Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law

History & Context

1. In 2011, the Australian Doctors' Federation (ADF) (then named the Australian Doctors' Fund) presented its submission and appeared before the Senate Inquiry into AHPRA. Our 2011 submission is Appendix A of this submission. The ADF maintains that the issues raised in our 2011 submission remain largely unresolved.
2. In presenting this submission, the ADF refers specifically to the Australian medical profession which has a detailed history of professional standards regulation through state and territory legislatures.

The lessons of COVID-19

3. Senators are aware of how the Australian medical profession performed during the COVID pandemic. Australia's medical response saw State jurisdictions play a leading role with Health Ministers and Chief Medical Officers directing the response. The ADF maintains that the ongoing registration and regulation of the Australian medical profession must take into account the reality of State and Territory governments and their traditional role in the delivery and regulation of healthcare compared to a growing bureaucracy, in reach and authority, which does not report to a single jurisdiction and which now has direct administrative control over the professional lives of more than 600,000 Australian healthcare professionals. [1]
4. It is not surprising that during the COVID pandemic, AHPRA played no practical role in our medical response, other than to suspend its requirements for compulsory CPD and to recall senior medical practitioners. AHPRA had previously removed these senior medical practitioners from having any clinical privileges (prescribing, test ordering and referral) despite advice that such a move would prejudice our response to a national crisis.

The foundations of AHPRA

5. In 2009, the most senior Federal public servant and Project Director of the National Registration and Accreditation Implementation Project (which created AHPRA) Dr Louise Morauta told the Senate Standing Committee: ***"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 …"***[2]

[1] AIHW Workforce Statistics 2018 estimates 586,342 all health professions. Average growth rate over previous 5 years of 2.8%
[2] Senate Hansard 7 May 2009

From the simple to the complex

6. Prior to AHPRA, State Medical Boards regulated medical practice. The line of communication under this model was **State Health Minister-> State Medical Board -> Medical Practitioner.**
7. Following the introduction of AHPRA, the line of communication is **State Health Minister -> 8 other ministers -> COAG -> AHMAC -> AHPRA -> National Medical Board -> State Medical Committees -> Medical Practitioner.**

Broad objectives, broad authority and red flags

8. The ADF has major concerns with AHPRA's new "public protection" objective. Every agency of government is involved in public protection in some form or another. **However, there are major hazards with granting a substantial shared-jurisdictional bureaucracy, broad objectives and broad authority.**
9. **Since AHPRA has the authority to remove practitioners from active practice, it should have very specific objectives which follow clear legal pathways.** Abuse of authority is a known hazard of governance. A safeguard is to ensure that the objectives of those who are able to exercise authority have specific clearly defined objectives and are directly accountable to a single jurisdiction.

Maintaining public confidence objective

10. Specifically, the ADF has major concerns about MBA/AHPRA's interpretation of its objective of "maintaining public confidence in the profession". In particular, its behaviour in regard to those doctors who, although having no clinical adverse outcomes, have been suspended indefinitely on the basis of their exercise of free speech or because their social media comments may be considered to be controversial or unorthodox. This area of free speech and professional accountability is an extremely grey area. The ADF calls on the Senate to thoroughly investigate the boundaries of free speech and professional responsibility and AHPRAS's reach, and retrospective reach, into the private lives of health professionals.

Symptoms of a flawed structure

11. The proliferation of reviews and inquiries into AHPRA strongly suggests that its structure and purpose are not based on meeting real needs, but rather misplaced idealism. As such, the public is less protected since there is no hierarchy of decision making in regard to clinical decisions made by Boards. Any Board is virtually free to extend its scope of practice.
12. This flaw was exposed when the Australian Society of Ophthalmologists sought clinical clarification of scopes of practice with the Optometry Board of Australia.[3] AHPRA was clearly unable to resolve the issue, which was eventually settled after action was commenced in the Queensland Supreme Court.
13. The ADF notes AHPRA's advisory output (guidance) has grown substantially, as has its bureaucratic reach. The majority of medical practitioners have no time to read its growing library of guidance and advice, multiple revisions of Codes of Conduct, changes to the National Law, investigations into senior medical practitioners and continuous modifications to CPD.

[3] *Australian Society of Ophthalmologists & Anor v Optometry Board of Australia [2013] QSC 350.* File Number 5582 of 2013, Supreme Court Brisbane, 19 December 2013

14. In reality AHPRA can be described as a computer registration system which has extended its role because it can, whilst passing the hard work back to State Medical Committees.
15. The ADF maintains that it is the concept, not the personnel who work for AHPRA or serve on its Boards, that is problematic for the above-mentioned reasons. Those who work for AHPRA are simply trying to make a bad structure work.

What to do – structural reform

16. A way forward for the medical profession would be a return to reality, namely State- and Territory-based medical boards with licensed access to a national registration database. The Medical Board of Australia would then be the chairpersons of State and Territory Medical Boards. Each board would be responsible for its own state regulation. During the COVID-19 pandemic, we have seen state jurisdictions operating under independent decision-making, which is the reality. This would suggest that there is a need to ensure that regulators are located as close as possible to those being regulated.
17. The ADF maintains that direct political accountability will require a return to the State and Federal jurisdictions of all of the functions that AHPRA currently undertakes, if the public is to be effectively protected and if 600,000 health professionals are to be given justice and due process, which they deserve and are entitled to as Australian citizens.

What to do - mandatory reporting reform

18. Senators have been made aware of the adverse impacts of a mandatory reporting system. A major and fatal hazard to this system has been well publicised through the tragic circumstances of doctors and medical students not seeking help because those who they seek help from are required to report them (except in WA). The guidelines for Mandatory Reporting notifications for registered health practitioners are now 37 pages.[4]
19. The ADF recommends that the WA exemption be implemented nationally to ensure that impaired health professionals are not discouraged from seeking appropriate treatment. *"Treating practitioners in Western Australia providing a health service to a practitioner-patient are exempt from the requirement to make a mandatory notification but may still be obliged to make a notification as a non-treating practitioner."*[5]

The ADF thanks the Senate for their consideration of this submission.

Dr Aniello Iannuzzi
Chairman
Australian Doctors' Federation

Mr Stephen Milgate AM
CEO
Australian Doctors' Federation

[4] AHPRA---Guidelines---Mandatory-notifications-about-registered-health-practitioners.PDF
[5] Guidelines: Mandatory notifications about registered health practitioners, March 2020, Pg 2