

Dear Subcommittee,

Thank you for the opportunity to place a submission before you. My name is Terry Pitsikas, General Dental Practitioner residing and practising in Perth WA.

I have been following the IGA and COAG development with some interest but keep going back to the original concept and the original brief that was issued. This was that there be a national registration for health care professionals with the specific emphasis being " a national registration that allowed portability of registration, mobility of the health care work force and reduced red tape." I would like to comment on several issues as detailed below.

Reduced Red Tape

The IGA further stated "*2.3 At its meeting of 14 July 2006, the Council of Australian Governments (COAG) agreed to establish a single national registration scheme for health professionals, beginning with the nine professional groups then registered in all jurisdictions.*" I accept that this has been increased to 10 groups.

I cannot accept that the proposed National Registration Board [NRB] and associated legislation to be pushed through Qld parliament in any way reduces red tape. The bureaucracy that will develop is mind boggling and grossly complicated by a myriad of Boards, National sub- committees and state subcommittees. The sheer cost of such is immediately becoming a considerable issue which seems to be glossed over for now and the unbelievable inefficiency in what is proposed has not been discussed from what I have been able to ascertain.

The whole issue was brought to the public's attention by the "Dr Death" issue in Qld yet we are being told it is from a productivity report – "*1 In 2005, the Commonwealth Government asked the Productivity Commission to undertake a research study to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals and propose solutions to ensure the continued delivery of quality healthcare over the next 10 years. The report was delivered in January 2006.*" And further "*The report recommended that there should be a single national registration board for health professionals, as well as a single national accreditation board for health professional education and training; to deal with workforce shortages/pressures faced by the Australian health workforce and to increase their flexibility, responsiveness, sustainability, mobility and reduce red tape.*"

Bureaucratic Monster

It appears quite clearly that the COAG directives have snow balled well beyond the initial concepts and have created what clearly is rapidly becoming a completely unworkable bureaucratic monster that will destroy existing professional registration boards and consumer complaints processes. In WA with respect to dentistry consumers have 4 extremely good and easily approachable avenues to voice complaint –

1. Dental Board of WA
2. Office of Health Review
3. Australian Dental Association WA

4. State Administrative Tribunal

Protection of the Public

There currently exist significant degrees of overlap and co-operation between the first 3 entities and with an extremely good claims and resolution history. The NRB concept cannot and will not match the ease and efficacy that these entities deal with complaints. Patients have very little trouble in establishing whether a dentist is registered – a simple phone call often suffices. How will a NRB deal with such? Especially with EST differences and of course added issues with daylight saving. One of the objectives listed states “5.3 *The objectives of the national scheme, to be set out in the legislation, are to:*

(a) provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;”

How does the NRB concept improve upon the current model? The Dr Death issue could and more likely arise under a NRB concept. The Dr Death issue was due to inadequate human intervention. Dr Death in all reality would be accepted for registration as a medico under the proposed NRB. Unless human intervention occurred to check for suitability as a surgical registrar the same will occur under the NRB but with the greater possibility of mobility the risk can be inflicted nation wide not just in one state.

Another issue that greatly concerns me is which responsible entity will be given the role of implementing and ensuring the State health professional acts are complied with? Is there now to be a national dental act? Is there now to be national acts for all professions? Clearly the end result must be national acts of lowest common denominators even though the IGA states otherwise. Is it the intention that certain procedures that are permitted by one state registration act but not the others now becomes the norm? If not, then it must be the NRB intention to cause those practitioners to cease practice in that area.

Promoting Access to Health

I have real concerns with one of the stated objectives of the national scheme being “(d) *have regard to the public interest in promoting access to health services;”* Why is it a role of a NRB to be promoting access to health services? How can a NRB promote access to health services unless its intention is to allow broader registration? ie lowering of registration standards. How does this protect the public?

Reasonable Fees

Another stated objective is “5.4 *The scheme will operate under the following principles, to be set out in the legislation:*

(a) it should operate in a transparent, accountable, efficient, effective and fair manner;

(b) it should ensure that fees and charges are reasonable; and

Please see the attached schematic flow diagram titled the “New Scheme”

I would like an explanation as to how fees and charges can be kept reasonable given the proposed scheme has created 7 entities that have some input into registration – 8 if the Ministerial Council [MC] is included. Currently for registration of professionals we have State Boards that incorporate their own secretarial services.

- Ministerial Council [MC] – will the ministers offset some of their costs to the NRB? The MC has the power to appoint any person or body to exercise functions with respect to accreditation.
- Australian Health Workforce Advisory Council [AC] – 7 members no doubt all paid
- Australian Health Practitioner Regulation Agency [AHPRA] – provides administrative assistance to National Boards and have a National Office and **at least one local** office in each jurisdiction – possibly 30+ staff as well as Consultants Must have progress reports as well as Annual report. It will have a finance fund established.
- Agency Management committee [AMC] consisting of panel of **at least 5** and a CEO and no doubt paid positions and it will also employ further staff as well as consultants. There is an obligation for Progress reports and Annual Report
- 10 x National Boards [NB] of varying size. The minimum being 4 persons. This could easily engage 150+ personnel. NB can have Committees to exercise functions of NB or provide assistance and also develop standards
- State and Territory Committees – 80+ staff
- State and Territory offices which provides assistance [support] to the State and Territory Committees – 80+ staff

The bureaucratic monster is growing – funding will be an enormous issue as will be finding suitable staff and members for the Boards and Committees. ie State and National. Who will fund the NRB?

The efficacy of dealing with complaints whether professional or from the public can only become increasingly cumbersome with such large numbers of Staffing and various committees.

Restrictions on Practice

“5.4 The scheme will operate under the following principles, to be set out in the legislation

(c) it should recognise that restrictions on the practice of a profession should only occur where the benefits of the restriction to the community as a whole outweigh the costs.”

This is an ACCC / NCP fundamental. There is no place for such in a NRB. It is the role of registration to determine suitable qualifications and to determine restrictions on practice. These are governed by competency and training and not costs.

False Premise

It now appears COAG has another motive and is utilizing a productivity commission report based upon so called shortage of health care professionals. COAG has quoted some 350,000 registrants for nursing alone. Based upon a population of 22 million that is one nurse for every 63 people in Australia – man, woman and child. Is there a shortage? Is there a lack of incentive to work?

There are approx 12,000 registered dentists in Australia – one dentist per 1800 which is around the optimum.

What are the figures for the other professions?

Accreditation

The details are not clear on accreditation but it appears another bureaucratic monster is looming. The Australian Dental Council performs such currently. A council made up essentially of representatives from teaching facilities, the profession and the State registration boards. Self contained, simple, effective and relatively inexpensive.

Ministerial control over accreditation looms as a significant danger to the well being of the public as it is becoming increasingly more apparent the COAG drive is workforce driven and not registration driven. Where is the public interest?

Discipline

Logically how can an NRB deal with discipline of some 650,000 registrants? The current State registration Boards deal with this issue in an appropriate manner. Where will the hearings be held? If State Committees are handed this duty then is this not what we currently have? Who will pay for transport for hearings if not held in each state? Will hearings be held in the State of the offence given the increased mobility?

Professional Assessment

The same arguments as above apply.

Current System

State Professional Boards have served Australia effectively for over a century. The proposed NRB will see the complete dismantling of these and the loss of manpower and intellectual knowledge that is irreplaceable. Once the knowledge is lost and if the proposed NRB fails to deliver what is expected, then task of resurrecting the existing system will not be possible.

There is no argument from the professions for a need of a National Health Professionals Register ie a National Registrar.

The original concept of portability, mobility and less red tape were exactly what the professions and the public require but one must question just how frequently do health professionals practice across State borders and if they do what is wrong with multiple registration as it serves as a second “check”?

I would be pleased to expand upon any of the issues I have raised if required.

I would also be prepared to attend any consultation that may occur in Perth in March 2009 as indicated in the discussion paper.

Yours sincerely,

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The New Scheme

