Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022

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Submitter Recommendations:	

Australian Society of Ophthalmologists

Committee Secretary
Health and Environment Committee
Parliament House
George Street
Brisbane Qld 4000

Via email: hec@parliament.qld.gov.au

To Whom It May Concern:

Re: ASO Response to the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 (the Bill).

The Australian Society of Ophthalmologists (ASO) represents the interests of most ophthalmologists and their patients in Australia. The ASO thanks the Queensland Health and Environment Committee for the opportunity to provide input into the proposed Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 (the Bill).

The ASO is against several of the proposed changes to the Bill and believes the Bill should not proceed in its current form. The ASO was not included in the initial stakeholder communication for this Bill and therefore due to time constraints is only able to respond to two significant areas of concern.

The ASO is concerned broadly with the following two proposed changes:

1. **Potential for systematic abuse through increased discretionary powers**

The proposed Bill will grant the NRAS (National Registration and Accreditation Scheme) and AHPRA (Australian Health Practitioner Regulator Agency) broader objectives and wider regulatory powers as evident by the below proposed clauses.

"In addition, the Bill clarifies that the National Agency may do anything necessary or convenient for the effective and efficient operation of the National Scheme, within the scope of the National Law." (Page 12).

"*Second, the amendments add new section 25(ka), establishing a function of the National Agency to do anything else necessary or convenient for the effective and efficient operation of the National Scheme*" (page 48)

The ASO is concerned this broader discretionary and largely unchecked power may result in systematic abuse.

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Recommendation

That the Bill be redrafted to remove the broad discretionary powers granted to the regulator and that the regulator's role in achieving the broad objectives of the legislation be clearly defined.

2. Potential for replacement of the Australian Medical Council and the impact on Australia's healthcare standards.

The ASO strongly objects to the Bill's proposed changes to the established accreditation processes and its impact on medical professionals and medical standards. The Bill proposes the following clause:

Clause 54 of the Bill "The Bill will allow the Ministerial Council to delegate its powers to approve registration standards to any entity it considers appropriate to exercise those powers."

This clause has the potential to replace the Australian Medical Council (AMC). The ASO does not support this.

The AMC is the independent body responsible for accreditation and assessment for medicine in Australia. The AMC in conjunction with medical schools and specialist medical colleges, in particular for ophthalmology the Royal Australian and New Zealand College of Ophthalmologists (RANZCO), provides training and accreditation for doctors to meet the challenging health needs of Australian patients. The ASO highly values the work of the AMC in promoting high standards of medical practice.

Medical training is not comparable to non-medical health professions, and it is critical that governance of specialist colleges remain independent to ensure specialist expertise. The AMC and RANZCO, provide world leading eye specialists that meet the eye healthcare needs of Australians.

Recommendation

That the Australian Medical Council be legislated in the Bill as the sole standard setter of all medical education, training & individual medical practitioner accreditation.

Conclusion

The ASO calls for an that inquiry to be undertaken to further consider the implications of the proposed amendments to the Bill to fully assess whether the Bill complies with its aims to '*strengthen public safety and confidence in the provision of health services'.*

For the committee's reference I have also included the ASO's submission to the Independent Review of the National Registration and Accreditation Scheme for Health Professions performed by Kim Snowball in 2014. Our submission includes several recommendations in relation to oversight of NRAS which remain relevant.

Please do not hesitate to contact me via the ASO if you have any questions in relation to this submission.

Sincerely,

A/Prof. Ashish Agar

President

1 June 2022

Attachment 1: ASO submission to the NRAS Review, 10 October 2014

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10th October 2014

Mr Kim Snowball
Independent Reviewer
Review of the National Registration and Accreditation Scheme for Health Professions
GPO Box 4541
MELBOURNE VIC 3001

Via nras.review@health.vic.gov.au

Dear Mr Snowball

Review of the National Registration and Accreditation Scheme for Health Professions

The Australian Society of Ophthalmologists (ASO) thanks you for the opportunity to make a submission.

Introduction

The ASO is a professional association committed to the welfare of its members and the community they serve. On behalf of Australia's eye surgeons, ASO implements a diverse program of charitable, educational and advocacy activities. This includes the Indigenous and Remote Eye Health Service (IRIS), which provides free eye consultations and surgeries for the most marginalised Australians living in remote areas of the continent.

With most people regarding eyesight as their most valued sense, ASO creates awareness of issues around eye disease and conditions that can cause blindness. It produces an array of print and digital materials for public dissemination.

As an advocacy body, ASO protects the public interest as it did when the rebates to patients for cataract surgery were slashed without warning in the 2009 Federal Budget, jeopardising the ability of people, particularly on low incomes, to protect or save their sight. Through a high profile, intensive national multimedia public and political pressure campaign for safety and fairness, ASO was able to persuade the federal government to amend the Budget and reinstate almost the full level of rebate to patients for cataract surgery.

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Overview of ASO position

While we recognise that the National Registration and Accreditation Scheme (NRAS) is less than four years old, there are some aspects of the National Scheme that are unsafe and unregulated and other less critical areas where the scheme would clearly benefit from some refinement and possible realignment. It is obvious from a number of indicators that the responsibilities of the National Scheme are too broad and too diverse for any one organisation to safely and effectively coordinate and administer. We see this as a critical failure highlighting the need for a clear division between the functions of regulation and assessment. AHPRA should continue in its role as coordinator and administrator of the National Scheme.

While it is conceded that there are other important issues raised in the NRAS Consultation Paper, the ASO considers this aspect as fundamental to safe and effective national medical and health policy. We have not included explanatory facts and figures in this submission, however these can be collated and provided to the Review Team upon request.

Further detail of the ASO's position and commentary on the other specific questions tabled by the Independent Reviewer in the Consultation Paper are provided in the following pages.

CRITICAL ASPECTS REQUIRING IMMEDIATE CHANGE

Supreme Court action in Queensland

The ASO and RANZCO have been forced to take unprecedented Supreme Court action against the Optometry Board of Australia (OBA) because of the current critical failings in the NRAS. Ophthalmologists acted as a united body in order to protect the sight of their patients as it became clear neither AHPRA nor any other entity appeared to have the ability or will to protect these patients.

A lack of adequate oversight allowed the OBA to make a unilateral decision through an amendment presented as a guideline change, which was in fact a clear change of the scope of practice for optometrists. This change allows optometrists to now independently diagnose and manage the treatment of chronic glaucoma. This decision was made without consultation and agreement of the Medical Board, or any substantial consideration of submissions made by both ASO and RANZCO.

ASO and RANZCO have received clinical detail relating to jury verdicts and settlements against optometrists in the United States associated with the non-ophthalmological treatment of glaucoma in their country [Appendix 1]. This information alone is sufficient to indicate the critical need for further assessment to be made on the likely impact of the ill-founded change to scope of practice for optometrists that it flies in the face of a National Health and Medical Research Council

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(NHMRC) study that found ophthalmological oversight in this area is essential. Most importantly clear evidence of this non-clinically supported change will take some time to become apparent as potential malpractice cases typically take between 3 and 4 years to come to final adjudication. By this time much damage, including blindness, may have been caused unnecessarily to many patients in Australia. Clearly the implications are alarming and are directly due to the critical failings of the NRAS.

Without effective, or indeed any apparent oversight, AHPRA's individual health boards are operating independently without the authorisation of any competent recognised medical authority or clinical trials. There is no compunction to act collaboratively. Clearly they are making decisions for their profession without adequate consideration of the impacts on public safety. The ASO believes that the review must consider this critical issue separately and immediately as a matter of highest priority as it impacts directly and negatively on patient safety. As you are aware, patient safety is the principal consideration of this review.

PRINCIPAL ASPECTS REQUIRING PRIORITY ATTENTION

ASO concerns about the consultation process

The ASO has considered the NRAS Review consultation paper at length.

We feel it is disappointing that a number of the key objectives outlined in the terms of reference have not been sufficiently explored and the resulting review questions do not relate to how the effectiveness and efficiency of the National Scheme can be improved to the benefit of the communities our medical and health professionals serve. The primary focus of this review after almost four years of operation should be on ensuring systems and processes are streamlined to clearly meet established benchmarks and are of a high standard to ensure patient safety. Unfortunately, the National Scheme's key principles of transparency, accountability and fairness in its processes do not seem to have been assessed as part of the review.

Despite the reservations about the consultation process raised above, the ASO wishes to express appreciation to the Independent Reviewer for making himself and members of his staff freely and fully available for individual and group discussions during the consultation process.

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ASO RESPONSES TO CONSULTATION PAPER QUESTIONS

Accountability

1. **Should the Australian Health Workforce Advisory Council (AHWAC) be reconstituted to provide independent reporting on the operation of the National Scheme?**

No. ASO does not agree that AHWAC be reconstituted to perform this role, as it does not have a sufficient level of independence from AHPRA to be in a position to report on its performance and at this time there is no evidence that AHWAC would have sufficient skill to be able to assess and report on the performance of health professionals.

As AHPRA and the Boards operate as national entities, it is appropriate that their performance be measured and reported in line with the Commonwealth Regulator Performance Framework. The Framework provides a more independent method of measuring and reporting performance of regulators and should eliminate the need to reconstitute the AHWAC for this purpose.

Unfortunately despite any legislative and/or regulatory changes that might be made to the role and function of AHWAC, there will remain an underlying stigma, or certainly the perception of such a stigma, associated with the previous AHWAC that would make its reconstitution and future operation difficult especially when the role and functions of the new entity would be different.

The ASO recommends the establishment of a new, small and independent oversight body of between 7 and 9 members, with senior legal, senior medical, health, community and Government representation which may be titled something like National Health Commission (NHC) although there would have to be clarity around this and the operation of the Australian Commission on Safety and Quality in Health.

2. **Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues be addressed?**

No. ASO believes that there is little transparency on the criteria for how consideration will be given to changes in scopes of practice by the Council.

The resolution of cross-professional issues should not lie with the AHWAC. As cross-professional disputes relating to scopes of practice are about protection of public safety and standards of care, the ASO believes that AHWAC lacks an appropriate level of clinical expertise and knowledge of health economics to resolve these types of issues.

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With clarification of the core principles for scopes of practice and the development of a cohesive framework for the handling of unresolved cross-professional issues, a carefully selected "safe scope of practice" assessment group (SSoPAG) would be an appropriate oversight body reporting to the proposed National Heath Commission. This will ensure that issues are resolved in a transparent, accountable, efficient, effective and fair way. Given that these types of issues directly impact the public interest, it is paramount that these disputes are handled as a matter of urgency.

The assessment group should comprise the following members:

- a Chairperson who is a non-practising clinician or a retired judge;
- a specialist general practitioner;
- a specialist medical practitioner;
- a nurse;
- a former President of a Medical College;
- a community member; and
- a health economist.

It is imperative when extensions of scopes of practice occur, there are sufficient measures in place to ensure ongoing external reviews of clinical audit outcomes and urgent reviews of adverse events are undertaken to ensure public safety is protected.

Future regulation of health practitioners in Australia

3. **Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? Estimated cost saving $11m per annum.**

No. The guiding principle here should be that all Australians expect safety to be of paramount importance in the regulation of health professionals. They expect all health practitioners to abide by the same high standards and evidence-based methodology that governs their medical treatment regimes.

The nine low regulatory workload professions are recognised as such because of the small number of registrants. Low numbers of registrants does not necessarily equate to lower potential risk of harm, particularly as seems to be the recent historical precedence that has seen scope of practice changes in these groups indicating a move towards greater involvement in procedural activities.

There can be no doubt that this in turn will lead to greater adverse reporting and therefore increasing workloads on such boards. By amalgamating these nine health professions into a single board, with a separate oversight regulatory framework, costs may be reduced. It will not however have the capacity to acknowledge the unique differences in practice and accreditation requirements between these nine health professions nor would it have the capacity to respond uniquely to their clearly different roles and responsibilities.

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This structure may lead to an increased risk to public safety should these nine health professions extend their scopes of practice into areas which are likely to increase the risk of causing harm to the public. Included within these nine professions are optometry, physiotherapy, podiatry and chiropractic therapy. Examples of extensions in scopes of practice continue to be evident within para-medical specialities.

Optometrists are actively seeking to treat sight-threatening and life-threatening illnesses (should a misdiagnosis occur) without clinical medical oversight. Physiotherapists are seeking the right to order investigations and direct treatment of potentially limb-threatening or life-threatening illnesses (should a misdiagnosis occur). The discipline of Podiatry also includes podiatric surgeons who are currently seeking to expand their scope of practice to include major knee surgery. Additionally, Chiropractors are involved in chiropractic manipulation of the spine that can have permanent and disabling side effects if a misadventure occurs during treatment.

The Australian public expects patient safety to be of paramount consideration and importance, so any proposal that is based on consolidating functions purely for cost savings will only result in a lack of requisite expertise to govern the health professions and protect public safety.

It is important for these low regulatory workload professions who represent only 4% of the work of the NRAS, have their own board to allow for future growth and expansion of work capabilities into the future.

4. **Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and regulation through a single service? Estimated cost saving $7.4m per annum.**

The ASO believes that each profession should have its own board and there should be further consideration around the sharing of regulatory functions of registration and notifications. It is agreed that increased efficiencies in 'back office' functions could be highly beneficial in regards to costs of the National Scheme and further details would be required.

5. **Should the savings achieved through shared regulation under option 1 or 2 be returned to registrants through lower fees?**

All fees payable by health professionals should only cover the costs of the scheme within a particular profession.

Any anticipated financial savings through a shared regulatory function assumes there is no impact on patient safety or the number of notifications received. Without undertaking a robust cost analysis including any impacts on patient safety, the realisation of any fiscal savings is highly unclear.

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Regulation should not be seen as a profit-making activity and so if it is proved that not all collected registration fees are required then certainly the annual fee should be reduced accordingly. While if it is proved that fees historically have been set at too high a level and there is a significant surplus then perhaps a one-year moratorium on fees should be considered.

OTHER ASPECTS REQUIRING MORE ROUTINE CONSIDERATION, ATTENTION AND CHANGE

National Scheme entry

6. **Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?**

The criteria and process by which health professions are included in the National Scheme are not evident at this time. The number of practitioners, educational requirements, risk of harm to the public, and the cost-benefit analysis that supports proposals for inclusion of health professionals is currently unclear. AHPRA should define the parameters for handling of future proposals, approved by the Australian Health Ministers and then circulated.

All proposals must be based upon scientific evidence to prove validity and should not be based on risk. All other healthcare workers should be subject to a jurisdictional based code of conduct mechanism.

All future proposals must consider whether there is in fact ''a gap in care'' or ''a gap in service'' to determine viability of a health profession's proposal.

7. **Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?**

No. The guiding principle must be that all health professions included within the National Scheme must adhere to the same standards of evidence-based treatment and regulatory oversight.

This would give health care workers undue status and credibility. The state-based health care complaints entities can offer protection for dissatisfied consumers.

8. **Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?**

No. The ASO believes that AHPRA should develop the principles of this and the Australian Health Ministers should provide approval.

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Complaints and notifications

9. What changes are required to improve the existing complaints and notifications system under the National Scheme?

Substantial improvements are needed in relation to the complaints and notifications system under the National Scheme. For members of the public, it is difficult to differentiate between notifications and complaints. In recognition of this aspect, the ASO is supportive of one common entry point for complaints relating to the health system. It is paramount that the Boards, and their stakeholders, AHPRA and Health Complaints Entities work together to make improvements to the processes around complaints and notifications, and to the process of managing and completing notifications.

For involved parties, confidentiality should be respected and maintained at all times. All complaints should be held in the strictest of confidence until all evidence can be examined. It should be noted that professional reputation is highly valued by all health professionals and there is potential for injustice to occur if details of a complaint against a practitioner are made public and the complaint is found to be incorrect, mistaken or even malicious in nature. In such situations, the complainant may suffer no consequence but the practitioner may sustain reputational, as well as most certainly financial damage that cannot be undone, even if the complaint is withdrawn or a correction to the initial allegation is published. Appropriate implications for vexatious claims should be established so that potentially malicious abuse of the notifications system can be strongly discouraged.

Both communications and support are vital to the success of this type of system. A substantial change needs to be made to move from the current adversarial and legally based system to one that is focused on conciliation and rapid resolution wherever possible. These notifications/complaints can be devastating for involved parties and everything should be done to provide a process that reduces stress and the time over which an investigation lasts. It is important to protect the public but it is also just as important to support the professions in an insightful and respectful manner.

The Independent Reviewer makes reference in the consultation paper to Ontario, Canada that appears to achieve a benchmark in resolving complaints with a required completion date of 150 days with extensions only for very specific reasons. None of the complaints mechanisms within Australia come close to achieving this type of benchmark, which is substantially increasing the costs of the notifications/complaints system and is one area that with substantial reform will noticeably reduce costs.

The ASO strongly supports the introduction of KPIs that are closely monitored and are reported to the professional groups, the public and the Health Ministers.

There needs to be a better system to keep complaints outside the National Scheme to ensure that resources are not diverted away from notifications. The Medical Board

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acts to protect the broader public from harm through the use of a notifications system, and not resolve individual grievances.

There needs to be a thorough analysis of whether the handling of notifications is efficient, effective, and consistent and the outcomes proportionate. It is important to measure these factors against the consequential impacts on practitioners who are subject to the notifications.

The National Scheme must be confined to regulating medical practitioners, and other health practitioners through the notifications system to ensure that departures from practice are brought to the attention of the Medical Board, which will then work with the medical practitioner with the aim of keeping them in the workforce.

10. Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?

The introduction of a co-regulatory approach, such as now exists in Queensland would help to keep complaints outside the National Scheme, which would in turn help to eliminate the diversion of resources away from the notification system. It may also resolve the concern that has been expressed by some state health ministers that they have lost sight and control of complaints raised within their states. As it would require additional funding outside of the current NRAS funding there would first have to be a commitment of the states to this additional cost.

The Queensland co-regulatory model that includes notifications is less than six months old and its effectiveness is yet to be proven and costs associated with the model are not yet known. Continued monitoring should be done over the next 12 months to assess if this model would be a viable alternative to the current complaints models in other States and Territories.

11. Should there be a single entry point for complaints and notifications in each State and Territory?

Clearly the costs and effort involved in developing and maintaining a public awareness of any such system and then supporting the ongoing operation of any such system is high. The cost associated with effectively sustaining more than one such entry point is both significant and counterproductive. There should be a single entry point. It is felt that this should be a single national point with internal referral to state/territory as appropriate.

12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

Yes, performance measures should be adopted nationally to provide some information about the capacity and efficiency of the National Scheme. The ASO is cautious about agreeing to prescribed timeframes until it is obvious that the National

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Scheme is in a position to bind to them. AHPRA is not currently meeting the KPIs, which may mean that the KPIs are inappropriate; the organisation is under-resourced, or just inadequate to handle the tasks.

13. Is there sufficient transparency for the public and notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?

No. From experiences to date there is insufficient transparency in relation to disciplinary processes of the National Scheme. Clearer guidelines need to be developed by AHPRA in relation to notifications so that the process is more transparent for practitioners and members of the public. This document should clearly set out the requirements for AHPRA staff for the handling of any investigation with appropriate due process. This document should be reviewed periodically and be updated as necessary to ensure ongoing improvement.

In relation to the disciplinary process, notifiers should not have any more rights to information about the outcomes for individual practitioners than that of the general public through the public register administered by AHPRA.

14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

Yes, ASO supports this suggestion. A more flexible means of dispute resolution would be desirable, as it is well known that this leads to a more effective and efficient use of the legal system. A major concern about the complaint/notifications process is timeliness and the adversarial approach currently being used, which then leads to increased costs.

15. At what point should an adverse finding and the associated intervention recorded against the practitioner be removed?

For medical practitioners, adverse findings in relation to matters proven on the basis of rules of evidence, a rigorous evidence base and due process, comparable to those applying in court proceedings can be permanently published. There needs to be more discussion about where these findings are published. Allegations and unproven matters should not be published. Any disciplinary sanctions such as suspensions, conditions and undertakings should be published on the public register while they remain current i.e. until the Board has permitted the practitioner to return to full practice.

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Public protection

16. Are the legislative provisions on advertising working effectively or do they require change?

The Consultation Paper does not provide sufficient analysis of the impact of the current arrangements to be able to answer the question, although history shows that health boards do not enforce the advertising guidelines well across their professions. Advertising will always be contentious. It is felt that it is APHRA's responsibility to ensure that it provides regulation and then enforces the prevailing advertising guidelines strongly and appropriately.

17. How should the National Scheme respond to differences in States and Territories in protected practices?

The practice of medicine and that of other health practitioners will always be subject to individual jurisdictional laws. However, unless there are critical geographical reasons, then all States and Territories should move to uniform practices across regions. This is a fundamental part of being able to improve workforce mobility and also to appropriately provide training to international medical graduates who have relocated to Australia. Any differences in legislation identified between regions should be highlighted to the corresponding Health Ministers, requesting a commitment from them to progressively align the different legislation.

18. In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

No. The report on consultation on the National Code of Conduct should identify what legislation is needed to support the appropriate implementation of the Code to protect the public from risk of harm from a potentially large number of unregistered health practitioners.

19. Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

The ASO supports the AMA position that treating doctors should be exempt from the mandatory reporting provisions of the Health Practitioner Regulation National Law Act (the National Law).

There should be national consistency in as many aspects of the law as possible. At this time there is no demonstrable or published benefit from having mandatory reporting arising from the treating practitioner - health professional interaction. Based on this it

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appears appropriate to adopt the Western Australian and Queensland provision in a National context.

Workforce reform and health service access

20. To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?

ASO strongly supports the statements in the Consultation Paper suggesting that workforce reform and regulatory measures must be balanced against the need to ensure the safety of the public. ASO is of the view that some Boards are exploiting the objectives and guiding principles of the National Law to act as champions of their practitioners. This exploitation, in the broadest sense, has resulted in extensions of scopes of practice without any robust assessment of any of the following:

- the need;
- the safety risks to patients;
- any existence of accredited education and training programs delivering the required competencies;
- the impact on training for and care provided by other practitioners; or
- the costs to the healthcare system.

The ASO therefore does not agree that the National Boards and Accrediting Authorities charged with protecting the public from harm should have a proactive role in health workforce reform. It has already proved to be a real and severe conflict of interest.

21. Should a reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?

The ASO does not agree to the reconstitution of AHWAC to address workforce reform priorities and key health service access gaps. Issues pertaining to access by the public to health services have multiple factors and are largely within the jurisdiction of the State and Territory health departments. The training of a sustainable health workforce is also funded predominately at a state and territory level. The gaps in health services will become evident as judged by both outpatient and surgical waiting lists.

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22. To what extent are Accrediting Authorities accommodating multi-disciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?

This question is difficult to address as very little analysis has been provided as part of the consultation paper.

It is critical that the safety and protection of patients be paramount in the development of multi-disciplinary education and training resources.

Within each medical discipline there are key para-medical and nursing related bodies with which a multi-disciplinary collaboration is essential, for example ophthalmology, optometry, and orthoptics; and orthopaedics and podiatry. The need for multi-disciplinary education varies widely across medical and para-medical disciplines and could prove difficult to mandate.

23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

There is an inherent conflict of interest in establishing a formal link between educational institutions and the minimum qualifications required for entry to health professions. Medical courses, both undergraduate and postgraduate, as well as vocational training through various Medical Colleges are accredited through the Australian Medical Council (AMC). The Australian public has grown to trust general standards of education and this can only be diminished if there is any movement to lower the standards of entry expected in the provision of medical care.

Our educational bodies are in the best position to provide advice on educational standards and to ensure that Australia's workforce continues to be educated according to world's best practice.

We have regulators to protect standards of patient safety and education institutions to ensure a baseline standard that qualified health professionals in a particular profession have a demonstrated ability to deliver a minimum expected safety standard.

24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

The ASO is concerned about the fragmented and inconsistent approach by AHPRA to the requirements of overseas trained medical practitioners who are coming to Australia to train in supernumerary positions and then leave to return to their home

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country. This needs to be more consistently handled or centralised across the various States and Territories to ensure consistency.

The other area of concern for the ASO is how Area of Need (AON) and District of Workforce Shortage (DWS) posts are approved and handled through various departments of health. There are obvious inconsistencies and little transparency in how these classifications are determined. Often positions are not tenable from the perspective of a surgical practice with regards to operative practice opportunities or after hours (safe-hours) requirements. AON and DWS posts need to be assessed by the relevant professional group before they are declared.

National Scheme Governance

25. Should the appointment of Chairperson of a National Board be on the basis of merit?

Meritocracy is the basis on which the Australian health care system has been founded and this must continue to maintain its transparency and effectiveness. It is essential that the Chairperson have experience and familiarity with healthcare models and processes to protect and maintain the quality of services for patient safety and quality of care.

26. Is there an effective division of roles and functions between National Boards and Accrediting Authorities to meet the objectives of the National Law? If not, what changes are required?

The role of the Australian Medical Council (AMC) in accrediting medical training programs throughout Australia has ensured a robust and rigorous system for decades. The AMC is notably recognised for its world leading work throughout Australia and internationally. To maintain consistent standards for the care and protection of the public all 14-health boards must insist upon using this effective system..

An independent verification system is required to ensure that training standards are adhered to by all 14 health boards. This is of particular importance in boards such as physiotherapy, optometry, podiatry and chiropractic treatment, where extensions in scopes of practice will see these para-medical boards seeking to treat patients where misadventure and/or complications have a real potential for permanent disability or mortality.

It is essential that appropriate mechanisms be in place to ensure safe and fair application of decisions for accreditation.

The ASO would not support the development of a committee structure within the various health boards to handle this and believes this function should be handled separately.

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27. Is there efficient oversight for decisions made by Accrediting Authorities? If not, what changes are required?

The failure of the current system to provide sufficient accrediting oversight has resulted in ASO and RANZCO having to take legal action through the Queensland Supreme Court to ensure patient safety. Under the provision of the National Scheme, Accrediting Authorities (other than AMC) answer only to their relevant National Board. It is essential that clinical experts with a societal perspective in public safety have a determining role in extensions of scopes of practice.

The standards required need to be clearly transparent and be open to both comment and challenge. A report of the AMC was undertaken in the last two years and to our knowledge it has not been released as it was an 'internal report'. This procedure should be re-considered so that these types of reports are always made available and with evidence that the concerns are clearly being addressed.

Conclusion

The current NRAS has no authoritative, competent or robust system of oversight and accountability that guarantees the decisions of individual health boards are made only in the best interests of public safety. The current National Scheme cannot guarantee the effective and efficient regulation of health professions. It is the view of the ASO that a new entity, such as a National Health Commission (NHC) as we have suggested earlier should be established immediately to provide this function with administrative and coordination support provided by AHPRA. The AHWAC should not be reconstituted.

The primary purpose of the National Scheme is to protect the safety of the public and this is a critically important role. There certainly has to be a focus on access and development of a sustainable workforce for the future, however this could provide a fundamental conflict of interest in the considerations of AHPRA and its Boards. It is therefore imperative that workforce reform and health service access are identified as the principal activities of another entity, after the closure of Health Workforce Australia.

This review has the challenge of identifying the parts of the National Scheme where improvements should be made and should not focus on possible solutions that are governmental and reflective of overseas systems, which have fundamental differences from the Australian health system. The compulsion to change things because of political drivers or bureaucratic control needs to be resisted. Instead, those areas of improvement need to be given clarity and then key measures for success established. While cost is an important aspect of the successful operation of AHPRA and the National Scheme, the health professionals who fund the scheme are most concerned about efficiency and effectiveness.

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The ASO has a major concern with excessive costs relating to the timeliness and adversarial aspects of the current notifications and complaints system.

AHPRA has been highly successful in providing the registration function across all health professionals. AHPRA's major challenges now lie in the area of notifications and complaints, where emphasis should be towards developing national uniformity and consistent processes. Keys to its success will be transparency of activities, natural justice and timeliness. The concerns raised about the current notifications and complaints system are greatly amplified when prompt resolution is not achieved. This should be one of the key areas of focus of this review.

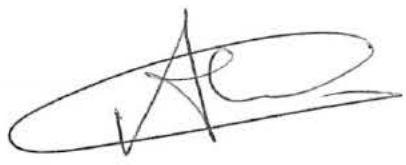
The key focus for AHPRA and its associated Boards should be on ensuring that effective and efficient processes are developed and maintained to meet the requirements of the National Law. It is the opinion of the ASO that the governing principle of the National Law should be that the same standards and evidence levels should be used by all healthcare professionals within the National Scheme and by their overseeing Boards.

It is critical that AHPRA articulate with clarity the principles that are applied for decision-making and ensure these are broadly communicated and understood within the health professions and by the general public. That will mitigate a number of ongoing concerns being raised by health professions.

The ASO appreciates the opportunity given to provide a submission to this critical review and remains available to the Independent Reviewer and Government to discuss the contents of this submission and to assist with the implementation of changes in the National Scheme.

Finally, the ASO would like to recommend that no matter what the final agreed changes are to the NRAS, a similar review be conducted in another three years or about 2018.

Yours sincerely



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June 18, 2014

Dr Brad Horsburgh
Vice President. RANZCO
Northside Eye Specialists
3/956 Gympie Rd
Chermside, Brisbane, 4032
AUSTRALIA.

Re: Malpractice Payments by Optometrists

Dear Dr. Horsburgh:

You have requested information pertaining to jury verdicts and settlements against optometrists in the United States associated with the provision of care in complex medical situations—such as glaucoma. To put my comments in perspective, I have served for over ten years as the President and Chief Executive Officer of Ophthalmic Mutual Insurance Company ("OMIC"). I would also like to introduce Paul Weber, JD, OMIC's vice president of risk management legal department who has over 20 year's serving ophthalmologists and their practices. OMIC insures over 4,500 ophthalmologists and 400 optometrists in the United States. I also have a perspective across the U.S. medical malpractice insurance industry from my position as Chair of the Regulatory Affairs Committee of the PIAA, the insurance industry trade association that represents a full range of entities doing business in the medical professional liability (MPL) arena. Therefore, we feel well-qualified to address this issue.

Mr. Weber and I recently reviewed payment reports processed by the National Practitioner Data Bank (NPDB) which indicate that the frequency of claims payments made on behalf of optometrists has been rising dramatically since 2009. In 2009, there were only 21 payments reported to the NPDB. By 2013 this number more than doubled to 48 reported settlements. The median payment for this five year period is $97,S00 and the mean is approximately $200,000. These are significant increases when compared to the 2011 report published in Journal of American Optometric Association (JAOA) showing a median payment of $S7,S00 and a mean of $1S6,000 (JAOA 1839(10),32-37).

The 2009-2013 NPDB data is also noteworthy in relation to treatment of glaucoma as it shows the large increase in the allegation code of "Failure/Delay in Referral Consultation". In the 2011 JAOA report mentioned above, Failure/Delay Referral was 7% of claims, however it has now risen to over 14% of the malpractice acts. Even more concerning is that 74% of these failure/delayed referral cases resulted in "Significant Permanent Injury" or "Major Permanent Injury" to the patient.

Regarding failure to treat glaucoma by optometrists, there have been two published reports of significant settlements against optometrists, $1.2 million dollars in New Jersey and $1.375 million in New York (See details below). These reports are from "Medical Malpractice Verdicts, Settlements & Experts". This publication comprises verdicts and settlements against both optometrists and ophthalmologists (as well as all medical specialties). Since 2010, these are the two highest reported settlements for failure to test or treat for glaucoma including for both optometrists and ophthalmologists.

I have been asked, "Why don't these large verdicts and the trend in claims payments lead to higher premiums for optometrists—closer to that paid by ophthalmologists". The answer is very straightforward and is actuarial in nature. Most optometrists in the United States do not manage complex glaucoma patients. Therefore, the number of 'opportunities' for potential malpractice is relatively small, and such cases typically take 3-4 years to come to final adjudication. Without large numbers of cases having yet moved through the system, there is little statistical information on which to base a request for higher rates. This is particularly true compared to an ophthalmologist who spends much of his or her time managing (including surgically) complex and sight-threatening cases.

In conclusion, although there is not a sufficient number of claims data to raise rates, the data emerging from the NPDB and jury verdict reporter is worrisome and should be seen as cautionary in increasing the scope of practice of optometrists regarding treatment of glaucoma and other complex eye conditions.

Please do not hesitate to contact me or Mr. Weber if you need any further assistance.

Sincerely,

Timothy J. Padovese

Timothy J. Padovese
President & CEO [redacted]

cc: Paul Weber, JD, ARM [redacted]

Reports:

MAY 2010

Failure to Test for Glaucoma—Glaucoma Causes Tunnel Vision and Balance Problems—$1.2 Million New Jersey Settlement. The plaintiff, age thirty-five, experienced diminished vision in 2005. His optometrist, Dr. Paul Ceran, referred him to a specialist. Glaucoma was a diagnosed. The plaintiff suffers tunnel vision, balance infirmity and loss of depth perception. The plaintiff claimed that Dr. Ceran, who had been seeing him since 1999, failed to test for glaucoma. Dr. Ceran claimed that the plaintiff had a sudden onset of glaucoma. According to a published account a $1.2 million settlement was reached. Mark Walsh and Catherine Walsh v. Paul Ceran, Morris County (NJ) Superior Court, Case No. MRS-L-183-08. Robert Francis Gold, Gold, Albanese and Barletti, Morristown, NJ for the plaintiff. Peter L. Korn, McElroy, Deutsch, Mulvaney and Carpenter, Morristown, NJ for defendant.

APRIL 2012

Failure to Act on Symptoms of Deterioration of Glaucoma—Man Becomes Legally Blind Before Referral to Ophthalmologist—$1,375,000 New York Settlement. The plaintiff, age fifty-five, began treatment for glaucoma with defendant Dr. Krall in February 2002. The treatment continued for seven years. The plaintiff claimed that during this time his eyes became increasingly painful and his vision progressively deteriorated. IN June 2009 the plaintiff was referred to an ophthalmologist, who determined that the plaintiff required surgery. The plaintiff's vision was stabilized, but the plaintiff

was still deemed legally blind. The plaintiff claimed that earlier intervention would have preserved much of his vision. The plaintiff claimed that Dr. Krall failed to act on his worsening symptoms despite increasing intraocular pressure. The plaintiff also claimed that degradation of this field of vision was reported and that he consistently reported that his eyes were becoming increasingly painful. The plaintiff claimed that a gonioscopy should have been performed. According to a published account a $1,375,000 settlement was reached. Glenn F. Peters and Kathleen Peters, his wife v. Robert F. Krall, O.D. and Millbrook Family Eyecare. Columbia (NY) Supreme Court, Index No. 2163/11. Alan S. Zwiebel, Zwiebel and Fairbanks, Kingston, NY for the plaintiff. Andrew F. Pisanelli, Milber, Makris, et al., White Plains, NY for the defendant.