Australian
Medical Council Limited

SENATE FINANCE AND PUBLIC ADMINISTRATION REFERENCES COMMITTEE

Inquiry into the administration of health practitioner registration by the
Australian Health Practitioner Regulation Agency (AHPRA)

Submission on behalf of an organisation:
Australian Medical Council Limited

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1. INTRODUCTION

The National Registration and Accreditation Scheme (NRAS) initiated by the Council of Australian Governments (COAG) and implemented in July 2010 represented the most radical reform of regulation of the health professions in Australia since the first Act of Parliament to regulate the practice of medicine in the British dominions was passed in 1837. The NRAS required dismantling of over 80 State and Territory regulatory authorities covering 10 health professions and multiple pieces of State and Territory legislation dealing with over 500,000 health practitioners. This structure is replaced with a single piece of national legislation, administered through 10 National Boards which are supported by a national agency operating through local offices in each State and Territory. The scale and complexity of this regulatory reform initiative is unprecedented in Australia.

Despite the challenges in implementing the national reform agenda, the fact that a national system is now in operation, albeit with some issues still to be addressed, is a credit to all those who have made a commitment to make the new national structure a success. This commitment to the NRAS includes not only the staff of AHPRA, who have worked under the most difficult circumstances imaginable, but also the existing organisations and health professions bodies that have worked with AHPRA to progress the national regulatory structure in health.

It is also important to recognise that AHPRA has not yet completed a full cycle of registration under the new legislative framework. Challenges associated with the implementation of new legislation often do not present until the legislation has been tested in its practical application. AHPRA is working with the National Boards to address problems experienced with the initial roll out of the Scheme and a number of these identified issues are being or already have been addressed. Organisations such as the Australian Medical Council (AMC) are working closely with AHPRA and the National Boards to identify operational challenges and to work through solutions to these issues.

There can be no doubt that once the national systems have shaken down and have overcome their initial implementation problems, the Australian community will be significantly better served.

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2. BACKGROUND TO THE AMC SUBMISSION

The Australian Medical Council is a national standards body responsible for the accreditation of basic medical education (University medical courses) and specialist medical education for the purposes of registration in Australia. It also administers the assessment of overseas trained medical practitioners for non-specialist (general) registration and facilitates the assessment of overseas trained specialists by the specialist medical colleges. The AMC was established in the mid-1980's by the Health Ministers and has over 25 years of experience in accreditation and examinations. It has been appointed by the (Health) Ministerial Council as the accreditation authority for the first 3 years of the national Scheme under the provisions of the Health Practitioners Regulation National Law Act 2009.

Prior to the implementation of NRAS in July 2010, the AMC was also involved in working with the former State and Territory Medical Boards on developing consistent national approaches to the registration of medical practitioners in Australia. In this capacity the AMC was also involved in the implementation of the 1992 mutual recognition scheme for medicine, the last major regulatory reform addressing registration issues prior to the NRAS initiative.

The AMC also has an international perspective on this issue, having been closely involved in the development of international standards for medical education through the World Federation for Medical Education and as a founding member of the International Association of Medical Regulatory Authorities.

3. ISSUES AND CHALLENGES

The inquiry of the Senate Finance and Public Administration Reference Committee has focussed on the following aspects of the AHPRA administration of the national regulatory process of the health professions:

1. The performance of AHPRA, including its capacity to administer the process, response times, and complaints processes.
2. The impact of the new national registration process, including any legal or financial liability on practitioners and service providers and the implications of the 'maladministration' of the registration process.
3. The budget and financial viability of AHPRA.

In order to undertake a fair and reasonable assessment of these issues, it is necessary to understand the scope of the challenge faced by AHPRA in implementing the COAG reform agenda.

Timing

Dismantling the existing state and territory based legal structures and establishing the new national regulatory framework involved the passage of a complex system of legislation to give authority to the new Scheme. Unfortunately, despite the optimistic timetable approved by COAG, two key pieces of legislation were delayed - Bill B, the key piece of legislation that specified the operational aspects of national registration for all 10 health professions, and the various Bills C, that dismantled the state and territory acts and transferred the authority to register, collect and maintain data and collect fees to the new national agency. Until these elements were enacted, many of the administrative and organisational steps necessary to commence the new system could not be established. In particular, this had implications for staffing, training, collection of registration data and testing of new operational and IT systems.

The requirement to maintain the momentum of the regulatory reform agenda necessitated short timelines on key consultations and review of key documents in support of the new initiatives. It is likely that longer timeframes in the consultation processes would have added insight and opportunity to anticipate and prevent some of the problems that have subsequently emerged from the implementation. This remains a concern in the roll out of the new Scheme, since the National Law requires consultation on a range of complex matters relating to the operation of the legislation.

The implementation of the 1992 mutual recognition scheme, which was less complex, retained the existing jurisdictions and organisational structures and had an appropriate lead-in time, still took 2 to 3 years to fully bed in.

Data Quality and Information Technology

One of the most significant challenges facing the Scheme has been the quality of the data transferred to the national registers from the existing state and territory registers and the IT infrastructure to support the registration activities of the National Boards.

Experience with the implementation of the 1992 mutual recognition scheme for medicine indicated that approximately 10% of the data collected from the State and Territory medical registers contained duplicate entries as a result of incorrect matching of the data held on individual practitioners on the separate state registers. Since the introduction of mutual recognition, considerable efforts have been made to improve the quality of data on the State and Territory medical registers. However, it appears that the quality of data varies considerably across the different professions that are now part of the national registration system. Addressing this variability would require very thorough data cleansing procedures prior to the transfer to the AHPRA-administered national registers. Since the AHPRA data set was a compilation of data drawn from the State and Territory registers, a significant number of the data quality problems experienced by AHPRA were inherited from these systems. It is important to note that AHPRA has undertaken considerable work to address the data quality issues. A recent project to cross match AHPRA registration data with AMC examination data for overseas trained doctors has confirmed that very few duplicate entries have been detected in the registration data sets.

Staffing and Communication

Experience with the implementation of new regulatory legislation in medicine, as occurred in Victoria, New South Wales and Queensland over recent years, has demonstrated the need for effective communication within the regulatory authority itself, as well as with key stakeholders and members of the profession. In the past major changes in processes or policy have been assisted by the presence of existing reporting channels, experienced personnel and established infrastructure and IT systems. However, in the case of the national registration projects and AHPRA, there has been a complete change of senior management with an unfortunate loss of expertise at both the state and national level. AHPRA staff now find themselves working under new reporting and management structures, dealing with health professions and issues which they have not previously encountered, operating under newly developed and unfamiliar legislation and navigating totally new and equally unfamiliar business processes and IT systems. Any one of these factors alone would have represented a significant challenge to a well established organisation, let alone to a new body with no corporate memory or established administrative practice and communication structures.

There is a wide variation in the size, experience and resources available to the bodies that work with AHPRA, including the 10 accreditation authorities for the currently regulated health professions. The AMC has found that communication has sometimes reflected a misunderstanding of these variations and of the capacity of independent accreditation authorities, with their own requirements for good business practices and due diligence, to review and respond to AHPRA plans in short time frames. Recent joint work between AHPRA, the National Boards and the accreditation authorities has helped to address some of the difficulties in communication and is based on a willingness of all parties to improve responsiveness and understanding. These processes will continue to require work.

Beyond Registration

A common misconception that has been brought to the attention of the AMC, is that the NRAS project is a straightforward transfer of existing registration functions and activities from the State and Territory regulatory bodies to the National Board and AHPRA. This view fails to recognise the additional requirements of Health Ministers in relation to the development and signoff of standards for each of the 10 health professions captured by the Scheme. This includes both registration standards and standards for the accreditation of programs of study and the institutions providing these programs. The development of these standards is complex and there are high-stakes for the educational institutions that provide the programs, the professions, health jurisdictions and the community. It requires careful consideration and stakeholder input. The consultation requirements, while essential to achieving national consistency, add to an already complex system and have contributed to time delays in other AHPRA processes. Again, there were no precedents for these in the legacy systems that were inherited by AHPRA from the State and Territory regulatory processes.

'Maladministration' of the Registration Process and Medicare

Accurate and up to date registration data is necessary to ensure the efficient operation of Medicare. If the registration data is not maintained in an accurate state it will have serious implications for Medicare. However, it is important to recognise that the Medicare and national registration databases are complex systems that need to be harmonised to ensure that accurate data can be accessed and processed.

In the initiatives to explore nationally consistent approaches to medical registration that pre-dated the COAG NRAS developments, the AMC was involved in a research project comparing data on approved providers from the Medicare databases with registration data from the State and Territory Medical Boards to establish how many medical practitioners held registration in more than one jurisdiction. In addition to a total pool of some 55,000 'active' registered practitioners, an additional 14,000 records were identified that had authority to bill Medicare but without current registration as legally qualified medical practitioners. At that time the problem appeared to be a failure to cross check provider numbers with registration data.

The new national registration system will be able to address this type of problem, since one of the advantages of the national process will be the capacity of the Medicare Australia to have direct access to a single registration data set through the national registers administered by AHPRA. The effectiveness of this type of access has already been demonstrated by the links that were established with the State and Territory medical registers for Medicare purposes prior to the implementation of NRAS. Again, the current problems experienced in this area can be seen as a direct consequence of the limited time available to test systems before going 'live'.

Budget and Financial Viability

The cost of establishing a single national authority to support the registration functions of 10 health professions ranging in complexity and scale from small health professions to nursing and medicine could be expected to be substantial. An indication of the lack of appreciation of the complexity of the NRAS project can be seen in the initial allocation of $19 million to set up the Scheme. The cost of the IT infrastructure alone would absorb this level of funding.

The National Registration and Accreditation Scheme has been established on a "user pays" principle, with the ongoing operational costs of the system funded from registration fees collected from each of the 10 professions in the Scheme. Since the Scheme is intended to cover both registration and accreditation activities, the professions are now solely responsible for funding both the oversight regulatory activities as well as monitoring the standards of education and, in some cases, postgraduate training. As a result governments (Commonwealth and State) are able to step away from funding all or part of these standards monitoring and quality improvement activities, although the final sign-off on standards rests with the Ministerial Council and not with the professions.

The AMC is concerned that the initial under-resourcing of AHPRA and the sole reliance on registration fees to cover both registration and accreditation activities may have a negative impact, in the long term, on the effectiveness of accreditation processes for medical education in Australia and the capacity to continue to maintain standards that reflect developments in professional practice, and changes in community need and government policy. An additional risk exists with the smaller health professions that may not have the number of registered practitioners needed to financially support high level and appropriately sophisticated accreditation processes.

Accreditation processes have the capacity to have a profound effect on quality of education and training, and on the alignment of training with government policy initiatives. The AMC submits that the value of accreditation, and the concentration of medical education delivery in the public health sector, means that there is an ongoing role for governments in supporting the quality assurance and quality improvement aspects of the accreditation of health professional education.

4. CONCLUSION

The AMC welcomes the opportunity to make a submission to this enquiry. The AMC strongly supports the National Registration and Accreditation Scheme. It has 25 years experience in setting standards for medical education, and has contributed its expertise to the implementation of the Scheme.

There are clearly significant challenges in rolling out a totally new regulatory and standards system on the scale envisaged for the NRAS project. The mutual recognition scheme implemented in Australia in 1992, which saw no loss of expertise and did not require dismantling the existing administrative structures, took some 3 years to bed down. Extrapolating from this experience, it would be reasonable to expect that the national registration project would also require some 2 to 3 years to acquire the necessary expertise, corporate knowledge and functional administrative and IT infrastructure to support the tasks that are encompassed in the National Law.

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