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

1. The Australian Doctors' Fund (ADF) maintains that the Australian Health Practitioners Regulation Agency (AHPRA) is a flawed, unsafe and unaccountable model for the registration and regulation of members of the Australian medical profession.

2. In this submission, **the ADF recommends that AHPRA no longer have any role in relation to the Australian medical profession and that the previous (pre-AHPRA) regulatory structures be re-established and upgraded in accordance with our recommendations at Point 25 of this submission**. This submission makes no recommendations in regard to other health professions or occupations which have been included in the national registration scheme.

Background

3. AHPRA was created as part of the National Registration agenda implemented by the Rudd federal government in co-operation with six state and territory governments which,
    1) dismantled or downgraded the Australian medical professions existing registration architecture,
    2) disregarded the existing national computer registration system known as the National Compendium of Medical Registries, which had been operating for many years,
    3) Ignored the existence of the Joint Medical Boards Advisory Committee, a national entity comprising the Presidents of all State and Territory Medical Boards.
    4) introduced a set of rigid registration classifications across all health professions and occupations, that disregards diversity of practice both within and between professions,
    5) created an agency (AHPRA) which is effectively unreachable by *any* parliamentarian, member of the public, or any member of a profession which it purports to regulate, particularly when seeking redress for its actions or corrections to administrative defects, hence denying any effective redress against its actions or lack of action.[1]

Mission Creep

4. The ADF notes that the AHPRA model which started as Health Practitioner Registration was soon transformed into Health Practitioner Regulation, also becoming the recipient of

[1] The ADF is currently involved in rectifying registration defects in the treatment of senior doctors. This will require representation in nine jurisdictions to both legislators and senior policy advisors, despite the fact that the proposal is consistent with the stated public policy of all political parties.

complaints against medical practitioners and other health professionals which is then directs on to its sub-committees. Furthermore AHPRA has been given the right to exercise direct control over professional boards so that their recommendations don't stray from the AHPRA agenda. **The ADF asserts that these restrictions severely limit the ability of the Medical Board of Australia to provide fearless and independent advice to legislators, particularly advice which would be in any way critical of the administration of AHPRA.**

"The Medical Board of Australia has used a process to develop this proposal consistent with the requirements set out by the Australian Health Practitioner Regulation Agency in the document Procedures for the Development of Registration Standards *(see www.ahpra.gov.au). The Board has made the following assessments, against the three elements outlined in the procedures."*[2]

Minority Shareholders

5. AHPRA is a creation of Council of Australian Governments (COAG), an unelected body which gives each jurisdiction (six state, two territory, and one federal) a 1/9 say in how AHPRA behaves. In reality, the process is directed and controlled by state and federal health department officials.

From Simple to Complex

6. In the pre-AHPRA model, branded as inefficient, the registration process for licensed medical practitioners was handled by a State Medical Board directly accountable to the Minister for Health in each state.

7. Under the new AHPRA-led model each state and territory health minister has delegated to COAG, which has in turn delegated to the Australian Health Ministers Advisory Council (AHMAC), which has delegated to AHPRA the responsibility for registering members of the Australian medical profession (on behalf of the Medical Board of Australia), who have then delegated this function back to what were previously State Medical Boards (now committees) as directed by AHPRA.

8. The line of communication for the old model was

   1 health minister → State Medical Board → medical practitioner

9. The line of communication for the new model is

   1 health minister → 8 health ministers → COAG → AHMAC →AHPRA → National Medical Board → State Medical Committees → medical practitioner

[2] Medical Board of Australia, Consultation paper, 27 October 2009, p17.

10. In summary, we have moved from one intermediary between health minister and medical practitioner to six intermediaries, or potential stopping points between a health minister and a medical practitioner. **This is extraordinary given that the state health minister is directly accountable to his or her constituency for the actions of medical practitioners in his or her state, but has no effective power to effectively legislate to protect those constituents.**

Early Warning Signs

11. The Project Director of the National Registration and Accreditation Implementation Project, Dr Louise Morauta, told the Senate Standing Committee on Community Affairs on 7 May 2009, *"Yes, It is quite a complicated structure. …. It is sort of underpinned by the IGA* [Inter-Governmental Agreement]. *We have a few things a bit like that around ….."* [3] [underlining added]

The Multiple Ministerial Model

12. On the question of accountability, Dr Morauta explained, *"The Boards are accountable to ministers; it's just that they are accountable to multiple ministers."* [4]

Press On Regardless

13. Despite clear evidence in May 2009 before the Senate that AHPRA was both complicated and virtually unaccountable, the then federal minister for health (The Hon. Nicola Roxon) chose to proceed. The reasons for proceeding which are further explained in this submission were primarily to use the national registration process along with changes to the CMBS to re-engineer the Australian health workforce as health minister Roxon explained in her speech of 20 September, 2008. *"And in doing so* [substituting nurses for doctors]*, we will not only be redressing the historical bias towards medical intervention and acute care, we will be redressing the historical bias against the traditionally female nursing workforce. A few good Labor principles all tied up in one set of reforms!"* [5]

A Solution Looking for a Problem

14. The ADF maintains that in the case of the Australian medical profession, the AHPRA model (as part of the National Registration and Accreditation Scheme or NRAS) was advanced without a compelling case. It's most public justification involved claims associated with public safety following the failure of the Queensland health bureaucracy to appropriately reference check a now convicted medical practitioner (recruited from overseas to fill a vacancy at a major

[3] Dr Louise Morauta, Project Director, National Registration and Accreditation Implementation Project, Senate Hansard, Senate Standing Committee on Community Affairs Inquiry into National Registration & Accreditation Scheme for Doctors & other healthcare workers, 7 May 2009

[4] Dr Louise Morauta, Project Director, National Registration and Accreditation Implementation Project, Senate Hansard, Senate Standing Committee on Community Affairs Inquiry into National Registration & Accreditation Scheme for Doctors & other healthcare workers, 7 May 2009

[5] The Hon Nicola Roxon MP, "The Light on the Hill: History Repeating", Annual Ben Chifley Memorial "Light on the Hill" Dinner, 20 Sep 2008

Queensland hospital). In addition, the medical profession was told that AHPRA (and the national registration process) was necessary to ensure that doctors could register in more than one state simultaneously. What should have been an upgrade to the existing database, was transformed into the central registration of over 400,000 health professionals and the creation of a new health bureaucracy.

"High profile cases of medical misconduct are being used to justify a combined national registration scheme for doctors and other health professionals."[6]

"Under the scheme, a health practitioner will only have to register once and will have that registration recognised throughout Australia. No longer will a health practitioner wanting to work interstate be required to hold additional or multiple registrations. This will be of particular benefit in responding to national emergencies where a workforce can be mobilised quickly from across the country. Patient safety will be improved by having a national register that will clearly identify whether a health practitioner is registered and any conditions that may be imposed on their registration."[7]

15. The above justification (for NRAS and the creation of AHPRA) ignored the fact that the highly publicised cases of alleged medical misconduct involved breaches of established safeguards, not defects in regulation architecture. A substantial amount of information was already available to decision makers in relation to these cases. In addition, medical boards started to offer online public access to their state registers well before 2009. Furthermore, the ADF can find no instance where doctors have been prevented from assisting in a national emergency because of registration jurisdictional issues. To the contrary, our doctors have responded with great speed and mobility to both national and international medical emergencies (e.g. Bali Bombings 2005, and Indian Ocean Tsunami 2004).

Professor Duckett's Unacknowledged Contribution

16. The ADF asserts that the publically stated 'patient safety' and 'national medical emergency' claims conveniently avoided a more thorough examination of plans to use national registration and AHPRA to facilitate unprecedented changes in the Australian health workforce as advocated by Professor Stephen Duckett in his 2005 paper entitled, 'Interventions to Facilitate Health Workforce Restructure'[8] and elsewhere.[9]

17. In this paper of June 2005, under the heading 'Change to structures' Prof Duckett advocates a radical change to the roles of health care professionals under the heading of 'Workforce flexibility' which he maintains requires changes to existing structures. He proposes "*The changes to facilitate flexibility outlined above can be undertaken **unilaterally by states changing registration board legislation** or by the Commonwealth changing the MBS*

[6] Michael Woodhead, "Push for National Registry", 6 minutes, 3 March 2008
[7] The Hon Nicola Roxon MP, "National Registration and Accreditation One Step Closer", Media Release, 7 October 2009
[8] Stephen J Duckett, "Interventions to facilitate health workforce restructure", Australia and New Zealand Health Policy 2005, 2:14.
[9] Stephen J Duckett, "Health workforce design for the 21st century, Australian Health Review, May 2005, vol 29, no 2.

arrangements."[10] Both these proposals are now a reality through the actions of COAG implementing national registration and the Commonwealth extending the MBS to cover 16 groups of "health providers".

18. Simultaneously Prof Duckett was a prominent contributor to COAG sponsored Productivity Commission Report dated 22 December 2005. In this report there are 16 references to his submissions. Remarkably the recommendations of this report closely mirrored Prof Duckett's proposals. The Productivity Commission also noted that its report, *"occurred in parallel with a review by CoAG Senior Officials of ways to improve Australia's health care system."* [11] The Productivity Commission Report was then used as a justification for introducing national registration and accreditation. In summary, there has been a remarkable convergence of events preceding the implementation of national registration and the creation of AHPRA.

19. Professor Duckett, a former secretary of the federal Department of Health and member of the National Health and Hospitals Reform Commission, as well as a consultant to state Labor health administrations in Queensland and Victoria prior to his most recent appointment as head of the Alberta Health Services in Canada (now ended), has remained actively involved in Australian health policy matters. On 5 March 2010, the Sydney Morning Herald reported, *"Doctor Duckett, who now heads Alberta Health Services in Canada, expressed doubt about the proposal to appoint local clinicians and community leaders to the boards of new "local hospital networks"."* [12]

AHPRA's Inherent Weakness

20. The ADF maintains that the AHPRA model's inherent weakness is that,
    1) It is not answerable to any specific parliamentary jurisdiction hence weakening public accountability for its decision making and administrative processes. **<u>This should be of grave concern to all legislators in all jurisdictions</u>**.
    2) Its real agenda is not the registration of health practitioners. This is a process it is using to fulfil a role substitution agenda designed to blur the boundaries of all health professions and occupations into a 'one size fits all' model. Evidence of this dual role is contained in the Health Practitioner Regulation (National Law) which created the national registration process. ***"The object of this law is to protect the public"*** [public justification]. Also listed in the objectives is ***"Innovation in the education of and the service delivery by health practitioners"*** [role substitution agenda].
    3) The model elevates the bureaucracy namely AHPRA and dis-empowers professional boards who are now subject to 'parameters' as laid our by AHPRA. In reality, the Medical Board of Australia is little more than a mirage. It has no staff and is directed by AHPRA. Even its website is submerged into the AHPRA identify. **<u>This should also be of grave concern to all legislators in all jurisdictions.</u>** The ADF therefore maintains

[10] Stephen J Duckett, "Interventions to facilitate health workforce restructure", Australia and New Zealand Health Policy 2005, 2:14, p 4
[11] Productivity Commission, "Australia's Health Workforce", Productivity Commission Research Report, 22 December 2005, p xv.
[12] Mark Metherell, "Boards and pricing pose challenges to hospital reforms", Sydney Morning Herald, 5 March 2010.

that there are no effective independent professional boards in the national registration process capable of offering fearless, independent advice to the Legislature. What has been created is the appearance of boards directly controlled by AHPRA - a triumph of semblance over substance.

Constitutional Validity Questioned

21. The ADF also maintains that in the case of the Australian medical profession, the legislation supporting national registration and AHPRA's role is constitutionally questionable, particularly since in the face of various state constitutions it claims the ability to overturn the constitutionally reinforced sovereign will of a state parliament within its own jurisdiction.

"A regulation disallowed under subsection (1) ***does not cease to have effect in the participating jurisdiction****,* ***or any other participating jurisdiction, unless the regulation is disallowed in a majority of the participating jurisdictions.****"*

*"****If a regulation is disallowed in a majority of the participating jurisdictions, it ceases to have effect in all participating jurisdictions*** *on the date of its disallowance in the last of the jurisdictions forming the majority.'*[13]

AHPRA's Administrative Record

22. The administrative deficiencies of AHPRA have been well publicised. Its inability to administer the registration function of thousands of health professionals including the medical profession (who were efficiently administered under the old system of state medical boards) is well known to the Senate Committee and to state and territory health ministers and the Federal Minister for Health. **What is not so well publicised is the substantial increase in registration costs** it has generated. As well as medical registration fees doubling in its first year of operation, doctors are now spending record amounts of time to register and confirm their registration. A sample of the complaints sent unsolicited to the ADF include the following:

a) *After paying $125 in September last year [2010] to be registered as a nothing (i.e.' non practising') I rang and emailed AHPRA a few times afterwards to ask why my name was not on the electronic searchable register. I eventually gave up after never getting a reply. However towards the end of the year my name did appear when one searched. My status was confirmed when 2 weeks ago I received a receipt for my $125 and a nice certificate to say that I was registered until 30/9/11. All was well with the world. But then this week I received (addressed to just 'Unnamed recipients') the following email: Dear Registrant, Your registration as a health practitioner lapsed on 31/1/2011 ……..etc Yours sincerely, Martin Fletcher, Chief Executive Office, [assumed AHPRA]*

b) ***I*** *have been a practising member of AMA for over 50 years in Victoria and a registered Orthopaedic Surgeon since 1973 in Victoria. I have paid my renewal fee with AHPRA in late October 2010. My cheque was sent to an address in Victoria and according to the Bank it has*

[13] Section 246, p 205 of the Health Practitioner Regulation National Law Bill 2009 at subsection 2 and subsection 3

been received but so far no renewal of registration. I cannot communicate with them on the phone.

c) *As you know AHPRA is a joke. My secretary spends days trying to get through only to be told that they are scanning applications from 1st December and his application went in on 9th December. Only after it has been scanned can it be considered. Meanwhile the poor chap is without an income and we are without a fellow.*

d) *I know of 2 other fellowship positions that will be giving up their fellowships because the paperwork to get through is so ridiculous. The end result will be fewer fellowship positions in Australia and fewer positions available to our graduates who want to go overseas. So much for a smooth transition to National Registration. A system that was supposed to make things easier and more streamlined than the state medical boards. What a joke!*

e) *..our new fellow started his AHPRA registration process mid 2010. After a lot of obstacles he received his Provisional registration in January. He then needed to get an occupational visa which he couldn't apply for until he received the AHPRA registration – this then took 8 weeks. He finally arrived this week 2 months late for his fellowship.*

No one should be under any illusion that this situation has improved. On 18 April 2011, the following complaint was sent unsolicited to the ADF out of sheer frustration:

f) I am a Sydney GP and I didn't receive notification of the expiry of my registration. I had to make three phone calls because my sent email was ignored and I had to make three phone calls to obtain the renewal papers. I was told by an AHPRA clerk by phone to attend the office in George Street, Sydney in person with completed papers to ensure that the renewal process was complete before my expiry date. This is absolutely indefensible. Is this the wonderful new efficient registration system we were all promised?

The Continuous Loop in the Search for Answers

23. The face of the faceless bureaucracy is evident to all who are victims of the continuous loop. This occurs when you ring the AHPRA 1300 number and a recording directs you to the AHPRA website which directs you to the AHPRA 1300 number.

The Hidden Face of the AHPRA Ombudsman

24. Perhaps the clearest evidence of the deluge of complaints concerning AHPRA's failure in public administration is the low profile of the AHPRA Ombudsman. The ADF has found no published names, telephone or fax numbers, and no email address. Those seeking the ombudsman's help are asked to write to the Office of the National Health Practitioner Ombudsman in writing at 30/570 Bourke St, Melbourne, Victoria 3000.

Recommendations

25. The ADF urges federal and state legislators to act decisively in the interests of public safety and public accountability to take whatever steps are legislatively necessary to implement the following recommendations:

    1) that the Australian medical profession be removed from any relevant legislation involving AHPRA,
    2) that the State Medical Boards be restored with majority medical representations and expertise, and with the responsibility of registration and complaints answering directly to the relevant state health minister,
    3) that the National Medical Board be constituted on the same grounds as the previous Joint Medical Boards Advisory Committee (JMBAC), namely that the board consist of the presidents of the medical boards of each state and territory with the right of the commonwealth to appoint one member and with appropriate staffing to support and maintain a national medical registry directly accessible to all state medical boards,
    4) that the National Compendium of Medical Registries be re-established and its computer systems upgraded to allow for multiple registrations of medical practitioners in each state (this register to be administered by a newly constituted National Medical Board to be located with the Australian Medical Council),
    5) that the independence of the Australian Medical Council be guaranteed in relevant state and federal legislation.

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