

Australian Medical Association (WA)

Submission: Exposure Draft

**Health Practitioners Regulation
National Law**

July 2009



WESTERN AUSTRALIA

HEALTH PRACTITIONER REGULATION NATIONAL LAW

OVERALL COMMENTS:

The Exposure Draft of the Bill is 187 pages and has gone through at least 17 drafts without substantive consultation with the AMA on the Bill itself. It represents the most comprehensive and potentially far reaching change in the “Regulation” of Health professions ever seen in Australia. It could have profound effects on the professions and standards of care enjoyed by patients.

Fundamental to the changes is the centralisation of registration, defining and codifying standards of professional conduct, regulating accreditation under a National Ministerial Council and National Agency and the diminution in the independence of professional regulation for both registration and accreditation functions relative to current and the role of State jurisdictions.

The proposals go far beyond the position agreed to in the Ministerial Communiqué of 2004 and falls far short of the concerns expressed in the joint letter of the professions dated 7th May, 2009 (Appendix 1) and the NSW Labor Minister’s proposed model (Appendix 2).

The proposals also appear to go beyond the IGA and the last Communiqué of the 8th May, 2009 (Appendix 3). Some of the NSW Labor Minister’s statements are particularly compelling and justify a far simpler, less bureaucratic approach which would achieve the stated objectives in a more appropriate way. e.g.:

“...a national index of medical practitioners (effectively a national register).”

“...can be achieved through adoption of a “driver’s licence” model of registration. This will ensure there are appropriate registers to link to the Health Workforce Agency Australia database to assist and support workforce planning and reform.”

“National registers can ... provide a basis for uniformity of provisions relating to specialist titles and qualifications.”

“...state amendments will support full information sharing and notifications/updating of Registers through the State/Territory boards as necessary.”

“The costs of the operation of National Boards ... be met via a fee levied through retained state registration systems, adopting the existing approach for funding of the Australian Medical Council and the Australian Dental Council.”

“...revise the role of the National Boards to focus more directly on these nation-wide issues.”

“...means the retention of State/Territory boards to continue to perform the main day to day operational functions inherent in running a registration system, including the disciplinary system.”

“The advantage of this approach is that the delineation of State/Territory vs. national roles will occur in legislation rather than rely on delegations from the national to State/Territory level. This means certainty for both professional groups and the community on exactly who does what at the national and local level – something not available under the delegated system.”

“...there is limited justification for the extensive National Agency (including the National Office and State/Territory Offices) referred to in the IGA.”

“The higher level of policy role for National Boards will only require policy support and a small administrative secretariat.”

“...revise the Agency Management Committee, to operate more as a forum for boards, professions and jurisdictional representatives to consider and advise AHMC on cross professional issues. Given the substantial reduction proposed in the national bureaucracy, there is no cogent justification for a substantial oversight group as originally proposed.”

The WA Minister has also previously expressed similar concerns and advocated a bottom up approach. The Bill however still adopts a top down centralist approach.

The proposals also have a long way to go to become Law given they have to pass through every State House of Parliament both Lower (except Qld), and Upper. Various Elections; State and indeed even Federal are also approaching. Clearly it is important that broad agreement is reached on the final form of the Bill if it is to progress through these processes without substantive variation between States.

Key Concerns:

1. In its present form, the medium / long term implications for professions, standards and patient care remain adverse.
2. National Law based on temporary delegations and controls can change over time. The Bill also provides that Laws on different jurisdictions will change automatically if the Queensland base Act is changed in that jurisdiction and regulations can only effectively be disallowed by a majority of States.
3. Registration- Excessive centralisation with delegation rather than delineation.
4. Task Substitution- Use of title “Doctor” not protected and will confuse if PhD’s in other professions use title “Doctor”. Title of “Surgeon” and “Physician” should be preserved for use by qualified Medical Practitioners only.
5. Accreditation- Lack of independence, lack of protection for continuation of AMC, lack of recognition of Colleges and capacity for substitution.

6. National Agency- Role – effective bureaucratic control of Boards re: staffing, budgets, funding, with future cost concerns and potential growth in bureaucratic control.
7. Medical Boards- Structure – control by Ministerial Council etc. appointment of Chairperson, loss of independence, re. staffing and budgeting etc.
8. Ministerial Directions- Based on opinions not circumscribed or subject to appeal.
9. New requirements and controls e.g. reporting and competency requirements.
10. Complaints Management- Seemingly centralised with temporary delegations contrary to IGA.

General Summary of Issues State and National Perspectives:

Whilst some changes have been made to addressing some concerns raised in general information, the Bill still falls far short on a number of issues.

The Bill is inconsistent with both the WA and NSW Minister's position and remains top down not bottom up with significant albeit somewhat more qualified potential for central control.

Specific comments in the order the provisions appear in the draft Bill:

1. Students will be registered –do they have a view? S3 etc.

2. S4.2(c) (pg.2) Task Substitution

“(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.”

i.e. Is not based on best practice but safety and “appropriate” quality which could diminish standards suggesting provision down to a “Holden”, down to a price with task substitution and extending prescribing rights on the premise is appropriate (and coincidentally cheaper?). Patients deserve to be treated according to “best practice” which may also save overall costs.

Recommendation: Amend by deleting “and are of an appropriate quality” and replace with: “consistent with best practice standards.”

3. S6 (pg.2) Definitions

Accreditation authority means “an accreditation entity approved by a National Board under S62.”

There is no protection for the continuation of the AMC.

The National Board is also effectively serviced by the National Agency which employ its staff rather than the Board. The Board's will potentially and almost certainly over time have to use Agency staff (further reducing independence and raising conflicts) and negotiate with the Agency over its budget. This provides increased controls which, in tandem with the integrated appointment systems, will be controlled by the Ministerial Council and the bureaucracy, centralising and increasing control. This contradicts the NSW and WA Minister's proposal for bottom up rather than top down approaches.

Recommendation: That Board's continue to appoint their own Registrars and senior staff.

4. "Approved accreditation standard" (p.3) and "external accreditation entity" appointed by the Ministerial Council (p.4) suggest, notwithstanding some improvements, continuing concern re. controls. See comments hereunder re. S60-68.

Recommendation: Amend to delete "Ministerial Council" and replace with recognition of the AMC and Colleges roles.

5. S6 (p.6)

"Local registration authority" refers to State Boards, but they are truly subservient and seemingly lose their staff. This is a significant and potentially irreversible change to what they have asserted. It is strongly argued that State legislation and State Boards should remain not as Committees, pursuant to a delegation that can be removed, but by statutory right i.e. State Boards are recognised not as Committees called Boards, but remain Boards under State legislation appointed under State legislation by the State Minister with the State Board nominating its representative on the National Board and the National Board electing its Chair. This would reduce the concern re. political interference.

Recommendation: That the legislation be amended accordingly.

6. Definitions of "professional misconduct" (p.7), "unprofessional conduct" (p.9) and new definition of "unsatisfactory professional performance" (p.10).

Need to be reviewed to ensure standards have not changed and won't result in further increases in rising indemnity/representation costs etc.

Similarly, "reportable conduct" (p.10) needs careful consideration as it appears to be fairly broad and unlike existing jurisdictions, extends the requirement to all registered practitioners rather than the profession concerned, to report on another profession member.

Recommendation: Review provisions across Bill to address the above concerns.

7. Part 2: Ministerial Council (p.11)

Is very top down-The Ministerial Council under Section 10 can give Policy "directions to National Agency (about policies to be applied by the National Agency in exercising its functions under the Law" which the NSW Minister said was too big and cumbersome.

Note: The Ministerial Council's "Direction" can be given based on a mere "opinion" (S10 (4)) (p.11) which must be complied with and can not be challenged (S10 (6)). This can amongst other things include giving a direction in relation to "a particular accreditation standard for a health profession "(S10 (3)(d)) if in the MC's opinion it will have a substantive and negative impact on supply etc.

Note: S4 (2)(c) Task Substitution (above).

Such powers if acceptable, in concept or otherwise, should be circumscribed as proposed by the NSW Minister and should be based on proper process, be evidenced based, not an opinion and if countenanced, should be subject to appeal.

Recommendation: That appropriate amendments reflecting the above be made.

8. S12(3) (p.12) Specialist Registration

Relative progress, but given other provisions, does not guarantee AMC or College roles versus other bodies set up under other provisions. Note also S12(4) re. Ministerial Council may give guidance. Currently, the Federal Health Insurance Act recognises the AMC and Colleges (Appendix 4) as does, for example, the new Medical Act 2008 (Appendix 5). As the draft stands, the roles of the AMC and Colleges which are not really as recognised under the Act, could be displaced over time.

Recommendation: That amendments which secure AMC and College mechanisms be made.

9. Part 3: Australian Health Workforce Advisory Council (p.14)

Why require legislation for an advisory committee we understood would not proceed. Again, is appointed by Ministerial Council rather than having State representation. Chairperson must not be a health practitioner-neither in fact do any others with just three to have expertise which is different. Also note that the separate "Health Workforce Australia Bill 2009 provides for "Health Workforce Australia" under a separate Act which the AMA, Colleges and others have criticised (see dissenting comments in recent Senate Report (Appendix 6).

Recommendation: That Part 3 be removed.

10. Part 4: Australian Health Practitioner Regulation Agency (p.16)

Again central control of functions which should be Board functions. The Boards under this model don't regulate - they are more administrative and titular in nature functioning under the Agency with delegations. This approach contradicts not just the AMA position but several Ministers including NSW. The detail provides the foundations for control rather than self regulation and independent accreditation. Failure to adequately deal with this now will undoubtedly facilitate political control and be to the detriment of standards.

Recommendation: That amendments, consistent with the previous proposals of the NSW Minister, be inserted.

11. Division 2: S27 (p.18) Agency Management Committee

The Agency Management Committee under the Bill as it stands, controls the National Agency (S29)(p.19).

Five members are again appointed by Ministerial Council (MC) and again the Chair is appointed by the Ministerial Council and who cannot be a Health professional nor do others need to be, as again they only need expertise in health or education and training rather than medical or other health qualifications. Other members are excluded from being health professionals.

Recommendation: Role of agency and composition be circumscribed/ appropriately constituted with a majority of health professionals.

One option worth considering is providing for some positions to be elected (as in New Zealand) from the professions (at the time of registration renewal) rather than political appointments.

12. Division 4: S35 (p.21) Public Interest Assessor

Establishes a member of Agency staff to assess complaints, yet complaints were supposed to be managed at a State level. Appears to be contrary to the IGA (S6.8 (p.4) of IGA) and previous assurances. The Bill is strongly central re complaints management throughout and many pose difficulties for consumers.

Recommendation: That State management of complaints be reasserted and this section be deleted.

13. Division 5: S39 & 40 (p.22) Staff, consultants and contractors

National Agency may employ staff and staff may also be seconded to National Agency from local registration authorities.

Boards have always employed their own staff and State Boards remit a component of registration fees to their National Board and do not assign their assets or income to a central entity. The Bill seeks to change this relationship. A bottom up approach is crucial if services are to be responsive at local level and countervailing forces are to be built in so the agency does not dominate over time.

Recommendation: Amendments be made to reflect actual retention of State Boards, employment of senior staff by the individual Boards, and the agency functioning as a service entity consistent with the previous proposals of the NSW Minister.

14. Division 6: (p.22) Reporting Obligations

This makes it even clearer so called Boards are largely functionaries rather than genuine Boards with the Agency submitting the Annual Report “and the so called National Board having to provide information the National Agency requires”.

Recommendation: That the Bill be amended to provide that the Board is responsible for its Annual Report.

15. Part 5: S44 (p.24) National Boards

Medical Radiation Practice Board– presumably this does not include Radiologists i.e. just Radiographers

Recommendation: That this be made clear.

16. S45 (p.24) Board Membership

The Bill provides that the Ministerial Council appoints the Board where as it was understood State Boards would be appointed by the State Minister and the State Board would nominate and the Board would then appoint its Chairperson. i.e. Bill proposes top down political control rather than bottom up. It is important that Boards have the confidence of the professions they regulate and are not seen as politically appointed entities.

Recommendation: Amend to stipulate that the National Board is comprised of State Board Chairs or nominees etc. not just members from State's (there is a substantial difference).

If this is not accepted then consideration should be given to providing for some elected members (similar occurs in New Zealand) to minimize criticism of political control. (Election could be held at time of Registration renewal).

Ministerial Council also appoints Chair where as it should prescribe that the Board elects own Chair.

Recommendation: That the National Board elect its own Chair from amongst its number.

17. **Note:** S47 (p.26) *Vacancies on National Board to be advertised*

Given this submission suggests that States appoint rather than the Ministerial Council, this provision should be deleted.

Recommendation: S47 be deleted.

18. S49 (p.27) Accreditation Standards approved by National Boards

The National Board functions are to "develop or approve standard etc. including accreditation standards submitted by an accreditation authority which the Ministerial Council under S60-S65 may appoint i.e. not necessarily the AMC or Colleges. This raises fundamental issues and contradicts for example, the Health Insurance Act and the WA Medical Act 2008 provisions (Appendix 4 and 5).

Recommendation: Recognition of the AMC's and Colleges be included

19. S54 (p.29) State Boards

Provides a National Board, "**may**" establish "a committee" (conveniently called a State or Territory Board but clearly only in name under the new proposal) probably to deal with very small boards where individual State Boards are not viable. The members of a State Board is determined by the individual Minister (S54 (3)) who could therefore abolish what are mere Committees at a future date. The legislation should provide for State Boards for large professions consistent with earlier recommendations re. a bottom up approach including retention of such Boards under State legislation. This Bill should complement or sit along side existing/remaining State legislation including complaints management rather than replacing all of it.

Note: Provision appears to again displace State Law and requires State appointments to be advertised rather than State nomination processes applying. A number of Registration Acts in WA provides for organisations including, for example, the College of Nursing and Deans of Medical Schools to nominate. These could disappear under this proposal.

Note: Whilst S45 provides for members of the National Board to be drawn from each "large jurisdiction", they are not necessarily drawn from State Boards which are subsequently appointed under S54 by the National Board. To address those concerns it is recommended that:

Recommendation: That amendments be made to retain and guarantee State Boards (rather than Committees) for large professions and that those Boards nominate their Chairs or a nominee to the National Board.

20. S58 (p.31) Use of Registration standards, codes or guidelines in disciplinary proceedings

Standard, Code or Guideline may be used to prosecute, hence, importance of getting them right. Given the problems with development of the current draft code need to ensure such problems are not repeated following passage of any legislation.

Recommendation: The Bill provides that formulating or amending any Code must be undertaken following consultation with the AMA and the Colleges in the case of Medical Practitioners and by analogy with other peak organisations for other groups.

Note: There are various legislation precedents for this approach.

21. S60-S63 (p.32) Ministerial Council may appoint an external accreditation agency
This provides the means for undermining or replacing the AMC and Colleges. This is a substantial concern. See also Division 3, S64-68 re. development of accreditation standards.

Recommendation: That appropriate amendments be formulated to ensure ongoing roles for the Colleges and AMC consistent with the Health Insurance Act. (Appendix 6)

22. Part 7 (p36) Registration

Again the scope of provisions suggests replacement of entire Acts rather than part amendment of State Acts and hence is not supported.

23. S73 (p.37) Professional Indemnity Insurance Arrangements

MDO policies have different expiry dates and hence may expire during a registration period.

Recommendation: The appropriateness of this be ascertained in consultation with MDO's.

24. S74 (p.38) Period of General Registration (12 months)

Consideration should be given to 3 or 5 yrs registration like drivers licence subject to Maintenance of Professionals Standards (MOPS) or discretion for length to be amended by regulation.

Recommendation: Consideration be given to advocating a longer period of registration or providing for Boards to be able to offer or increase the period by regulation.

25. S77 (p.39) Examination or Assessment for Specialist Recognition

Accreditation authority to exam or assess. This raises concerns similar to those summarised at point 21 above.

Recommendation: Amendments be made consistent with point 21 above.

26. S94 (p.44) Non-Practicing

No provision for referrals or scripts - contrary to Western Australian State Minister's position etc.

This is contrary to some states. The issue of occasionally practicing Doctors who have retired from remunerative practice but still provide referrals and scripts pro bono without unnecessarily burdening an already stressed workforce e.g. General Practice or ED,s (or less qualified Nurse Practitioner-who are far less qualified than recently retired Drs?) and at no cost to the Commonwealth etc could be provided for example, for 5 yrs from formal retirement.

Note: S125 (3)(a) refers to "non practicing registration" which under definition e.g. "registered health practitioner" (p.7/8), can not practice at all.

Recommendation: Seek amendments providing for occasionally practicing per practice in some states.

Recommendation: That if appropriate, this be confined to issuance of prescription and referrals for up to 5 years of retirement from Practice.

27. S101 (1)(a)(ii) (p.47) Continuing Professional Development etc.

Practitioner can be required to complete a continuing professional development program required by the National Board.

Recommendation: That appropriate amendments recognising College MOPS programs etc. be included.

28. Division 7 (p.49) Student Registration

Recommendation: The implications/practicalities be checked with Deans and AMSA.

29. Division 8 (p.51) Endorsement in Relation to Scheduled Medicines

Potentially allows (subject to other legislation) non Drs to prescribe as determined by non-medical Board which raises major concern. See also rest of Division re. other potentials for example, Endorsement of Nurse Practitioners (S111 (p.52)). This raises major concerns re process, circumventing for example, the Poisons Act processes and the potential reducing of standards of care.

Recommendation: That these provisions be removed and existing mechanisms as prescribed under existing legislation, such as the WA Poisons Act etc and its interstate equivalents be maintained.

30. Division 9: S122 (p.56) Renewal of Registration or Endorsement.

Continuing professional development per S125 (3) requiring a practitioner to complete a CPD program approved by the National Board. This may not correlate with a College's MOPS program.

This reflects a fundamental shift in the orientation of Registration Acts from protecting the public interest to setting and regulating standards. AMA WA) is concerned those provisions undermine the role of Colleges in setting standards and submits the draft

should be amended to prescribe “CPD programs approved by the National Board on the advice of the relevant College”.

Recommendation: The Bill be amended to provide that in the case of Medical Practitioners CPD programmes, shall be approved by the National Board on the advice of the relevant College.

31. Division 11: S128 (p.61) Title and Practice Protections etc.

There is no protection for use of “Doctor” or “Physician” (which is current not used outside of Medicine) or “Surgeon”. Some non Medical Practitioners even refer to themselves as “Doctor” without a PhD which is false and misleading. Government should clearly protect the public from being misled.

AMA(WA) would argue strongly that the term “Doctor” should be confined to registered Medical Practitioners and that where another Health Professional has an Australian recognised PhD, they be allowed to use the title “Doctor of..” in their profession but that it must be made clear they are not a “Medical Practitioner” i.e. PhD (non medical). To protect the public and distinguish Medical Doctors from others who use title “Dr”.

There is also confusion re the use of “Chinese Medicine” which could suggest medical as distinct from health qualifications. Presently in WA and most States, Chinese Health Practitioners are not regulated and hence, are not subject to “Protection of Title”. It is suggested that the title “Chinese Health Practitioner” be protected to avoid confusion with Medical Practitioners.

In addition, the current structure under “Chinese” is inconsistent with all titles being prefaced by “Chinese” or “Oriental” except ‘Acupuncture’ which logically, should have either of these prefaces added.

Recommendations:

Provide for protection of titles of “Physician” and “Surgeon” by Medical Practitioners only and;

Recognise the title “Doctor” for Medical Practitioners. Provide that only practitioners with recognised PhD’s make may use the title of “Doctor of...”

“Chinese Medicine” be amended to “Chinese Health” and “Acupuncturist” be amended to either “Chinese Acupuncturist” or “Oriental Acupuncturist”.

32. Subdivision 3: S142 (p.70) Obligation of registered health practitioner to provide information re offences, clinical privileges and billing privileges (under Medicare or by a Private Health Insurer?). This is wider than recent Mandatory Reporting laws and needs critical review in tandem with S156: Mandatory Reporting.

Billing issues are commercial issues and should be removed from the legislation. The Mandatory Reporting provisions are also wider than existing laws and enable any health professional to report on another different discipline. They have the potential to lead to unnecessary reports, increased stress and costs. As stated under point 36., issues such as quality assurance activities and health professionals treating other health professionals should be excluded.

Recommendation: The provision be reviewed and refined in consultation with the AMA and Medical Defence Organisations to address and reflect the above.

33. Subdivision 6: S148 (p.74) Person Inciting Unprofessional Conduct

Only corporate control is welcome, but clearly deficient compared to WA State Medical Act. Is only a business expense fine rather than potential prohibition on corporate licence to practice. AMA (WA) would advocate similar provisions as prescribed presently under WA Law if WA Law is to be displaced.

Recommendation: The existing WA law be reviewed and adopted or the issue be left to State Law.

34. Part 8, S150 (p.75) Complaints,

Provides, under various provisions that complaints may be made and managed by the National Agency via Independent Assessor nominated by State Minister to the National Agency, S151 (p.75) and National Board may take action S158 (p.78) - contrary to State Medical Boards roles, the IGA and the understanding complaints would continue to be managed at State level.

Also provides that National Agency must assist a complainant make a complaint about a registered practitioners or student which raises conflict issue S154 (p.75).

Recommendation: Whole section needs to be removed and State Complaints Management per IGA, S6 (8) be reasserted.

35. Subdivision 7: S174 (p.86) Performance Assessment

Again, National Board oversees performance assessment. Major concerns throughout which contradicts State jurisdiction.

Recommendation: The existing State mechanisms be retained.

36. S156 (p.76) Mandatory Reporting by Health Practitioners

Needs specific review given scope in tandem with S142. Whilst MDOs appear to have an exemption, many others managing complaints within hospitals and in health care services to the satisfaction of authorities such as the Coroner's Office and undertaking quality assurance processes etc. Complainants within hospitals can complain to external authorities if they wish, could be required by this provision to report beyond the hospital which may not be appropriate for many instances, which are performance management matters, as distinct from disciplinary matters. In addition as detailed earlier, the Bill requires any health professional e.g. Nurses, Midwives to report a Doctor and hence, will considerably increase reports.

Recommendation: That the Bill provide exemption for such processes but where individuals exercise their discretion and report the indemnity provisions can also apply.

37. S200 (p.98) Health Panels

This suggests there will be a Medical Practitioner on every other Boards Health Panel - has this been discussed? What will be the level of work involved? How will they be nominated / remunerated?

Recommendation: Matter be further considered in consultation with the AMA.

38. S211 (p.102) Investigations

Again by National Board (S212), not State Boards which have no real recognition.

Also substantial powers including power to obtain information (without warrant), demand answers and seize Medical Records (S225) which needs review by MDOs.

Recommendation: These provisions be reviewed in consultation with MDOs and appropriate amendments made.

39. Amendments to the Act

The proposal whereby all States except WA adopt the Act passed by a single house in Queensland and by implication, any subsequent legislative amendment in that State circumvents the legislative process in those States. WA is not adopting that approach replicating where appropriate, provisions of the Bill.

A related aspect however, relates to the regulatory powers under the Bill. Bill B at S287 states “the disallowance of a regulation by a House of the Parliaments of a majority of jurisdictions has the same effect as a repeal of the regulation”. S 286(2) states however, a regulation disallowed by a single jurisdiction “does not cease to have effect in that participating jurisdiction unless the regulation is disallowed by a House of the Parliaments of a MAJOIRTY of the participating jurisdiction”. Thus, a regulation could be imposed on a jurisdiction. This is inappropriate.

Recommendation: S286 and S287 be amended to enable a single jurisdiction to disallow a regulation in its jurisdiction.

The foregoing raise significant concerns with the Bill in its current form. The Bill, released for the first time, contradicts previous assurances and the NSW Minister’s assessment. If presented to State Parliament’s, there is significant potential for vigorous debate, reference to Committees and amendment. In AMA(WA’s) view, it would be far better to get the draft Bill in a more acceptable form before goes to various Parliamentary systems.

There are two levels of amendments required; those that are fundamental to protecting the independent regulation, accreditation and standards with minimal political interference and those that increase bureaucracy and costs. Both should be addressed rather than acceding to inappropriate control.

Addressing the detail and ensuring the profession’s future independence is not underpinned and patient standards are maintained without increasing bureaucracy, costs and remoteness from patients within each State is vital. AMA (WA) commends the above analysis and seek changes as recommended above.

AMA (WA)

July 2009