and to ensure that the additional role that the states are taking on in terms of the complaints processes and that the members on the community boards—the additional members; we have now got at least two—are actually operating in a way that ensures that that level of safety is paramount for consumers.

Senator SIEWERT—I want to talk about your interaction with the states in a minute, but what interaction have you had with the department or the government around your concerns about the assessor role being removed? How assured are you that they have taken on board your concerns and that your concerns are being addressed in the alternative processes that they have put in place?

Ms Bennett—That is a good question. Given that we had been part of the professions reference group discussions, to be in a meeting of that group at which the person from the department, Louise Morauta, was talking through the draft bill, exposure bill B, when the public interest assessor role at that stage—I think it was probably September last year—was still included in the draft legislation and then to see, once the final draft was produced, that that had actually been removed was quite a surprise. We had no conversations with anybody about that. It was buried on the second page of that communiqué. It simply said that the additional role that the states would take on in terms of complaints, and the strengthening of the roles of the community members by having two of them rather than one, would assure compensation for the removal of the public interest assessor. In short, we had no conversations around that. We have raised it as a concern with government obviously in response to this bill, and in the media, but so far there has been very little response to that.

Senator SIEWERT—I presume that while you welcome an additional person on the boards you are not satisfied that that in fact replaces the role of the assessor.

Ms Bennett—No.

Senator SIEWERT—In terms of the process with the states and the various mechanisms through the states, is there a danger that, while we have a national system going now, we are fragmenting it by having different state processes for complaints? Is that a concern, or are you not that worried about it?

Ms Bennett—We were always concerned about some of the states. We knew that New South Wales, for instance, was keen to retain its own complaints mechanism and we were concerned about the reduction of consistency that that might entail, but I guess we accepted that in order to get national consistency there has to be some compromise around some of those things. As with all of this scheme and its implementation, it remains to be seen how it works in meeting the needs of consumers and ensuring their safety.

Senator SIEWERT—I have one final question. Would it be fair to say that the concerns you have are mainly about still refining the overall process and that you are okay with this particular bill?

Ms Bennett—Yes.

Senator SIEWERT—I am not trying to minimise your concerns, but with this particular bill would that be a fair summary? There are still ongoing concerns about some of the process of implementation, but you do not have so much of a problem with the bill itself.

Ms Bennett—That is right.

Senator SIEWERT—I totally appreciate that this is an opportunity where we can look at the broader issues as well. Since there is a bill before us, I can understand why you have brought the issues up, but you are okay with the actual things in the bill.

Ms Bennett—Yes. Overall, we support it.

Senator BOYCE—Could I just follow up on that line of questioning. What would you perceive the public interest assessor doing that is not currently covered?

Ms Bennett—The public interest assessor provides another layer of independent checking of complaints reporting or any particular issues that arise at the national board level. It provides a way of ensuring that there is another way of independently dealing with those issues. So it was important to us as way of providing an independent check and balance.

Senator BOYCE—Would you also see them as someone who might pull together issues from particular state health complaints bodies and decide whether there was a national application?

Ms Bennett—Not so much. It was more just having that additional and independent layer of ensuring that there was a way of dealing with really serious issues that were being dealt with by the national board.

Miss Wise—In our submission back in July to the Senate inquiry into the scheme overall, we actually called for the role to be strengthened to have additional powers. We valued the role as it stood, but we could see the potential for additional benefits as well.

Senator BOYCE—I was struck by your opening comments, Ms Bennett, around the transparency of the qualifications et cetera of the medical people that people might visit. How would you propose that that should be available to a consumer?

Ms Bennett—There has been discussion about having a national register but about there being accessibility for consumers. There has been discussion about a website that people could go on, which would provide a transparent, accountable way for people checking for all of the things that they are looking for when they are seeking to find a health practitioner. The sorts of things that I raised, the range of issues that people are interested in knowing about, were raised with us by consumers in our consultations. We believe that those things are entirely appropriate and achievable. So possibly there will be a website. Some of our consumers indicated that they would also like a telephone line which they could phone up and find out about qualifications, accreditation, location and specialty areas, those sorts of things, for practitioners that they were looking at using or practitioners that they were currently using.

Senator BOYCE—I note that you are supportive of the reserve powers for the ministerial committee, but you will be aware that there have been some concerns expressed within some of the health professions that that might be used to dilute qualifications et cetera. Why don’t you share those concerns?

Ms Bennett—As with the public interest assessor, we believe that additional levels of scrutiny and additional powers that would enable intervention where it is required—we are talking about exceptional circumstances and where it is warranted—are in consumers' best interest. We do not have a particular problem with that and, where the ministerial council believe that there is reason to consider issues that have not been dealt with by the boards or that they believe need to be considered outside of the board process, then we would support that.

Senator ADAMS—Could you tell me how the two consumers are elected to go on the board and what qualifications they have? Do you have any idea about that situation?

Ms Bennett—We provided some names of consumers that we thought would be really well placed to be members of the boards, and they had to apply independently of Consumers Health Forum to, I think, the national agency at the time when the selections were being undertaken. We do not know on what basis people were selected for those positions. There was an internal process conducted, which we had no knowledge of. We were not invited to officially nominate representatives, but within our circles we did alert people to the fact that the positions had been advertised and we encouraged people who we thought would make good community representatives to apply for those positions.

Miss Wise—It is worth noting as well that these positions are for community representatives as opposed to consumer representatives. There is a bit of a distinction there.

Senator ADAMS—When I was involved with the review of the divisions of general practice I was always trying to get the message through that they must be community rather than consumer representatives, because it gets quite tricky. So do those people come back to you with information, just for feedback?

Ms Bennett—They actually cannot because they are bound by confidentiality provisions, so we cannot have a conversation with them about their role, and certainly not about the content of the discussions on the boards. I am aware that some of those consumers have talked about the need to have some mechanism to network and talk with each other about the sorts of issues that they are facing. Given that there are only two of them on each board, they can sometimes feel quite isolated in terms of approaching some of the issues and would benefit from having a discussion with other community board representatives about how they approach particular issues without necessarily talking about the specifics. We have written to AHPRA to seek that kind of capacity for those representatives to meet and have that opportunity to support each other, I guess, in meeting the needs of their role.

Senator ADAMS—I probably asked the question back to front, but that is really what I was thinking about—how they gain the information to go forward and if they were part of the network.

Ms Bennett—Currently they do not. In fact, there are only two of those appointments nationwide that are within our networks, so we only know two of them. The short answer is that they do not have the capacity to draw on existing broader networks and knowledge. They are independent and they are chosen as individual community representatives, not consumer representatives who are networked and have the opportunity to draw on the broader consumer network.

Senator ADAMS—With the new health reforms, can you see anything that might strengthen these positions? A lot of us are not really up to speed with exactly what is happening, but I wonder, as an organisation, how you see this fitting into this particular situation.

Ms Bennett—That is a good question. I suppose we do not really know how the broader health reforms will operate and how that will dovetail with the scheme at this stage, but we would certainly hope that there will be that capacity for the scheme to operate within the context of the broader reforms and that it would be adaptable to the circumstances that eventually arise once the new reforms are implemented.

CHAIR—I would like to get something on record about the whole area of consumers. We had a bit of a discussion in the previous inquiry that we did and Senator Adams's questions about the process for consumers is one of the things that was part of that discussion. When you raised these very important issues about the role of consumer representation, training and networking with the various bodies of consultation with whom you were working, what response were you given?

Ms Bennett—We were actually funded by the Department of Health and Ageing to conduct that two-year project.

CHAIR—Around the consultations?

Ms Bennett—Around the consultations. So throughout the development of the legislation we were consulting consumers and providing input and feedback about their views. We were part of that professions reference group—the 10 groups who will form part of the first stage of the implementation and the national boards. We were providing feedback to them as well. Generally throughout that process I believe our views were taken into account and it was a good opportunity, in having that resourcing in place, to talk with consumers and to feed that back in, having the capacity to sit at the table at the professions reference group and to have an official discussion with the Department of Health and Ageing. Generally I believe our views were taken into account and, as a result, I think we are generally happy with this legislation. The only issue that really was not taken into account was that public interest assessor role. Certainly there were some concessions for other professional groups around some of the powers and the roles of the boards and those sorts of issues—

CHAIR—A number of concessions, Ms Bennett.

Ms Bennett—There were a number of concessions that we did not necessarily agree with, but we do feel that, at the end of the day, overall it came together in such a way that we can now support the overall legislation, with the exception of a couple of issues.

CHAIR—I note that in your evidence you said that the decision to remove the public interest assessor position was taken through the whole process, which is how it worked—feed-in, further meetings and so on.

Ms Bennett—Yes, that is right.

CHAIR—But there was no attempt by anyone in that process to contact your group.

Ms Bennett—No.

CHAIR—According to the discussions we have had, this had probably been the core issue that you were raising in the whole process. There was no attempt to engage with you to explain why and to assure you that things had been done.

Ms Bennett—No. That is right.

CHAIR—I remember that in the original committee we were told that things were put on the website and it was up to the people who were involved to read the website, and that would be how people would find out.

Ms Bennett—That is right.

CHAIR—I have to admit that I have not read that website recently, but was there any explanation on the website about why the public interest assessor had been removed from the process?

Ms Bennett—It is interesting that you say that, because I recall being told to go to the website.

CHAIR—We were all told to go to the website.

Ms Bennett—I guess that because we had a funded project we were checking the website, but otherwise we would probably not have been doing so, without the capacity. My understanding is that all of the official documents, including the communiques from the COAG meetings or the health ministers' meetings, were posted up on that website and that that final draft communique before the bill was finalised contained the advice about the removal of the public interest assessor. I think it was on the second or third page, and it was in the middle of the page. It was not until you read through it—

CHAIR—Like a special test to find it.

Ms Bennett—Yes.

CHAIR—I think that in your submission you mentioned that you believe it was the COAG group that were not supportive of the public interest assessor. It was in a communique.

Ms Bennett—Yes.

CHAIR—We will ask the department. I have a number of questions here so far from your evidence that we will be asking the department to clarify when they come later. You answered the questions from Senator Adams about the way that the consumer representatives—they are not called 'consumer representatives'; they are called 'community representatives'—have been placed on the various boards. It has been a longstanding interest of mine. We have always had the commitment to engaging consumers in development of policy—it is critical—but how do you get individuals who are able to speak for the mass of people that have interest in this area? It has always been an interest. It seems to me—I just want to have it confirmed—that it comes down to

the board themselves tending to appoint people; it is some kind of internal process. As an example, the dental board will determine who the community representatives on that board will be.

Ms Bennett—That is right.

CHAIR—And there is no transparent process for that—nothing at all.

Ms Bennett—No.

CHAIR—It is just two people, and you represent the whole community.

Ms Bennett—We did raise concerns throughout the development of the legislation. We would have preferred those positions to be consumer positions rather than community positions. We certainly raised issues about the selection process and how that would work. At one stage we had developed, at the request of the department, some criteria for the selection of the 'community' representatives to those boards, and we did that in consultation with consumers after a national workshop, but it was made very clear to us after that that those positions were not going to be consumer positions and that therefore those criteria would not apply, because they were going to be individual community representatives who were chosen through a process that was outside our influence or jurisdiction. So the positions were advertised in national newspapers, and then the process was conducted separately. As I said, we encourage of people to apply to that external process but we did not as an organisation officially provide nominations or have any role in the selection process.

CHAIR—And you were specifically told you could not.

Ms Bennett—Yes.

CHAIR—Did you actually get any information about the process that was used when you asked for that? Did you receive information from the department about how the process was going to work for those community representatives?

Ms Bennett—No, not that I can recall.

CHAIR—The other thing you mentioned was you being in contact with the department subsequent to it all being over to raise the issue of the need for support and networking options for whoever does become the community representatives. Once again it strikes me as difficult, as the professional members of those boards go through a process within their professional groups to determine who will represent them. I would take feedback from that as well. How does any individual who has the responsibility for the significant decisions that these groups are going to be making and have made in the past at the state level—it is not a new process—learn and train for their role? Do they talk with other people about how best to perform the role? Did you receive any information in response to that letter you said in your evidence that you wrote to the board about your concerns about how this would happen?

Ms Bennett—We had a teleconference with the CEO of AHPRA last week or the week before, and we wrote to him this week. He had welcomed the opportunity for us to submit a request to AHPRA for that to occur. We have not heard as yet, but I would not have expected to hear so soon.

CHAIR—Could you send a copy of your letter to the committee? That would be very useful, and we can take it up.

Ms Bennett—Yes.

CHAIR—Have you been able to see your submission to our inquiry today?

Miss Wise—Apparently it was not received by the Senate, so they have provided us with a copy of another submission we made to the department. We did make a submission, though.

CHAIR—Do you feel as though you can make any—

Miss Wise—Yes.

CHAIR—I think would be useful, seeing that we are talking about the other bill, in which you have shown great interest this afternoon, if you would make any comment for the record about the Health Insurance Amendment (Pathology Requests) Bill 2010. We are more than happy to receive your submission that we have not received if you can get it to us. That would be very useful. Are you prepared to make any comment on that bill from your organisation's perspective?

Ms Bennett—Yes. We have recently undertaken a series of nationwide consultations with consumers on pathology. That includes consultations in every state and territory, a national workshop and various other mechanisms, including consulting our representatives who sit on national pathology committees. Throughout

that process it became very clear to us that consumers want the choice of the pathology provider that they choose to use. They believed that that was a very good thing in terms of being able to source the most cost effective provider—for instance, providers who bulk bill, which are becoming increasingly scarce. In terms of convenience for consumers, some of them talked about being referred to providers who were a long way from where they lived. Transport for some consumers, particularly consumers with chronic conditions or who are ill, is quite a challenge, so that is an important consideration, as is disability access for premises. Those sorts of things—convenience to consumers as opposed to providers—were considered important.

There were some concerns raised by consumers about the sorts of benefits that doctors might be receiving for referring consumers to particular providers. We know that is supposed to be covered under legislation; however, consumers still had concerns and were sceptical.

Senator BOYCE—What sort of concerns? What did they think was happening?

Ms Bennett—They were concerned that doctors were receiving kickbacks for referring them to a particular provider. Whether those were pecuniary or other rewards is not clear and was not clear to consumers.

Senator BOYCE—A weekend in Port Douglas type of thing.

Miss Wise—Even going beyond the kickbacks, I think there was one consumer who raised the issue that her doctor referred her to a particular provider because there was some research going on about the condition she had and she was going to be part of that sample. That was not made clear to her. They are just not always clear about the motivations, whether they are pecuniary or otherwise.

Senator ADAMS—Do you have any concrete evidence of any issues that have happened? Hearsay is fine, but do you have evidence that can prove that this is happening?

Ms Bennett—We have the advice of consumers, which we believe is a qualitative form of evidence. Consumers come to us and provide us with their opinions, their views and their experiences, which we use as a valuable way of developing our positions on particular things. It is qualitative evidence, but these are the sorts of things that we heard from consumers in relation to their experiences with pathology and accessing pathology. We have no reason to believe that those experiences are either not true or not valid in any way. Certainly the people who choose to come to these consultations choose to do so because they have a real interest in ensuring that these services are accessible and of the highest quality. They are people with chronic conditions who really rely on these services and need them to work. They provide us with the best evidence that they can. We can then use that to speak with you and with others. There were lots of these stories as we went around the country. Lots of concerns were raised with us.

Senator BOYCE—Should anything more formal now happen with regard to those concerns?

Ms Bennett—I suppose this bill offers us the opportunity to provide consumers with choice where they do have those concerns. There are codes of practice in place for health professionals. There is legislation in place. Nonetheless, there are still some concerns about whether or not this is working as well as it could. I suppose this gives consumers greater options for choice and empowerment to make another decision where they have those concerns. However, we do believe that, where consumers choose to go to another provider, they should have that conversation with their health practitioner, because sometimes there are reasons why a health practitioner sends somebody to a particular provider. They may get reports in a particular format that they can understand or that they are used to getting. They may believe that a particular provider provides a level of quality that is higher than others—although we acknowledge that, given that all of these providers are covered by accreditation and standards, that should not really be the case, so we do not have concerns about the quality of providers. There may be reasons why practitioners choose to send consumers to particular providers. We would encourage consumers, where they choose of their own volition to see a different provider, to have that discussion with their treating practitioner.

Senator SIEWERT—I have a question about your survey and your interaction. One of the issues that came to me when I was reading the submissions is the issue of consumers knowing that they have a choice. I have never once been to a doctor where the doctor said, ‘Which pathology services would you like?’ I did not even know that you could do that. I thought you had to go to the doctor chose. They gave you the form and made the decision.

CHAIR—You have to.

Senator SIEWERT—You can ask, but I did not know.

Senator BOYCE—I have, however, had the experience of having it explained to me as to why a particular pathology service should be used.

Senator SIEWERT—I have never once. I am just wondering how many consumers indicated or are aware that in fact they are going to have more choice under the bill but how many knew that they could have a discussion with their doctor about it.

Ms Bennett—I would say it certainly was not something that our members were aware of—and our members are quite informed. They are people that use the health system. They use pathology services frequently and they did not raise that with us as something that they were aware of. Certainly, when this legislation was announced we made them aware of that and they welcomed that, embraced that and said that they would value having that option for choice.

Senator SIEWERT—There is a point here around if people are making informed choices, and there is going to need to be a process of awareness raising in terms of what pathology services provide; how you go about choosing one; all the issues that have been raised in submissions about making sure that you are going to a provider that does what the doctor wants et cetera; and enabling people to have an informed conversation with their physician.

Ms Bennett—That is right and that is important. We agree with that.

Senator BOYCE—Just to follow on from that: have you had consumer complaints about being referred to a certain pathologist and they do not want to go there; they want to go somewhere else. Have you had many?

Ms Bennett—Yes. We have had many reports of people being sent to providers that were a long way from where they lived or being sent to a provider that was not sensitive to their needs. For instance, one person—one of our disabled members—was in a wheelchair and was asked to hop on the bed to have their blood taken. Some of these stories were outrageous but, absolutely, many instances of that throughout.

Miss Wise—It can be as simple as the pathology lab is up a steep set of stairs and someone has mobility issues, it is not on a public transport route, there is a pathology lab right where they do their shopping or something like that. These are big issues for some consumers, particularly if they have got chronic conditions or mobility issues.

Senator BOYCE—But how have they got on? If they have mentioned that to their GP and said, ‘Look, I can’t go there because of A, B and C,’ have they then been given another place to go where it is accessible?

Ms Bennett—It varies. Some GPs will take that into account and others will say, ‘We recommend this one and therefore we are sending you to this one.’ Some GPs have their script pads with the name of the pathology provider on it ready to go and they do not have an alternative. So that is the provider that they recommend and use and there is not much choice around that. I suppose the onus comes back on the consumer to talk with the doctor about that. Again, it needs to be a conversation but sometimes they would be given some concessions, if you like, or some alternative options but it depends on the doctor.

Senator ADAMS—Often in rural areas of course you have only got one contractor that is providing the service. They come round like a courier and do the service, take the specimens, collect them and away they go. In that respect, if you wanted to have another provider, of course, you are going to be inconvenienced because you will have to go somewhere else to try to access that service. There is that, and I do not see that as being a conflict for the GP. It is a fact, and everybody is very grateful that they have got a service, I can assure you. It is pretty important that you have that service.

Ms Bennett—Obviously, in regional and rural areas the situation is a bit different as it is across the board in health, but in a large city we are talking about people who have frequent pathology tests and chronic illnesses in general. That is why we could attract so many people to these pathology consultations. We were surprised. We thought that we would not necessarily get a lot of interest in these consultations but we were swamped with interest. That is because people are having these sorts of experiences and feel that there does need to be some improvement to the way things operate. For those people it may seem like a minor inconvenience to have to drive 10 minutes down the road but, for people who are really ill and need these tests quite often, that can be a very big factor. It can sometimes influence whether or not they have the test, even when they need it.

Senator ADAMS—Where once GPs might have been in a solo practice or a two-doctor practice, now in the cities they tend to be going to the big medical service practices and, as well, they have the x-rays, blood tests and everything is within that area so the GPs are probably going to refer to whatever is in their service. How do you deal with that one?

Ms Bennett—Again, it is up to consumers to have the conversation with their doctor and we would like to think that that is a two-way communication process, that the reasons for them being referred to a particular provider are clear to them and given to them, and that reasons for them similarly choosing to go to a different provider would be explained to the doctor. This legislation creates more of an option for consumers to have the conversation, which is a good thing.

I would just add that one of the issues that consumers raised with us as well was the increasing knowledge that sometimes doctors' practices are owned by the pathology companies and therefore there is an incentive, I suppose, for them to use that particular provider. Again, that is one of those issues about the sorts of benefits that doctors might be getting from the providers for choosing their service. This legislation helps us to overcome some of those concerns that consumers might have and provide them with an opportunity, not only to make a choice if they choose to do so, but also to have the conversation with practitioners, which is a bigger issue, I think. It empowers people but it also enables them to make the decision that best suits their needs.

Miss Wise—If there is a legitimate reason why the doctor wants them to go to a particular pathology provider, they will take it on board and make that decision accordingly. Some machines are calibrated differently from one lab to another, which can affect the results. Consumers are very open to recognising the impact that that can have.

CHAIR—Thank you very much, and thank you for giving the information on both bills. If we could get your detailed submission it would be very useful particularly as we have heard about the wide range of consultation you did, and we need to have that information. Thank you.

[9.58 am]

BRYCE, Ms Julianne, Senior Federal Professional Officer, Australian Nursing Federation

FOLEY, Ms Elizabeth, Federal Professional Officer, Australian Nursing Federation

CHAIR—Good morning and welcome. We acknowledge your patience. We are running slightly behind, but that is the way we operate, as you well know from your regular attendance with us. You have information on the protection of witnesses and evidence. We have your submission, thank you very much, and if either, or both of you, would like to make some comments you are welcome, then we will go to questions.

Ms Bryce—Thank you for the opportunity to speak to you today. The Australian Nursing Federation has been a strong supporter of the move to national registration and accreditation for health professions in Australia. The associated legislation when enacted on 1 July 2010 will have a significant and positive impact on the nursing and midwifery professions. One of the many benefits of the national registration and accreditation scheme will be national consistency for the profession. This includes consistent use and shared understanding of terminology.

The Health Practitioner Regulation (Consequential Amendments) Bill 2010 proposes to insert the terms 'division 1' and 'division 2' in the definition of 'nurse'. The ANF position remains that the inclusion of 'division 1' and 'division 2' in the definition of 'registered nurse' and 'enrolled nurse' is not appropriate. This is not common terminology for nursing or universally accepted terminology for the profession. It is not used in seven out of the eight jurisdictions. Its inclusion will lead to confusion for registered and enrolled nurses, other health professionals and the community.

There are two levels of nurse clearly understood by the terms 'registered nurse' and 'enrolled nurse', not two divisions. The ANF requests that the words 'division 1' and 'division 2' be removed from the proposed definition of 'nurse' in the legislation. The ANF's position on this issue is reflected in the position of the Australian Peak Nursing and Midwifery Forum and has been consistent throughout submissions regarding the national regulation of nurses and midwives.

The ANF is also concerned about the proposed removal of the word 'registered' from the definition of 'nursing care'. It is the role of the registered nurse to supervise and, where appropriate, delegate to the enrolled nurse. Although enrolled nurses are responsible for the care they provide, the registered nurse remains accountable for care delegated to enrolled nurses. The definition should state that nursing care means care that is given by a nurse or under the supervision of a registered nurse. We have raised these key issues in our submission and welcome the opportunity to discuss our concerns and clarify any points raised.

Senator SIEWERT—I can understand why you are annoyed. How has this happened? I understand that it is consistent with one jurisdiction—that is, Victoria. Coming from Western Australia, I do not think Victoria rules the world, sorry. How has it happened and what has been the response?

Ms Bryce—Although we are representing the national office of the Australian Nursing Federation, we both reside in Victoria and are registered in Victoria. Certainly in Victoria it was introduced back in 1994. As we had a register and not a roll, nurses were registered nurse division 1 and registered nurse division 2. 'Enrolled nurse' is the common nomenclature. Every other state and territory uses that. The adoption in Victoria has not been followed by any other state and this has led to further confusion around the term 'division' and what a registered nurse is. Certainly the other states and territories would not use that terminology and have had to adopt it to understand how Victoria functions. This is an opportunity under the national scheme to go back to using a term that is understood by all, including the profession itself.

Ms Foley—Given the length of time that that terminology has been in Victoria, the other states and territories have had a lot of years to consider the merits or otherwise and they have obviously considered that it is not necessary and want to stay with 'registered nurse' and 'enrolled nurse', which are quite clear terms.

Senator SIEWERT—That was going to be my next point. It has been in place for 16 years in Victoria. It has been accepted. So why was it adopted when there is only one state doing it? All the other states are not using it and obviously are not enthusiastic about adopting it. I will obviously be asking the department this, but in your opinion why was the Victorian approach adopted?

Ms Foley—That is a very good question.

Ms Bryce—The only understanding we have in relation to the matter is that enrolled nurses were on a roll and registered nurses were on a register. So, with the introduction of only the register, enrolled nurses were not

going to be on a roll, so they made both sorts of nurses registered nurses, with one being in division 1 and one being in division 2. The way the terminology is used even in Victoria is that where people declare they are a registered nurse (division 2) they will often follow that with, ‘I am an enrolled nurse,’ so that people can understand what it actually means in real terms, particularly the community but also the profession itself and other health professionals who are coming to terms with the role and scope of practice of the worker they are working with. That is my understanding of how it came about and why it was introduced.

They thought it was an opportunity to credit the role of the enrolled nurse to say they were a registered nurse but they were in a different division. But the common understanding of the profession is that there are two levels of nurse who work well together but one is an RN and one is an EN. They are the two levels.

Senator SIEWERT—Outside the ANF, are the state jurisdictions concerned as well?

Ms Bryce—They are, yes. The Australian Peak Nursing and Midwifery Forum is made up of seven peak nursing and midwifery organisations. Through the process they have made a submission in relation to this issue. They are all in agreeance. They represent all the nursing and midwifery professions from the peak nursing and midwifery organisation perspective. They all feel the same way—that ‘division’ is not appropriate language and should be removed. The Australian Nursing and Midwifery Council made a submission to this inquiry as well and also stated it throughout the whole process. It is an agreed position that the terminology is ‘registered nurse’ and ‘enrolled nurse’.

With the introduction of the national scheme we are receiving communication from the Nursing and Midwifery Board of Australia. As a registered nurse in Victoria I got a letter which stated that I am a registered nurse (division 1). A Victorian would look at that and not think a lot of it, but an enrolled nurse in Queensland who gets a letter saying they are an enrolled nurse (division 2) will be asking what that means. For a lot of registered nurses and enrolled nurses the meaning of this and what is in the legislation will be front and centre for them now because they will be receiving letters saying what will go on their cards, their practising certificates. They will be asking what division 1 or division 2 means, when in fact they are registered nurses or enrolled nurses.

Senator ADAMS—Where does the midwife fit into this? Where does the nurse practitioner fit into it? For goodness sake, the general community understand what a registered nurse is, they understand what a midwife is and they understand what an enrolled nurse is. It was hard enough going from a nursing aide and then the nursing assistant, but at least one was yellow and one was pink and away we went. It is a wee bit different now. Really and truly, with division 1 and division 2 I would have to ask the same questions. I think the committee will be very strongly looking at this as a recommendation.

Ms Foley—Having been a consumer or having attended a family member in a hospital in Victoria, you will have found that the enrolled nurses just call themselves div 2s, so you would have heard the terminology ‘div 1’ and ‘div 2’. What does that mean to the community? I knew because I was a registered nurse, but I am sure the general community would understand ‘EN’ more than ‘div 2’.

Ms Bryce—The new scheme is giving us an opportunity to have a register for midwives. It is a fantastic opportunity because people have called themselves registered midwives in the past and have from a regulatory perspective been corrected and told: ‘You are not a registered midwife. There is no register for midwives. You are a registered nurse with recognition of your qualification as a midwife.’ That is a quite confusing area. This will give clarity to say they are a registered nurse with endorsement as a nurse practitioner or a registered midwife or an enrolled nurse. The divisions do not add any clarity for any of the parties involved.

Senator ADAMS—I would agree with that. Years ago you had to register in each state as a midwife. If you were a registered nurse, you were a registered nurse; if you were an enrolled nurse, you were a registered enrolled nurse because you had the qualifications to do the work that pertained to that position. Anyway, I will not go on about that. I certainly support what you have said in your opening statement. There is just one other thing. The AMA has called for the introduction of a public interest test in respect of the ministerial council directions to registration boards on accreditation standards. Do you have a view on this particular issue?

Ms Bryce—We do. We would certainly support that from the perspective that the profession itself should be responsible for determining the standards that courses need to meet in order to lead to registration or enrolment. From that perspective we would support that it needs to be a public transparent declaration should there be any issues with accreditation standards, which have been developed by the profession in consultation with the profession, as they are developed in the best interests not only of the profession but of the people we care for.

Senator ADAMS—Thank you.

Senator BOYCE—I should probably put on record that I have a daughter who is a registered nurse, so we can just keep this all in the family! I was intrigued by your earlier comments, Ms Bryce, around rolls and registers. What is the difference between a roll and a register?

Ms Bryce—A great deal further back there were rolls for an enrolled nurse. I worked for the nurse regulatory authority in Victoria for a number of years and we actually had an archival document that was in a cabinet that was the register. That was the book that you signed for the register and, in much the same way reflecting that second level nurse position, there was a roll.

Senator BOYCE—But the information contained in a register and in a roll would be very similar, would it not?

Ms Bryce—Yes, it was really just a measure to separate the two roles so that people understood the difference between the first level nurse and the second level nurse and how they worked together. Over the years we have continued to work with an understanding of how our roles fit together and we have had the ongoing challenge of articulating that not only within the profession but to other health professionals and to the public.

Senator BOYCE—You talked earlier about registered nurse division 1 and registered nurse division 2. It appears it really has not become embedded in the culture even over 16 years in Victoria from what you are telling us. Are you able to give us any examples of problems or issues that naming has caused?

Ms Bryce—A good example would be in a general practice setting. There has been a lot of work done as practice nurses have evolved very quickly over the last five years. Anecdotally we have around 8,000 practice nurses. They are registered nurses and enrolled nurses and a lot of support has been given to general practitioners who are employing nurses in their practice so that they understand how to employ a registered nurse and an enrolled nurse and how they work together and what the supervision responsibilities are. You could have a general practitioner who would employ an enrolled nurse directly without employing a registered nurse. In that instance, the enrolled nurse needs to be supervised by a registered nurse. There are certainly issues around understanding the role and scope of practice of an enrolled nurse and how they work together with a registered nurse, what the supervision responsibilities are and who is responsible and accountable for care. There have certainly been a number of issues around understanding what an enrolled nurse can do, what is in their scope of practice, and how they should be working within those employment arrangements.

Ms Foley—I am not aware that there have been any studies done in Victoria around the understanding of the difference between an enrolled nurse and a registered nurse division 2. I think anecdotally from my own experiences and those of other people I have talked to, people understood the nurses aide terminology that was used previously. They understood the difference between an enrolled nurse and a registered nurse but if a person says, ‘I am a registered nurse division 2’, then a member of the public just thinks they are a registered nurse.

Senator BOYCE—That is right; you have to be in the profession to know.

Ms Foley—And therefore they will be working with the same scope of practice that a registered nurse division 1 would.

Senator BOYCE—You mentioned that a member of the public would not understand; would a member of other health professions understand?

Ms Foley—Yes. Regarding the examples that Ms Bryce used of general practice, I was involved in the very early days when the federal budget of 2000-01 allowed for incentive funding for nurses to be employed in general practice. Certainly they had been beforehand, but this increased the numbers in general practice, and I know that the medical colleagues in Victoria did not understand the difference between a registered nurse division I and a registered nurse division 2.

Senator BOYCE—It could be said that you are simply opposed to change; you like things to go on the way they are. What would your response to that be?

Ms Bryce—With the National Registration and Accreditation Scheme, nurses and midwives have been the first ones lining up to embrace this. Certainly the Australian Nursing Federation has been part of leading that charge. We see the benefits of national consistency and, in order to achieve that, we need to change a lot of things. Certainly I would see us as advocates for change—and this is actually a change because we have tested this in one of the states and none of the other states or territories have adopted it. I think that is a good measure

of whether the profession is looking to move this way. If it actually gave clarity and supported those registered nurses to feel more valued in the profession, it would have been adopted more widely. So I would say that we are leading the change in this regard.

Senator BOYCE—You have also said quite forthrightly that the definition of nursing care should be revised to reflect the fact that it is under the supervision of a registered nurse. Do you think the way that definition was changed to just 'nursing care' is simply a result of the division 1 or division 2 issue? Or do you think something else was going on with that change?

Ms Bryce—I do not think anything more was going on; it was really just people's understanding of what a nurse is and the role and scope of practice of a nurse. Should an enrolled nurse have an issue whereby they are answerable to the Nursing and Midwifery Board of Australia, they will not ever go alone. The registered nurses are responsible and accountable for the care that is provided and delegated. That accountability remains with the registered nurse. They are the ones that supervise the enrolled nurse and work together with them. We are educated that way and the enrolled nurses are educated to understand that model. This is just reflecting that the role of the registered nurse is to provide that supervision of nursing care and that they will be held accountable and responsible for that care. The enrolled nurses are certainly accountable for their actions, but they are also accountable to the registered nurse for everything that they do.

Senator BOYCE—You do not think there is any suggestion that anyone wants to change that model?

Ms Foley—We are not aware of that move taking place. We just believe that it was an omission that needed to be corrected to ensure that the distinction between the two roles was quite clear.

Senator BOYCE—Thank you.

CHAIR—How strongly do the Victorians feel that this is the way to go?

Ms Bryce—Do you mean the Victorians as in—

CHAIR—With the divisions having been tested there. I am just trying to work out how the negotiations went on. In your understanding, how strongly do the Victorians support maintaining this division?

Ms Bryce—Our membership in Victoria comprises 50,000 of the 88,000 registered nurses in Victoria.

CHAIR—A very large percentage.

Ms Bryce—Yes. Certainly it has been supported through our membership. The move to registered nurse and enrolled nurse is seen as being another move towards national consistency. We are not getting any push-back from the Victorian membership.

CHAIR—This went through a COAG process. Are you are aware of any particular desire by the Victorian government to retain divisional status? Have they spoken to your organisation to say they think this is the model that should exist?

Ms Bryce—They have not spoken to us directly in relation to that, no.

CHAIR—You have been raising this all the way through—you raised similar issues when you appeared before the committee last time. What has been the response when you have raised this issue?

Ms Bryce—It has continued to be included, so certainly we—

CHAIR—That is one way of getting rid of you! But what about explaining to you? You have been a participant in the whole process; from the very start, the ANF and various nursing bodies have been in there. When you have put up your information about why you feel so strongly about this, the basis of it and the feedback you have got through the various mechanisms that have been in the process for endless meetings and so on, what has been the response that you have got?

Ms Bryce—Although people have been supportive of our issue and seemed to understand it, I think there is a level of misunderstanding about the difference between 'level' and 'division'. I do not think it is seen as being quite so important as it is within the profession for our understanding and with other health professionals. I think the move to include it as a division is because they think that they are achieving the same aim as we are saying, where there are two different levels. My understanding is that they think that they are differentiating with 'division', and it is certainly not achieving the aim that we are seeking more broadly for the whole profession.

CHAIR—Have you felt that the strength of your feeling has been acknowledged?

Ms Bryce—Certainly the process has been represented by Lee Thomas, our assistant federal secretary. She has certainly communicated it in no uncertain terms in the past. I could not speak to whether her strength of feeling has been acknowledged, but I would certainly say that it could not have been ignored.

CHAIR—Are you regular readers of the website?

Ms Bryce—The AHPRA website?

CHAIR—Yes.

Ms Bryce—Absolutely.

CHAIR—Good. I always like to check. Do you have any other comments that we have not been able to include yet? Is there anything else that we have missed that you would like to put on record?

Ms Bryce—No.

Ms Foley—I do not think so.

CHAIR—Thank you very much for your time. If there is something you do think of later, please get it to us. We are in the unrecognisable position of running five minutes early. I have no experience in this area, so we will break.

Proceedings suspended from 10.20 am to 10.50 am

SULLIVAN, Mr Francis, Secretary General, Australian Medical Association

CHAIR—Good morning. Welcome back, Mr Sullivan. You have all the information on the protection of witnesses and evidence. We have your submission—thank you very much—and we know the ongoing interest your organisation has taken in this process. If you would like to make some opening remarks, then we will go to questions.

Mr Sullivan—Thank you for the opportunity to appear before you today. We are getting closer to the start date of 1 July for national registration, so I am sure everybody feels under a bit of pressure. While the AMA acknowledges that the bill the committee is considering today only has to do with the Medicare benefits arrangements, I would like to take the opportunity to update the committee on recent developments with the national scheme. Of course, the committee is quite familiar with the national registration and accreditation scheme, having conducted an inquiry on it last year, amongst many others. Last week it became clear that the registration fees for the medical profession are likely to be increased by nearly 85 per cent of the current weighted national average registration fee.

The AMA has always suspected that the national registration and accreditation scheme would not deliver the promised administrative efficiencies. This was because the scheme came with additional bureaucratic structures, administrative agencies and layers of oversight. These have now all proven to be expensive, and our fears about higher registration fees unfortunately have been realised. The ministers made a commitment to cover the transition costs, and they should live up to that commitment now and provide a further subsidy to the Medical Board rather than forcing the board to impose such an unreasonable increase in registration fees for medical practitioners. The AMA have raised this with the health ministers, but we want to bring it to the committee's attention today to highlight that the new scheme is not more efficient.

In setting the registration fee, the chair of the Medical Board has said that she expects the board to have a lot more to deal with now because of the mandatory reporting obligations. The AMA is concerned about the potential impact mandatory reporting will have upon the medical workforce. Such a significant issue needs to be properly evaluated and monitored, and there is no provision for this in the legislation for the scheme. We urge this committee to recommend that the Minister for Health and Ageing report annually to parliament on the impact of the mandatory arrangements. We would want the registration boards to consult the professions on the exact details of the report.

We also urge the committee to consider the federal health minister's role as a member of the ministerial council in making decisions about accreditation standards for education and training. The committee will recall that your report to parliament on the scheme last year recommended that the Australian Health Workforce Ministerial Council should consider and evaluate its role in issuing policy directions on accreditation standards, but that did not occur. We ask this committee to recommend that an amendment be made to the Health Insurance Act that requires the federal Minister for Health and Ageing to apply a public interest test when considering directions on accreditation standards. The AMA believes this is necessary so that the impact on patient safety and quality of care is weighted against workforce considerations.

Finally, we remain concerned that nothing has been done to stop the inappropriate use of titles such as 'surgeon', 'physician' and 'doctor' by health professionals who are not appropriately qualified. The risk to members of the public is that they may think they are seeing a medically qualified practitioner when they are not. The AMA have asked each of the health profession boards to address this issue. Only the Psychology Board has addressed this, by recognising psychologists who hold doctorate qualifications.

We address the following issues in the spirit of constructive criticism. We appreciate that the NRAS legislation has been complex and that at times inadvertent drafting errors have occurred. In that light, we have two major issues to raise. The first is the reserve powers in the bill that will allow the minister to impose additional requirements on consultant physicians and specialists to obtain provider numbers for Medicare benefit purposes. Frankly, we do not know why these powers are needed, particularly when they are not in the bill for general practitioners and allied health professionals. We understand that the Department of Health and Ageing officials are looking at this and we are optimistic that a pleasant solution will be found shortly. However, our concerns are that, if the provisions somehow remain, they would enable future bureaucracies to regulate where consultant physicians and specialists could practise and under what conditions. We have been assured that this is not the intention and we respectfully ask that these provisions be removed.

It is somewhat ironic that currently the Health Insurance Act sets out the requirements for consultant physicians and specialists in obtaining Medicare provider numbers. This means, in effect, that the parliament gets to decide these issues. As it stands, this bill would shift that responsibility and decision making to the minister. In effect, without wanting to overcook this, this is an example of why the AMA did not want the ministerial council to have reserve powers to determine medical practice standards under the National Registration and Accreditation Scheme.

We also think that all healthcare providers who attract Medicare benefits for their services should be subject to the same rules and regulations. That is why we have asked for the MBS offences in the Health Insurance Act that currently apply to medical practitioners who provide services outside the scope of their registration to be extended to all nationally registered health professions whose services attract Medicare benefits. We had expected that one of the principles of a national registration scheme would be that a level playing field would be applied to all health professionals, so we respectfully ask that it apply in this circumstance. Thank you very much.

CHAIR—Thank you, Mr Sullivan. Can you clarify the point you made about the provision that you asked all medical professions to use but that only the psychologists agreed to. I missed that and I do not think it is in your submission.

Mr Sullivan—Yes. We were concerned in the context of how we use titles in the health system. It was to do with ‘doctor’, ‘surgeon’ and the like. The AMA have consistently asked for, in a sense, some protection of title and its use. We have written to all the other professions’ boards, which is the current system, and at this stage we have got a response from only the Psychology Board.

CHAIR—You would expect that a few of the other professions would have an interest in this area.

Mr Sullivan—I am sure that they all have a view; ours has been probably the most consistent and public.

CHAIR—Okay. Senator Adams.

Senator ADAMS—To go back to our last witnesses, from the ANF, and the inclusion of division 1 and division 2 nurses, once again it is very confusing. ‘Registered nurses’, ‘enrolled nurses’, ‘practice nurses’ and ‘nurse practitioners’ are the things that the community understand. ‘Division 1’ and ‘division 2’ are very, very difficult. I can see that in your profession it would be exactly the same.

Mr Sullivan—Yes.

Senator ADAMS—Once we get specialists mixed up with consultants and all the rest of it, it becomes a little bit blurred. But I am surprised that you have not had more response from the other professions.

Mr Sullivan—We do have the specialist registrar which will occur under this new scheme, but obviously, with the subspecialties and the like, what a specialist is actually practising in may at times confuse some people. But, generally speaking, we have been pressed to make sure that the titles themselves are appropriate. If you are a doctor in the health system, the general understanding in the community is that you are a medical practitioner, and we would argue that the use of that title can be confusing if you are not a medical practitioner.

Senator ADAMS—Thank you. The Royal Australian College of General Practitioners sees a requirement that any directions on accreditation standards be made public as a sufficient safeguard. How do you feel about that?

Mr Sullivan—Yes, we are happy for the directions to be made public. The AMA, through this whole process in the past, was very concerned that the push for national registration not become a regulated health workforce planning scheme per se. This was debated very strongly in the lead-up, as you would recall. In a spirit of trying to be constructive around this over the period, we put forward a number of submissions to clarify powers or delegated powers and the like between ministerial councils, boards and the like. You have been through this, so I do not want to labour the point, but one of the points we made throughout the process is that directions should be made public. Therefore we would agree.

Senator ADAMS—With the new proposed health reforms, do you see any problems arising in that respect with this bill?

Mr Sullivan—I might take that one on notice, because the new health reform proposals are at the moment somewhat at the headline level and there is a fair bit of detail that we are all seeking.

Senator ADAMS—That is right.

Mr Sullivan—There is no question that issues to do with registration and availability of the workforce go to the heart of it. We know that some of the announcements inside COAG and before it were to do with training in the area of general practice, which goes to issues of supply. We, the AMA, have some very particular concerns around how the workforce can be allocated to various regions and the like. I am advised that maybe it is best for me to take it on notice.

CHAIR—I think we all agree on that.

Senator ADAMS—Thank you.

Senator BOYCE—We will just go back to your comments around the fact that we have specific requirements, or the potential for specific requirements, for consultant physicians and specialists. You said you do not understand why. Could you explain to us what you have done to seek to have an explanation and what you understand the response to have been.

Mr Sullivan—We have obviously made representations to the department, and they have been well received. My personal sense on this is that it is possibly an inadvertent drafting error. I think the idea was that, in moving from the old scheme to the new, we would be trying to take the current arrangements for obtaining a Medicare provider number and bringing it into the new legislation. I do not know whether there has been a slip of the pen there—it is causing us a degree of anxiety, which we have raised in the submission—but let us just take it in the spirit that that is all it is and that the department will be able to tell you that it is easily amended and removed, which is our hope, desire and aspiration.

Senator BOYCE—All right; let's. You also note in your initial submission that one of your other concerns related to the failure to restrict the Medicare payments for services by any nationally registered health professional that are outside the scope or conditions of their registration.

Mr Sullivan—Yes.

Senator BOYCE—Could you tell us about your discussions.

Mr Sullivan—It has been raised. The point we are making is well recognised, and that is that if any health professional who is able to claim the MBS rebate for their patient then, as it is with medical practitioners now, there can be penalties applied if you are outside the scope with regard to the MBS. It just makes sense that this should apply from a public policy point of view to any other health professional who accesses the MBS. It is probably an oversight.

Senator BOYCE—Have you had discussions with the department or the minister about the amendments that would be necessary to achieve that?

Mr Sullivan—Yes. We would happily take advice about how best this can be addressed. In our examination of the bill it is best that it simply applies and says it does apply to more than medical practitioners.

CHAIR—To anyone accessing it. Basically, you want a standard clause that any Medicare payment is dependent on people practising within the scope of their qualifications—something like that?

Mr Sullivan—Whatever the words need to be so that it is consistent.

CHAIR—There is nothing there of that kind at the moment?

Mr Sullivan—Not that I am aware of.

Senator BOYCE—So the end result could be that a podiatrist could be prescribing antibiotics for the flu? I am just trying to think of a silly example.

Mr Sullivan—Yes, it could be outside their scope. That is the point. Again, as I said, in the spirit of constructive criticism, we think at times there has been the need for some more drafting.

Senator BOYCE—I have another question. As you pointed out to us, your concern about the reserve power and the way that could be used has been a very long and ongoing concern that the AMA has had. You are now at the stage where you are saying that your concern could be addressed by insisting that the public interest must be taken into account. Could you explain to me how you would anticipate that working? What would that mean? How would that fix it?

Mr Sullivan—You may recall that last time we were very strong on this point—that a public interest test is, in our sense, a responsibility that ministers collectively should embrace. The point of the exercise is that, when ministerial councils make decisions, and given that we want to make this a transparent process, they make those decisions hopefully in the public interest. We want to make sure that decisions that are made are

decisions that are firstly made about patient safety. There is no question in our mind that health service planning will always have a temptation to want to run the workforce arrangements in such a way as to cover, where possible, areas which are heavily underserved. That makes sense. The risk is that the fundamental safety net of the health system in Australia, which is medical diagnosis—if you think about it, that is the fundamental safety net—could be compromised in workforce planning arrangements. So we are arguing that, if a public interest test is applied to decisions, whereby it can be demonstrated that—if it is a workforce issue—the decision is taken in the full knowledge that it will ensure patient safety and quality of services, then the ministers are in a sense doing the job and demonstrating their responsibility in this process.

It would be fair to say the public interest test processes and procedures are not warmly embraced by bureaucracies because they are troublesome and might take time and effort. Thus it would not surprise me that maybe advice comes in another way that this is not necessary. With regards to the public responsibility role that ministers have as opposed to the health system management role that departments may have, we think it is important that the public interest test not be shifted aside and, for the purposes of this legislation, given that the minister responsible in this legislation is the federal minister, we would at least ask that there is some obligation on the part of the federal health minister to apply a public interest test, to be seen to have applied it and to demonstrate how it has been applied.

Senator BOYCE—This has been a long and ongoing conversation with the AMA. If the public interest test is not included, how concerned does the AMA remain about the idea that there could be a dilution of standards for health professionals?

Mr Sullivan—It is one of our major concerns and it would remain as such, if it is not included in the legislation or if the ministerial council does not adopt one, regardless of the legislation. The AMA would still press for this and would not remain silent in the future about situations where we felt a public interest test would have been a good safety net.

Senator BOYCE—But the issue with that would be that the only protection then is the AMA getting its view out into the general media.

Mr Sullivan—Yes, which we are not shy of doing.

Senator BOYCE—I have noticed that they have done that once or twice. I have got some questions on mandatory reporting. You are asking that there be an annual review of the mandatory reporting provisions. What would you see that achieving; and what would you see that report saying?

Mr Sullivan—Again, when the issue of mandatory reporting came up during the period—and you will recall even here we had concerns with the introduction of it—we felt that operationally it was going to cause problems. For example, at what point can doctors married to each other pass information to each other about how their work is going? We have counselling services for doctors. Would there be any provisions that quarantined those services? And none of our concerns were picked up by legislators.

Secondly, it is rather alarming to think that one of the justifications for an increased registration fee is that the medical board believes it will be having to do a lot of this, which almost sounds like a tsunami. Given the fact there was no case made in the lead-up to the legislation, that seemed to imply that there would be this heavy workload on mandatory reporting. It begins to raise concerns about what is going to happen; how this is going to work; what is going to be part of the scope and the content and so on. Again, I think in the interests of transparency, particularly given the fact that it is now imposing costs on the profession, that it seems reasonable to have a report annually, particularly to the parliament. Again, I think if we are going to be consistent across how the registration scheme will work and that is it is meant to be transparent. I think, at the other side of it, for those that would think that mandatory reporting and the introduction of it may give some confidence to various members in the community then why not report on it?

Senator BOYCE—I am just having some problems imagining what this report looks like in a way that is not perhaps more harmful than helpful.

Mr Sullivan—You may note in the introduction that we would like to be consulted about how that would work—and I am sure so would the other major medical groups—and about what would be reported, and the like. In the first instance, though, we are trying to make the point that mandatory reporting was slipped in during the process on NRAS.

CHAIR—It went in very early, Mr Sullivan.

Mr Sullivan—Not at the start, though, I notice, Senator.

CHAIR—No; but it was very early.

Mr Sullivan—I think we are probably talking degrees of time there. So I think more of a point is that we would want some transparency about the whole process. It might be instructive for the committee to examine with the department and others what type of report could possibly be provided and what would give, in a sense, a value-add to the public information.

Senator BOYCE—Thanks, Mr Sullivan.

Senator SIEWERT—We have covered most of the questions I was going to raise, but I just want to go back to the conversations you have had with government about the different treatment of specialists. You said that the talks are ongoing—

Mr Sullivan—Yes.

Senator SIEWERT—What has been the reason given to date for the different approach?

Mr Sullivan—As I understand it, it is a bit like what I said: the provisions we are talking about are related to how a doctor actually achieves a Medicare provider number. It was my understanding that when instructions are given to draft a new bill the idea is to take what exists and put it in the new bill, and for some reason an extra subclause has been inserted. It may be that this subclause has been inserted to try to address a current situation which we are all comfortable with, but the wording of it is alarming to us. The wording of the subclause appears to give the minister, in this case, an open-ended capacity to provide other criteria. I do not wish to be alarmist—and I am not trying to be alarmist in responding to the question—but one of the things we have always been concerned about is that the NRAS legislation could begin to become a workforce planning instrument that starts to either curtail particular scopes of practice of specialists or begins to put conditions on where people can work—and of course Medicare provider numbers have a bit of that debate around them as well. So we have been seeking clarification. We have been led to believe that an answer will come forward that we will be happy with. I really cannot give you anything more than that, but others after me may.

Senator SIEWERT—Obviously, we will be following that up. The point is that, other than that summary, there has been nothing to explain whether this was done by accident or whether there is a philosophy behind the approach.

Mr Sullivan—As I said in the intro, it is our understanding that it is not the intention of the these to try to be assertive in a new agenda; no.

CHAIR—The 85 per cent increase in registration—how did you find out about that?

Mr Sullivan—It was released by the medical board last week.

CHAIR—Do you know whether other professions have had a similar experience?

Mr Sullivan—I do not know what the other professions had. I think the Medical Board might be the first board to come out with its fee. It would not surprise me if other professions are hearing about theirs soon, but we are not aware. Are we? No, we are not.

CHAIR—I was unaware of that and it does seem to be a major increase, and certainly one for which we were not prepared in our last committee hearing when we were talking about the way the NRAS would impact on professions. At no stage was there any consideration that there would be an increase of that size in the process. In fact, we were being told consistently that one of the reasons for this bill was to make it simpler and easier for people to register, and all those sorts of things. When the medical board brought down its decision, did it give reasons? You did say in your opening statement that a reason they gave was mandatory reporting. Was there anything else that came into that?

Mr Sullivan—Yes, I will read them. The rationale is that they need extra resources for ‘the smooth transition to a national scheme’, and they make the point there that transition costs were meant to be borne by governments not the profession.

CHAIR—That is actually part of the commitment you were given at the start, yes.

Mr Sullivan—To promote consistency of processes between states and territories. Read that as whatever. To meet prudential requirements imposed by the national law, including the costs of processing an expected increase in complaints against doctors when new mandatory reporting laws start on 1 July. Bear in mind that the national board has actually been able to take the assets of the other boards.

CHAIR—Which was a vexed point in our previous discussion.

Mr Sullivan—They have already taken some and are now wanting more. The point that is galling at another level is that, given that the argument is about compliance costs because the law will impose the board to have to deal with mandatory reporting, an area we had major concern about anyway, it is just like a double whammy. During the implementation process officials and others went to great lengths to say to us that there would not be a heavy impost when it came to the new fees.

CHAIR—And the same statement was made to us.

Mr Sullivan—We are at one here.

CHAIR—In terms of the way it works—and I will certainly ask the department; I just do not know—the medical board has the ability to set its own fees. Government cannot tell the board what their fees will be. So there is no ability for the minister to say to the medical board under legislation, 'You must not increase your fees by 85 per cent.' That would be your understanding?

Mr Sullivan—Yes. We asked, of course, that the ministerial council not interfere in the decision-making of boards and that they could only accept and reject and the like. We think here it is a situation where governments themselves should take some responsibility for the fact that they said they would carry the transition costs. We would argue that everything the board has raised there as rationale would go to issues of transition. So there is no reason why governments could not subsidise those costs so that the board then decides that they can reduce the fee. There are ways in which boards and ministers can deal with the issue which do not require the board to interfere in a decision, if the board wants to turn around and, for example, seek meetings with ministers to say, 'Well, these are the reasons, these are transition costs,' and so on. So I think the ways in which it can be addressed. But it concerns us obviously about the fee itself.

Senator BOYCE—What is the quantum we are talking about with 85 per cent increase, just as an example?

Mr Sullivan—I have got it here in the advice I have received. It varies across different states, of course. In the ACT it would be a $325 increase—I am reading this incorrectly. I had better do it correctly. It is a $650 fee and I can table this information for you.

CHAIR—Then we will be able to look at it in detail. I think we need to have a look at this. It is certainly a flow-on that we were unaware of and we will be asking questions about it. It was something that in the previous discussion when this particular legislation or process came to this committee there were concerns raised about increased cost and there was no indication that there would be increased costs at this level. We will ask about that. The way the medical board is appointed, that is the internal medical profession process?

Mr Sullivan—No, we did not appoint the board.

CHAIR—The government did that. I am just trying to work it through.

Mr Sullivan—It was probably the ministerial council.

CHAIR—So you cannot really vote them out.

Mr Sullivan—We cannot vote them out. We can vote out those that appointed them.

CHAIR—The idea of the accreditation registration being a professional process which is separate to government was one of the core aspects of the independence of the process. But the first step of the new board to increase fees by that amount is an interesting introduction to the process.

Mr Sullivan—Yes, it certainly seems a funny signal.

CHAIR—We will follow up on that. On the public interest test, I know Senator Boyce was questioning you about this, but we did have some discussion about how the public statement about mandatory reporting could appear—and you need consultation. From the way you are claiming it should happen, how would that public interest test operate and what would be your expected process?

Mr Sullivan—In the current legislation of many states, and I think it is probably even in the Commonwealth legislation, there are provisions for public interest tests and established processes. So there are as established bureaucratic processes and we would suggest that the same would just transfer into this. The whole idea of a public interest test is that various, if you like, communities or microcommunities in our community that can be affected by a decision are in a sense assessed for that impact. It does not mean you are talking about a roadshow doing inquiries; it simply means being mindful of the impact a particular decision will have on, for example, access to health services or on the standard of medical practice. I am just making up examples. There are various communities involved in a public decision. Our point in this all along was that it

is like saying, ‘Oh, we will have to approve such and such a workforce situation, because there is no other service there.’ As opposed to saying, ‘Can we not be looking at a situation that involves a collaborative arrangement involving the profession rather than just a substitution away from doctors?’ We would argue that this runs the risk that quality and safety issues may not have been fully addressed because the urgency of providing a service has taken precedence. We would all think that there are occasions in the past where that may have occurred, regrettably, and we would not want to see that again.

CHAIR—Which is a common concern in terms of that process.

Mr Sullivan—Yes, sure.

CHAIR—Thank you very much, Mr Sullivan. Was there anything that you wish to put on record that we have not got from you?

Mr Sullivan—No, thank you very much. I assume this might be the last time we are here on this matter, but we never know.

CHAIR—Thank you very much.

Mr Sullivan—Thank you.

[11.28 am]

HORVATH, Professor John, Principal Medical Consultant, Department of Health and Ageing

JOLLY, Ms Maria, Acting First Assistant Secretary, Health Workforce Division, Department of Health and Ageing

KHIANI, Ms Radha, Director, Registration and Accreditation Taskforce, Department of Health and Ageing

SANTIAGO, Ms Gay, Assistant Secretary, Workforce Development Branch, Department of Health and Ageing

CHAIR—I welcome representatives of the Department of Health and Ageing. As departmental officers you will not be asked to give opinions on matters of policy, although this does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. As experienced witnesses, you know about the protection of witnesses and evidence, and you have that information.

We have your submission. We were disappointed that the submission was significantly late. This committee has a very tight timeframe. This bill was referred to us by the Senate Selection of Bills Committee and we referred it to the department immediately. My understanding is that the submission did not come in until just on two weeks after the due date. I want to put that on the record. I do this when it happens. It is not a particular point at you, although it may seem that way. It is important it is on the record. I invite any or all of you to make some opening comments and then we will go to questions.

Ms Jolly—I would like to put on the record my apologies for the lateness of that submission. First of all, I would like to thank the committee for the opportunity to provide information and to respond to questions about the proposed amendments to Commonwealth legislation to support the implementation of the National Registration and Accreditation Scheme. As the committee is well aware, at the COAG meeting on 26 March 2008 there was an intergovernmental agreement signed to implement the scheme. The scheme was to address the current inconsistencies in registration standards between states and territories, improve patient safety by recording registration details in a single system, and enable the mobility of the health workforce. Delivering this scheme was initially the responsibility of an implementation project team, who undertook extensive consultation, including national forums in each state and territory and other forums across the country—and I know you were also involved.

The legislative framework for the National Registration and Accreditation Scheme is an applied laws model with Queensland as the lead state. The first tranche of legislation—the Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008 Queensland, known as act A—received royal assent on 25 November 2008. This act established the structure and functions of the scheme, including the new national agency, the Australian Health Practitioner Regulation Agency, which we refer to as AHPRA, and the Australian Health Workforce Ministerial Council.

The second tranche of legislation—the Health Practitioner Regulation National Law Act 2009 Queensland, known as the national law—received royal assent on 3 November 2009. The national law details the substantive provisions for registration and accreditation and replaces act A. The national law continues the administrative arrangements established under act A and covers the more substantial elements of the scheme, including registration and accreditation arrangements, complaints, conduct, health and performance arrangements, privacy and information-sharing arrangements, and the transitional arrangements.

The third tranche of legislation involves the states and territories passing legislation to apply the national law and to include jurisdiction specific consequential provisions, and we refer to these as bill C. The Commonwealth does not need to apply the national law in the way that the states do; however, the Commonwealth does need to enact consequential amendments to Commonwealth legislation to recognise and support the scheme.

The Health Practitioner Regulation (Consequential Amendments) Bill 2010, which is in front of you, is the Commonwealth bill C equivalent. It covers consequential amendments that the Commonwealth is required to progress in order to recognise and support the implementation of the scheme. The two main themes in the bill are to modernise and align definitions so that they are consistent with the national law and to streamline administrative processes involved in the recognition of doctors for Medicare purposes under the Health

Insurance Act 1973. The proposed amendments in the bill are intended to ensure that all billing medical practitioners continue to access Medicare rates as they currently do.

CHAIR—Ms Jolly, issues have been raised by people who have made submissions, and I am sure you have read them and know of them. Some of them specifically relate to this bill and we can handle them in this bill and others relate to ongoing concerns about other things within it. It would be really good if when senators ask questions, which I know they are going to, it is clear to the committee what this bill can do and what it cannot do. I feel sure that is going to be an important aspect.

I think it is absolutely reasonable that all the issues we have heard about can be vented, but the process to address them would be very useful. We would like the department's clear perspective on that. There are things here about what can fit that I am confused about. I put that on the record. We need to be very clear about what this bill can address. We will start with nursing because that was an issue that was particularly fraught in terms of the process. Senator Adams has asked to lead off on that for obvious reasons. We will go through this issue by issue. We will raise them as we got them from the submissions and the evidence.

Senator ADAMS—Thank you for your submission. On nursing, regarding division 1 and division 2, which describe a registered nurse and an enrolled nurse, we know that Victoria has had those abbreviations for registered nurses and enrolled nurses—division 1 and division 2. The other states have not taken that up. I am looking at it from a community point of view as to just how confusing that terminology is, especially now that we have nurse practitioners, practice nurses, midwives, registered nurses, enrolled nurses, mental health nurses—and I could keep going. If I had been asked before I was aware of what was in this bill, as to what a division 1 or a division 2 nurse was, I would question it, especially if you had a registered nurse who was also a registered midwife. So, could you tell me why we have that in the bill?

Ms Jolly—Certainly. Before I do, I would just like to make a couple of comments. Firstly, bill C in front of you picks up the definitions that are in the national law. That is, in part, the purpose of bill C is to ensure that the Health Insurance Act is consistent with what is in the national law. That is where the definition stems from. Secondly, I would like to talk a little bit about some of the definitions in the national law, but in doing that I want to make very clear that I do not in any way want to be dismissive of the issue, because there are some technical issues with the way it is defined in the law. That is obviously of concern to the nursing profession. I do not want my comments to be perceived as dismissing that concern. With those two comments on the table, if you turn to the national law there is the definitions section. I will read it to you:

division, of a health profession, means a part of a health profession for which a Division is included in the National Register ...

The term 'division' is meant to apply to any health professional group that chooses to divide themselves for the purposes of registration. I understand the terms 'division 1' and 'division 2' have a history, but for the purposes of the national law it is the definition of division that is picked up. I do not know whether I am explaining that very clearly.

Also, in the law there are two different ways in which you will see a definition. You will see one on the register, as to how somebody is registered. I will turn to that part of the law. On the register you will see:

Registered nurses (Division 1), Enrolled nurses (Division 2)

The other point is about the ways in which titles are protected—the ways in which health professionals refer to themselves. The protected titles are 'nurse', 'registered nurse', 'nurse practitioner' and 'enrolled nurse'. I am trying to explain that the way the national law has been drafted uses the term 'division', and the bill C that we have has picked that up to ensure that we are consistent for the purposes of Medicare. The definition that was discussed this morning is really contained in that bill.

CHAIR—In the national law?

Ms Jolly—In the national law.

CHAIR—About which this piece of legislation has no impact.

Ms Jolly—No, it picks up that definition from the national law.

CHAIR—So it would have to be an amendment to the national law. You would have to go right back through the whole process—

Ms Jolly—Correct.

CHAIR—with all the state based things. That would be the only way you could amend that law, not through this piece of legislation.

Ms Jolly—Yes.

CHAIR—I think that Senator Adams's point is about awareness and access to the community and other professions—that is the point, isn't it, Senator Adams?

Senator ADAMS—It is, but where does a registered midwife come in? Are you saying, 'No, not registered any longer,' or something?

Ms Jolly—No, I did not read out the full list; my apologies. I can read out the full list of protected titles.

Senator BOYCE—And where does it come in the national law?

Ms Jolly—This is in the national law in section 114. It lists all protected titles: 'nurse', 'registered nurse', 'nurse practitioner', 'enrolled nurse', 'midwife', 'midwife practitioner'. So that is the title which people will be known by—obviously, their professional title.

Senator BOYCE—So an 'enrolled nurse' becomes a 'nurse'; is that what you are saying?

Ms Jolly—No, 'enrolled nurse' is a protected title under the national law. Under the national law there are penalties for anybody who calls themselves something that they are not, and that is referenced to the list that is there. That is the list of protected titles. You cannot call yourself an enrolled nurse unless you satisfy the definition. You cannot call yourself a registered nurse unless you satisfy the definition.

Senator ADAMS—I just have to get this straight. Under 'division 2', the only category is an enrolled nurse; is that correct?

Ms Jolly—On the registration record, yes—you have 'Register of Nurses' in section 222 of the national law. The Register of Nurses has divisions:

Registered nurses (Division 1), Enrolled nurses (Division 2)

If you have a look at that table, you will see in the far column that it lists all the divisions for other professions as well.

Senator ADAMS—Can you just tell me what is in division 1 again, please?

Ms Jolly—It says:

Registered nurses (Division 1), Enrolled nurses (Division 2)

Senator ADAMS—Therefore your midwives, nurse practitioners and all the rest come in under division 1; is that correct?

Ms Jolly—There is also a separate Register of Midwives.

Senator ADAMS—I see. All right. That explains where it has come from. We were very confused about it. From evidence we knew that Victoria was following that particular route, but the other states certainly have not. How are we going to then get the message across to the community? Someone comes along and says, 'I'm a division 1 nurse'. What are they? Who are they? How are they? Are we going to have some sort of amendment that explains this, or is it just going to be 'division 1' and 'division 2'?

Ms Jolly—On your registration record there would be either the term 'registered nurse (division 1)' or the term 'enrolled nurse', and your protected title would be the same. You would be a registered nurse or an enrolled nurse.

Senator ADAMS—But I am looking at it from a community point of view as to how we get the message across, because legislation is difficult enough but I think that somewhere there must be an explanation—within that particular clause, anyway—as to the definition of 'registered nurse' and 'enrolled nurse' and the encompassing of other professions, such as midwives. If a registered nurse is just a division 1 nurse, you have the nurse practitioner, who has a higher qualification, and also the general registered nurse and the registered midwife. It is very confusing.

CHAIR—Ms Jolly, would that be something where there could be—I hesitate to use this term—a website that would have some information about current registrations and where, when NRAS is fully operational, consumers or community groups would be able to scroll through, and under 'nursing' there would be an information page that would explain all this in English?

Ms Jolly—I could certainly feed that back to AHPRA.

CHAIR—I think that could be something in terms of—

Senator ADAMS—I think it is very important.

Senator BOYCE—Would you anticipate that there would be any changes to the way nurses describe themselves because of the split into division 1 and division 2?

Ms Jolly—There should be no change in the way in which nurses describe themselves, because they—

Senator BOYCE—Use those protected titles.

Ms Jolly—have the protected titles, as do other professional groups. So there should be no change. Certainly under bill C, which picks up the definition, there is no intention to change that in any way. That is covered by the protected titles. As I pointed out, you will get into a lot of trouble if you use an incorrect title.

Senator BOYCE—How many other professions currently have divisions?

Ms Jolly—On the table—which is, as I said, section 222 of the national law—under the heading 'Divisions of public national register' there are four other professions that have titles listed—

Senator BOYCE—Internal divisions?

Ms Jolly—under that general heading.

Senator BOYCE—Okay. By way of background, if bill C is amended, what is the backflow process that would need to happen? This is a hypothetical.

Ms Jolly—Sure. Our concern is to ensure that those practitioners can access Medicare in the way that they do now. Our concern about not being in line with the national law would be that there would be problems for that group of health practitioners accessing Medicare in the way that they do now.

Senator BOYCE—I expect that your answer is that if bill C is amended then the national law would need to be amended in every jurisdiction.

Ms Jolly—No, I think the processes would need to be in parallel, because our bill picks up the definitions from the national law, so there is an implication if they are not consistent right now. If they were not consistent because of bill C and we change what is in bill C, that may present an issue for the Medicare issue now. In order to have a change in the national law, that would need to go through a process through ministers, through amendment and through the Queensland parliament.

Senator BOYCE—Just the Queensland parliament, still?

Ms Jolly—It would need to go through the Queensland parliament, and then other states are adopting the Queensland law.

Senator BOYCE—Yes, but they have not as yet?

Ms Jolly—Not all have.

CHAIR—You have given us a little table.

Ms Jolly—But I would need to give the committee further advice about whether that is an automatic flow-on across the country or whether there would need to be other changes. It depends on the—

Senator BOYCE—I am just trying to think about the ramifications, obviously.

Ms Jolly—Sure. It would depend on how the state has adopted the law as to what changes they need to make to reflect the Queensland law, so I would need—

Senator BOYCE—I am not suggesting that I think it should affect our recommendations for amendments if we think they are required, but I think we do need to understand what we are setting in train if we do.

Ms Jolly—Yes, and as I said earlier our main concern is to ensure that we align specifically with the national law, since that is the purpose of the law—to ensure that those things are consistent.

CHAIR—Anything more on nursing?

Senator BOYCE—Just the definition.

Senator ADAMS—Yes, the definition. You would have seen the ANF's submission, in which they say:

The ANF is also concerned about the proposed removal of the word "registered" from the definition of "nursing care".

They argue:

There is a difference in the accountability level of a registered nurse and an enrolled nurse.

Has this been reviewed?

Ms Jolly—We have certainly had a look at that submission, along with the others. The issue again—and I apologise for presenting a legal argument—is that the term ‘registered’ in that sentence can now mean several things. If you are a ‘registered nurse’, you may be an enrolled nurse or you may be a registered nurse. Because the term now has several meanings, the suggestion was to amend the current way it is defined, again in order for it to be consistent with the national law. There is no intention in that to change who provides nursing care, how that is structured or any of the arrangements in place around supervision. None of those things are intended. It is an issue of consistency with what is in the national law.

Senator BOYCE—But do you feel that it currently addresses the concerns of the nurses that it could, over time, mean a change to the current system whereby registered nurses would supervise enrolled nurses?

Ms Jolly—No. I do not think that in and of itself it will have that impact. Again, it is about how that connection flows through the system into the Health Insurance Act. But I would not presume that we have satisfied the nurses on that, and certainly they made it very clear this morning that we had not. So we are very aware of that. I guess what I am presenting to the committee is that the reason it is there is for consistency and so that the term ‘registered’ is not read as ‘registered nurse, protected title’ but ‘ registered nurse, those that are on the register’, and there are now several categories that fit that definition. So in order—

Senator BOYCE—If you changed that to a division 1 registered nurse, would—

Ms Jolly—We could certainly look at an alternative option there, and we could consider that and we could talk to the Nursing Federation about that, but that is the intention of what is in the bill.

Senator BOYCE—Okay. Thank you.

CHAIR—Anything more on nursing? No. We will move to issues about the public interest and the related concerns of consumer organisations. Senator Siewert.

Senator SIEWERT—You would be aware of the issues the Consumers Health Forum have been raising for some time around the Public Interest Assessor role. That was originally in bill B in the exposure draft, but it was dropped and is now not part of the process, and they remain concerned about that. Could we talk about why it was dropped and the consultation process that was carried out afterwards—how the community and consumers were informed when it was dropped and why it was dropped.

Prof. Horvath—I cannot comment on the latter, as to what consultation occurred and what information was given to the consumer lobby. The Public Interest Assessor was an issue that was looked at very carefully, and very early on in the discussions and in the structure of bill B it was thought that they would handle all the current work of the state based complaint entities—and there are very strong such entities in all states now.

It became very clear that the state jurisdictions were very firm that they wished to retain those very strong health complaints entities in each state and territory which deal with complaints against all health professionals to ensure that the public interest is met. Ministers felt that (1) because at least one third of all boards were consumer representatives and (2) that there were strong health complaints entities in each state and territory and that it was a requirement that all complaints be exchanged that the public interest was in fact well served and it was not necessary to have an additional layer. So that was the reasoning behind and, in the exact words that went with the frequently answered questions:

> Ministers have agreed that the combination of a stronger role for the Health Complaints Entity and strong community representation on boards mean that a further layer of public interest assessment is not necessary.

So that was the background to why that was dropped from bill B following all the consultation processes.

Senator SIEWERT—There are a couple of issues I want to follow up there. One is: one third of people you said consumer interests.

Prof. Horvath—Each board can have a maximum of two-thirds health professionals.

Senator SIEWERT—The point that we discussed with the Consumer Health Forum is the fact that they are not consumer. I understand they are not consumer representatives; they are community representatives. Is that correct? Because there were issues raised about they carry out their consultation process as well. I am not trying to be pedantic, but it is very important point that health consumers have made consistently and that is the difference between the definition of a consumer and a community representative.

Prof. Horvath—I apologise for my mistake.

Senator SIEWERT—I was just making sure that I understood it. I am correct in that understanding, aren't I? I am seeing someone nod behind you.

Prof. Horvath—You are correct.

Senator SIEWERT—When the decision was made to change it, what process was undertaken to consult or reply to, particularly the Consumer Health Forum and other consumer advocates? I know, Professor Horvath, you said—

Prof. Horvath—I could not answer.

Senator SIEWERT—you could not answer. I am wondering if someone from the department can.

Ms Jolly—I need to refer back to my opening statement, which is that there was a committee that—let me just get the words. It was an implementation project team who undertook that work and that then resulted in APRA taking that forward in terms of what they now do with the national boards and with consultation and information around what is happening with the scheme. So the department does not manage that process.

Prof. Horvath—And to clarify, Senator: that implementation task force was not of the department.

CHAIR—That was Dr Morauta's board.

Prof. Horvath—Correct.

CHAIR—And Dr Morauta gave evidence in the previous committee. It just seems to be across the board a sticking point with organisations that had very strong views in all this process presenting to us that they did not have appropriate feedback about issues which were very dear to them, which ended up not being picked up in the legislation. We have not had a chance to talk with people since the legislation has been passed to know what had happened, so we want to put on record a concern that has been raised by a number of organisations and professional bodies that they felt there was consultation. People were very clear that there was a whole range of mechanisms being used but on sticking points, where people perhaps did not get the result that they sought, there has been a view put by a number of people that, subsequent to that, they did not have effective feedback and discussion about why something did not happen. I know that is not the department; it was actually the previous group that was responsible, but it is a serious issue that has come up from bill A, bill B and now bill C and it impacts on the way the future trust will be in getting the system to work.

We were actually told, I think it was the bill A committee hearing—because we did have the joy of a bill B one as well—'Look on the website,' and we made the point in our recommendations that we felt that was inadequate. If you are going to get people onside, you do not tell them to look at a website—and that includes committees. Do you have questions on the public interest area, Senator Boyce?

Senator BOYCE—The evidence we had this morning from the Consumers Health Forum included the fact that the community representatives, who are perceived as strengthening public interest, have signed confidentiality agreements. Is that true?

Ms Jolly—I would need to seek advice from AHPRA and I am happy to.

Senator BOYCE—It would seem to me that we appear to have strengthened the public interest input into these groups, but I am not at all sure, if these people are not able to communicate with each other or with the general public, that we have strengthened the public's knowledge of public interest. That is the area that would concern me here. I would certainly like to confirm that they are bound by confidentiality from those meetings and I certainly think that would affect my views on whether we had met a public interest test sufficiently.

Ms Jolly—I am certainly happy to get that information. I was pleased to hear this morning that the Consumers Health Forum have written to AHPRA and have received very positive feedback from them about the issue that you have raised. They are the appropriate agency to take that issue forward, given their role, so it was very pleasing to hear that this morning.

Senator BOYCE—They are all the questions I have in that particular area.

CHAIR—We will now move on to the issues that were raised by the AMA. Senator Siewert?

Senator SIEWERT—I am sure you are well aware of the issues that were raised by the AMA. Let's go to the point around the apparent differentiation between specialists and the rest of the health professionals, whether that was an intention and, if it was, what was behind the intention. Then we will go to the consultation process, if that is okay.

Ms Jolly—Are you referring to the—

Senator SIEWERT—The issue around MBS requirements for the majority of the groups listed for registration and for specialists.

Ms Jolly—The AMA have raised a concern about subclauses 9(a)(iii) and 2(a)(iii). Correct me if I am wrong on the technical detail.

CHAIR—You are confusing us with details.

Ms Jolly—My apologies! It was pointed out that that was partly a drafting issue. I am happy to explain why it is there. The explanation from the AMA is certainly correct from our perspective. What bill C does is to take what currently happens and try to describe that for the purposes of the new national law.

At the moment under Medicare if you are a specialist there is a determination as such, and if you are a consultant physician there is a determination as such. One of the opportunities for bill C was to streamline that arrangement so that you did not have to have determinations, and there are a small group of professionals who are both consultant physicians and specialists. The clause that is there was meant to pick up that group so that it did not have to go through dual processes. It was a transition from what currently happens under a banner of, ‘We want to make it easier in the future, so we need to pick it up, for drafting purposes, in the new bill.’

We are looking at whether that is still a requirement and whether Medicare Australia does need a mechanism to distinguish that particular group, and that is the undertaking we have made: to look at, first of all, whether or not in that transition there is something that is no longer required and then to advise appropriately.

Senator SIEWERT—You heard the comments earlier, and there is not an agenda around those.

Ms Jolly—Absolutely.

CHAIR—To impose additional requirements on consultant physicians and specialists in order to be eligible. There is no intention—

Ms Jolly—No. Again it is about trying to take what happens now and translate it into a new arrangement, and that was the process that happened.

Senator SIEWERT—It seems fairly straightforward to me. Why has there been this sensitivity around it and the AMA apparently not understanding the transition process and not being clear on that? When you explain it, it seems fairly straightforward to me.

Ms Jolly—The AMA this morning indicated that we have had discussions about that. I think that it is the process in which the drafting happened and it did not flag as an issue as it went through, until it was looked at post it being submitted. So it is just simply the drafting of that particular section. Yes, we have had conversations with the AMA about that.

Senator BOYCE—I do not have any questions in this particular area at present.

CHAIR—I think we have taken care of the issue around consultant physicians and specialists. Do you want to move on to another point within the AMA issues?

Senator BOYCE—Particularly their issue regarding increases averaging 85 per cent in fees, to take the registration fee nationally to $650. Were you aware that that had happened?

Ms Jolly—The fees are set, as was pointed out by the AMA, by the medical boards and all boards are currently undergoing that discussion. Our understanding is that the fees are not yet final. That is the information we have from AHPRA, that these are being considered.

Senator BOYCE—This letter says the Medical Board of Australia has set the registration fee. So as far as you understand that is a suggestion, not a—

Ms Jolly—But that it is not something that we can comment on. That is a process that is currently happening through all of the boards.

Senator BOYCE—Except in the sense that, as we have heard, there was to be funding made available if necessary to help with transitional arrangements within the boards. Have you been consulted around that or has all that happened with AHPRA?

Ms Jolly—That is certainly AHPRA’s role. Their processes will be to have the discussions with all the boards, with the national fees, and then AHPRA has their governing committee, which of course will go to all ministers. So in terms of a discussion around costs you would expect that to flow from APRA at the point in which they bring forward that discussion.

Senator BOYCE—So the department has no role to play at all here.

Ms Jolly—Obviously the minister sits on the governing council, but at this stage I do not have a position that I can give you on that matter. It is a matter at the moment that is being discussed between the national boards and AHPRA, what is appropriate, and what they are currently doing. Boards are at different points. The AMA has obviously had an early consultation and has put out a letter which you have. Other boards are doing similar things but it has not yet been raised to the level of discussion about the impact of that.

Senator BOYCE—What is being discussed at the moment? Is that the costs of transition and potential reimbursement, subsidy, whatever?

Ms Jolly—If I could just read to you what the boards are required to do under the legislation, because that is in essence what is currently happening. Under the national law in section 26 it talks about what needs to happen in the process of fees. That section talks about the fact that:

(1) The National Agency—

and that national agency is AHPRA—

must enter into an agreement (a health profession agreement) with a National Board that makes provision for the following--

(a) the fees that will be payable under this Law by health practitioners and others in respect of the health profession for which the Board is established (including arrangements relating to refunds of fees, waivers of fees and additional fees for late payment);

(b) the annual budget of the National Board (including the funding arrangements for its committees and accreditation authorities);

(c) the services to be provided to the National Board by the National Agency to enable the National Board to carry out its functions under this Law.

There are a couple of other clauses there. In essence, that is where the process is. The national agency is having the negotiations around that process.

Senator BOYCE—It still leaves me a little bit puzzled that the letter sent to the AMA says the Medical Board of Australia 'has set' the registration fees. You are telling me that in fact that is not a settled issue.

Ms Jolly—I guess what I have—and I would not want to refer to a website—is a statement from—

Senator BOYCE—Drug problems being referred to a website—

Ms Jolly—It basically says that it will be announced before 1 July 2010. That is the date they have listed. We can get clarification from AHPRA about where those fees are at, but I would need to seek their advice on that, if that is useful to the committee.

CHAIR—That is very useful.

Senator BOYCE—I would really like to suggest that we call it 'arpra', because 'apra' means the Australian Prudential Regulatory Authority to me, but I am probably too late.

To **Ms Jolly**—I will try.

CHAIR—Is there anything else on the AMA stuff, Senator Boyce?

Senator ADAMS—There is the mandatory reporting.

CHAIR—Were you going to cover mandatory reporting, Senator Adams?

Senator ADAMS—Yes, I will start on that. This has raised some concerns, especially regarding doctors having a therapeutic relationship with another doctor as far as drug problems and things like that—or somebody perhaps having treatment for psychological issues and things like that. There has to be a relationship somewhere, because these people have got to get help from somewhere and not be cast out into the ether. So could you explain whether there would be an exemption in that respect or would that all come in under mandatory reporting?

Prof. Horvath—Firstly, on the origins of mandatory reporting, I am aware that there was significant concern expressed throughout the professions about this. However, due to a significant number of high-profile cases that we are all aware of that perhaps could have surfaced a lot earlier had there been a mandatory reporting, a number of states already had mandatory reporting in their legislation and it was very clear that state health ministers were not of a mind to dilute their public protection by removing that. There was a view of all ministers that this was an important public protection. Have you got the exact words in there for the

protection of those exemptions? We do not have exact words. I know this was discussed—that there are conditions where it would not be appropriate. I do not have the exact bits of legislation in front of me, but we could take that on notice.

Senator ADAMS—All right. Thank you.

Prof. Horvath—But the issues you raised around spouses and therapeutic relationships were certainly an issue. I can talk only from my previous experience chairing the New South Wales Medical Board for 12 years. They were taken into account in that legislative environment. So I think we will have to take on notice how this has been dealt with by either legislation or regulation.

Senator BOYCE—What about that point of an annual report on the topic? Has that been brought to you?

Ms Jolly—Not to my knowledge.

Senator BOYCE—The AMA is suggesting that there should be an annual review of this, which might include a report to parliament on how it is working. I must admit that I was having some difficulty trying to understand what this report would say.

Prof. Horvath—It has not been raised prior to this as far as I am aware.

Senator BOYCE—Can I ask some questions about the other AMA concerns.

Senator ADAMS—Yes, I was just looking at this with the accreditation standards.

Senator BOYCE—One of the other concerns that the AMA raised, of course, was that there was nothing in the bill as far as they were aware that would restrict the payment of Medicare benefits for services provided outside the scope or conditions of registration. I used the example of a podiatrist who prescribes antibiotics for the flu as, presumably, the sort of thing that they are concerned about. What is the department's response to that?

Ms Jolly—In the drafting of bill C, as I mentioned earlier, it picked up what currently happens and put it into the context of the national law. At the moment, those restrictions apply to medical practitioners. What you are seeing is the fact that the way in which Medicare has operated has changed over time, and those provisions have not been updated to reflect those changes. So when bill C was drafted—again, along the lines of everything in bill C—it took what currently happens and codified it for the purposes of the national law. We are certainly working with the AMA on this as an issue, and it is something that we are considering, but it is to do not so much with the national registration scheme as with the fact that the way that Medicare operates and the health professionals that are accessing Medicare have changed over time. The short answer is that we are looking at it and working on how that might look different for the future.

Senator BOYCE—Because obviously the current arrangements cannot be taken into the new system.

Ms Jolly—The AMA makes the point that that is correct: the rules that apply are currently applied only to medical practitioners.

Senator BOYCE—Assuming this amendment, which seems to be very sensible, is made to bill C, what ramifications, if any, does that have for the national law?

Ms Jolly—I do not think there would be an implication, because this is about how Medicare operates, so I do not envisage that there would be an issue. If I get different advice, I will inform the committee, but because this is really about how health practitioners access the Health Insurance Act I cannot see that there is an issue for the national law.

Senator BOYCE—The other issue in that is: how will what is in scope and what is out of scope from Medicare, for example, be communicated to newly registered health professionals?

Ms Jolly—We have not got to that level of detail, given that there need to be a series of things that would happen before that change would—

Senator BOYCE—But that is supposed to start on 1 July, isn't it?

Ms Jolly—Sorry; I do not think I am explaining myself very clearly. On 1 July, I would need to answer that question in the context of what legislation was passed. Bill C will make changes in relation to the way health practitioners access Medicare. Bill C, from the Commonwealth's perspective, is a proclaimed piece of legislation, and it is to be proclaimed once all states and territories have passed their legislation, because it is about ensuring that everyone has access to Medicare consistently. So, until the bill is proclaimed, current arrangements will apply to ensure that that access is continuous.

Senator BOYCE—So if I go and see a newly registered—I will stick with the podiatrist for the sake of it—

CHAIR—You have done it so far.

Senator BOYCE—So, if I went to see a podiatrist on 2 July and had normal podiatric treatment, would MBS cover that?

Ms Jolly—As it does now. There would be no change to the MBS arrangements.

Senator BOYCE—What you are telling me is that the status quo stays.

Ms Jolly—Correct.

Senator BOYCE—In every area?

Ms Jolly—Until there is a change in the Medicare arrangement. What bill C is trying to do around the Medicare arrangements is to update the definitions to ensure that we are absolutely consistent and to streamline the amount of paperwork that goes backwards and forwards to Medicare. That is its main purpose. Until that is in place, the bits of paper that go backwards and forwards to Medicare will continue. That system is in place now and that the system would continue.

Prof. Horvath—Senator Boyce, could I clarify the AMA's concern about this. This may help. Until recently, only medical practitioners could access Medicare. There is a provision in the current Medicare bills, basically one of the sanctions—and this is beyond my pay grade—that, if you act outside of your scope for conduct, Medicare payments could stop. In transferring the provisions in the current bill C, we did not take into account that a whole lot of other professions are now progressively able to access Medicare.

Senator BOYCE—And could act out of scope.

Prof. Horvath—Correct. The AMA has brought this to our attention. This is what Ms Jolly is saying, that we now need to look at how we bring that into scope, but until the amendments are done it will not affect disadvantaged patients or practitioners.

Senator BOYCE—But, also, we are currently looking at a fairly tight time frame, aren't we? My concern is that, even if we get this amended and sorted in time, how will practitioners have a sense of it and therefore not disadvantage patients?

CHAIR—Senator Boyce, correct me if I am going over the line, but the Health Insurance Act already has a clear definition of who can access Medicare. If we are talking about psychologists or social workers, who are the other kinds of professionals who are being mentioned, they already know the rules. They know which numbers they can use and the access they can have, so there would be no change. Basically, what the AMA wants is that the standard provision that applies to them now will be extended to all professions who use the act. There will be no change in the transition. Everyone was very quiet then. I just want to see whether I have this right or not. The impact on the client will not be affected at all, and the impact on the practitioner will not be affected at all because they already act within their own professions and their use of Medicare. The suggestion from the AMA is just to tidy everything up, with everything going—

Senator BOYCE—To put a legal basis under it.

CHAIR—There is already a legal basis if you are a psychologist accessing Medicare. If you do not access it appropriately, using your access qualifications, you are already breaking the law. There would be no extra legal implication. Is that right?

Prof. Horvath—Absolutely correct.

Senator BOYCE—Thank you for tidying that up.

CHAIR—I am sorry for answering, but that is where we are, isn't it?

Prof. Horvath—Absolutely.

Senator BOYCE—But the omission is to be rectified. Is that correct?

Ms Jolly—We are certainly looking at it.

CHAIR—Is there anything else for the AMA? There was certainly the ongoing issue of protection of titles. My understanding is that that goes back, because they were talking about their ongoing concerns. I think it is similar to the thing about the nurses: what is your appropriate title; who can be called a doctor and who can be called 'Mr'?

Prof. Horvath—I think that is very clearly dealt with. There were a lot of negotiations and a lot of consultations about this, and it is very clear, under section 119, about who can actually do it. There are very harsh penalties. To claim to hold a type of registration or endorsement under this law that the practitioner does not hold—it is very clear. A specialist obstetrician can only call themselves a specialist obstetrician if they are on the specialty register of the Medical Board of Australia. That is very clearly defined in section 119 of the act, and it goes on. In the case of an individual who is not a specialist obstetrician and calls themselves a specialist obstetrician, the fine is $30,000.

CHAIR—Professor Horvath, were you able to hear Mr Sullivan's evidence earlier?

Prof. Horvath—I did.

CHAIR—From your perspective, does that clause respond to the concerns he continued to raise about protection of title?

Prof. Horvath—I believe it does. There was a consultation which I happened to chair, and this was accepted by the medical colleges and their representatives as being adequate to protect title. You cannot call yourself a specialist unless you are on the specialty register.

Senator BOYCE—But I thought their concerns also went to the idea of perhaps naturopaths or some such who had a doctorate referring to themselves as doctors and that sort of suggestion where people could be misled as to the qualifications of a person. It goes right back to the fact that you can be a doctor with a bachelor degree et cetera.

Prof. Horvath—That is a 50-year problem. It really comes down to the point of holding yourself out to be a medical practitioner. That is actually covered elsewhere. But, for the protection of title, that was the negotiated situation we got to with the colleges.

Senator ADAMS—I have one more question regarding accreditation standards. Could you please confirm that any direction by the ministerial council regarding accreditation standards would need to be published on the relevant website and in the annual report?

Prof. Horvath—I refer you to part 2, which is under the terminology of the ministerial council, at section 17. It is entitled 'Notification and publication of directions and approvals'. It says:

1) A copy of any direction given by the Ministerial Council to the National Agency--

(a) is to be given to the Chairperson of the Agency Management Committee; and

(b) must be published by the National Agency on its website as soon as practicable after being received by the Chairperson.

(2) A copy of a direction or approval given by the Ministerial Council to a National Board--

… … …

(c) must be published by the National Board on its website as soon as practicable …

(3) A copy of a direction or approval given by the Ministerial Council to the National Agency or to a National Board is to be published in the annual report of the National Agency.

I think that should cover the fact that it is a very public and transparent process. That is section 17, part 2.

CHAIR—Is there anything else that officers wish to place on the record that we have not been able to get through our questions?

Ms Jolly—No, Senator.

CHAIR—Thank you very much for your time and your evidence, Ms Jolly. It was very useful. We have to have this reported very quickly. It may well help the committee if you could give us something on notice which clearly sets out the relationship between bill C and bills A and B. In your submission you put the sequence, but the clarity of the relationship as to exactly how this bill fits into the others, using the knowledge you have, would be very useful to our committee, I would think, in writing our report. If we could have that early next week it would be very useful.

Ms Jolly—That will be fine.

CHAIR—Thank you very much. That now ends the committee's inquiry into the Health Practitioner Regulation (Consequential Amendments) Bill 2010.

Committee adjourned at 12.30 pm