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# Inquiry into the Performance of the Australian Health Practitioner Regulation Agency

Legislative Council

Legal and Social Issues Legislation Committee

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**Inquiry into the Performance of the Australian Health Practitioner Regulation Agency**

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# Legal and Social Issues Legislation Committee

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## Chair's Foreword

I have pleasure in presenting this Report from the Legal and Social Issues Legislation Committee into the performance of the Australian Health Practitioner Regulation Agency.

Ensuring that Victorians can receive high quality care from health practitioners is essential. This Inquiry presented a timely opportunity to review the performance of AHPRA and the National Registration and Accreditation Scheme since its implementation in July 2010, and to specifically assess the extent to which the Scheme is protecting the Victorian public.

Based on its evidence, the Committee has some concerns regarding the performance of AHPRA and the National Scheme since its commencement almost four years ago. The Committee acknowledges there is potential for many benefits in a national registration system, such as national consistency in standards, practices and process, and increased workforce mobility. Despite the many initial implementation problems experienced in 2010/11 and a significant increase in practitioner registration fees, the Committee acknowledges AHPRA's performance in the registration process has improved and accordingly, the Committee believes Victoria should remain part of the National Scheme with respect to registration and accreditation.

However, the Committee's report highlights a number of issues that must be addressed including improved handling of complaints, greater financial transparency, the need to provide ongoing funding to health programs supporting doctors, nurses and midwives, and a further streamlining of the large bureaucracy that supports the National Scheme.

A large part of this Report, and the Committee's investigations, deals with the health complaints process under the National Scheme which is designed to protect the public. Chapter Six concludes that there are numerous problems with the existing health complaints process in Victoria including time delays, inadequate communication, confusion over the roles of AHPRA, the Boards, and the Health Services Commissioner, inadequate rights of notifiers, and inadequate ministerial and parliamentary accountability and oversight. The Committee also notes that there is no longer national consistency in the health complaints processes, with 60 per cent of notifications now being managed by co-regulatory jurisdictions in New South Wales and Queensland.

The Committee's evidence indicates that the process for managing health complaints is best managed at a local level, rather than at a national level by AHPRA, and most importantly, with the main aim of protecting the Victorian public. Accordingly, the Committee believes it is timely for Victoria to consider becoming a co-regulatory jurisdiction with respect to managing health practitioner complaints.

The Committee greatly benefitted from the input received from many individuals and organisations throughout the Inquiry in the form of submissions, public hearing evidence and additional correspondence. The public's interest in this Inquiry increased as the Inquiry progressed with the issue of the health complaints process becoming a major focus.

I would like to take this opportunity to extend my gratitude to the Committee Members who worked on this Inquiry. In particular, I wish to acknowledge Mr Edward O'Donohue who chaired the Inquiry in the first six months. Finally, on behalf of the Committee, I express thanks to the staff of the Committee, Mr Richard Willis, Secretary, and Ms Sarah Hyslop and Mr Sean Marshall, Research Assistants, for their hard work and support to the Committee.

**GEORGIE CROZIER, MP**

**CHAIR**



# Findings and Recommendations

## Chapter Two: Establishment, Structure and Governance of National Scheme

### FINDINGS

- 2.1 The Council of Australian Government's Intergovernmental Agreement for a National Registration and Accreditation Scheme for health practitioners was signed shortly after Victoria had implemented structural and legislative reform for the regulation of Victoria's registered health professions. Some key components of the Victorian *Health Professions Registration Act 2005* were ultimately not carried forward when the Act was replaced by the *Health Practitioner Regulation National (Victoria) Act 2009*.
- 2.2 The final model for the National Registration and Accreditation Scheme differed from the Productivity Commission's recommendation that there be separate entities for the registration and accreditation functions.
- 2.3 Implementation of the National Law in 2009 to 2010 was not consistent across the States and Territories with New South Wales modifying the law as it applies in that State with respect to health, conduct and performance matters. In addition, Western Australia modified the mandatory reporting requirements in that State.
- 2.4 Despite the consolidation of numerous State and Territory health profession boards and administrations into one National Registration and Accreditation Scheme, the Scheme managed by AHPRA remains a large and complex bureaucracy with potential confusion over lines of responsibility and accountability.
- 2.5 The Victorian Minister for Health has less control over the registration and regulation of Victorian health practitioners than existed prior to the commencement of the National Scheme in 2010.
- 2.6 The tabling of an annual report by AHPRA in each State and Territory Parliament does not constitute sufficient accountability and scrutiny measures.
- 2.7 The establishment of 11 separate accreditation authorities does not reflect the Productivity Commission's 2006 recommendation that there be a single national accreditation authority.

- 2.8 Evidence indicates there is some support for further streamlining of the accreditation functions within the National Scheme.

## RECOMMENDATION

1. That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that the three-year review of the National Registration and Accreditation Scheme include consideration of the following:
  - the need for enhanced AHPRA accountability and performance reporting mechanisms to State and Territory Parliaments;
  - the need to streamline the functions of the separate accreditation authorities; and
  - the need for greater flexibility in the composition of National Boards, eligibility requirements and appointment of Chairs. In particular, the review should consider the merits of increased non-practitioner membership and flexibility to appoint non-practitioner chairs to National Boards.

## Chapter Three: Overall Performance of AHPRA

### FINDINGS

- 3.1 Health practitioners were highly critical of AHPRA's performance in its first 12 months of administering the National Scheme. The implementation problems are well documented in a 2011 Senate Committee report.
- 3.2 The numerous implementation problems with the National Scheme adversely impacted upon health practitioner confidence in AHPRA's administration of registrations and service delivery.
- 3.3 Evidence indicates AHPRA has progressed in the past two years to address many of the implementation problems associated with the registration process.
- 3.4 The majority of health practitioners support the general principles of a National Registration and Accreditation Scheme, believe the performance of AHPRA has improved and consider that the Scheme has the potential to create benefits including:
  - nationally consistent registration and accreditation processes, practices and standards;
  - enhanced workforce mobility and flexibility;

- operational efficiencies from economies of scale;
  - greater collaboration and learning between professions; and
  - delivery of a national database.
- 3.5 There remain several performance issues that require the ongoing attention of AHPRA including:
- time delays with the health complaints process;
  - inadequate communication and responsiveness;
  - lack of transparency and accountability;
  - inconsistent decision making; and
  - need for greater cost efficiencies.
- 3.6 There is a small, but important, group of practitioners which contends that the National Scheme is less efficient and effective than the previous state-based systems and as such believes the Scheme should be dismantled and that there be a partial or full return to the previous state-based system.

## RECOMMENDATIONS

2. That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that the three-year review of the National Scheme include a thorough examination of AHPRA's response to the 2011 Senate Committee's recommendations and stakeholder input into any implementation concerns that remain outstanding.
3. That Victoria remain committed to the registration and accreditation components of the National Scheme and that the Victorian Government remain a signatory to the Intergovernmental Agreement.
4. That the Victorian Minister for Health advise the Australian Health Workforce Ministerial Council that there remain a number of issues concerning the performance of AHPRA that must be addressed including:
  - time delays with health complaints processes;
  - inadequate communication and responsiveness;
  - lack of transparency and accountability;
  - inconsistent decision making; and
  - need for greater cost efficiencies.

## Chapter Four: Cost Effectiveness and Registration Fees

### FINDINGS

- 4.1 Evidence highlights concerns over AHPRA's cost effectiveness and transparency. In addition, AHPRA's Annual Report lacks sufficient financial data to comprehensively assess its cost effectiveness.
- 4.2 AHPRA's large operating expenses of approximately \$150 million resulted in significant increases in registration fees in the first year of the National Scheme. In some professions, such as the medical profession, registration fees have doubled since the commencement of the Scheme. However, the Committee notes that recent fee increases have been in line with the Consumer Price Index.
- 4.3 While it is difficult to assess, there are some concerns in evidence that the larger professions may be cross-subsidising smaller professions in the Scheme.
- 4.4 Additional performance reporting is necessary to assess the cost effectiveness of the 14 National Boards, the State and Territory Boards, and AHPRA national and local offices.

### RECOMMENDATIONS

5. That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that future annual reports of the Australian Health Practitioner Regulation Agency include additional information relating to the financial statements including:
  - total staff employed by the Agency including a breakdown of staff allocation for each office and broad function/unit;
  - a breakdown of the number of meetings held for each National, State and Territory Boards and their committees;
  - detailed income and expenditure breakdown for each National Board; and
  - cost analysis of the Agency Management Committee, the Australian Health Workforce Advisory Council and each State and Territory AHPRA office.
6. That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that health practitioner registration fee increases be no greater than CPI increases and that such be enshrined in the National Law.

## **Chapter Five: Health Programs for Doctors, Nurses and Midwives**

### FINDINGS

- 5.1 The Victorian Doctors Health Program and Nursing and Midwifery Health Program are important Victorian initiatives established prior to the implementation of the National Scheme to provide support services for the health and well-being of doctors, nurses, midwives and students. The continuation of these programs is vital to maintain productivity and well-being in the workplace and therefore plays an important role in the protection of the Victorian public.
- 5.2 The long term future funding and nature of these programs is uncertain. Evidence suggests the Victorian health programs should continue in their current form and that any proposed nationally focussed cross-discipline programs would be considered a retrograde step for Victorian doctors, nurses and midwives.

### RECOMMENDATION

7. That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that AHPRA be required to provide on-going funding for the continued operation of the Victorian Doctors Health Program and the Nursing and Midwifery Health Program to support Victorian registered practitioners in these professions. That such funding be provided without increasing health practitioner registration fees in real terms.

## **Chapter Six: Health Practitioner Complaints Process**

### FINDINGS

- 6.1 The Committee received evidence that there has been an effective reduction in the levels of supervision of international medical graduates since the National Scheme commenced which may adversely impact upon the protection of the public. This is particularly the case in some parts of rural Victoria where there is a higher prevalence of overseas trained doctors.
- 6.2 Mandatory reporting of notifiable health practitioner conduct is an important initiative under the National Scheme aimed at protecting the public. The Committee shares AHPRA's concerns that there is no longer a nationally consistent approach to mandatory reporting.

- 6.3 Evidence suggests that some confusion exists as to the circumstances which are required to be mandatorily reported.
- 6.4 There is evidence of lengthy time delays in the National Scheme's notification process together with, at times, inadequate communication and information from AHPRA to notifiers, practitioners and health service providers.
- 6.5 There are no current statutory timeframes prescribed under the National Law for completion of an investigation process. The Committee does not consider the proposed key performance indicators established by AHPRA commencing from 2014-15 are sufficient in comparison with statutory timelines now in force in the co-regulatory jurisdictions of New South Wales and Queensland.
- 6.6 Notifiers in Victoria have limited ability to appeal or seek review of a notification assessment decision. Notifiers have:
- fewer rights than they were previously afforded under the Victorian Health Professions Registration Act 2005;
  - fewer rights to appeal a decision than the practitioner involved; and
  - limited appeal and review rights compared to what exist in the co-regulatory jurisdictions of New South Wales and Queensland.
- 6.7 Approximately one-third of all notifications about health practitioners managed under the National Scheme were initially referred to health complaints entities. Evidence indicates this is an illustration of the confusion surrounding the respective roles of AHPRA and the Health Services Commissioner which can lead to delays and lack of public confidence in the complaints handling process in Victoria.
- 6.8 The health practitioner complaints processes managed by the NSW Health Care Complaints Commission and State-based professional councils is considered to be a highly successful and well established model. The NSW system provides a number of key features that differ from the National Scheme including improved timelines and communication, rights of review for notifiers, and enhanced accountability and oversight to the Minister for Health and to Parliament.

## RECOMMENDATIONS

8. That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that it undertake a review to ascertain the appropriate ratio of supervisors to International Medical Graduates.
9. That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that mandatory notification provisions under the National Law be specifically considered in the forthcoming three-year review of the National Scheme with the aim of achieving greater national consistency.
10. That the Minister for Health advise the Australian Health Workforce Ministerial Council that there are numerous problems with the existing health complaints process in Victoria including:
  - confusion and inconsistencies with the mandatory notification process throughout Australia;
  - time delays and inadequate communication during investigations;
  - delays associated with, and confusion with respect to, the roles of AHPRA, the Boards and the Health Services Commissioner;
  - inadequate rights of notifiers;
  - lack of consistency across all jurisdictions with New South Wales and Queensland now managing their complaints processes independent to the National Scheme; and
  - inadequate ministerial and parliamentary accountability and oversight.
11. That the Minister for Health advise the Australian Health Workforce Ministerial Council that Victoria will consider amending the *Health Practitioner Regulation National Law (Victoria) Act 2009* to become a co-regulatory jurisdiction for Part 8 (health, conduct and performance matters) of the National Law.
12. That the Victorian Department of Health examine the co-regulatory models of New South Wales and Queensland and consult with key stakeholders when reviewing a complaints process for the Victorian public which would ensure that:
  - rights of notifiers to appeal decisions are enshrined in legislation;
  - the Minister for Health has overall responsibility for the system;
  - performance is monitored by Parliament; and
  - time frames for dealing with complaints are set out in legislation.





# Acronyms

AAS – Australian Association of Surgeons

ATSIHP – Aboriginal and Torres Strait Islander Health Practitioners

ACNP – Australian College of Nurse Practitioners

ACN – Australian College of Nursing

ADAVB – Australian Dental Association Victorian Board

ADF – Australian Doctors Fund

AHPRA – Australian Health Practitioner Regulation Agency

AHWMC – Australian Health Workforce Ministerial Council

AMA – Australian Medical Association

AMC – Australian Medical Council

ANF – Australian Nursing Federation

ANMF – Australian Nursing and Midwifery Federation

AOA – Australian Osteopathic Association

APA – Australian Physiotherapy Association

APS – Australian Psychological Society

ASO – Australian Society of Ophthalmologists

ASOS – Australian Society of Orthopaedic Surgeons

COAG – Council of Australian Governments

COP – College of Organisational Psychologists

CPI – Consumer Price Index

HCE – Health Complaints Entity

HCPC – Health Care Professions Council (UK)

HRCA – Health Rights and Community Action

HIC – Health Issues Centre

HQCC – Health Quality and Complaints Commission

HSC – Health Services Commissioner

IGA – Intergovernmental Agreement

IMG – International Medical Graduate

LSILC – Legal and Social Issues Legislation Committee

MBA – Medical Board of Australia

MBQ – Medical Board of Queensland

MPBV – Medical Practitioners Board of Victoria

NMBA – Nursing and Midwifery Board of Australia

NMHP – Nurses and Midwives Health Program

NRAS – National Regulation and Accreditation Scheme

OHSC – Office of the Health Services Commissioner

QBMBA – Queensland Board of the Medical Board of Australia

RACGP – Royal Australian College of General Practitioners

RANZCP – Royal Australian and New Zealand College of Psychiatrists

RDAV – Rural Doctors Association of Victoria

VBMBA – Victorian Board of the Medical Board of Australia

VCAT – Victorian Civil and Administrative Tribunal

VDHP – Victorian Doctors Health Program

# Chapter One: Inquiry Process

## 1.1 Terms of Reference

On 23 October 2012, the Legislative Council agreed to the following motion:

That, with reference to the 2009-10 and 2010-11 reports of the Australian Health Practitioner Regulation Agency, tabled in this House on 8 February 2011 and 7 December 2011 respectively, and any subsequent reports of the Agency tabled in this House, this House requires the Legal and Social Issues Legislation Committee to inquire into, consider and report on the performance of the Australian Health Practitioner Regulation Agency including the cost effectiveness, the regulatory efficacy of and the ability of the National Scheme to protect the Victorian public and the Committee is required to present its final report no later than 29 November 2013.<sup>1</sup>

On 17 October 2013, the Legislative Council agreed to extend the Committee's reporting date to 13 March 2014.<sup>2</sup>

## 1.2 Inquiry Rationale

The Australian Health Practitioner Regulation Agency (AHPRA) commenced operations on 1 July 2010 following the introduction of the *Health Practitioner Regulation National Law Act 2009*. This law means that for the first time in Australia, 14 health professions are regulated by nationally consistent legislation under the National Registration and Accreditation Scheme (NRAS). AHPRA is the national agency which provides administration and operational support to the Scheme. Chapter Two provides background to the Scheme including governance arrangements.

The scale and complexity of the task in bringing together multiple professions and jurisdictions resulted in significant problems during the implementation stage. These problems are well documented in a 2011 Senate Committee review, details of which are outlined in Chapter 3 of this Report. However, the Legal and Social Issues Committee's evidence indicated that while many of these implementation problems were or are being addressed, there remain a number of issues necessitating further review.

The Committee notes that the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions indicates that the Australian Health Workforce Ministerial Council (AHWMC) will initiate an independent review of the scheme following three

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<sup>1</sup> Legislative Council, *Parliamentary Debates*, 23 October 2012, p. 4687.

<sup>2</sup> *Ibid.*, 17 October 2013, p. 3206.

years of operation (from July 2013).<sup>3</sup> At the time of concluding this Report, the terms of reference and details of this review had yet to be announced. The Committee is also aware that the Productivity Commission is reviewing its December 2005 report on issues impacting on the health workforce, including supply and demand of health professionals, and will be proposing solutions to ensure the continued delivery of quality healthcare over the next ten years.

The Ministerial Council review of the National Scheme and a possible further Productivity Commission review of health workforce issues may be nationally focused and may not specifically address issues of particular concern to Victorian health professionals and consumers (such as health programs for doctors and nurses, protection and well-being of Victorian health consumers, and the role of the Victorian Health Minister). The Victorian Parliamentary Legal and Social Issues Committee Inquiry therefore presents a timely opportunity to review the effectiveness of AHPRA since its implementation, and specifically assesses its impact on Victorian health practitioners and consumers. In support of the Inquiry, the Australian Medical Association (Victoria) noted:

...AMA Victoria supports this inquiry as a means of evaluating the effectiveness of the new national scheme... We think that this is an appropriate time to assess its performance.<sup>4</sup>

The Committee's evidence and Report confirm that the most important purpose of health practitioner regulation is to ensure the public is protected. Indeed, AHPRA's submission to the Inquiry noted:

The National Scheme aims to protect the public by dealing with practitioners who may be putting the public at risk as a result of their conduct, professional performance or health.<sup>5</sup>

As the Victorian Minister for Health commented when moving his motion to refer the Inquiry to the Committee:

The key thing here is that the primary task of registration authorities, beyond all else, is to protect the public. This is a key focus, and in conducting this inquiry members of the Legal and Social Issues Legislation Committee need to keep it at the forefront of their minds.<sup>6</sup>

During the Inquiry, the Committee noted significant developments in Queensland with respect to how complaints about registered health practitioners are received, assessed, investigated and prosecuted in that State. Reviews into the Queensland health complaints process subsequently led to the passing of legislation by the Queensland Parliament to reclaim responsibility for the complaints process from the National Scheme by the creation of a Queensland Health Ombudsman. The Committee discusses this important development in Chapter Six of the Report.

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<sup>3</sup> Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, 7.5.

<sup>4</sup> Australian Medical Association (Victoria), *Transcript of Evidence*, 29 May 2013, p. 50.

<sup>5</sup> Australian Health Practitioner Regulation Agency, Written Submission No. 40, p. 24.

<sup>6</sup> Legislative Council, *Parliamentary Debates*, 23 October 2012, p. 4688.

### 1.3 Powers of the Committee to Inquire into AHPRA

The Legal and Social Issues Legislation Committee has the power to investigate any annual report, estimates of expenditure or other documents laid before the Legislative Council in accordance with an Act, provided these are relevant to its functions. The Committee's function, as described in Legislative Council Standing Orders, is to inquire into and report on any proposal, matter or thing concerned with community services, education, gaming, health, and law and justice.<sup>7</sup>

Victorian legislation, in the form of the *Health Practitioner Regulation National (Victoria) Act 2009*, requires that annual reports of the Australian Health Practitioner Regulation Agency be tabled in the Victorian Parliament each year. To date, four annual reports have been tabled (2009-10, 2010-11, 2011-12 and 2012-13). These reports, together with the above Act, form the basis of the Committee's investigations into AHPRA and the National Scheme.

AHPRA is a national agency established by all States and Territories under a July 2006 Council of Australian Governments (COAG) intergovernmental agreement and by State and Territory legislation. Victoria's Minister for Health is a member of the Australian Health Workforce Ministerial Council (AHWMC) which has responsibility for the oversight of the implementation of the National Registration and Accreditation Scheme and performance of AHPRA. The recommendations within this Report are directed to the Victorian Minister for Health who is responsible for health services in the State and who may pursue matters within this Report with the AHWMC.

### 1.4 Inquiry Focus

The Committee's broad reference to examine the performance of AHPRA included an examination of:

- the cost effectiveness of AHPRA;
- the regulatory efficacy of the National Scheme; and
- the ability of the Scheme to protect the Victorian public.

The Committee did not narrow its investigations into the performance of AHPRA as a stand-alone entity. As will be explained in Chapter Two dealing with governance arrangements, AHPRA is one of many components of the National Scheme. The Department of Health, in its hearing with the Committee noted:

...AHPRA is just one part and one element of the national scheme, albeit an important and a central one. It is effectively the administrative arm of the 14 national bodies... Most of the statutory powers under the national scheme reside with the national boards rather than with AHPRA.

<sup>7</sup> Legislative Council, *Standing Orders 2010*, SO 23.02, p. 70.

The performance of AHPRA cannot be evaluated on its own, and I do not think you should read your terms of inquiry as being too narrowly cast about just the administrative arm, but really the administrative arm in the context of the total scheme. There is a requirement to address the performance of the national boards and other structural elements of the scheme, including the ministerial council.<sup>8</sup>

The focus of the Inquiry was inevitably shaped by the issues raised in written submissions and public hearing evidence. The Committee received evidence relating to the health practitioner complaints process including concerns over time delays, investigation processes, rights of notifiers and the extent to which the system provides adequate protection of the public. The future of programs to support the health of doctors and nurses, an important safeguard in the protection of the public, was also the subject of a body of evidence and emerged as a key focus of the Inquiry.

## 1.5 Receipt of Evidence

The Committee called for written submissions to the Inquiry on 21 November 2012 through public notices in *The Age* newspaper and *Weekly Times*. Further notification took place in the form of advertising on the Parliament website and a direct mail-out to numerous key stakeholders throughout Australia. The initial deadline for written submissions was 1 February 2013 and was subsequently extended to 1 March 2013 due to an increased level of public interest and a number of requests for additional time to submit. The Committee received a total of 55 written public submissions to the Inquiry (see [Appendix A](#)).

Public interest in the Inquiry continued throughout 2013 which resulted in numerous further contributions being received beyond the close of submissions. The Committee welcomed these valuable contributions which were received and accepted as non-published correspondence in accordance with previous practices. These late contributions largely focused on the health complaints process.

In addition to the receipt of written submissions, the Committee invited organisations and individuals to provide evidence at public hearings. The Committee's initial hearings with the Victorian Department of Health in December 2012, and with AHPRA in April 2013, provided the Committee with background information and advice on the operation of the National Scheme including possible matters for investigation. Further Melbourne public hearings were held on seven separate days throughout 2013, with 18 different organisations or individuals providing evidence.

In order to fully investigate the important legislative changes to the health complaints process in Queensland referred to earlier in this Chapter, the Committee conducted a day of hearings in Brisbane on 22 November 2013 with key Government, Parliament and other stakeholders.

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<sup>8</sup> Department of Health, *Transcript of Evidence*, 12 December 2013, p. 2.

The public hearing process concluded when the Victorian Board of the Medical Board of Australia (VBMBA), and AHPRA, gave evidence on 27 November and 11 December 2013 respectively. These final hearings aimed to provide key agencies with an opportunity to respond to matters raised in evidence throughout the course of the Inquiry and to update the Committee on operational matters. A full list of public hearing witnesses is provided in [Appendix B](#).

As noted above, the Committee received a number of submissions and additional correspondence relating to specific health complaints and pertaining to individual practitioners. Several of these matters have been highlighted in Chapter 6 dealing with the health complaints process and illustrate the wider concerns about complaint systems and processes. Nevertheless, it is important to note that the Committee has no power to act as a form of tribunal or system of review with respect to specific complaints against health practitioners or other individuals.

The Committee acknowledges the valuable contributions made by all submitters and public hearing witnesses, together with those individuals who submitted late correspondence. In particular, the Committee acknowledges the ongoing assistance and advice provided by the Victorian office of AHPRA and the Victorian Department of Health.





## Chapter Two: Establishment, Structure and Governance of National Scheme

In November 2009, the Victorian Parliament passed the *Health Practitioner Regulation National Law (Victoria) Act 2009*. The template legislation was initiated by Queensland Parliament, with Victoria joining the other States and Territories in adopting a national law to implement the National Registration and Accreditation Scheme.

The then Victorian Minister for Health, in presenting the Bill to the Victorian Parliament, noted:

The national scheme is a significant milestone in the reform of the Australian health care system. It creates a single national registration and accreditation system for ten health professions... The Victorian government is fully committed to the implementation of the national scheme for health professionals. The national law contains measures designed to protect both the public and practitioners and to facilitate greater workforce flexibility and mobility. It is a contemporary regulatory framework to support standards of excellence in the delivery of services in the Victorian health-care system.<sup>9</sup>

As noted earlier, the Health Practitioner Regulation National Law resulted in the establishment of the Australian Health Practitioner Regulation Agency which commenced operation on 1 July 2010. The Act involved the repeal of at least 66 State and Territory acts and regulations.<sup>10</sup> As the Department of Health highlighted in its evidence, from that date there were significant changes to the way in which health practitioner registration and accreditation were managed in Australia:

Over 90 registration boards were abolished and 38 separate administrations were abolished; 14 new National Boards were established, and 8 new state and territory offices and a national office, which is based in Melbourne. Over 600 staff transitioned, a new IT system was built, 1.5 million registration records were transferred, over 500 000 registrants were also transitioned and over 12 000 new registrants were grandparented into the scheme.<sup>11</sup>

### 2.1 Impetus for Reform

The change to a national health practitioner regulation system was linked to a 2005 Productivity Commission review into health workforce productivity, which led to a COAG agreement to establish a single national registration and accreditation scheme. However, the impetus for reform commenced over 20 years ago when 'mutual recognition' was enshrined in all jurisdictions' legislation in 1992, enabling medical practitioners to practice in other states (whilst being registered in one jurisdiction).

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<sup>9</sup> Legislative Assembly, *Parliamentary Debates*, 15 October 2009, pp. 3695-7.

<sup>10</sup> Department of Health, Written Submission No. 50, p. 5.

<sup>11</sup> *Ibid.*

In evidence to the Committee, the Victorian Department of Health outlined the impetus for reform that led to the National Scheme:

First was the public outcry over some fairly high-profile cases of a breakdown in professional standards, notably with Dr Patel in Queensland and Dr Reeves in New South Wales. We have had our own perhaps not quite so high-profile cases, but there have certainly been some problems. There has been continuing pressure to reform under Competition Policy and increasing demand from the professions for greater portability of registration across state boundaries as increasing numbers of people want to do locum work interstate or are required to be registered in every state and territory because of telemedicine requirements. All of those factors have been important, but probably the most important single factor in driving the national reform has been workforce shortages, so it is about cost efficiency and cost effectiveness but not about the actual regulators themselves; it is more about the health system and how to ensure that governments have available to them the levers to drive workforce reform.<sup>12</sup>

The Australian Medical Council (AMC), the accreditation authority for the medical profession under the National Scheme, noted that 'since 1992 when the mutual recognition scheme came into operation in Australia, gradually over time the medical boards and councils in Australia managed to work quite closely together.'<sup>13</sup> The AMC commented:

When NRAS was mooted in 2005-2006 there was already a lot of work being done on developing uniform standards for ID checking for English language proficiency, for certificates of good standing and so on. A lot of work had been done across the state boards that established a national perspective or a national dimension in what was happening in medicine. The move into NRAS was I think for medicine a little bit smoother than perhaps for some of the other councils and bodies and professions.<sup>14</sup>

In October 2002, the Victorian Department of Human Services commenced a review of the regulatory framework governing registered health professions. Key findings from stakeholder consultation included:

- cumbersome and inefficient legislative framework;
- poor separation of powers in disciplinary processes;
- lack of consumer confidence in the transparency and fairness of complaints handling;
- inefficiency and duplication in administration; and
- workplace inflexibility and poor practitioner/system quality linkages.<sup>15</sup>

The review led to the creation of the Victorian *Health Professions Registration Act 2005* which came into operation on 1 July 2007 and repealed the eleven separate health practitioner registration Acts previously in operation. The 12 professions regulated in Victoria under the 2005 Act were:

1. Chinese Medicine Registration Board of Victoria
2. Chiropractors Registration Board of Victoria
3. Dental Practice Board of Victoria

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<sup>12</sup> Department of Health, *Transcript of Evidence*, 12 December 2012, pp. 6-7.

<sup>13</sup> Australian Medical Council, *Transcript of Evidence*, 12 June 2013, p. 58.

<sup>14</sup> *Ibid.*

<sup>15</sup> Department of Health, Written Submission No. 50, p. 37.

4. Nurses Board of Victoria
5. Medical Practitioners Board of Victoria
6. Medical Radiation Practitioners Board of Victoria
7. Optometrists Registration Board of Victoria
8. Osteopaths Registration Board of Victoria
9. Pharmacy Board of Victoria
10. Physiotherapists Registration Board of Victoria
11. Podiatrists Registration Board of Victoria
12. Psychologists Registration Board of Victoria

In addition to the creation of 12 Victorian health profession registration boards, the 2005 Victorian legislation was notable for creating ministerial powers to approve Board codes and guidelines and to appoint non-practitioners to Boards and office-bearing positions. The Act also aimed to improve accountability and flexibility in the complaints handling processes and provided rights of appeal for persons making a complaint where a board decided to take no action.<sup>16</sup>

The Committee notes that the *Victorian Health Professions Regulation Act 2005* received Royal Assent in December 2005, the same time as the Productivity Commission review and six months prior to the COAG decision to create a single national registration and accreditation scheme. As will be noted later, important reforms made in Victoria at the time were to be changed, and in some cases weakened, only a few years later under the National Law.

## 2.2 Productivity Commission Review

In June 2004, the Council of Australian Governments requested the Productivity Commission prepare a paper on health workforce issues, including supply and demand pressures over the next 10 years. The Productivity Commission released its report in December 2005 titled *Australia's Health Workforce: Productivity Commission Research Report*. The report found that there existed:

- fragmented roles and responsibilities;
- compartmentalisation of workforce policy by profession;
- lack of an integrated 'cross profession' approach;
- inflexible and inconsistent regulation;
- lack of collaborative policy efforts;
- inhibition of changes to scopes of practice;
- limited incentives for delegation of tasks; and
- entrenched workforce behaviours heavily influenced by 'custom and practice'.

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<sup>16</sup> Department of Health, Written Submission No. 50, pp. 29-30.

The report also found that mutual recognition was seen as being ineffective in dealing with cross border practice.<sup>17</sup> Under previous mutual recognition laws, where a practitioner's registration was cancelled in one State or Territory, it was automatically cancelled in all others. However, this relied on the registration board that cancelled the registration notifying the other boards, and the other boards acting to remove the practitioner from their registers.<sup>18</sup>

As at December 2005 much of the accreditation task in Australia was undertaken on a national basis by over 20 different bodies, with considerable differences in approaches. Submissions to the Productivity Commission review were concerned that the accreditation arrangements reinforced traditional professional roles and boundaries and impeded job innovation. There were further concerns about the lack of consistency in the requirements that different accreditation agencies imposed on educational institutions. The solution in the submissions was seen to be the consolidation of the accreditation functions for the various professions within one national framework, thereby reducing inconsistencies and inefficiencies, reducing complexity, and avoiding duplication.<sup>19</sup>

The Productivity Commission favoured the single national accreditation approach, acknowledging that there would be some disruption and transitional costs. It also argued that an accreditation board should be separate from a registration board – being 'good regulatory practice' to separate the two, making them 'impartial and independent'.<sup>20</sup>

With respect to the registration of health professionals, the Commission's review noted 'the current fragmented and uncoordinated multiplicity of registration boards with their variable standards' inhibiting 'workforce efficiency and effectiveness', hindering 'workforce innovation and flexibility across jurisdictional borders', and increased administrative and compliance costs.<sup>21</sup>

The Productivity Commission's report called for the:

- staged introduction of a single national accreditation regime and agency to provide a basis for nationally uniform registration standards for health professions; and
- creation of a single national registration board with supporting professional panels, to provide for national registration standards for the health professions.<sup>22</sup>

AHPRA's submission to the Inquiry noted the significance of the Productivity Commission's recommendations in terms of reforms to the health practitioner workforce:

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<sup>17</sup> Productivity Commission, *Australia's Health Workforce*, December 2005, p. 137.

<sup>18</sup> Department of Health, Submission No. 50, p. 22.

<sup>19</sup> Productivity Commission, *Australia's Health Workforce*, p. 115.

<sup>20</sup> *Ibid.*, p. 122.

<sup>21</sup> *Ibid.*, p. 136.

<sup>22</sup> *Ibid.*, p. xiv.

...the Productivity Commission report presented a further and potentially seismic shift for health practitioner regulation in Australia by recommending a single national board for health professions be established, as well as a single national accreditation board for health professional education and training to deal with workforce shortages/pressures faced by the health workforce. These initiatives were proposed to increase these organisations' flexibility, responsiveness, sustainability, mobility and reduce red tape.<sup>23</sup>

The Committee notes later in this Chapter that the final governance arrangements for the National Scheme differ from the model recommended by the Productivity Commission. The Victorian Department of Health noted:

The governance arrangements under the National Scheme reflect a compromise that was agreed by COAG during framing of the Intergovernmental Agreement underpinning the National Scheme, in response to concerns raised by professional bodies about the recommended model.<sup>24</sup>

### **2.3 Establishment of the National Registration and Accreditation Scheme**

In July 2006, COAG agreed to establish a single national registration scheme for health professionals, beginning with the nine professional groups then registered in all jurisdictions. COAG further agreed to establish a single national accreditation scheme for health education and training.<sup>25</sup>

On 26 March 2008, a COAG Intergovernmental Agreement (IGA) was signed by the Commonwealth and all States and Territories to implement a National Registration and Accreditation Scheme by 1 July 2010.

The Intergovernmental Agreement states that COAG subsequently agreed to establish a single national scheme with one single national agency responsible for both the registration and accreditation functions. The Agreement stipulates that the National Scheme will consist of:

- a Ministerial Council;
- an independent Australian Health Workforce Advisory Council;
- a national agency with an agency committee;
- national profession-specific boards;
- committees of the boards;
- a national office to support the operations of the scheme; and
- at least one local presence in each State and Territory.

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<sup>23</sup> Australian Health Practitioner Regulation Agency, Submission No. 40, p. 8.

<sup>24</sup> Department of Health, Submission No. 50, p. 17.

<sup>25</sup> Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, 2008, 2.3-4.

The national office to provide administrative support to the operations of the Scheme is the Australian Health Practitioner Regulation Agency, which commenced operations on 1 July 2010. At that commencement date, 10 national boards were established covering the following professions:

- chiropractors
- dental practitioners
- medical practitioners
- nurses and midwives
- optometrists
- osteopaths
- pharmacists
- physiotherapists
- podiatrists and
- psychologists.

From 1 July 2012, the following four additional professions joined the National Scheme:

- Aboriginal and Torres Strait Islander health practitioners
- Chinese medicine practitioners
- medical radiation practitioners and
- occupational therapists.

The objectives of the National Scheme, as described in the Health Practitioner Regulation National Law, are to:

- a) provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
- b) facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction;
- c) facilitate the provision of high quality education and training of health practitioners;
- d) facilitate the rigorous and responsive assessment of overseas-trained health practitioners;
- e) facilitate access to services provided by health practitioners in accordance with the public interest; and
- f) enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.<sup>26</sup>

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<sup>26</sup> Section 3 (2) of the *Health Practitioner Regulation National Law 2009*.

The Committee notes that a key element of the National Registration and Accreditation Scheme is the 'bringing together [of] multiple jurisdictions and professions into a single regulatory framework.'<sup>27</sup> However, despite the Scheme's aim to achieve national consistencies, this was not achieved when each State and Territory adopted the Law in their jurisdictions.

An important aspect of the National Law implementation was the decision by New South Wales at the commencement to modify the Law as it applies in that State in order for NSW to retain its existing health complaints management process. Further, the Scheme commenced in Western Australia three months later (18 October 2010) and that State decided not to adopt the mandatory reporting requirements when transitioning to the National Scheme. More recently, Queensland has modified the National Law to join NSW to become a co-regulatory jurisdiction with respect to complaints handling. These issues are discussed further in Chapter Six.

AHPRA's inaugural annual report in 2009-10 noted that 'national registration will bring substantial benefits to the community, individual practitioners and to the health professions, including:

- **mobility:** practitioners with general registration can register once and practise in any participating jurisdiction in Australia;
- **uniformity:** there are consistent national standards in relation to registration and professional standards for each profession;
- **efficiency:** less red tape associated with registrations and notifications, over time, processes will be streamlined and there will be considerable efficiencies of scale;
- **collaboration:** sharing, learning and understanding of innovation and good regulatory practice between professions; and
- **transparency:** national online registers displaying all registered health practitioners, including current conditions on practice (except health-related conditions)'.<sup>28</sup>

Evidence from the Victorian Department of Health highlights that there were several reforms in the Victorian *Health Professions Regulations Act 2005* that were not carried forward into the National Law, these included:

- Ministerial powers vis a vis the setting of qualification requirements for entry to a profession that may adversely impact the health workforce;
- board powers to require evidence of continuing competence for renewal of registration;
- mandatory provision by registrants of data for workforce planning purposes;

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<sup>27</sup> AHPRA, Submission No. 40, p. 3.

<sup>28</sup> Australian Health Practitioner Regulation Agency, *Annual Report 2009-10*, p. 6.

- settlement of complaints by consent (alternative dispute resolution), between the board, practitioner and notifier;
- an internal review process for notifiers when their complaint is closed with no further action following an investigation, or proceeds to an internal panel hearing rather than to the tribunal;
- offences for persons who breach prohibition orders following conviction for a 'direct or incite' offence;
- Ministerial powers to approve codes or guidelines that impact on qualifications for registration, supervised practice, examinations, or scope of practice;
- Ministerial power to appoint lawyer members to National Boards;
- Ministerial power to appoint community members to chair National Boards;
- statutory governance requirements to ensure boards access suitable expertise prior to seeking Ministerial approval for new or expanded scheduled medicines endorsements.<sup>29</sup>

## **FINDINGS**

- 2.1** *The Council of Australian Government's Intergovernmental Agreement for a National Registration and Accreditation Scheme for health practitioners was signed shortly after Victoria had implemented structural and legislative reform for the regulation of Victoria's registered health professions. Some key components of the Victorian Health Professions Registration Act 2005 were not carried forward when the Act was replaced by the Health Practitioner Regulation National Law (Victoria) Act 2009.*
- 2.2** *The final model for the National Registration and Accreditation Scheme differed from the Productivity Commission's recommendation that there be separate entities for the registration and accreditation functions.*
- 2.3** *Implementation of the National Law in 2009 to 2010 was not consistent across the States and Territories with New South Wales modifying the law as it applies in that State with respect to health, conduct and performance matters. In addition, Western Australia modified the mandatory reporting requirements in that State.*

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<sup>29</sup> Department of Health, Submission No. 50, pp. 37-38.



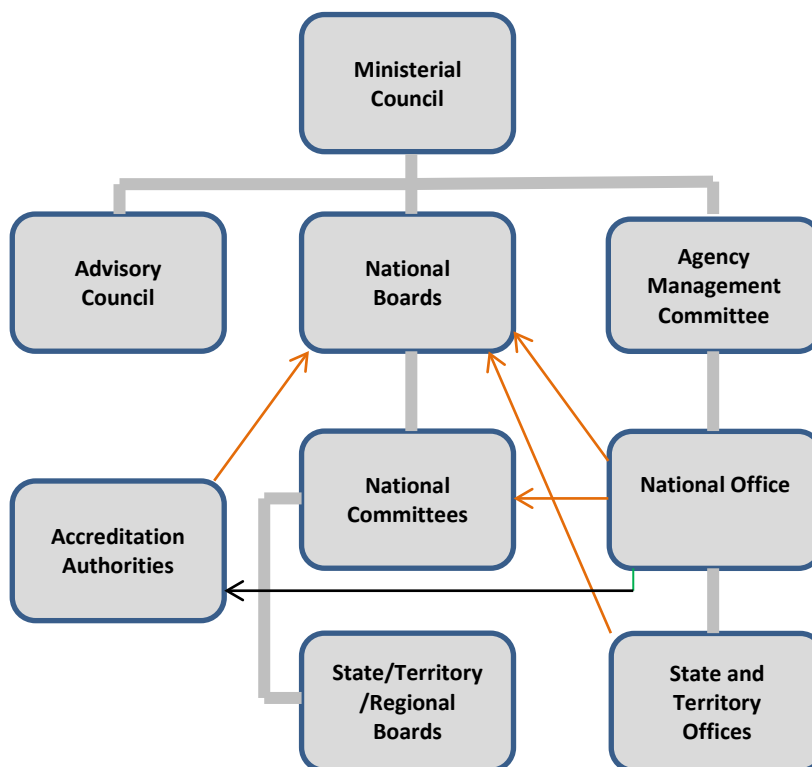
## 2.4 Structure of the National Scheme

AHPRA's first annual report notes that the 'success of the National Scheme depends on a number of different groups working in partnership to deliver the objectives.'<sup>30</sup> As outlined above, the creation of the National Scheme resulted in the abolition of over 90 registration boards and 38 separate administrations. However, the Committee's evidence has highlighted that the National Scheme continues to encompass multiple bodies with different, and at times, overlapping functions. The Scheme is now comprised of:

- a national agency (AHPRA) with national, State and Territory offices;
- 14 National Boards including national, State and Territory committees;
- 24 State/Territory Boards;
- two Regional Boards;
- an Agency Management Committee;
- an Advisory Committee; and
- 11 separate accreditation authorities and three accreditation committees.

The chart below illustrates the structure of the National Scheme while the following section describes each component. A more detailed diagram illustrating the complexities of the structure is shown in [Appendix C](#).

**Figure 1: Structure of the National Scheme**



<sup>30</sup> AHPRA, *Annual Report 2009-10*, p. 7.

Further bodies with key responsibilities in the Scheme include health complaints entities and responsible tribunals. In Victoria, the health complaints entity is the Office of the Health Services Commissioner (OHSC), while the tribunal is the Victorian Civil and Administrative Tribunal (VCAT).

#### **2.4.1 Australian Health Workforce Ministerial Council and Advisory Council**

The functional role of the Australian Health Workforce Ministerial Council (AHMWC), which comprises Commonwealth, State and Territory Health Ministers, is to provide high-level decision making and ministerial oversight for the scheme.<sup>31</sup> Under the Intergovernmental Agreement, the Ministerial Council is responsible for:

- providing policy direction;
- agreeing on the inclusion of new professions in the Scheme;
- proposing legislative amendments through processes of governments, consistent with the IGA;
- providing funding as appropriate in the set up phase of the Scheme;
- appointing members to the Advisory Council, National Boards and Management Committee of the national agency;
- approving profession-specific registration, practice, competency and accreditation standards and continuing professional development (CPD) requirements provided by the Boards;
- requesting Boards to review approved profession-specific registration, practice, competency and accreditation standards and CPD requirements;
- maintaining a reserve power to intervene on budgets and fees, with any intervention to be transparent; and
- initiating an independent review following three years of the Scheme's operation.<sup>32</sup>

The Agreement stipulates that the Ministerial Council, which includes the Victorian Minister for Health, cannot involve itself in the day-to-day operations of AHPRA and has no power to intervene in registration, examination or disciplinary decisions relating to individuals, or decisions relating to the accreditation of specific courses.<sup>33</sup>

An Australian Health Workforce Advisory Council is also in place to provide independent advice to the Ministerial Council about matters related to the National Scheme but not in relation to a particular person, qualification, application, notification or proceeding.<sup>34</sup>

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<sup>31</sup> AHPRA, Submission No. 40, p. 11.

<sup>32</sup> Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, pp. 5-6.

<sup>33</sup> *Ibid.*

<sup>34</sup> AHPRA, *Annual Report 2009-10*, p. 8.

According to the Intergovernmental Agreement, the role of the independent Advisory Council is to provide authoritative advice to assist the Ministerial Council in exercising its responsibilities under the Scheme. In making decisions in relation to the Scheme, the Ministerial Council must take into account any advice provided by the Advisory Council.<sup>35</sup> The Advisory Council comprises ‘an independent, eminent chair, who is not a current or recent health practitioner’ and six other members of whom three ‘should have appropriate health and/or education expertise.’<sup>36</sup> Members of the Advisory Council were in the first instance appointed by COAG but thereafter have been appointed by the Ministerial Council.<sup>37</sup>

AHPRA’s 2012-13 Annual Report notes:

The consensus decision-making of the Ministerial Council is a critical component of the National Scheme. It provides each state and territory Health Minister and the Commonwealth Health Minister the opportunity to debate and raise issues related to the National Scheme and make decisions at a national level that are informed by the administration of the health portfolio in their jurisdictions. There are also some important decisions and interactions that individual Health Ministers can make independently of the consensus decisions made by the Ministerial Council, for example, appointments to state and territory boards.<sup>38</sup>

The Committee’s evidence, highlighted in later chapters, discusses the Victorian Minister for Health’s role and powers under the National Scheme, particularly with regards to the Boards’ relationships and accountability to the Minister.

#### **2.4.2 National Boards**

The 14 National Boards in the National Scheme are:

- Aboriginal and Torres Strait Islander Health Practice Board of Australia
- Chinese Medicine Board of Australia
- Chiropractic Board of Australia
- Dental Board of Australia
- Medical Board of Australia
- Medical Radiation Practice Board of Australia
- Nursing and Midwifery Board of Australia
- Occupational Therapy Board of Australia
- Optometry Board of Australia
- Osteopathy Board of Australia
- Pharmacy Board of Australia

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<sup>35</sup> *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions*, Attachment A, 1.2.

<sup>36</sup> *Ibid.*, Attachment A, 1.9.

<sup>37</sup> *Ibid.*, Attachment A, 1.10.

<sup>38</sup> AHPRA, *Annual Report 2012-13*, p. 19.

- Physiotherapy Board of Australia
- Podiatry Board of Australia
- Psychology Board of Australia

In addition to the 14 National Boards, the professions of medicine, nursing/midwifery and physiotherapy each have separate State and Territory Boards (28 in total). There are also four regional Boards for psychology, with Victoria covered by the ACT/Victoria/Tasmania Board of the Psychology Board of Australia. Several boards also have extensive standing committees. Details of the National Board structures are outlined in Appendix D.

AHPRA's 2012-13 Annual Report states the main responsibilities of the Boards are to:

- develop national registration standards for their professions;
- develop and approve codes and guidelines;
- approve national accreditation standards developed by the accreditation authority for the profession;
- register suitably qualified and competent persons;
- deal with notifications about the health, conduct or performance of registrants (and in specific circumstances, registered students); and
- set national fees.<sup>39</sup>

The Intergovernmental Agreement stipulates that all National Boards will comprise:

- a chair who is a member of the relevant profession;
- at least 50 per cent of the remaining members from the relevant profession, with no more than two-thirds of the board including the chair being members of the relevant profession; and
- at least two community members.<sup>40</sup>

### **2.4.3 The National Agency (AHPRA)**

The Australian Health Practitioner Regulation Agency is established under the National Scheme as the national agency responsible for providing administrative and operational support to the National Boards. Specifically, AHPRA:

- manages the registration and renewal processes for health practitioners and students around Australia;
- supports the National Boards in the development of registration standards, codes and

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<sup>39</sup> AHPRA, *Annual Report 2012-13*, p. 19.

<sup>40</sup> Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, p. 14.

guidelines;

- on behalf of the National Boards, manages investigations into the professional conduct, performance or health of registered health practitioners (except in NSW);
- maintains online registers that publish accurate and up-to-date information about the current registration status of every registered health practitioner in Australia.<sup>41</sup>

AHPRA has local offices in each State and Territory. The role of each office entails the:

- receipt and management of local enquiries regarding registration and registered practitioners;
- receipt of applications for registration and renewal of registration and management of local processes associated with these;
- receipt and processing of complaints against registered practitioners;
- monitoring of conditions on registration and management of impaired practitioners; and
- provision of administrative support as needed for local committees set up by the boards.<sup>42</sup>

#### **2.4.4 Agency Management Committee**

AHPRA is governed by the Agency Management Committee, which is responsible for overseeing AHPRA policy and ensuring AHPRA functions properly, effectively and efficiently in working with the National Boards. Committee membership comprises:

- a Chair who is not a registered health practitioner and has not been a health practitioner in the last five years;
- at least two people with expertise in health and/or education and training; and
- at least two people with business or administrative expertise who are not current or previously registered health practitioners.

Members are appointed for up to three years by the Ministerial Council.<sup>43</sup>

#### **2.4.5 Accreditation Authorities**

The functions of the accreditation authorities, defined in the National Law, are to:

- develop program accreditation standards for assessing qualifying programs for entry to the professions;
- assess programs of study for registration or endorsement purposes;

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<sup>41</sup> AHPRA, *Annual Report 2012-13*, p. 22.

<sup>42</sup> Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, p. 13.

<sup>43</sup> AHPRA, *Annual Report 2012-13*, p. 20.

- recognise the equivalence of overseas regulatory bodies (competent authorities);
- assess overseas qualifications for equivalence with Australian standards; and
- examine overseas trained practitioners.<sup>44</sup>

AHPRA's submission outlines that 'each National Board is required under the National Law to decide who will exercise the accreditation functions for the profession; either a single external accreditation body (such as a council) or a special committee established by the Board.'<sup>45</sup>

Eleven National Boards have delegated accreditation functions to external authorities. The Aboriginal and Torres Strait Islander Health Practice Board of Australia, the Chinese Medicine Board of Australia, and the Medical Radiation Practice Board of Australia have established internal accreditation committees. The 14 accreditation authorities are:

- Aboriginal and Torres Strait Islander Health Practice Accreditation Committee
- Chinese Medicine Accreditation Committee
- Council on Chiropractic Education Australasia
- Australian Dental Council
- Australian Medical Council
- Medical Radiation Practice Accreditation Committee
- Australian Nursing and Midwifery Accreditation Council
- Occupational Therapy Council (Australia & New Zealand) Ltd
- Optometry Council of Australia and New Zealand
- Australian and New Zealand Osteopathic Council
- Australian Pharmacy Council
- Australian Physiotherapy Council
- Australian and New Zealand Podiatry Accreditation Council
- Australian Psychology Accreditation Council

Later in this chapter, the Committee comments on the structural arrangements for the accreditation functions.

#### **2.4.6 Health Complaints Entities**

AHPRA works with the health complaints entities in each State and Territory to ensure the appropriate organisation investigates community concerns about registered health practitioners.<sup>46</sup> In Victoria, the entity is the Office of the Health Services Commissioner.

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<sup>44</sup> Department of Health, Submission No. 50, p. 18.

<sup>45</sup> AHPRA, Submission No. 40, p. 12.

<sup>46</sup> AHPRA website, <http://www.ahpra.gov.au/Notifications/Fact-sheets/Health-complaints-entities.aspx>, accessed 5 December 2013.

The Committee received a body of evidence dealing with the respective roles of the OHSC and AHPRA in the complaints process. These issues are dealt with in Chapter Six.

#### **2.4.7 Responsible Tribunal**

Section 6 of the *Health Practitioner Regulation National Law (Victoria) Act 2009* declares that VCAT is declared to be the responsible tribunal for this jurisdiction for the purposes of the Health Practitioner Regulation National Law (Victoria).

### **2.5 Comment on Structure and Governance Arrangements**

The Committee's evidence has highlighted several concerns with the existing structure and governance arrangements within the National Scheme. These can be summarised as follows:

- large and complex bureaucracy which can be difficult to navigate and results in public uncertainty with respective roles and functions;
- no one single person or authority responsible for Victoria's health complaints;
- composition of National and State Boards is too heavily weighted towards practitioners; and
- additional streamlining of accreditation agencies could be considered.

#### **2.5.1 Size and Complexity of Scheme**

The Committee's evidence illustrates that while the National Scheme has seen a reduction in the number of health practitioner boards and staff throughout Australia, together with a consolidation of the legislative framework, the new Scheme is supported by a large and complex bureaucracy with some confusion over lines of responsibility and accountability. These concerns are further illustrated in regards to the health complaints process which is dealt with in Chapter Six.

In summary, the existing health practitioner regulation arrangements in Victoria are managed by the Victorian AHPRA office. There are 14 National Boards with three separate Victorian Boards for medicine, nursing/midwifery, and physiotherapy. There is also a regional Board for psychology: the ACT/Victoria/Tasmania Board of the Psychology Board of Australia. The Dental, Medical, Nursing/Midwifery and Psychology Boards all have standing committees for Victoria (and other jurisdictions).

Each National and State Board has a series of internal committees which deal with accreditation, registration, notifications assessment, immediate action on notifications, performance and professional standards, finance and governance and other matters including communications and overseas qualifications assessment.

A detailed structure of the National and State Boards, together with Committees, is shown in [Appendix D](#).

The Boards work in partnership with AHPRA which is overseen by an Agency Management Committee. All of these bodies report to the Ministerial Council comprising all State and Territory Health Ministers. The Ministerial Council receives advice from a separate Advisory Council. Then there are the separate accreditation authorities, health complaints entities and tribunals.

Further, as highlighted in Chapter Six, the health practitioner complaints process is managed by AHPRA and the Boards in partnership with a separate entity, the Victorian Office of the Health Services Commissioner.

AHPRA points out in its submission that:

While the structure of the National Scheme and reporting relationships between the key entities may appear complex on paper, on a daily basis the National Scheme is delivered by AHPRA in partnership with the National Boards, with the Ministerial Council providing high level oversight, and accreditation authorities exercising accreditation functions for the professions under the Scheme.<sup>47</sup>

The Victorian Office of the Health Services Commissioner, which works in close partnership with AHPRA in managing health complaints, raised some concern over the structural arrangements which lead to time delays:

The consolidation of over 90 registration boards with 38 separate administrations across the States and Territories into 14 new national boards, 8 State/Territory offices and a national office was a significant task. It is worth noting AHPRA is the administrative arm of a much bigger organisation. All the power vests with the National Boards and is delegable by each of the National Boards. This has meant that AHPRA institutes different processes for different National Boards which has created some frustration about what AHPRA can and cannot do without reference to the Board and has led to delays.<sup>48</sup>

The Victorian Department of Health's submission noted the benefits of the National Scheme such as streamlined and uniform registration standards and increased workforce mobility. However, the Department also noted the 'increased size and complexity of the regulatory agency may be more difficult to navigate for outsiders, with more distance between where issues arise and where decisions are made.'<sup>49</sup>

The Department highlighted the scope for possible further rationalisation of the Scheme:

With respect to the number of government appointed members on boards, the analysis shows that

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<sup>47</sup> AHPRA, Submission No. 40, p. 10.

<sup>48</sup> Health Services Commissioner, Submission No. 5, p. 1.

<sup>49</sup> Department of Health, Submission No. 50, p. 39.



under the National Scheme, there is a total of 400 members appointed to statutory boards under the National Scheme: 144 National Board members, seven Agency Management Committee and seven Advisory Council members appointed by the Ministerial Council, and 206 State/Territory/Regional Board members appointed by the respective state and territory Ministers. The exact number of members on previous state and territory boards is unavailable. However, if it is assumed that there was an average of 9 members per board (noting that previous boards ranged in size from 5 to 20 members), then it is likely there were over 830 government appointed board members on previous state and territory boards.

It seems reasonable to conclude that the level of bureaucracy associated with the delivery of regulatory arrangements has been reduced with the abolition of 93 separately constituted boards, each with their own committee structure, and the establishment of the NRAS agencies. However, there is room for further rationalisation if some of the functions currently being dealt with by profession specific committees were dealt with by cross profession committees that draw on profession specific expertise as required.

The Department is of the view that there is considerable scope to streamline the current arrangements to achieve greater efficiencies, without sacrificing robust regulatory decision making supported by essential professional expertise.<sup>50</sup>

The Department elaborated further in its public hearing evidence:

The cost of the scheme to the community is a matter of concern or the hydra-headed monster which is the national scheme, comprised as it is of many boards and accreditation agencies. I think AHPRA reported last year that there were 1200 meetings of various parts of the scheme. So it is both hydra-headed and active, and that carries with it a cost.<sup>51</sup>

The Committee received further evidence on the cost effectiveness of AHPRA which is dealt with separately in Chapter Four.

The Victorian Department of Health also questioned the role of the Australian Health Workforce Advisory Council, noting that ‘the inclusion of the Advisory Council in the regulatory regime was strongly opposed by many of the peak professional bodies, who saw it as a diminution of the power of the professions to determine their own standards.’<sup>52</sup>

The Department commented:

The policy rationale for inclusion of an independently constituted Advisory Council in the structure of the National Scheme was based on international experience of how to best drive health workforce reform. During discussions around framing of the Intergovernmental Agreement, the Department’s view was that provision of an independent, evidence based mechanism to advise Ministers on proposals for regulatory change which impact on professional scopes of practice (particularly those that are contested between professions, such as the prescribing of scheduled medicines) would balance the influence of the professions and potentially accelerate workforce reform processes.

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<sup>50</sup> *Ibid.*, p. 17.

<sup>51</sup> Department of Health, *Transcript of Evidence*, 12 December 2012, pp. 3-4.

<sup>52</sup> Department of Health, Submission No. 50, p. 20.

However, this policy rationale was not clearly reflected in the provisions of the National Law, the result being lack of clarity on the role of the Advisory Council.<sup>53</sup>

The Department further comments that ‘with regard to the role of the Advisory Council... it has not had much work to do since it has been established, so there are questions about that.’<sup>54</sup> The Committee is not in a position to discuss the value of the Australian Health Workforce Advisory Council other than noting it adds another layer to a large bureaucracy.

The Nursing and Midwifery Board of Australia (NMBA) also points to the ‘size and complexity of the National Scheme and AHPRA’ which it considers ‘is a consideration when compared with the previous regulatory arrangements in Victoria’. The Board referred to the support provided by AHPRA to the Victorian Board of the NMBA which is necessary to ensure the Board ‘is able to navigate the inherent organisational complexity.’<sup>55</sup>

Dr Peter Radford, a medical practitioner in Benalla, supports the ‘notion of Australia-wide registration in principle’, but believes the ‘mechanism of implementation has meant that no one is responsible and accountable for setting standards’. Dr Radford commented that ‘the present situation, where there are three bodies responsible for medical registration, is cumbersome, wasteful, and invites disaster’.<sup>56</sup> Dr Radford stated:

If one contacts AHPRA, one is referred to the Medical Boards, if one contacts the Medical Boards one is directed to the Australian Medical Council (AMC), and if one contacts the AMC, one is directed to AHPRA.<sup>57</sup>

Evidence put to the Committee that was highly critical of AHPRA and the National Scheme was from the Australian Doctors' Fund Limited (ADF). The ADF, as will be reported in Chapter 3, called for the dismantling of the National Scheme. One of its main concerns relates to the structure and accountability of AHPRA:

Since AHPRA reports to nine health ministers, it is virtually reporting to none. This should be of major concern to all legislators, i.e., that an agency responsible for over 560,000 health professional's registration and regulation exists in a self-constructed parliamentary no-man's land is unprecedented. Furthermore, the fact that this regulator has effective control over elected state parliaments and ministers in the regulation of medical practitioners and others practicing within their state is a situation never envisaged in State or Federal constitutions. It rests not on law but on a ‘memorandum of understanding’, and can be seen as a clumsy attempt to circumvent the protections inherent in State and Federal Constitutions.<sup>58</sup>

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<sup>53</sup> *Ibid.*, p. 20.

<sup>54</sup> Department of Health, *Transcript of Evidence*, 12 December 2012, p. 10.

<sup>55</sup> AHPRA Joint National Boards, Submission No. 41, p. 19.

<sup>56</sup> Peter Radford, Submission No. 1, p. 1.

<sup>57</sup> *Ibid.*, p. 2.

<sup>58</sup> ADF, Submission No. 2, p. 4.

Evidence from the Australian Society of Ophthalmologists was similarly critical of the National Scheme (see Chapter 3). Reflecting on the structure of AHPRA, the Society believes 'AHPRA is quite cumbersome'<sup>59</sup> and further that 'as an exercise in bureaucratese, AHPRA has few equals - it has established offices in every capital city and employed 700 staff to manage input from 475 board members.'<sup>60</sup>

In a further submission, the Rural Doctors Association of Victoria contends that 'Government will find it quite difficult to control an organisation the size of AHPRA.' The Association stated:

Perhaps the scope and size of AHPRA as a monolithic bureaucracy is not appropriate to its aims. It has been very difficult to understand its structure and function. People can be forgiven for being confused about the State Boards, for which a list of members, an address, but no other details are available. In correspondence we have often not been sure as to precisely who we have been dealing with.<sup>61</sup>

AHPRA, in its response to concerns raised in evidence over the structure and governance arrangements, noted:

The shared governance arrangements of the National Scheme established by the National Law, involve a range of entities and shared accountabilities and responsibilities for delivering the objectives of the National Law. AHPRA is focused on ensuring there is clarity about these complementary accountabilities and effective working relationships.

The Australian Health Workforce Ministerial Council (AHWMC) provides the high-level Ministerial oversight of the National Scheme. Therefore, AHPRA and the National Boards are accountable to all nine Health Ministers and to AHWMC. Regular updates and information is provided to the AHWMC and individually in states, territories and the Commonwealth. It is important that each state, territory and Commonwealth Health Minister retains confidence in our work. Changes to the Health Practitioner Regulation National Law, as in force in each state and territory, must be agreed by the AHWMC as agreed under the Intergovernmental Agreement (section 13). AHPRA and the National Boards provide updates at all levels of joint health department committees, including the Australian Health Ministers' Advisory Council, and at Australian Health Workforce Ministerial Council meetings.

The consultation processes adopted by National Boards and AHPRA include close involvement with governments and key stakeholders at all stages. Under the National Law, the Boards and AHPRA work in partnership to implement the National Scheme, each with specific roles, powers and responsibilities set down in the National Law. Each year each of the National Boards and AHPRA publish a health profession agreement that details the fees payable by health practitioners, the annual budget of the National Board and the services provided by AHPRA that enable the National Boards to carry out their functions under the National Law.<sup>62</sup>

The Victorian Board of the Medical Board of Australia explained the roles, and relationship, of AHPRA and the national boards and the confusion surrounding them:

From the beginning I think it is fair to say that the actual framework of the national scheme was not fully understood. I think even though the national boards and the national office of AHPRA took some

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<sup>59</sup> Australian Society of Ophthalmologists, *Transcript of Evidence*, 9 August 2013, p. 114.

<sup>60</sup> Australian Society of Ophthalmologists, Submission No. 39, p. 2.

<sup>61</sup> Rural Doctors Association of Victoria, Submission No. 22, p. 7.

<sup>62</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 12.

pains in trying to, as far as possible, educate the profession and the key stakeholders which were representing the public, there was still a fundamental misconception that AHPRA was the key central focus of regulation, that they were making the decisions, that it was a stand-alone bureaucracy that received complaints, made their own decisions, had no professional input into that decision making and then managed it to an outcome.

That has never been the case, although it was a very common misconception in the early days and to some degree still exists now that the concept of the national board and the state boards — which are a de facto-appointed committee of the national board, if you like — have no role and no professional input into complaint handling or in fact setting standards for the profession. That has never been the case, and it still is not the case. So we have been at some pains to try to educate all stakeholders as to the appropriate framework and where it goes.

The fact is that the national boards are the central key focus of the scheme. They implement standards. They regulate the professions. They are assisted by AHPRA in doing that. Even though AHPRA have some powers delegated by the national board, nevertheless, the national board does have the power under the national law to do that. That concept still is not very well understood in public circles.<sup>63</sup>

## **FINDING**

**2.4 *Despite the consolidation of numerous State and Territory health profession boards and administrations into one National Registration and Accreditation Scheme, the Scheme managed by AHPRA remains a large and complex bureaucracy with potential confusion over lines of responsibility and accountability.***

### **2.5.2 Role of Victorian Minister and Accountability to Parliament**

Under the terms of the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, the Victorian Minister for Health, together with other State and Territory Ministers and the Commonwealth Minister for Health, sit on the Australian Health Workforce Ministerial Council which oversees the National Scheme. According to the Intergovernmental Agreement, the Ministerial Council is responsible for:

- providing policy direction;
- agreeing on the inclusion of new professions in the Scheme;
- proposing legislative amendments through processes of governments, which are consistent with this Agreement;
- providing funding as appropriate in the set up phase of the scheme;
- appointing members to the Advisory Council and making appointments to the management committee of the national agency;

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<sup>63</sup> VBMBA, *Transcript of Evidence*, 27 November 2013, p. 269.

- appointing members of boards;
- approving profession-specific registration, practice, competency and accreditation standards and continuing professional development (CPD) requirements provided by the boards;
- requesting boards to review approved profession-specific registration, practice, competency and accreditation standards and CPD requirements;
- maintaining a reserve power to intervene on budgets and fees, with any intervention to be transparent; and
- initiating an independent review following three years of the scheme's operation.<sup>64</sup>

The Intergovernmental Agreement further clarifies the limitations upon the Ministerial Council's role:

To clarify, the Ministerial Council will not seek to insert itself into the day-to-day operations of the national agency. In particular, the Ministerial Council will not have any power to intervene in registration, examination or disciplinary decisions relating to individuals, or decisions relating to the accreditation of specific courses.<sup>65</sup>

The Committee has significant concerns that the structure of the National Scheme, with a Ministerial Council taking overall responsibility, has resulted in a very limited role for the Victorian Minister for Health in so far as there is no one individual responsible for health practitioner regulation and performance in this State. The Victorian Department of Health also raised some concern with the current Scheme's structural arrangements compared to the pre-2010 system in Victoria:

More complex accountability arrangements (accountability shared by all state and territory Ministers via the Ministerial Council, rather than direct accountability from Victorian boards to Minister) may result in reduced local responsiveness to Ministerial and government concerns and increased confusion in lines of responsibility.<sup>66</sup>

According to the Australian Doctors Fund (ADF), the National Scheme has no effective ownership, no one person or body who is accountable:

We have got a situation where no state or territory health minister has any majority ownership. The only thing they can tell you is, 'We will take your concerns to a meeting of ministers or to an advisory group' and they have a long list of concerns they have to take.

If you are an average citizen of this country trying to get some redress for some issue that may have happened to you, you have no way in the world of getting any parliamentary redress to an issue. You cannot lobby nine ministers. You may have the resources to do it, but it is unlikely, whereas under the old system you could take it to your state member or upper house member, they can raise it in the house, the minister can ask the board to investigate this issue on behalf of the constituent if it warrants that investigation and the medical board has to report on that. For the average person without resources and lobby groups and so forth, the old system gave direct parliamentary

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<sup>64</sup> Intergovernmental Agreement, 7.5.

<sup>65</sup> *Ibid.*, 7.8.

<sup>66</sup> Department of Health, Submission No. 50, p. 38.

accountability for their concerns, and that may have required an investigation of health practitioners in a hospital or whatever, so be it, but there is a very short line of redress.<sup>67</sup>

The ADF also questions the constitutionality of the current situation wherein a State Parliament cannot override legislation without a majority of other jurisdictions under the Agreement.<sup>68</sup>

The Australian Society of Ophthalmologists (ASO) is also concerned that the involvement of the Victorian Health Minister in the National Scheme is insufficient:

I think we need a state health minister to know and be responsible for the doctors who work in their state. I notice that Queensland and New South Wales have moved in that direction...<sup>69</sup>

Furthermore, the Society believes the current role of the Ministerial Council is cumbersome and inefficient:

Where you have nine health ministers together as a collective, okay, you get a great overview, but... it is incredibly difficult to get anything onto that council of health ministers' agenda. We spoke to the Queensland health minister and were told that we could not get anything, that they could not get over even their existing issues for the next seven or eight months, let alone raise a new issue and get that onto the agenda of the council of health ministers. That effectively means... that really the buck stops nowhere. In the earlier days, when you had state-based administrations, at least the Victorian minister took responsibility for what was happening in that patch.<sup>70</sup>

The College of Organisational Psychologists (Vic) would like to see the Victorian Health Minister have a stronger role in the National Scheme. It believes that an enhanced ministerial role would lead to a system whereby specialty professions, such as organisational psychology, may be afforded greater levels of protection.<sup>71</sup>

The Australian Association of Surgeons also highlighted concerns regarding the reduced role of the Victorian Minister for Health under the National Scheme:

...the Australian Association of Surgeons (AAS) is firstly concerned that the Victorian Health Minister is presently denied any influence upon the registration and regulation of Victorian doctors and other health professionals and yet may be expected to answer to Victorians when problems arise.<sup>72</sup>

The Association called for greater involvement of the Victorian Minister for Health in the registration and regulation of Victorian health practitioners in order to ensure greater regulatory efficacy and protection of the Victorian public:

The Victorian Health Minister must be afforded an input into administrative matters relating to the registration and regulation of doctors and other health professionals in Victoria. AHPRA is a "headless monster" as no single health minister carries responsibility for all of the many important matters under the control of the national scheme... To make a significant change would require all of the nine

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<sup>67</sup> Australian Doctors Fund, *Transcript of Evidence*, 26 June 2013, p. 77.

<sup>68</sup> *Ibid.*, pp. 76-77.

<sup>69</sup> ASO, *Transcript of Evidence*, 9 August 2013, p. 117.

<sup>70</sup> *Ibid.*, p. 118. Cf. ASO, Submission No. 39, p. 2.

<sup>71</sup> College of Organisational Psychologists (Vic), *Transcript of Evidence*, 18 September 2013, p. 179.

<sup>72</sup> Australian Association of Surgeons, Submission No. 3, p. 2.

governments to agree and so the scheme is presently bureaucrat controlled rather than government and health minister controlled.<sup>73</sup>

The Victorian Board of the Nursing and Midwifery Board of Australia advised it desires a greater level of contact with the Victorian Health Minister:

The Victorian Minister for Health appoints members to the state board. However, in the National Scheme, the primary contact between the minister and his department is with the AHPRA Victorian and national offices rather than directly with the Victorian Board. The Victorian Board would welcome the opportunity for ongoing, constructive and direct contact with the minister on issues that advance the regulation of nurses and midwives in Victoria.<sup>74</sup>

In its submission, the Australian Doctors Fund illustrated the many levels of communication between a practitioner and the Health Minister under the current Scheme compared to the previous State-based system:

- The line of communication for the old model was:- 1 health minister → State Medical Board → medical practitioner
- The line of communication for the new AHPRA model is:- 1 health minister → 8 health ministers → COAG → AHMAC → AHPRA → National Medical Board → State Medical Committees → medical practitioner<sup>75</sup>

AHPRA, in its submission to the Inquiry, outlined the role of the Ministerial Council and each individual Minister:

The consensus decision making of Ministerial Council is a critical component of the National Scheme. It provides each state and territory Health Minister and the Commonwealth Health Minister with the opportunity to debate and raise issues related to the National Scheme and make decisions at a national level that are informed by the administration of the health portfolio in their jurisdiction.

There are also some important decisions and interactions that individual Health Ministers can make independently of the consensus decisions made by Ministerial Council. For example, the Victorian Minister for Health:

- decides and appoints the Chairs and practitioner and community members of the Victorian Board of the Medical Board of Australia, the Victorian Board of the Nursing and Midwifery Board of Australia, the Victorian Board of the Physiotherapy Board of Australia, and Victorian members on the ACT/Tasmania/Victoria Regional Board of the Psychology Board of Australia, and
- may declare if there is an 'area of need' for health services if the minister considers there are insufficient health practitioners practising in Victoria (or a part thereof) to meet the needs of people living in Victoria. This enables a National Board to grant limited registration (area of need) to suitable practitioners to fill this need.<sup>76</sup>

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<sup>73</sup> *Ibid.*, pp. 5-6.

<sup>74</sup> AHPRA Joint National Boards, Submission No. 41, p. 20.

<sup>75</sup> ADF, Submission No. 2, p. 5.

<sup>76</sup> AHPRA Submission No. 40, p. 11.

The Committee shares many submitters' concerns that the Victorian Minister for Health has less authority over the registration and accreditation scheme for health practitioners than previously existed. Earlier in this Chapter evidence from the Department of Health highlights that under the National Scheme, the Victorian Minister no longer has powers with respect to National Board appointments, and the setting of qualification requirements and guidelines. Chapter Six highlights concerns over the health complaints process and the lack of accountability to the Victorian Health Minister.

In response to concerns raised about the role of the Victorian Minister for Health, AHPRA advised the Minister does have power to appoint members to the three state-based Boards (Medicine, Nursing and Midwifery, and Physiotherapy), but agreed the Minister has no powers over National Board appointments.

I would like to reinforce the fact that the health minister in Victoria has significant powers over regulation in Victoria, both as minister and as a member of the ministerial council. He can seek and receive advice on local matters now. The minister also has the power to appoint the state boards and to adjust the mix of community and practitioner members on state boards, which I know he intends to do to increase community member involvement. There are community members on all national and state boards.<sup>77</sup>

Furthermore:

In general terms there is not terribly much difference between that and the way the scheme worked prior to this, apart from the fact that he did have oversight into more of the board appointments. But when we take it as a proportion, his effect, board-wise, over the number of practitioners is around 80 per cent of those. In other words, psychology, medicine and nursing account for a larger proportion of practitioners within the scheme.<sup>78</sup>

AHPRA summarised the Minister's powers as:

- appoints local board members;
- controls board membership and mix;
- seeks and receives advice about local matters; and
- can request protected information and data.<sup>79</sup>

The Committee is not satisfied that the existing governance arrangement and reporting mechanisms under the National Scheme provide adequate Ministerial control at a local level. Evidence indicates that if the Victorian Minister for Health wished to make a decision regarding Victorian health practitioner registrations, accreditation and notifications, he would be required to obtain the agreement of other State and Territory Ministers at a Ministerial Council level. Other than being able to appoint members to three state-based Boards, the Victorian Minister has minimal control and responsibility over the Scheme as it operates in this State.

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<sup>77</sup> AHPRA, *Transcript of Evidence*, 11 December 2013, p. 281.

<sup>78</sup> *Ibid.*, p. 286.

<sup>79</sup> AHPRA, public hearing presentation slides, 11 December 2013.



Further, the Committee is concerned that the National Scheme and performance of AHPRA, lacks direct accountability to the Minister and to Victorian Parliament, other than the tabling of an annual report in the Victorian Parliament. Chapter Six explores this issue further with respect to key performance indicators in the complaints process. When the Committee questioned AHPRA about the need for greater accountability, AHPRA was open to further local reporting mechanisms:

The point I make about the minister in relation to accountability is that we have an accountability to him for performance. One of the key ways that we do that...is through the annual report. The annual report is a key accountability tool, and that is tabled in every Parliament in Australia, including the Victorian Parliament. But we want to do more than that, and hence, as I say, our commitment... reporting publicly and hence the point that I made in my opening comments that, if you felt there was more we could do in that area, that could be required of us in the Victorian context.

For example, you could develop a set of key performance indicators or adopt the key performance indicators that we proposed for the timeliness of our processes. You could require us to report those regularly to the minister and the Victorian Parliament.<sup>80</sup>

## **FINDINGS**

**2.5 *The Victorian Minister for Health has less control over the registration and regulation of Victorian health practitioners than existed prior to the commencement of the National Scheme in 2010.***

**2.6 *The tabling of an annual report by AHPRA in each State and Territory Parliament does not constitute sufficient accountability and scrutiny measures.***

### **2.5.3 Accreditation Authorities**

The Victorian Department of Health has questioned the need for 11 separate accreditation entities and suggests the 'Committee may wish to address the need for streamlining of the structural arrangements for delivery of accreditation functions, in the interests of both efficiency and good accreditation practice.'<sup>81</sup>

As noted earlier in this Chapter, the Productivity Commission had originally recommended that the Australian Health Ministers' Conference should establish a single national accreditation board for health professional education and training.<sup>82</sup>

The Productivity Commission found that:

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<sup>80</sup> AHPRA, *Transcript of Evidence*, 11 December 2013, p. 288.

<sup>81</sup> Department of Health, Submission No. 50, p. 19.

<sup>82</sup> Productivity Commission, *Australia's Health Workforce*, p. 127.

the (then) current accreditation arrangements can inappropriately reinforce traditional professional roles and boundaries, and thus impede job innovation. Inconsistent requirements imposed on educational institutions and trainers by different agencies create further inefficiencies. A national cross-profession approach to accreditation would preserve the best features of the current arrangements while facilitating:

- more timely and objective consideration and adoption of beneficial cross profession job evolution and redesign options;
- interdisciplinary and multidisciplinary education and training and articulation between VET and higher education and training;
- improvements in the appropriateness and consistency of accreditation in the different professions;
- uniform national standards on which to base professional registration; and
- reductions in administrative and compliance costs.<sup>83</sup>

The Victorian Department of Health makes the following comments on the Productivity Commission's recommendations relating to the accreditation bodies involved in the national scheme:

The Productivity Commission's recommendations concerning the accreditation functions were not implemented. Instead, the National Law included provisions that empowered the Ministerial Council to 'assign' accreditation functions to the respective Accreditation Councils, for the first three years of the National Scheme.

Under section 253 of the National Law, following this initial 'assignment' of accreditation functions by the Ministerial Council, each National Board was required to review its accreditation arrangements. All National Boards have now completed these reviews, and it seems that they have chosen not to address the significant structural inefficiencies that are associated with the operation of the 11 separately constituted accreditation councils and three internally operated National Board committees.

Access to profession specific expertise is essential for the delivery of these accreditation functions. However, this is a missed opportunity for National Boards to harness the potential benefits of a cross profession accreditation regime, one that would, if implemented present considerable opportunities to facilitate workforce reform. It is also a clear indication that National Boards are unlikely to deliver structural reform in this space and that the active intervention of governments is required.<sup>84</sup>

However, some evidence opposed any merging of accreditation councils. The Australian Society of Ophthalmologists believes that AHPRA has too much power over accreditation at the expense of the individual health professions' accreditation bodies. It argues that AHPRA's original purpose was to 'ameliorate cross-border registration issues' but 'when the AHPRA legislation came into the federal Parliament it gave AHPRA the power over accreditation of medical specialists'.<sup>85</sup> In particular, the ASO is unhappy that recently AHPRA gave optometrists the right to diagnose and treat glaucoma without, it asserts, adequate consultation with the ASO or the Royal Australian and New Zealand College of Ophthalmology.<sup>86</sup> The ASO asserts that this encroachment of AHPRA over accreditation

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<sup>83</sup> *Ibid.*, p. 111.

<sup>84</sup> Department of Health, Submission No. 50, p. 19.

<sup>85</sup> ASO, *Transcript of Evidence*, 9 August 2013, p. 115.

<sup>86</sup> *Ibid.*, p. 114.

functions, enabling the expansion of scope of practice without expert and clinical oversight, 'is a dreadful danger to the Australian public'.<sup>87</sup>

The Health Professions Accreditation Councils' Forum believes that accreditation functions already operate very efficiently under the current set-up wherein accreditation, for 11 of the professions, is contracted out. In evidence to the Committee, it asserted:

...[W]e have calculated that the funding coming from the board through AHPRA to accreditation councils at this point in time is less than three per cent of their total budget – 2.8 per cent. I think for the amount of money they spend it is money very well spent because most of the councils run very efficiently, so the accreditation functions are being delivered in a very efficient way. It is a small call on AHPRA funding really for the job that the councils do because... funding of the councils also comes from fees.<sup>88</sup>

In a submission to the Inquiry, the Australian Society of Orthopaedic Surgeons also stated its support for the retention of the medical accreditation body, the Australian Medical Council.<sup>89</sup>

The Australian Doctors Fund is critical of what it perceives as AHPRA's intervention in accreditation matters:

[AHPRA] originally began as a regulatory body – in other words, it collected subscriptions. It then morphed into an accreditation body, but if you look carefully, the accreditation of the colleges, of hospitals and of training programs in medicine, through all 12 specialties, was already being carried out by the Australian Medical Council, which is an internationally reputed body composed of the best of the Australian medical specialist colleges personnel, and that is still the case. The AMC is still doing the accreditation on behalf of AHPRA. There has been no change, but if you read the report about AHPRA, it purports to be the accrediting body. It actually is not. It is just an overlay, and it adds a number of layers of bureaucracy...<sup>90</sup>

## **FINDINGS**

- 2.7** *The establishment of 11 separate accreditation authorities does not reflect the Productivity Commission's 2006 recommendation that there be a single national accreditation authority.*
- 2.8** *Evidence indicates there is some support for further streamlining of the accreditation functions within the National Scheme.*

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<sup>87</sup> *Ibid.*, p. 118.

<sup>88</sup> Health Professions Accreditation Councils' Forum, *Transcript of Evidence*, 12 June 2013, p. 71.

<sup>89</sup> Australian Society of Orthopaedic Surgeons, Submission No. 23, p. 1.

<sup>90</sup> ADF, *Transcript of Evidence*, 26 June 2013, p. 75.

## 2.5.4 Composition of Boards

Section 33 of the National Law sets out the composition of National Boards as follows:

1. A National Board is to consist of members appointed in writing by the Ministerial Council.
2. Members of a National Board are to be appointed as practitioner members or community members.
3. Subject to this section, the Ministerial Council may decide the size and composition of a National Board.
4. At least half, but not more than two-thirds, of the members of a National Board must be persons appointed as practitioner members.
5. The practitioner members of a National Board must consist of—
  - a) at least one member from each large participating jurisdiction; and
  - b) at least one member from a small participating jurisdiction.
6. At least 2 of the members of a National Board must be persons appointed as community members.
7. At least one of the members of a National Board must live in a regional or rural area.
8. A person cannot be appointed as a member of a National Board if the person is a member of the Agency Management Committee.
9. One of the practitioner members of the National Board is to be appointed as Chairperson of the Board by the Ministerial Council.

AHPRA's submission to the Inquiry indicated that Victoria is well represented in membership on the 14 National Boards.<sup>91</sup> Commenting on the composition of Boards, AHPRA noted:

As a large participating jurisdiction it is a requirement of the National Law for there to be a practitioner member from Victoria on each National Board. A practitioner member is to be appointed by Ministerial Council as Chair of a National Board. The Chairs of the Chinese Medicine Board of Australia, Medical Board of Australia and Pharmacy Board of Australia are from Victoria. The Chair of the Pharmacy Board also currently chairs the Forum of National Board Chairs. In addition, there are community members from Victoria appointed by Ministerial Council on six National Boards: the Chinese Medicine Board of Australia, the Dental Board of Australia, the Nursing and Midwifery Board of Australia, the Osteopathy Board of Australia, the Pharmacy Board of Australia, and the Psychology Board of Australia.<sup>92</sup>

The Committee notes the submission from the Victorian Department of Health which raises concern with the extent of community representation on Boards and the inability of community members to chair a Board. The Department noted that:

Under the (now repealed) Health Professions Registration Act 2005 (Vic), there was flexibility for the Minister for Health to appoint community members to office bearing positions on registration boards, where the Minister considered that it was 'necessary for the good operation of the board'. This power

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<sup>91</sup> AHPRA, Submission No. 40, p. 23.

<sup>92</sup> *Ibid.*

was exercised by the Victorian Minister, and proved to be a particularly effective arrangement that continued for over 10 years and was well accepted by the profession concerned. There is no such flexibility in the National Law.

In a recently completed recruitment process for National Board positions, there were over 100 applications received for community member positions, many of high calibre with extensive board and regulation experience. However, such persons are ineligible for leadership roles on National Boards.

In accordance with the previous Victorian arrangements, the Department suggests that the AHWMC should have the flexibility to appoint to office bearing positions people who may not have profession specific expertise but who possess:

- A thorough knowledge of the principles of procedural fairness and natural justice
- Good skills in chairing meetings
- An ability to provide strong leadership, achieve consensus and resolve conflicts.<sup>93</sup>

AHPRA has pointed out that while the National Law stipulates at least two-thirds of National Boards must be practitioners and must also be chaired by a practitioner, the Law does not stipulate requirements for composition of State Boards. In responding to the concerns over Board composition, AHPRA advised:

AHPRA recognises the importance of effective local accountability arrangements to the Health Minister and parliament in each state. Insofar as the Committee may be considering the need for legislative amendment in Victoria relating to governance and performance oversight of the complaints system, it is important to note that a number of changes are expressly available under the Minister's current powers within the National Law. For example, the Victorian Minister of Health maintains the power to appoint members to boards for professions that have a state or regional board.

The National Law requires that at least half, but not more than two-thirds of members are practitioner members from the profession being regulated by a board. There is no existing barrier to the Minister determining that half of the members of a state board are to be community members. Similarly, the Minister maintains the power to appoint a Chair for each of the state boards. AHPRA submits that changes to strengthen community member participation can be made without fundamentally changing the structure of the National Scheme and its complaints (notifications) provisions.

AHPRA points out that 'community members have the same remuneration, voting and procedural rights as practitioner members of National Boards'. However, the National Law currently requires that the Chair of the National Board must be a practitioner member, therefore community members are not eligible to seek appointment to this role.<sup>94</sup>

The issue of Board composition is considered to be of particular relevance when Boards sit in judgement on notification decisions concerning practitioners. The Victorian Department of Health highlighted this issue in their submission:

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<sup>93</sup> Department of Health, Submission No. 50, pp. 27-8.

<sup>94</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 13.

...the governance structures for the National Scheme are based on a collegiate regulatory model that places the principle of peer review at the centre of all regulatory decision making. The Committee may wish to consider whether a more corporate like governance structure for the National Scheme would be less costly, more efficient and still secure the necessary profession specific expertise to ensure robust regulatory decision making.<sup>95</sup>

The Committee received some evidence from members of the public who had negative experiences with AHPRA and the Boards and particularly questioned the impartiality of the current peer-review system.

Mrs Gwen Woodford, observed in her submission:

The Medical Board of Australia, and the MPBV before that, have their first allegiance to their profession and protection of their integrity. The dilemma is that the public can only complain to the same organisation when they have suffered damage. An organisation to give an impartial investigation would need the assistance of medical professionals so in the past the only direction for complaints has been back to the medical registration board itself.<sup>96</sup>

Similarly, a notifier, Miss Jennifer Morris commented:

An organisation partly funded by practitioners -and which stands to benefit financially from their ongoing registration – cannot impartially oversee disciplinary matters which may jeopardise the registrations of those practitioners. This is especially true where there is no external oversight of such regulation – to the point that even notifiers themselves cannot attend hearings into their own notifications.<sup>97</sup>

In response to comments about the composition of Boards, AHPRA believes the issue could be part of the three year review of the Scheme:

The forthcoming three year review of the National Scheme provides a timely opportunity to review National Board composition and eligibility requirements, including for the role of Board Chair. The Committee may support or provide advice to this review.<sup>98</sup>

## **RECOMMENDATION**

**1. That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that the three-year review of the National Registration and Accreditation Scheme include consideration of the following:**

- **the need for enhanced AHPRA accountability and performance reporting mechanisms to State and Territory Parliaments;**
- **the need to streamline the functions of the separate accreditation authorities; and**

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<sup>95</sup> Department of Health, Submission No. 50, pp. 43-44.

<sup>96</sup> Gwen Woodford, Submission No. 53, p. 1.

<sup>97</sup> Jennifer Morris, Submission No. 31, p. 26.

<sup>98</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 13.

- *the need for greater flexibility in the composition of National Boards, eligibility requirements and appointment of Chairs. In particular, the review should consider the merits of increased non-practitioner membership and flexibility to appoint non-practitioner chairs to National Boards.*





## Chapter Three: Overall Performance of AHPRA

This Chapter deals with the overall performance of the Australian Health Practitioner Regulation Agency since its commencement in July 2010. Comment is made on the many implementation challenges highlighted in a 2011 Senate Committee Inquiry, and more recent feedback on the extent to which AHPRA has managed these challenges and addressed the Senate Committee's findings. Comment is also provided on the broader ongoing performance of AHPRA, notwithstanding later chapters will specifically focus on performance related issues such as cost effectiveness and the health complaints process.

### 3.1 2011 Senate Inquiry

The implementation of the National Registration and Accreditation Scheme by AHPRA in 2010 created significant problems with respect to the transition of health practitioner registrations throughout Australia. A 2011 Senate Inquiry found that the inadequate implementation had negatively impacted upon the ability of health professionals to practice and had added implications for health consumers in terms of Medicare benefits and private health insurance claims.

Following complaints that health professionals were facing delays renewing their registration and some were inadvertently de-registered, the Australian Senate agreed to review the implementation of the Scheme and the first year performance of AHPRA.

On 23 March 2011, the Australian Senate referred to the Finance and Public Administration References Committee an Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency. Matters to be investigated included:

- ability and performance of AHPRA in implementing and administering the national registration of health practitioners;
- impact of AHPRA processes and administration on health practitioners, patients, hospitals and service providers;
- related implications of any maladministration of the registration process for Medicare benefits, private health insurance claims, legal and financial liability;
- AHPRA's complaints handling processes; and
- budget and financial viability of AHPRA.

The Senate Committee 'acknowledged that the implementation of the new registration and

accreditation regime for some 500,000 health practitioners was a huge undertaking, but concluded that the implementation was far from well managed.<sup>99</sup>

In summary, the Senate Committee found that:

- many stakeholders raised concerns about the implementation of the Scheme;
- timeframes for implementation were inappropriate;
- migration of databases created significant problems;
- registration processes were totally inadequate resulting in loss of income and, in some cases, loss of employment for practitioners, as well as some incorrect deregistrations;
- AHPRA's poor management of the registration process also adversely impacted upon patients and recruitment of overseas practitioners; and
- complaints handling processes were inefficient and timeframes for resolution were unreasonable.

In evidence to the Senate Inquiry, the Australian Medical Association (AMA) was highly critical of the transition arrangements describing them as 'an absolute debacle'. The AMA was:

...particularly concerned that AHPRA considers that it has overcome the difficulties with the transition to national registration and that from now on registration will be a smooth process for registrants. We are not convinced this is the case, because we have not seen evidence that business protocols exist to guide the administration of the registration process and deal with the unique registration situations for medical practitioners.<sup>100</sup>

The Senate Committee report made recommendations in a number of key areas including the accountability of AHPRA, redress for practitioners deregistered due to administrative errors, and possible amendments to the National Law to address perceived shortcomings in the legislation.<sup>101</sup>

In a minority report, the then Government Senators disagreed with the majority of findings, however acknowledged the frustrations experienced by some practitioners during the transition to the new national system. Government Senators believed the problems were transitional rather than systemic and that AHPRA would respond to address issues with registration processes and systems. They believed that once AHPRA and health practitioners became more familiar with the new system, the benefits of the national system would be realised.<sup>102</sup>

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<sup>99</sup> Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, April 2011, p. 111.

<sup>100</sup> Australian Medical Association submission to the Senate Finance and Public Administration References Committee Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency, April 2011, pp. 2-3.

<sup>101</sup> Department of Health, Submission No. 50, p. 57.

<sup>102</sup> Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, p. 137.

In response to the Report and submissions to the Inquiry, AHPRA:

...acknowledged that many concerns expressed by stakeholders about the early implementation period were valid and noted that most submissions from organisations confirmed support for the National Scheme. The Ministerial Council also monitored the implementation of the National Scheme. In February 2011, responding to challenges with the early implementation, Ministers agreed to provide additional support for AHPRA in strengthening systems and making processes more robust. This additional support was greatly appreciated. AHPRA continues to feedback regularly to the Ministerial Council and provide updates on the progress of the National Scheme.<sup>103</sup>

AHPRA's submission to the Legal and Social Issues Committee Inquiry noted it had 'experienced some well-documented difficulties with transition and early implementation of the National Scheme.' Highlighting its response to the implementation problems, AHPRA stated:

Equally well documented are the steps that AHPRA took to remedy these issues and confront the challenges of the transition from legacy arrangements to the new National Scheme. Despite these challenges, the fundamentals of the National Scheme were sound. AHPRA's major focus during this period was to get the basics right by progressively strengthening the systems and procedures required to effectively deliver the National Scheme in partnership with the National Boards, to ensure that 'services to the community and practitioners were more accessible and responsive.'<sup>104</sup>

And further:

The National Scheme has been in place for nearly three years. Early transition challenges have been addressed and AHPRA systems and processes are working smoothly to support National Boards and enable them to meet their core regulatory responsibilities of protecting the public and facilitating access to health services.<sup>105</sup>

The Victorian Department of Health's submission also noted the significant initial challenges in implementing the National Scheme including:

- the development and enactment of two principal Acts by the Queensland Parliament in 2009, involving extensive consultation with stakeholders in all jurisdictions;
- the passage of adoption and amending legislation in State, Territory and Commonwealth Parliaments and the repeal of 66 pieces of legislation across the nation;
- the decommissioning of 100 State and Territory based health practitioner registration boards and the commissioning and bedding down of eight new State and Territory offices, and a new National Office in Melbourne;
- delivering a new IT system to capture the data of over 550,000 registrants and over 1 million registration records from 37 separate databases, while at the same time commencing the first round of online registration renewals;

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<sup>103</sup> AHPRA, *Annual Report 2010-11*, p. 14.

<sup>104</sup> AHPRA, Submission No. 40, p. 14.

<sup>105</sup> *Ibid.*, p. 7.

- continuing to maintain the existing system of registrations, investigations and open disciplinary cases in accordance with transition provisions of the National Law;
- setting new national standards for registration for each nationally registered health profession, by newly appointed National Boards whose members had not worked together as a group;
- auditing to ensure the accuracy and reliability of transferred registrant data;
- dealing with an increased number of transactions by email, phone and mail from registrants confused about the transition; and
- dealing with new cross jurisdictional governance arrangements for securing Ministerial Council decisions required under the National Law.<sup>106</sup>

The Medical Board of Australia observed that the timelines and resources allocated for implementation of the Scheme were inadequate from the start which exacerbated the extent of problems:

There has been a great deal documented about the challenging transition to the National Scheme. It was always going to be difficult to bring together 10 health professions and eight jurisdictions at the one time. There were delays between the announcement of the scheme and the signing of the Intergovernmental Agreement, and the finalisation of detailed policy that was necessary for the legislation to be finalised and agreed for introduction to state and territory parliaments. A small implementation team funded by governments did the preliminary work that enabled the scheme to commence on 1 July 2010, on schedule, in all but one jurisdiction. However, the Medical Board believes that as the scheme began, it was under-resourced and under-prepared. Systems were not sufficiently developed and staff were not adequately trained to operate in the new regulatory framework. In many states and territories, the enabling legislation was delayed well beyond the timeframes agreed to in the Intergovernmental Agreement. It is important to be clear that neither AHPRA nor the National Boards were responsible for this. AHPRA, as a fully staffed organisation, in effect started on 1 July 2010. Given the circumstances, these start-up difficulties were probably inevitable.<sup>107</sup>

The AMA Victoria's written submission also highlighted the effects of the implementation problems upon medical practitioners:

The move to a national scheme for registration has been an arduous and costly process. While the magnitude of the task at hand is not to be underestimated, there are a number of ways in which the transition could have been better managed...The failure by AHPRA to properly plan for and coordinate the transition to national registration was short-lived however it has had a detrimental effect on individual medical practitioners and has lessened confidence in the system.<sup>108</sup>

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<sup>106</sup> Department of Health, Submission No. 50, pp. 6-7.

<sup>107</sup> Medical Board of Australia, Submission No. 42, p. 3.

<sup>108</sup> Australian Medical Association (Vic), Submission No. 18, p. 1.

Clearly the implementation of the National Scheme was a considerable task complicated by inadequate planning and unrealistic timeframes. Evidence suggests the numerous implementation problems adversely impacted upon health practitioner confidence in AHPRA's administration of registrations and service delivery. This was further exacerbated by a significant increase in registration fees. As will be reported in Chapter Four, registration fees almost doubled in the first year of AHPRA's existence and such increases were not reflected in improved service delivery during this period.

### 3.2 Implementation Issues Three Years Later

The Legal and Social Issues Committee's Inquiry presented many of the submitters to the 2011 Senate Inquiry a further opportunity to comment on the Scheme's implementation issues. In general, evidence suggests AHPRA has progressed to address many of the initial concerns of practitioners, however there remain some outstanding matters which will be dealt with throughout this Report.

At a public hearing in March 2013, AMA Victoria spoke more positively of AHPRA's performance since its first year in operation, which is in contrast to the AMA's initial view that the implementation was a 'debacle':

...with the passage of time the performance of AHPRA has, as far as the medical profession is concerned, improved quite substantially, and I think it is important that that be recognised...We note that the response of AHPRA, certainly at a national level, was to work fairly closely with the AMA and to take on board a number of our criticisms. Again, we want to acknowledge that and say that things have moved in the right direction. We would think from where we sit here and now that many of the teething problems — not all — have been overcome, that there are advantages and that there is still some way to go, but overall we would not want a return to a series of seven or eight state and territory bodies that act relatively independently of each other.<sup>109</sup>

Returning to implementation issues, the Victorian Department of Health believes the 'views about the performance of AHPRA have been coloured by the significant difficulties experienced in the first 12 months of the National Scheme.' In its public hearing appearance, the Department noted:

There were some teething problems and transition issues. Certainly bedding down a new organisation, given the pace of reform, was challenging. It was important so far as possible to retain the existing staff knowledge and skills and the existing board members. The transition of registrants and their data was a huge exercise. Part of the problems involved the lack of consistency of the data — how it was described, how it was maintained, the IT systems across the 90 separate boards across the country — and migrating that into one system. The accuracy of the registration data was at times problematic. The partially regulated professions had to be assessed for inclusion in the scheme.

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<sup>109</sup> AMA (Vic), *Transcript of Evidence*, 29 May 2013, p. 50.

The project team managing the process had to deal with the late entry of WA and some carve-outs in the statutory functions that New South Wales implemented to retain their complaints handling and disciplinary functions with their local councils. Also the accreditation arrangements had to be bedded down with new organisations established and conferred with powers. For the four new professions entering the scheme the new boards had to be up and running and grandparenting of those practitioners into the scheme had to take place.<sup>110</sup>

Consistent with the AMA Victoria's evidence, the Department acknowledged most of the initial problems relating to the registration process have now been addressed:

I believe there are now indicators of the responsiveness, and I think we will look back at the initial period of time as a particular hump that was substantially addressed. I am not saying that there are not delays and whatnot now, but I think the order of dimension is substantially different.<sup>111</sup>

The Victorian Health Services Commissioner, who works in close cooperation with AHPRA concurred, noting that the Agency 'has made significant progress in rectifying these (implementation) issues in a comparatively brief timeframe.'<sup>112</sup>

The federal branch of the Australian Nursing Federation (ANF)<sup>113</sup> continued to express its support for the National Scheme since its commencement, but acknowledged 'that the implementation path from State/Territory based registration to a national regulatory process, has been complex and fraught with difficulties'. Commenting on its initial evidence to the 2011 Senate review, the ANF stated:

We were candid in outlining issues experienced by our members regarding assessment of qualifications, initial and renewal of registration and the online register for the new Scheme. However, we were also forthright in arguing that many of these issues pointed to a lack of resourcing of the National Registration and Accreditation Scheme in terms of personnel to handle the volume of registrants – both existing and new applicants; and, also in terms of preparation and knowledge level of the call centre staff.<sup>114</sup>

The ANF noted that some of its initial concerns have since been addressed by AHPRA and the Nursing and Midwifery Board of Australia and that other matters are being progressed. The ANF commented:

...given our commitment to the success of this important scheme, the ANF continues to work with AHPRA and the Nursing and Midwifery Board of Australia, on issues which have had the potential to undermine the credibility of the national scheme.<sup>115</sup>

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<sup>110</sup> Department of Health, Submission No. 50, p. 6.

<sup>111</sup> Department of Health, *Transcript of Evidence*, 12 December 2012, p. 14.

<sup>112</sup> HSC, Submission No. 5, p. 2.

<sup>113</sup> In July 2013, the Australian Nursing Federation (ANF) changed its name to the Australian Nursing and Midwifery Federation. For the purpose of this Report, the Committee refers to the former name which is consistent with evidence received prior to the name change.

<sup>114</sup> Australian Nursing Federation, Submission No. 16, p. 6.

<sup>115</sup> *Ibid.*

The ANF's submission suggests such issues include the registration process, communication with AHPRA and the need for additional resources.

Evidence to the Committee indicates there are still some implementation problems which remain outstanding. The Australian Medical Council, the accreditation authority for the medical profession, believes there are areas that continue to be improved and views the 'process as being a three to five-year project at the very minimum and possibly even slightly longer to get fully bedded in.'<sup>116</sup> Southern Health acknowledges 'that there has been a huge change process in the transfer to National Registration and Accreditation Scheme and that the efficiency and effectiveness of AHPRA will improve over time.'<sup>117</sup>

The Victorian Medical Directors Group, comprising chief medical officers and directors of medical services from Victorian public health services, acknowledges 'that there are many benefits to the National registration scheme'. However, the Group believes 'there remain a number of issues, predominantly procedural, that are posing issues for health services in Victoria'. These matters relate to processing and tracking of registration applications, the scheduling of Board meeting dates, and documentation requirements.<sup>118</sup>

The Australian Dental Association, Victorian Branch, provided a further example of evidence illustrating that AHPRA has worked well to overcome the initial problems:

In the early stages of national registration implementation, AHPRA was not well regarded by the dental profession and the comments received by the ADAVB reflected this perception. The ADAVB is pleased to report that since the initial registration process, there has been minimal negative feedback from members in regard to the operation and efficacy of AHPRA registration processes. Furthermore, AHPRA has consulted closely with the ADA Inc. and the ADAVB on registration matters and responded appropriately to our queries regarding notification processes.<sup>119</sup>

The Australian Physiotherapy Association referred to several initial performance problems including missing renewal notices, payments not being processed and poor communication. However, the Association now believes these problems have largely disappeared.<sup>120</sup>

When asked at a public hearing to respond to implementation issues, AHPRA observed:

You have made reference to the Senate submission, which is now two years ago, and I think we acknowledged in our submission to that inquiry that there certainly was a set of issues around the start-up of the national scheme to do with the scale and scope of the change that occurred where we essentially turned off on one day a set of state-based arrangements and moved on the next day to a whole new national system.

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<sup>116</sup> AMC, *Transcript of Evidence*, 12 June 2013, p. 60.

<sup>117</sup> Southern Health, Submission No. 10, p. 3.

<sup>118</sup> Victorian Medical Directors Group, Submission No. 25, p. 4.

<sup>119</sup> Australian Dental Association, Victorian Branch, Submission No. 27, p. 3.

<sup>120</sup> Australian Physiotherapy Association, Submission No. 49, pp. 3-4.

Our view, certainly as we have tried to reflect very strongly on an empirical basis, so we have tried to provide data and not just assertions, is that the fundamentals of the national scheme here in Victoria are very sound and that the foundations of the national scheme are very strong. That is not to say that we think it is perfect and that is not to say that we do not think there are areas that need to be improved. Clearly one of the themes, as I picked up in my presentation, is that we need to continue to make sure that the customer experience, if you like, of dealing with AHPRA in terms of getting questions answered and getting clear information and that occurring in a streamlined way is something we continue to pay very close attention to.

I think we have made enormous gains in that area, and that is recognised in many of the submissions. I believe from my reading that people recognise that there was a period of start-up issues. A lot of them have been addressed, and now this is really about how we make sure that the scheme is the best it can be, particularly, as I said, that the customer experience, as a practitioner, is as smooth as it can be as well.<sup>121</sup>

The Medical Board of Australia supported AHPRA's assessment that the initial implementation tasks were significant and that early problems have largely been addressed:

Given the huge scope of reform, there were bound to be unpredictable consequences with implementation. 'Teething trouble' occurred early with its well documented and reported inefficiencies, immature systems and untested processes. From the beginning, and to its credit, AHPRA had the necessary purpose, intent and pragmatism to attack each problem head on and demonstrated the necessary rigor and resolve to iron out issues as they appeared. In those early days, all available time was spent with reactionary troubleshooting with little or no time to critically analyse future direction. During this period, the Victorian office of AHPRA correctly identified the priorities of coming to grips with unfamiliar legislation, establishing key staff roles and responsibilities, interacting with new stakeholders and creating a solid foundation upon which to build future progress.<sup>122</sup>

The Committee agrees with AHPRA, the Medical Board of Australia and other submitters that the early implementation problems associated with the registration process have now largely been addressed. Many of these problems may have been avoided with better planning, additional resources and more realistic implementation timeframes. However, evidence suggests the problems experienced in the first 12 months may have lessened confidence in the new Scheme and this will take some time to fully address.

## **FINDINGS**

### **3.1 Health practitioners were highly critical of AHPRA's performance in its first 12 months of administering the National Scheme. The implementation problems are well documented in a 2011 Senate Committee report.**

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<sup>121</sup> AHPRA, *Transcript of Evidence*, 17 April 2013, pp. 29-30.

<sup>122</sup> Medical Board of Australia, Submission No. 42, pp. 9-10.



- 3.2** *The numerous implementation problems with the National Scheme adversely impacted upon health practitioner confidence in AHPRA's administration of registrations and service delivery.*
- 3.3** *Evidence indicates AHPRA has progressed in the past two years to address many of the implementation problems associated with the registration process.*

#### **RECOMMENDATION**

- 2.** *That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that three-year review of the National Scheme include a thorough examination of AHPRA's response to the 2011 Senate Committee's recommendations and stakeholder input into any implementation concerns that remain outstanding.*

### **3.3 General Comments on Performance of AHPRA**

The Committee believes it is important to broadly deal with the merits or otherwise of the National Registration and Accreditation Scheme and ongoing performance of AHPRA as the agency responsible for administering the Scheme. The following evidence is drawn largely from the health professions, whereas health consumer views mainly relate to the complaints process.

Given that a key aim of the Scheme is to protect the public, AHPRA's performance in managing investigations into the professional conduct, performance or the health of registered health practitioners is of paramount importance. This assessment is dealt with separately in Chapter 6.

From a health practitioner perspective, opinions on AHPRA's performance are varied. Many key stakeholders fully support the National Scheme and note its intended benefits. Other evidence raised concerns over various operational aspects of the Scheme, accepted there are potential benefits and suggested ways for further improvement. However, some evidence was totally opposed to the Scheme and recommended a partial or full return to the previous state-based health practitioner regulatory model.

The total number of Victorian health practitioners registered under the National Scheme is approximately 142,000, dominated by two professions: Nursing and Midwifery with approximately 90,000 registrants and medical with 22,000. The views of these professions are therefore of particular relevance.

The AMA (Vic) raised a number of concerns in both its written submission and public hearing evidence which were predominantly limited to AHPRA's first year of operation and are referred to

above. The AMA's ongoing concerns are in relation to the need for greater transparency in terms of AHPRA's cost effectiveness (Chapter Four) and future funding of health programs for doctors (Chapter Five).

In reference to the current Victorian Board of the Medical Board of Australia, the AMA (Vic) concluded that:

With regard to the issue of the national scheme, the new legislation protecting the Victorian public, we think that the notion of national registration but state-administered disciplinary processes is very much the right way to go. There have been uncertainties, or transition issues I should say, in the context of the date of reports, resulting in different forms of administration, and that is almost inevitable when you go from an old system to a new one. But the system of having state-based management of disciplinary procedures is a very appropriate one and we strongly support it.<sup>123</sup>

When further questioned as to the future of AHPRA and whether Victoria should return to the previous state-based system, the AMA (Vic) reiterated its commitment to the National Scheme:

This is really, I suppose, saying that if that is where the state chose to head, we would not be happy with it, but again what we are saying is you would want to consider the pros and cons. You would look at the risks and you would look at the opportunities. We would think from where we sit here and now that many of the teething problems—not all—have been overcome, that there are advantages and that there is still some way to go, but overall we would not want a return to a series of seven or eight state and territory bodies that act relatively independently of each other.<sup>124</sup>

The Royal Australian College of General Practitioners (RACGP) is Australia's largest professional general practice organisation representing over 21,000 Australian GPs. In its written submission to the Inquiry, RACGP advised it supports the national system of medical registration in principle and considers the Scheme has the potential to achieve:

- nationally consistent registration requirements and processes;
- increased medical workforce portability and flexibility;
- streamlined investigation and disciplinary proceedings;
- operational efficiencies typically derived from economies of scale; and
- greater transparency/public accountability.<sup>125</sup>

However, in further evidence at a public hearing and follow-up correspondence, RACGP expressed several concerns that remain including:

- the length of time taken to complete investigations;

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<sup>123</sup> AMA (Vic), *Transcript of Evidence*, 29 May 2013, p. 50.

<sup>124</sup> *Ibid.*, p. 55.

<sup>125</sup> Royal Australian College of General Practitioners, Submission No. 19, p. 1.

- poor and/or delayed communication to GPs regarding investigation milestones and outcomes;
- an increase in frivolous or vexatious complaints through the National Registration Scheme;
- mandatory reporting; and
- cost effectiveness, transparency and accountability.<sup>126</sup>

Support for the National Scheme was also demonstrated by the Royal College of Pathologists of Australasia which observed that ‘new arrangements in general are an improvement overall, despite the cost increase compared to single jurisdictions’. The College considered the positive outcomes since the introduction of AHPRA included:

- the standardisation of criteria for registration and records of credentials across State boundaries;
- the ability of the general public to review registration details of individual doctors;
- a coordinated national response to complaints against health practitioners, particularly given increased workforce mobility; and
- more stringent attention to communication skills.<sup>127</sup>

Further support for AHPRA was received from the Royal Australasian College of Surgeons which considered ‘[o]verall the introduction of AHPRA has been a strong positive with benefits arising from a more uniform approach to regulation issues across Australia. This has reduced confusion for doctors moving between states and enabled access to a single public register that more appropriately displays the status of the individual health practitioner’. However, the College further advised that improvements are specifically required with respect to the registration of international practitioners.<sup>128</sup>

The Committee received several submissions from groups representing the nursing and midwifery professions. Aside from concerns with initial implementation problems and the future funding of the nursing and midwifery health programs (see chapter 5), the federal and Victorian branches of the Australian Nursing Federation expressed their ongoing support for the National Scheme and performance of AHPRA.

The national ANF stated it ‘remains a strong supporter of the move to national registration and accreditation for health professions in Australia’:

We believed that the enactment of legislation to introduce the National Registration and Accreditation

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<sup>126</sup> Royal Australian College of General Practitioners, correspondence in response to questions taken on notice at public hearing, 23 September 2013, p. 2.

<sup>127</sup> Royal College of Pathologists of Australasia, Submission No. 7, p. 1.

<sup>128</sup> Royal Australasian College of Surgeons, Submission No. 11, p. 1.

Scheme (NRAS) for the health professions would have a significant and positive impact on our two professions – nursing and midwifery, and we maintain that position. The overriding aim of the national Scheme was to introduce simplicity and a shared understanding of terminology across the country in relation to regulation of health professionals. The intention to simplify processes and terminology was not only seen as essential for the health professionals themselves, but also, and critically, to reduce confusion for consumers of health and aged care services about the codes, guidelines and standards applying to health professionals.

The implementation of the national Scheme has brought clear and tangible benefits to the Australian public through consistent practice standards and the management of registrants who are unable to practice safely. However for the Scheme to be truly effective, the body that administers the Scheme, AHPRA, must be adequately resourced. This resourcing must include not only additional and properly trained personnel for the timely management of registrant matters, but also provide the capacity for state/territory offices of AHPRA to collaborate to a greater extent, so that the procedures regarding registration and notifications can be applied consistently across all state jurisdictions.<sup>129</sup>

The ANF listed the benefits of national registration and accreditation under the Australian Health Practitioner Regulatory Agency to include:

- common governing legislation and mandatory standards across disciplines;
- improved health complaints notification;
- development of national database;
- common registration fee amount; and, one national registration fee;
- greater clarity for consumers, with common titles;
- greater mobility of nurses and midwives around the country with common standards;
- removal of the need for cross-border arrangements;
- ease of registration – central point; and
- greater monitoring of overseas qualified nurses/midwives working in Australia.<sup>130</sup>

The ANF (Vic) agreed with the above benefits but highlighted a number of suggested improvements to the Scheme centred around accreditation and the notification process.<sup>131</sup>

The Australian College of Nursing (ACN) is a key national professional nursing organisation and authorised higher education provider and registered training organisation.<sup>132</sup> The College 'strongly supports the national registration of health practitioners to improve public and patient safety and acknowledges that introducing nationally consistent standards and registration processes across ten

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<sup>129</sup> ANF, Submission No. 16, p. 2.

<sup>130</sup> *Ibid.*, p. 4.

<sup>131</sup> Australian Nursing Federation (Vic), Submission No. 21, p. 2.

<sup>132</sup> <http://www.acn.edu.au>, accessed 5 December 2013.

different boards from eight states and territories remains a significant undertaking.<sup>133</sup> In particular, the College believes:

The consistency of accreditation and registration across the country remains invaluable to the nursing and midwifery professions and to the community in ensuring appropriate standards are in place.<sup>134</sup>

However, the ACN highlighted some existing performance issues that should be addressed:

Notwithstanding ACN's strong support for the NRAS and establishment of AHPRA, it has been a point raised by some members that AHPRA have had difficulties processing their queries. For example, it has been reported that staff handling telephone inquiries have had some difficulty in answering specific questions regarding nursing and midwifery scope of practice and registration, and have at times, not been able to adequately address the queries made. The importance of staff being able to answer callers' queries regarding scope of practice, or at the very minimum, being able to direct callers to resources that are currently available for nurses and midwives, should not be overlooked.<sup>135</sup>

The Australian College of Nurse Practitioners, the peak national body representing the interests of nurse practitioners, was less supportive. The College's submission highlighted 'lengthy delays, inconsistency in decision-making, increased costs in relation to the delay in health services being available to the public, and also the cost to the individuals involved.'<sup>136</sup> The College also raised concern over AHPRA's cost effectiveness which is covered in Chapter Four.

The College elaborated on its concerns:

Delays in Nurse Practitioner application result in delays in quality and timely health services being available, compromising equity of access to all members of the community, and this occurs more often in high need and rural and remote areas, as the applicant is not able to work to full capacity until their application is finalised. Additionally, it can also risk the terms of employment of the applicant. There is an extraordinary amount of effort on the part of the applicant to progress their application, and associated costs with loss of productive work time. Additionally, the ACNP is aware of applicants, advanced clinicians, who have 'given up' and not pursued endorsement as a Nurse Practitioner, further depriving the community of high quality and accessible health services. We are also committed to ensuring that NMBA is consistently applying the same standards to all applications for endorsement as a Nurse Practitioner, in order to protect the public.<sup>137</sup>

The Committee's only evidence received from a health service provider was from Southern Health, the largest health service in Victoria. Southern Health believes that the transition to the National Accreditation and Registration Scheme was a 'huge change process' and notwithstanding implementation problems, further improvements are needed in transparency, communication and responsiveness.

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<sup>133</sup> ACN, Submission No. 14, p. 1.

<sup>134</sup> *Ibid.*, p. 2.

<sup>135</sup> *Ibid.*, p. 1.

<sup>136</sup> Australian College of Nurse Practitioners, Submission No. 13, p. 3.

<sup>137</sup> *Ibid.*, p. 3.

Southern Health noted:

The Australian Health Practitioners Regulation Agency was a small part of this massive transition which included disbanding of over 90 Registration Boards and implementation of 14 National Boards and 11 Accreditation Councils. However for the health services the Agency was the face of this reform and the sole contact for health services during this transition phase. Better communication of this change process could have eliminated a lot of anxiety during the change...We believe that the initial operational issues have been largely overcome by the agency and it is meeting its objective of protecting the public. However further work is required to improve transparency, communication and responsiveness to the needs of health services as they endeavour to ensure their health workforce is fit to practice.<sup>138</sup>

The Australian Osteopathic Association (AOA) also supports the Scheme but notes there remains room for improvement. Importantly, the Association advises it would be concerned to see any return to what it considers 'the insular and parochial State based systems':

AOA also urges the Committee, in its examination of the scheme, to be cautious in distinguishing long-term structural issues, from teething troubles. For example, the Agency has taken a long time to issue various quasi-regulatory guidelines. These, however, have often dealt with very contentious issues and their development has required careful, even iterative, consultation.<sup>139</sup>

The AOA believes that a national system of professional registration:

- assists professional labour mobility;
- provides a uniform standard for the provision of professional healthcare services throughout Australia; and
- delivers economies of scale in administrative costs, especially for the smaller professions.<sup>140</sup>

Avant Mutual Group, while critical of some aspects of AHPRA's notification process, is broadly supportive of the National Scheme:

Avant supports national registration and the national registration scheme primarily for the reasons of mobility of the workforce and national consistency... We would not support Victoria withdrawing from the national scheme. In our view a national scheme provides better support to practitioners and also better protection for the public, with a consistency of approach in all aspects, including registration, accreditation and complaints handling.<sup>141</sup>

The Tasmanian Government, in its submission to the Inquiry, stated 'the National Scheme has significant potential to deliver improved public protection, improved professional standards, greater workforce mobility and better quality education and training and AHPRA is well placed to play the key support role in delivery of these benefits.'<sup>142</sup>

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<sup>138</sup> Southern Health, Submission No. 10, p .6.

<sup>139</sup> Australian Osteopathic Association, Submission No. 48, p. 3.

<sup>140</sup> *Ibid.*, p. 4.

<sup>141</sup> Avant, *Transcript of Evidence*, 9 August 2013, p. 129.

<sup>142</sup> Tasmanian Government, Submission No. 20, p. 12.

The Australian Psychological Society believes ‘there are still some issues that must be addressed relating to consistency between States for both complaints processes and standards of training, and appropriate and proactive risk management by AHPRA in order for the scheme to fully achieve its objectives of cost effectiveness, regulatory efficacy and protection of the Victorian public.’<sup>143</sup>

However, the Victorian Section of the College of Organisational Psychologists, a College of the Australian Psychological Society, was less supportive of the National Scheme and does not consider that the Scheme has yet produced the results intended. The College contends that:

It [AHPRA] has not thus far demonstrated greater efficacy and efficiency than the previous separate jurisdictional systems, save for improved practitioner mobility in some respects...Many problems still exist. For example complaints avenues for aggrieved clients (and others) are still multiple and complexly interrelated. Hearings of complaints are still slow resulting in “justice delayed and thus justice denied”. Practitioners may still be bankrupted by such delays or by multiple versions of the same basic complaint brought by an aggrieved party simultaneously or sequentially in those multiple avenues. ‘Jurisdiction hopping’ is still possible in some circumstances. Mandatory reporting requirements are still contentious and in sore need of review.<sup>144</sup>

Evidence from the Rural Doctors Association of Victoria mainly focused on the supervision of overseas trained doctors which will be dealt with in Chapter 6. The Association has a number of concerns with the performance of AHPRA and the Medical Board of Australia with respect to the oversight of the supervision and postgraduate training of untrained doctors in General Practice. It submits that:

It is suggested that the State needs to maintain some avenue of control and moderation with respect to the AHPRA (MBA). The State has a Health Agenda and has to be prepared to put pressure on the AHPRA to respond constructively to that agenda. The Minister is responsible for appointments to the State Board. Greater transparency of operation is required so that the separate operating of the State and the Australian Boards is visible and the level of response is discernible, which at present it is not.<sup>145</sup>

Despite the general widespread support for principles of the National Scheme, the Committee reports that some evidence strongly opposed the Scheme and called for a return to the previous state-based regulatory system.

The Australian Doctors Fund ‘maintains that medical practice in Australia and Victoria achieved high standards long before the establishment of AHPRA.’ It contends that ‘administrative harmonisation does not require the creation of authoritarian structures and ‘bureaucratic managers’’.<sup>146</sup> In its submission, the ADF recommended that:

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<sup>143</sup> Australian Psychological Society, Submission No. 24, p. 6.

<sup>144</sup> Victorian Section of the College of Organisational Psychologists, Submission No. 36, p. 10.

<sup>145</sup> RDAV, Submission No. 22, p. 6.

<sup>146</sup> ADF, Submission No. 2, p. 1.

...the Victorian Parliament (and all state and territory parliaments) move to reclaim direct responsibility for the registration and regulation of all medical practitioners in Victoria, i.e. to install a Victorian Medical Board as the only intermediary between a registered medical practitioner practising in Victoria and the Victorian Minister for Health. i.e. the Australian Doctors' Fund is recommending that the Australian medical profession be no longer under the management/control/partnership of AHPRA.<sup>147</sup>

The Australian Society of Ophthalmologists (ASO) advised it is deeply concerned by what it considers to be the imposition of AHPRA on the practice of medicine in Australia. The ASO believes:

The fundamental issues arising from AHPRA's nearly three years of existence are: have patient outcomes improved as a consequence and has cross-border registration of doctors become more effective and efficient? In the absence of any substantial, documented examples of enhanced service delivery, patient safety and national administrative efficiency, the valid conclusion must be that it has served no obvious or beneficial need. Instead, it has resulted in significantly increased costs and significant reported inefficiencies to all clinicians across most states and territories. In light of this, there are many clinicians who view AHPRA simply as an attempt to impose uniformity on the numerous and culturally diverse medical professions. In addition, resolution of state-based issues have become exceedingly difficult and sometimes impossible.

The ASO also recommended that 'as a matter of urgency to recover previous levels of efficiency and effectiveness, that the Victorian Government utilises all available avenues to resume direct responsibility for the registration and regulation of all medical practitioners in that State'.<sup>148</sup>

The Australian Society of Orthopaedic Surgeons also submits that there be a return of medical registration and disciplinary matters to State and Territory Medical Boards and hence the removal of these processes from the control of AHPRA.<sup>149</sup>

### 3.4 Conclusion on Overall Performance of AHPRA

The Victorian Department of Health's submission listed what it considers to be the main advantages and disadvantages with the National Scheme. The Department considers advantages to include:

- consistent national standards for entry to and practice in the regulated health professions improves efficiency of health system;
- removal of barriers to portability of registration may improve recruitment of interstate practitioners for cross border services, locum positions and specialty services;
- opportunities for stronger, more robust protection of the public through improved cross profession and cross border regulatory action;
- opportunities for streamlined registration assessment and renewal processes may result in

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<sup>147</sup> *Ibid.*

<sup>148</sup> ASO, Submission No. 39, p. 3.

<sup>149</sup> ASOS, Submission No. 23, p. 1.



more timely recruitment of practitioners;

- improved access to reliable and up-to- date information about the registration status of Victorian registered health practitioners, with comparative data available across 14 professions;
- improved availability of accurate national health workforce data for workforce planning purposes;
- streamlined interfaces with government and non-government agencies;
- opportunities for greater collaboration and learning across professions, in regulation, accreditation, standard setting;
- productivity improvements for Australian Economy; and
- regulatory mechanism of adoption of laws maximises national consistency while strengthening the power of the states and preserving the federal balance.<sup>150</sup>

The Department believes the disadvantages include:

- substantial increases in registration fees for Victorian registrants;
- more complex accountability arrangements (accountability shared by all state and territory Ministers via the Ministerial Council, rather than direct accountability from Victorian boards to Minister) may result in reduced local responsiveness to Ministerial and government concerns and increased confusion in lines of responsibility;
- increased size and complexity of regulatory agency may be more difficult to navigate for outsiders, with more distance between where issues arise and where decisions are made;
- increased complexity in governance arrangements in regards to relationships between National Boards and AHPRA;
- reduced scrutiny of regulatory arrangements by Victorian integrity agencies;
- reduced diversity of regulators may adversely impact on innovation in regulation; and
- greater rigidity in the regulatory arrangements and less innovation.<sup>151</sup>

In its final response to evidence received by the Committee, AHPRA noted:

The National Registration and Accreditation Scheme is working effectively in Victoria to protect the public and facilitate access to health services. Improvements to support transparency, consistency, timeliness and service have been made. More are scheduled. We welcome feedback and suggestions that strengthen our current plans and response within the current regulatory framework.<sup>152</sup>

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<sup>150</sup> Department of Health, Submission No. 50, pp. 38-9.

<sup>151</sup> *Ibid.*

<sup>152</sup> AHPRA, Correspondence received, 26 November 2013, covering letter, p. 3.

On balance, the Committee's evidence supports the concept of the National Registration and Accreditation Scheme and believes it has the potential to achieve many benefits. While evidence suggests the performance of AHPRA is improving, there remains further room for improvement in order to fully realise the benefits of the National Scheme with respect to registration and accreditation of health professionals.

However, as highlighted in Chapter Six, the Committee believes there remain significant concerns over the health complaints process and the ability of the National Scheme to adequately protect the Victorian public.

## **FINDINGS**

**3.4** *The majority of health practitioners support the general principles of a National Registration and Accreditation Scheme, believe the performance of AHPRA has improved and consider that the Scheme has the potential to create benefits including:*

- *nationally consistent registration and accreditation processes, practices and standards;*
- *enhanced workforce mobility and flexibility;*
- *operational efficiencies from economies of scale;*
- *greater collaboration and learning between professions; and*
- *delivery of a national database.*

**3.5** *There remain several performance issues that require the ongoing attention of AHPRA including:*

- *time delays with the health complaints process;*
- *inadequate communication and responsiveness;*
- *lack of transparency and accountability;*
- *inconsistent decision making; and*
- *need for greater cost efficiencies.*

**3.6** *There is a small, but important group of practitioners, which contends that the National Scheme is less efficient and effective than the previous state-based systems and as such believes the Scheme should be dismantled and that there be a partial or full return to the previous state-based system.*

**RECOMMENDATIONS**

- 3. That Victoria remain committed to the registration and accreditation components of the National Scheme and that the Victorian Government remain a signatory to the Intergovernmental Agreement.**
  
- 4. That the Victorian Minister for Health advise the Australian Health Workforce Ministerial Council that there remain a number of issues concerning the performance of AHPRA that must be addressed including:**
  - time delays with health complaints processes;**
  - inadequate communication and responsiveness;**
  - lack of transparency and accountability;**
  - inconsistent decision making; and**
  - need for greater cost efficiencies.**



## Chapter Four: Cost Effectiveness and Registration Fees

The Committee's terms of reference specifically required an examination of the cost effectiveness of AHPRA. The Minister for Health, in moving the Inquiry referral to the Committee, noted:

One claim made at the time the national system was put in place was that it would be more cost efficient and effective to regulate those professional groups at a national level. That has not been the case with most of those groups; registration under the new system has proven to be more costly. I do not speak about other States but about the costs to Victorian registrants and, ultimately, the patients they serve. Cost is an important feature, because the cost and delivery of health services affect accessibility. Costs are ultimately passed through to consumers. Higher fees and higher charges result in reduced access.<sup>153</sup>

Two guiding principles of the National Registration and Accreditation Scheme, as set out in the National Law and Intergovernmental Agreement, are:

- the Scheme is to operate in a transparent, accountable, efficient, effective and fair way; and
- fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the Scheme.<sup>154</sup>

AHPRA's 2012-13 Annual Report states that the National Scheme will result in 'less red tape associated with registrations and notifications, processes are being streamlined and there will be considerable economies of scale'.<sup>155</sup>

Evidence highlighted in the previous Chapter briefly refers to the cost effectiveness of the National Scheme in terms of the significant increases in practitioner registration fees since its introduction in 2010, and the extent to which services have improved commensurate with fee increases. This Chapter will assess the cost effectiveness of AHPRA and the National Scheme in light of registration fee increases and highlight evidence that questions the budget transparency, efficiency and level of service provided by AHPRA.

### 4.1 Review of AHPRA's Financial Statements for 2012-13

AHPRA and the National Boards recorded a surplus of \$26.9 million for the 2012-13 year. This was an increase of almost \$20 million from the previous financial year.<sup>156</sup> The largest surpluses were recorded by the Boards with the largest number of registrations. The Nursing and Midwifery Board

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<sup>153</sup> Legislative Council, *Parliamentary Debates*, 17 October 2012, p. 4688.

<sup>154</sup> *Health Practitioner Regulation National Law 2009*, s. 3; Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, Part 5.4.

<sup>155</sup> AHPRA, *Annual Report 2012-13*, p. 11.

<sup>156</sup> *Ibid.*, p. 176.

recorded a surplus of almost \$13 million, a result that AHPRA indicates 'establishes a sound foundation of reserves to support the delivery of the comprehensive program of work required to meet the contemporary regulatory needs of the nursing and midwifery professions in Australia'.<sup>157</sup> AHPRA's Annual Report notes that the Medical Board of Australia recorded a surplus of \$5.3 million due 'to strong registration income and prudent management of expenditure items.'<sup>158</sup>

The cost of operating AHPRA in 2012-13 was \$138.9 million, representing a \$7.5 million expenditure increase from the previous financial year. The main items of expenditure are:

- staffing costs - \$76.6 million;
- Board sitting fees and direct board costs - \$15.7 million; and
- legal costs - \$13.6 million.<sup>159</sup>

The Medical Board and the Nursing and Midwifery Board account for over 70 per cent of AHPRA's costs, which is consistent with the total number of registrations for these professions. When combined, these two professions account for approximately 75 per cent of total registrations across all professions.

The Committee notes that 55 per cent of AHPRA's costs relate to staff costs. However, the Committee could find no reference in AHPRA's Annual Report as to the total number of staff employed by the Agency or a breakdown of staffing numbers and costs throughout the national and state offices and by function, other than a reporting of approximately \$1.3 million in remuneration for the AHPRA Chief Executive Officer and National Directors.<sup>160</sup>

The total staffing costs over the past two financial years have remained at a similar level, however there was an increase of \$24 million from 30 June 2011 to 30 June 2012.<sup>161</sup> The Committee notes this increase coincided with the introduction of the four new professions into the Scheme.

Given that staffing costs are a major part of AHPRA's total costs and the Committee was required to examine the cost effectiveness of AHPRA, the Committee questioned AHPRA in a public hearing on the non-public reporting of staff levels. AHPRA's CEO, Mr Martin Fletcher, advised that AHPRA employs 'just over 750 full-time equivalent staff across Australia, of which 145 full-time equivalent staff are based in the Victorian state office.'<sup>162</sup>

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<sup>157</sup> *Ibid.*, p. 173.

<sup>158</sup> *Ibid.*

<sup>159</sup> *Ibid.*, p. 176.

<sup>160</sup> *Ibid.*, p. 197.

<sup>161</sup> AHPRA, *Annual Report 2011-12*, p. 113; AHPRA, *Annual Report 2012-13*, p. 178.

<sup>162</sup> AHPRA, *Transcript of Evidence*, 11 December 2013, p. 295.

Mr Fletcher confirmed that despite previous AHPRA annual reports providing details of staff numbers, AHPRA's 2012-13 Annual report did not include such data. The Committee is concerned that such basic operating performance data to support major expenditure was excluded from current public reporting, particularly during the course of this Inquiry into AHPRA's performance and cost effectiveness.

As noted above, National, State and Territory Board sitting fees and direct Board costs amounted to \$15.7 million. Notes to the current AHPRA Annual Report state that 'Board sitting fees and direct board costs includes all national, state and regional board expenditure relating to meetings held by the boards and their committees and for projects commissioned by the boards.'<sup>163</sup> These costs increased by approximately \$4.8 million from the previous financial year. This 43 per cent cost increase was attributed to increased '[d]irect board expenditure for sitting fees and meetings relating to the four 2012 NRAS professions joining the scheme.'<sup>164</sup>

In previous AHPRA Annual Reports, reference was made to there being 'almost 1,500 meetings of National Boards, State and Territory Boards and their committees'.<sup>165</sup> However the Committee could find no reference in the current AHPRA Annual Report to the number of meetings held during 2012-13. Again, the Committee questioned AHPRA as to why this data was excluded from the current annual report. Mr Fletcher commented that:

...what that reflects is that we regulate 14 professions across every jurisdiction in Australia. There are now close to 600 000 registered health practitioners. Of course it is the boards and the committees, as we have said, that make the decisions about practitioners. If they are not meeting, decisions do not get made, so it is obviously important that they meet regularly because that is an important part of the timeliness of our processes.<sup>166</sup>

With respect to non-reporting of Board meetings, Mr Fletcher advised that:

On balance I think we did not think it was a particularly helpful number...There is no problem with us doing it, but I do not think the number of meetings is a measure of our bureaucracy.<sup>167</sup>

Given that Board sitting costs are the second largest items of AHPRA expenditure, behind staffing costs, the Committee was again concerned that AHPRA decided to reduce its public reporting of this data from previous annual reports. The Committee accepts that AHPRA's 2012-13 Annual Report contains a greater amount of data relating to notifications, but given the concerns raised in evidence over transparency and cost effectiveness, it would have been timely for AHPRA to increase its public reporting of data supporting high expenditure levels in staffing and Board meetings.

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<sup>163</sup> AHPRA, *Annual Report 2012-23*, p. 182.

<sup>164</sup> *Ibid.*, p. 174.

<sup>165</sup> AHPRA, *Annual Report 2010-11*, p. xi.

<sup>166</sup> AHPRA, *Transcript of Evidence*, 11 December 2013, p. 296.

<sup>167</sup> *Ibid.*

The third major AHPRA expenditure is legal costs. The \$13.6 million legal costs in 2012-13 represented a 25 per cent (\$2.8 million) increase from the previous year. AHPRA explains the increase in legal costs is consistent with the increase in notification cases. Legal costs include external costs relating to managing the notification process. These costs include legal fees paid to external firms and costs of civil tribunals. They do not include the costs associated with AHPRA staff in the assessment and investigation of notifications or the cost of legal staff employed by AHPRA.

Mr Fletcher explained the basis for legal costs:

Our external legal costs primarily reflect our costs in relation to notifications. We have moved to a set of panel arrangements where we went through a national procurement. We have contracts with providers around the country for which we are very focused not only on the quality of the legal advice but also the cost.<sup>168</sup>

The Committee notes that there was a reduction in some minor expense items over the past reporting period in:

- travel and accommodation costs – down approximately \$1 million to a total of \$1.8 million at 30 June 2013;
- systems and communications costs – down approximately \$2.2 million to a total of \$5.6 million; and
- strategic and project consultant costs – down approximately \$800,000 to a total of \$1.78 million.<sup>169</sup>

AHPRA's total income in 2012-13 was \$165.8 million, a \$27.2 million increase from 2011-12. Income is predominantly derived from registration fees (\$152.8 million) with additional income received through interest and other non-registrant fees or grants. AHPRA reports the increase in registration fee income was a result of the adjustment to NMBA fees from 31 May 2012, and solid application income fees.<sup>170</sup> A discussion on registration fees is provided later in this chapter.

The Committee also highlights AHPRA's level of investments which total \$81 million at 30 June 2013. AHPRA's investment policy states the Agency 'pursues a policy of maximising the investment return on cash balances and investments in an economic and efficient manner, subject to an overriding commitment to financial prudence in managing investment. The primary objectives in the investment of assets shall be to:

- invest AHPRA's funds to maximise real returns within appropriate risk and liquidity constraints so AHPRA can meet its funding and cash flow requirements;

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<sup>168</sup> *Ibid.*, p. 297.

<sup>169</sup> *Ibid.*, p. 176

<sup>170</sup> AHPRA, *Annual Report 2012-13*, pp. 174, 176.



- provide absolute bank account security and accessibility for regular transactions; and
- provide a high degree of security and accessibility and a competitive interest rate within a cash portfolio.<sup>171</sup>

In its evidence to the Committee, the Australian Doctor's Fund questioned the need for such investments:

I hesitate to comment on the concept of investments in a group like this, but it does seem on the surface of it to be inappropriate. This is not a company which is producing a product; it is a collection agency for registration fees.<sup>172</sup>

The Committee does not consider AHPRA to be merely a collection agency for registration fees given its important roles in the complaints process, accreditation and the development of standards. Nevertheless, the issue of AHPRA's level of investments warrants consideration in view of the significant registration fee increases which are outlined in the following section, and the need to fund services such as health programs for doctors and nurses (Chapter Five).

Responding to the Committee's terms of reference pertaining to cost effectiveness, AHPRA submitted:

AHPRA placed a major emphasis in 2011/12 on implementing initiatives which supported nationally consistent work processes that benefit the public and health practitioners and helped make the administration of the scheme more cost-effective.<sup>173</sup>

AHPRA's submission listed a number of recent initiatives to help improve cost effectiveness and deliver greater economies of scale, including:

- increasing the uptake of online registration renewals to consistently above 90%, making it easier for practitioners to renew;
- rolling out new national processes for managing notifications through each state and territory office;
- increasing consistency and reducing unnecessary variation in administering the National Scheme, through standardised processes;
- supporting all meetings with electronic paperwork, leading to savings and improved document security;
- reducing both high mail/print costs and our environmental footprint through email renewal campaigns;

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<sup>171</sup> AHPRA, 'Investment Policy', September 2011, p. 1.

<sup>172</sup> Australian Doctors' Fund, *Transcript of Evidence*, 26 June 2013, p. 76.

<sup>173</sup> AHPRA, Submission No. 40, p. 39.

- rationalising printing of registration certificates to reduce costs and improve sustainability;
- facilitating multi-profession policy development; and
- establishing multiple data-exchange partnerships, for example with Health Workforce Australia and the Australian Institute of Health and Welfare, and Medicare Australia and NEHTA.<sup>174</sup>

Further analysis of AHPRA's Annual Report highlights that some professions with smaller registration numbers are less cost effective than the larger professions. There are 300 registered Aboriginal and Torres Strait Islander Health Practitioners (ATSIHP) throughout Australia with this Board receiving \$26,000 in registration fee income during 2012-13. However, ATSIHP Board costs during this period were \$900,000. Further, the Committee notes the Chiropractic Medical Board and the Chinese Medicine Board recorded net losses of \$311,000 and \$177,000 respectively during 2012-13.

The Department of Health raised the issue of the cost effectiveness of the ATSIHP Board:

The ongoing financial viability of the ATSIHP Board is of concern, given the small practitioner base, and the limited means of registrant cohort to pay registration fees at a level necessary to finance the operations of a National Board. It is unlikely that this Board will be self-funding in the future. Under current arrangements, Victoria is contributing funding for this Board in accordance with the AHMAC Cost-share formula. The Committee may wish to consider whether there may be more efficient and effective mechanisms for delivering regulation of this workforce, and whether amendments to the National Law may be required.<sup>175</sup>

## 4.2 Registration Fees

The National Scheme, as set out in the Intergovernmental Agreement, is designed to be self-funding, with a single national set of fees for each medical profession. These fees are agreed on between each of the National Boards and AHPRA. If agreement is unable to be reached the matter is then referred to the Ministerial Council.<sup>176</sup> AHPRA states that there is no cross-subsidisation between the professions,<sup>177</sup> with each profession funding all its own costs from its registration fees,<sup>178</sup> as well as other features of the National Scheme. A guiding principle of the National Scheme, and enshrined in the National Law, is that fees required to be paid by all health practitioners in order to gain registration, are to be 'reasonable having regard to the efficient and effective operation of the Scheme'.<sup>179</sup> There is no clarification as to what is considered to be 'reasonable'.

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<sup>174</sup> AHPRA, Submission no. 40, p. 39.

<sup>175</sup> Department of Health, Submission No. 50, p. 43.

<sup>176</sup> Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, 12.3-4.

<sup>177</sup> AHPRA, Submission no. 40, p. 38.

<sup>178</sup> AHPRA, *Transcript of Evidence*, 17 April 2013, p. 37.

<sup>179</sup> *Health Practitioner Regulation National Law 2009*, s. 3.

When developing the registration fee model, the Ministerial Council decided to adopt the approach followed previously in Victoria and in some other States, with Boards having the power to set their own fees, rather than Government prescribing fees. The ‘overarching principle that each Board is required to bear in mind is that the process of setting fees be equitable and transparent to registrants.’<sup>180</sup>

The Australian Medical Council observed that:

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 for each of the professions in the Scheme. The Scheme covers both registration and accreditation activities, with the professions now responsible for funding both the regulatory activities and the monitoring of standards of education through accreditation processes.<sup>181</sup>

#### **4.2.1 Fee Increases**

The significant increase in registration fees for health practitioners is well documented in evidence to the 2011 Senate review and in evidence received by the Committee. Table 4.1 illustrates the increases in registration fees for Victorian registered practitioners over the past four years, taking in the last year of the previous state-based system and the first three years of AHPRA. The extent of fee increases is further illustrated in Table 4.2 showing percentage increases for each of the first three years of the National Scheme.

It is evident that most professions were faced with large registration fee increases in the first year of the Scheme but that only modest increases were experienced in years two and three, with the exception of nursing and midwifery.

In the first year of the National Scheme, medical practitioner registration fees increased from \$425 to \$650; a rise of over 50 per cent. Nurses and midwives experienced less of a dramatic increase in the first year, with fees rising by 21 per cent, going from \$95 to \$115. However, the latest fee for this profession is now \$160 which represents a 68 per cent increase over the past three years.

Other professions to experience large fee increases include chiropractic (up 41%) and physiotherapy (up 73%). The most significant increase was in the osteopathy profession with registration fees rising from \$200 to \$480 in the first year, an increase of 140 per cent.

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<sup>180</sup> Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, 12.5.

<sup>181</sup> AMC, Submission No. 33, p. 5.

**Table 4.1: Health Practitioner Registration Fees – 2009 to 2013**

<b>Profession</b>	<b>Vic 2009</b>	<b>NRAS 2010-11</b>	<b>NRAS 2011-12</b>	<b>NRAS 2012-13</b>
Chiropractic	350	495	510	518
Dentist	478	545	563	572
Medical	425	650	670	680
Nursing & Midwifery	95	115	115	160
Optometry	250	395	408	415
Osteopathy	200	480	496	504
Pharmacy	250	295	305	310
Physiotherapy	110	190	196	199
Podiatry	315	350	362	368
Psychology	365	390	403	409
ATSI health practitioners	-	-	-	100
Chinese Medicine	475	475	475	550
Medical Radiation	150	155	155	325
Occupational therapy	-	-	-	280

(Source: Victorian Department of Health, Submission No. 50)

In response to criticism about the increased costs of registration under the National Scheme, AHPRA has offered the following factors as an explanation:

- that the scheme needs to be self-funding;
- that each profession needs to pay its own way;
- fewer assets than expected were transferred to National Boards from existing State and Territory boards;
- the cost of implementation, including investment in new IT systems and customer service infrastructure and processes, was greater than anticipated and more than the funding allocated by governments; and
- National Boards need to fund new services, including the new national complaints model, student registration (at no cost to students), identity and criminal history checks, and the costs associated with mandatory reporting.<sup>182</sup>

<sup>182</sup> AHPRA, Submission No. 40, p. 38.

**Table 4.2: Health Practitioner Registration Fees – Percentage Variance 2010 to 2013**

Profession	1st Year % increase	2nd Year % increase	3rd Year % increase
Chiropractic	41.43	2.94	1.54
Dental	11.91	3.2	1.57
Medical	52.94	2.99	1.47
Nursing & Midwifery	21.05	0	28.13
Optometry	58	3.19	1.69
Osteopathy	140	3.23	1.59
Pharmacy	18	3.28	1.61
Physiotherapy	72.73	3.06	1.51
Podiatry	11.11	3.31	1.63
Psychology	6.85	3.23	1.47
Chinese Medicine	0	0	16
Medical Radiation	3	0	110
Occupational Therapy	N/A	N/A	N/A
ATSI Health Workers	N/A	N/A	N/A

(Source: Victorian Department of Health, Submission No. 50)

The Medical Board of Australia advised that a comparison of fees between the old and new regulatory systems is difficult, because the range of obligations imposed by the previous and current legislation is different. The MBA provided the following explanations for the increase in registration fees:

- lost revenue from multiple registration;
- the removal of previous government subsidisation in some jurisdictions;
- new elements in the National Scheme, including criminal history screening;
- development and implementation of nationally consistent approaches to registration and notification processes and outcomes;
- additional costs of funding Boards at both state and territory and national level;
- transitional costs not covered by government;
- income from reserves of previous Boards less than originally estimated; and
- decommissioning costs.<sup>183</sup>

<sup>183</sup> MBA, Submission No. 42, p. 4.

The Victorian Department of Health also includes the following additional costs as contributing to substantially higher registration fees:

- Under the National Law, National Boards are required to deliver a number of functions that were previously not delivered by some or all of the state boards, identity and criminal record checking, mandatory reporting, performance assessment, new tribunal services and student registration;
- The costs of implementing the scheme were greater than the funding allocated by governments. Additional costs included the set up of AHPRA State offices in each capital city; National Board sitting fees and the employment of State managers and other key staff, in some cases for a full year in advance of 1 July 2010; and
- The level of assets transferred from state boards to the National Boards was lower than expected, including assets transferred from Victorian boards. Initial estimates were approximately 45% higher nationally than the eventual amount transferred to National Boards (approximately \$71 million in total).<sup>184</sup>

Some health professional bodies, such as AMA (Vic) and the Australian Society of Orthopaedic Surgeons, warn that AHPRA and the Boards need to keep fee increases to no more than the CPI.<sup>185</sup> AHPRA itself expects that, for the ten original professions, there will be no increase in registration fees above CPI.<sup>186</sup>

AHPRA advised that since the start of the National Scheme, National Boards have applied only CPI fee increases to the registration fees (except for nursing and midwifery, which went above this in 2012). AHPRA further advised that National Boards are committed to limiting fee increases to CPI if no unforeseen circumstances arise.<sup>187</sup>

While registration fees did initially increase to cover the more robust and protective requirements of national regulation, National Boards have since applied only national CPI fee increases to the national fees. The only exception is nursing and midwifery, which applied an above- CPI fee increase in 2012. However, the Nursing and Midwifery Board of Australia froze its fees in 2013 and has recently cut fees to graduates from Australian universities.<sup>188</sup>

The Medical Board of Australia stated:

Since the first year of the National Scheme, the Medical Board has managed to contain registration fee increases to CPI. However, there continues to be cost pressures on the Medical Board such as:

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<sup>184</sup> Department of Health, Submission no. 50, p. 13.

<sup>185</sup> AMA (Vic), Submission No. 18, p. 2; ASOS, Submission no. 23, p. 1.

<sup>186</sup> AHPRA, *Transcript of Evidence*, 17 April 2013, p. 25.

<sup>187</sup> AHPRA, Submission No. 40, p. 39.

<sup>188</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 4.

- increased payments for the accreditation function, as the Commonwealth government has stopped funding the Australian Medical Council (AMC) for certain accreditation-related activities. In 2011/12, the Board provided an additional \$700,000 to the AMC for core accreditation activities;
- a request from Health Ministers for the Board to fund external doctors' health services across Australia;
- regular requests by government departments for a range of information. This often requires changes to IT and business processes and therefore adds to costs;
- an increase in the number of notifications about medical practitioners; and
- costs associated with auditing for compliance with registration standards.<sup>189</sup>

The Committee deals with health program services in Chapter Five.

In regards to the cost of accreditation functions, the Australian Medical Council expressed some concerns as to the extent to which existing AHPRA resources can adequately fund accreditation activities:

The AMC has expressed concern in previous submissions on the Scheme that the initial under-resourcing of AHPRA and the 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. Through ongoing work with the National Boards and AHPRA, the AMC looks forward to a deepening appreciation of the resource requirements for effective accreditation functions.<sup>190</sup>

The College of Organisational Psychologists raised concern over increasing registration costs arguing that the recent CPI-based funding model developed by AHPRA does not satisfy the objectives of the National Law which states that 'fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme.'<sup>191</sup> The College asserts that a CPI-based model 'ignores efficiencies and always increases fees whether warranted by the costs of activities or not', thereby contravening the National Law.<sup>192</sup>

The Committee notes that while the majority of health practitioners were aggrieved at the sharp rise in registration fees during the first year of the Scheme, most now accept the annual registration fees and expect only CPI increases in the future. It should also be noted that health practitioner concerns over the large fee increases in the first year of the Scheme were magnified by the poor performance of AHPRA in the implementation year.

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<sup>189</sup> MBA, Submission No. 42, p. 4.

<sup>190</sup> AMC, Submission No. 33, p. 5.

<sup>191</sup> *Health Practitioner Regulation National Law 2009*, s. 3.

<sup>192</sup> COP, Submission no. 36, p. 3.

The AMA (Vic) referred to the importance of protecting the public when commenting on the higher fees:

The medical board conducted a fairly wide consultation process, and AMA Victoria submitted that we believed the system should continue in its current form, that the funding should continue to come from funds raised out of medical registration fees particularly given that initial very hefty jump of over 50 per cent in those fees. Because this does not just support the profession; this supports the public as well. It is an investment because the public has spent so much money in the training of students into doctors that if a health issue can be adequately dealt with and managed, then that doctor can practise in a society where the need for qualified medical practitioners has never been greater. That is a far better alternative than someone who is unable to practice medicine, or worse still has an illness that deteriorates and which results in a preventable adverse outcome for the public.<sup>193</sup>

The Victorian Department of Health notes that while there had been an expectation that the National Scheme would 'reduce red tape', 'at no stage were commitments made that registration fees would be reduced as a result of the establishment of the National Scheme.'<sup>194</sup>

The Productivity Commission argued in a recent report on the impacts of COAG reforms that while 'significant' transition costs are presently being incurred by the health professions, the bulk of these costs were incurred over the several years leading up to the National Scheme's commencement in 2011. The Productivity Commission observed that 'at this stage, it is not clear that there will be net increases in on-going administrative and compliance costs to the professions'. However, it also remarked that the financial benefits of the scheme are assessed as being prospective and that therefore the ongoing benefits 'could progressively accrue over the next twenty years.'<sup>195</sup> If this were to be the case, presumably this would have the effect of limiting ongoing substantial increases to registration costs.

It should be noted that the introduction of the National Scheme has seen fees decrease for all those practitioners who register in two or more jurisdictions. The Department of Health stated:

On commencement of the National Scheme, those practitioners who had previously maintained registration in two or more jurisdictions paid significantly less in total registration fees under the National Scheme. It is understood that approximately 11% of Victorian registered medical practitioners (the practitioners who experienced the largest fee increase compared to the average single jurisdiction fee), fell into this category.<sup>196</sup>

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<sup>193</sup> AMA (Vic), *Transcript of Evidence*, p. 51.

<sup>194</sup> Department of Health, Submission No. 50, p. 14.

<sup>195</sup> Productivity Commission, *Impacts of COAG Reforms: Business Regulation and VET*, vol. 2, April 2012, p. 231.

<sup>196</sup> Department of Health, Submission No. 50, p. 10.



## 4.2.2 Value for Money

Evidence put to the Committee has questioned the level of services provided by AHPRA and the Boards in light of the increased registration fees. Many participants in the National Scheme are of the view that they currently receive the same level or even fewer services than they received under the previous state-based scheme.

Both the medical profession and the nursing and midwifery profession were particularly concerned that vital services such as health programs may be lost despite the significant increase in registration fees. The Committee notes, in relation to MBA's concern, that the provision of national external health services for doctors may place pressure on the level of registration fees. The Committee argues this existing service for Victorian doctors should be funded within the current fee structure.

The AMA (Vic) noted:

The concerns that the medical profession had started, after AHPRA's establishment, with the fact that the registration fee went up dramatically and the service deteriorated. As far as Victorian doctors were concerned, in 2009 we paid \$415 each for medical registration. The following year it was \$650 — the first year of the Australian or national medical registration. Did that correspond with an improvement in service? Clearly not at that stage, and as I will mention a little bit later in my submission, it put into question something that we have taken for granted and regard as an incredibly important service, and that is the Victorian Doctors Health Program.<sup>197</sup>

The AMA (Vic) also comments that in light of the fees it charges, doctors are right to expect better quality service from the registration body.<sup>198</sup>

The Australian College of Nurse Practitioners also highlights concern over registration fee increases for nurses with what it considers to be no improved service delivery:

All registration fees for nurses and midwives under the NMBA across Australia have significantly increased since AHPRA commenced in 2010. There have been no additional services added in this time to support registrants, and administration issues have not improved. As a minimum, we would like to see full-time staff available in each State or Territory to handle enquiries, including those with the specialist knowledge required to manage Nurse Practitioner issues. In Victoria, there is a professional officer able to handle Nurse Practitioner enquiries and issues two days per week, and a response can take several weeks. This person is also responsible for handling applications for endorsement as a Nurse Practitioner from Victoria and interstate. At times, there have been staff available up to four days per week; however there have still been significant issues with backlog and efficiency. This is one example of how our increased fees are not supporting registrants, with over 90,000 registered nurses and midwives in Victoria alone.<sup>199</sup>

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<sup>197</sup> AMA (Vic), *Transcript of Evidence*, 29 May 2013, p. 50.

<sup>198</sup> AMA (Vic), Submission No. 18, p. 2.

<sup>199</sup> ACNP, Submission No. 13, p. 1.

Both the VDHP and the NMHP point to the fact that doctors and nurses are not only dismayed at the rise in fees under the National Scheme, but also that they seem to be provided with fewer services including possibly less comprehensive health support programs in the future.<sup>200</sup>

In its written submission to the Inquiry, the Royal Australian College of General Practitioners highlighted cost efficiency as an issue requiring attention:

The transition to the national registration scheme has been accompanied by a significant increase in registration fees, despite the expectation that the amalgamation of the state and territory medical boards would lead to operational efficiency gains and cost reductions. The RACGP believes that the national medical board should be able to perform the pre-existing state and territory medical boards' duties, and any new activities, within the new budgetary allocation.<sup>201</sup>

The Australian Association of Surgeons questions the justification of medical practitioner fees doubling since the introduction of the National Scheme. It suggests that such increases have supported the costs of AHPRA's administration, particularly at senior levels. It also asserts that a lack of staff planning has contributed to fees increasing, as 'many of the former Victorian Medical Board staff were simply offered positions in the new scheme without careful consideration as to actual staffing needs once the scheme was in place.'<sup>202</sup>

The Australian Doctors' Fund was of the view that practitioners are not getting value for money:

This essentially is quite an empire and engine financially, providing large amounts of money, and I think we have to question whether this is actually value for money or not. In particular, I do not believe that it is, and our group does not believe that it is.<sup>203</sup>

The Australian Society of Ophthalmologists was highly critical of the performance of AHPRA commenting that 'many patients would be distressed to learn that AHPRA staff costs alone amount to \$53 million, especially when service enhancements are not evident.'<sup>204</sup>

In contrast, despite the physiotherapy profession experiencing a large registration fee increase in the first year of the Scheme (\$110 to \$190) the Australian Physiotherapy Association believes:

There has not been a significant change in the cost to physiotherapists in Victoria since the introduction of the scheme. Any changes to the charges applied by the Physiotherapy Board of Australia can be justified by the increased scope of activities now being undertaken.<sup>205</sup>

AHPRA advised out that managing health practitioner notifications 'is a significant driver of costs in health practitioner regulation.' In response to evidence from practitioners that they are not

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<sup>200</sup> Nurses and Midwives Health Program, Submission no. 9, p. 3; VDHP, Submission No. 15, p. 2.

<sup>201</sup> RACGP, Submission No. 19, p. 2.

<sup>202</sup> Australian Association of Surgeons, Submission No. 3, pp. 2-3.

<sup>203</sup> Australian Doctor's Fund, *Transcript of Evidence*, 26 June 2013, p. 76.

<sup>204</sup> ASO, Submission No. 39, p. 3.

<sup>205</sup> APA, Submission No. 49, p. 3.

receiving an appropriate level of service for the fees paid, AHPRA responded:

It is important to note that regulation is not a service to practitioners but rather, a decision by government about how best to protect the public.<sup>206</sup>

When questioned further on whether health practitioners are getting value for money as a result of the transition to the National Scheme, the Chair of the Medical Board of Australia, Dr Joanna Flynn advised:

First of all, the scheme is not here for practitioners; the scheme is here for the community. There are a number of checks on registration that were not there before: criminal history checks, more rigorous identity checking, more rigorous checking at all sorts of levels which enhance public protection... As the medical board we are responsible for overseeing notifications about medical practitioners, and we have to require of AHPRA a standard of service delivery that requires resourcing. It is not sufficient for us to say, 'We can't put the fee up, therefore we can't regulate properly'. We have to charge the fees that are needed.<sup>207</sup>

Health Rights and Community Action (HRCA) is a South Australian consumer group established in 1996, and has been promoting consumer health rights and better health complaint processes since that time.<sup>208</sup> The group's submission highlighted the Productivity Commission's May 2012 report on the impact of COAG reforms which made the following comments in relation to cost effectiveness of the National Scheme:

The new Scheme is designed to improve the efficiency of the system of accreditation and registration, as well as the labour market for health professionals more generally. These benefits are derived from achieving economies of scale.<sup>209</sup>

HRCA believes 'the substantial increase in registration shows that no cost savings have been achieved through the National Registration Scheme.'<sup>210</sup>

Evidence was received that registration fees for certain professions are significantly lower in comparable jurisdictions than under the National Scheme in Australia. For instance, the College of Organisational Psychologists (APS) pointed out that a psychologist's registration fee in the UK is the equivalent of AUD \$129 versus AUD \$409 currently in Australia.<sup>211</sup> However, AHPRA warned against using international comparisons when dealing with two different systems. It explains that the NRAS is unique: there is no other country in the world that regulates the same mix of professions.

While there are some similarities with the UK Health Care Professions Council (HCPC), there are also significant differences. The HCPC regulates 16 professions, but only five professions are common to

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<sup>206</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 3.

<sup>207</sup> AHPRA, *Transcript of Evidence*, 11 December 2013, p. 293.

<sup>208</sup> Health Rights and Community Action, Submission No. 34, p. 1.

<sup>209</sup> *Ibid.*, p. 8

<sup>210</sup> Health Rights and Community Action, Submission No. 34, p. 9.

<sup>211</sup> COP, *Transcript of Evidence*, 18 September 2013, p. 177.

both the National Scheme and to the HCPC. The HCPC does not regulate medicine, nursing and midwifery, pharmacy, dental practitioners, chiropractors, osteopaths and optometrists. Each of these professions has a separate professions specific council in the UK. It explains that a significant driver of costs in the National Scheme is the management of notifications, 95% of which relate to five professions, only one of which is managed by HCPC. AHPRA commented:

Therefore, any fee comparison to health regulators in the UK must not only consider the fees charged by the HCPC for its 16 professions (currently £76 (\$129) per annum), but also the annual fees charged by the professions with separate councils – General Medical Council - £390 (\$667), dentists - £576 (\$984) and chiropractors - £800 (\$1367). The fees charged by the separate councils are equal to or exceed the fees charged by the separate councils are equal to or exceed the fees charged by the National Boards in the Australian scheme.<sup>212</sup>

### 4.3 Financial Transparency

The Committee's ability to comprehensively analyse the cost effectiveness of AHPRA was restricted due to limited financial data published in AHPRA's Annual Report. The Committee has previously referred to lack of data relating to staff costs and Board costs. In addition, there is no public reporting of AHPRA's costs on a State and Territory breakdown and limited data on the breakdown of each Board's costs.

The Committee notes AHPRA provides financial statements for each National Board through separate Health Profession Agreements published on AHPRA's website. The Committee could find no reported data, either in annual reports or AHPRA's website, of the costs of the three Victorian State Boards for Medicine, Nursing and Midwifery, and Psychology.

The *Health Practitioner Regulation National Law Act 2009* requires that AHPRA enter into a Health Profession Agreement with each National Board that provides for the following:

- the services to be provided by the Agency to the Board to enable it to carry out its functions;
- the fees payable by health practitioners; and
- the annual budget of the Board.<sup>213</sup>

Despite these agreements being published on AHPRA's website, many submitters believed greater transparency is required in AHPRA's budget reporting particularly in view of the significant increase in registration fees. In particular, there is concern that cross-subsidisation may occur between professions, although the Committee cannot verify this either way due to insufficient publicly available data.

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<sup>212</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 3.

<sup>213</sup> *Health Practitioner Regulation National Law 2009*, s. 26.

When developing the registration fee model, the Ministerial Council decided to adopt the approach followed previously in Victoria and in some other States, with Boards having the power to set their own fees, rather than government prescribing fees. The overarching principle that each Board is required to bear in mind is that the process of setting fees be equitable and transparent to registrants.<sup>214</sup>

The AMA (Vic) would like to see more details of the specific costs of administering the various professions. Despite assertions that each profession is self-funding, the AMA (Vic) remains concerned that medicine could be funding other professions. It believes that there needs to be enhanced budget transparency with respect to the allocation and expenditure of registration fees. In its public hearing evidence, the AMA made the following observations regarding the need for greater transparency, while noting AHPRA has made some recent improvements:

- I think, of the way the finances were being administered, at least as far as the profession was concerned, that we could not tell whether that money was being confined to the medical profession administration or whether that was cross-subsidising other health professions.<sup>215</sup>
- There is not enough transparency. We need to know where the money is going, where it is allocated, in which professional bodies and where it is actually going to. That is why we are calling for more transparency.<sup>216</sup>
- We believe there has been some improvement in transparency, and we look forward to seeing more of that. As I said, I think AHPRA has made some real progress over the last two to three years in terms of its performance, and I think financial transparency is one of those improvements.<sup>217</sup>

Similarly, the RACGP states that ‘clear reporting of the costs associated with administering the national legislation and regulation of the profession would improve transparency, accountability and possibly acceptability of current and any future pricing structures’ of registration fees.<sup>218</sup>

In response to a question from the Committee as to where improvements could be made to AHPRA’s transparency and accountability, RACGP advised:

The RACGP believes that AHPRA should provide each of the health professions with a detailed breakdown of their registration costs, including the costs for registration administration, complaints handling, staffing, IT, etc. This is particularly important for any fee increases.<sup>219</sup>

The Australian College of Nursing noted that ‘as the largest health practitioner groups, the nursing and midwifery fees will generate significant income for AHPRA. The College therefore considers it is

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<sup>214</sup> Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, 12.5.

<sup>215</sup> AMA (Vic), *Transcript of Evidence*, 29 May 2013, p. 52.

<sup>216</sup> *Ibid.*, p. 53.

<sup>217</sup> *Ibid.*, p. 52.

<sup>218</sup> RACGP, Submission No. 19, p. 2.

<sup>219</sup> RACGP, letter dated 23 September 2013, response to question taken on notice at hearing on 9 August 2013.

essential that the income generated from these groups does not subsidise the registration costs of other professions.<sup>220</sup>

The Australian Osteopathic Association urged AHPRA to ensure costs are lowered and believed 'the eight individual jurisdictions represented on the Ministerial Council should ensure their respective Parliamentary arrangements for budgetary scrutiny do operate with respect to AHPRA's budget and efficiency in operation.'<sup>221</sup>

Responding to transparency concerns, AHPRA stated:

We also recognise very much the importance of transparency. Boards are very conscious of the legitimate interest of the professions in understanding how fees are spent and what they are used for. As you would be aware through our annual report, we are externally audited by VAGO on an annual basis, and we have to provide an annual report, which is tabled in each Parliament around Australia. We have moved to provide quite detailed information in that annual report, broken down by profession, of how fees are used and what they are spent on. We also have a thing called a health profession agreement, which is a formal agreement between the board and AHPRA for fees, work programs and budgets on an annual basis, and we also publish those health professions' agreements on our website.<sup>222</sup>

Responding to suggestions there may be cross-subsidisation, AHPRA advised:

Probably just to add for completeness, the costs of AHPRA are shared between the boards. What we have is a formula which we have independently validated and negotiated with the boards, which essentially reflects a share they pay of our operating costs of that \$101 million based on the proportion of work we do on behalf of that particular board, and that looks both at issues of volume and complexity in terms of the work that we do. For example, around half of our notifications are associated with medicine, so medicine obviously ends up paying a bigger share of our costs around the administration of notification systems than other professions might do.<sup>223</sup>

In its supplementary response to evidence, AHPRA again rejected the notion of possible cross profession subsidisation:

There is no cross subsidisation between professions in the National Scheme. AHPRA has conducted cost allocation studies, with independent advice, to provide a solid foundation for the proportionate costs attributed to the National Boards. This is kept under ongoing review.<sup>224</sup>

It is difficult for the Committee to fully assess whether cross-subsidisation exists as suggested in some evidence. AHPRA's publicly reported financial statements do not allow for such detailed analysis. However, the Committee notes AHPRA's statement that 'each profession needs to pay its own way'. To reiterate it's earlier observations, the Committee points to several Boards that made a

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<sup>220</sup> Australian College of Nursing, Submission No. 14, p. 2.

<sup>221</sup> AOA, Submission No. 48, p. 4.

<sup>222</sup> AHPRA, *Transcript of Evidence*, 17 April 2013, p. 23. Cf. AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 4.

<sup>223</sup> AHPRA, *Transcript of Evidence*, 17 April 2013, p. 37.

<sup>224</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 4.

net financial loss in the 2012-13 financial year. This suggests the registration numbers and fees for certain professions may not be sufficient to cover the cost of running these individual Boards.

## **FINDINGS**

- 4.1 Evidence highlights concerns over AHPRA's cost effectiveness and transparency. In addition, AHPRA's Annual Report lacks sufficient financial data to comprehensively assess its cost effectiveness.**
- 4.2 AHPRA's large operating expenses of approximately \$150 million resulted in significant increases in registration fees in the first year of the National Scheme. In some professions, such as the medical profession, registration fees have doubled since the commencement of the Scheme. However, the Committee notes that recent fee increases have been in line with the Consumer Price Index.**
- 4.3 While it is difficult to assess, there are some concerns in evidence that the larger professions may be cross-subsidising smaller professions in the Scheme.**
- 4.4 Additional performance reporting is necessary to assess the cost effectiveness of the 14 National Boards, the State and Territory Boards, and AHPRA national and local offices.**

## **RECOMMENDATIONS**

- 5. That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that future annual reports of the Australian Health Practitioner Regulation Agency include additional information relating to the financial statements including:**
  - total staff employed by the Agency including a breakdown of staff allocation for each office and broad function/unit;**
  - a breakdown of the number of meetings held for each National, State and Territory Boards and their committees;**
  - detailed income and expenditure breakdown for each National Board; and**
  - cost analysis of the Agency Management Committee, the Australian Health Workforce Advisory Council and each State and Territory AHPRA office.**
- 6. That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that health practitioner registration fee increases be no greater than CPI increases and that such be enshrined in the National Law.**





## Chapter Five: Health Programs for Doctors, Nurses and Midwives

One of the major concerns raised in evidence was the future of programs to support the health and well-being of the medical, nursing and midwifery professions. As noted earlier, these professions comprise three-quarters of all registered health practitioners in Victoria.

The Victorian Doctors Health Program (VDHP) and the Nursing and Midwifery Health Program (NMHP) were established in Victoria under the previous state-based health practitioner regulation system to support doctors, nurses, midwives and students with health problems such as drug, alcohol and mental health issues. The programs are considered vital to maintain productivity and wellbeing in the workforce, and ensure the provision of high quality patient care. As such, the programs are an important factor in the performance of the National Scheme and the protection of the public.

Concerns raised in evidence were that the Victorian services would no longer be funded under the National Scheme, or would become nationally focused. Any potential end to the Victorian Health Programs, or diminution in services was seen to be unacceptable especially in view of the large increase in practitioner registration fees under the National Scheme.

### 5.1 Victorian Doctors Health Program

The Victorian Doctors Health Program is an independently governed organisation jointly established in 2000 by the AMA (Vic) and the previous Medical Practitioners Board of Victoria (MPBV).

The creation of the program was a response to the growing awareness of shortcomings in the provision of health services to medical practitioners. In particular, VDHP provides assistance to doctors and medical students who are faced with stress and anxiety; substance use problems; mental or physical health concerns; and other health issues.<sup>225</sup> The program also supports research into the prevention and management of illness in medical practitioners and students, facilitates early identification and intervention for medical practitioners and students, acts as a referral and coordination service in order to access appropriate support and encourages rehabilitation, re-training and re-entry to the workforce.<sup>226</sup>

Each year, around 200 doctors approach the VDHP for the first time. The AMA (Vic) submits that the program's success, and the degree to which it has come to be relied upon, is evident by its

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<sup>225</sup> <http://www.vdhp.org.au/website/services.html>, accessed 6 August 2013.

<sup>226</sup> MPBV and Board of VDHP, 'The future of the Victorian Doctors Health Program', February 2009, pp. 2, 4.

consistently growing workload.<sup>227</sup> Dr Stephen Parnis of AMA (Vic) spoke of the increasing importance of this program to medical practitioners in Victoria:

It has been very successful. The fact is that the work of the health program is increasing each year, and the growth of that service is in referrals both from oneself and from colleagues or friends or family, particularly in the younger members of our profession. I think it is a positive sign — that people are recognising that there is the potential for problems and getting those things dealt with at the early stage.<sup>228</sup>

Several witnesses referred to the importance of the program in protecting the public. The VDHP Board suggests that the increasing uptake of the program represents earlier identification of potentially more serious health issues, thereby demonstrating the importance of the work of VDHP towards the welfare and protection of the community, by preventing impairment in doctors.<sup>229</sup>

Dr Parnis commented that the program supports the profession and the public:

It is an investment because the public has spent so much money in the training of students into doctors that if a health issue can be adequately dealt with and managed, then that doctor can practise in a society where the need for qualified medical practitioners has never been greater. That is a far better alternative than someone who is unable to practise medicine, or worse still has an illness that deteriorates and which results in a preventable adverse outcome for the public.<sup>230</sup>

The Acting Health Services Commissioner also highlighted the importance of the health programs and associated benefits to the public:

The public investment into doctor and nurse education is significant and doctors and nurses are a scarce public resource. While the National Scheme should focus on the management and certification of registrants, a body should exist to support, treat and supervise registered practitioners to practise safely. There is benefit to the public in maintaining a safe workforce. As such, health programs should be kept and, if not within the National Scheme, by another separately funded body.<sup>231</sup>

The previous Medical Practitioners Board of Victoria funded the VDHP through a levy of approximately \$25 per registered medical practitioner in Victoria. However, evidence from the AMA (Vic) suggests the program's future is uncertain under the National Scheme:

The Victorian Medical Board was able to run the program on a budget of approximately \$25 per registered practitioner in Victoria however the implementation of the national registration scheme has meant that the state board can no longer continue to do so. Former Victorian Health Minister Daniel Andrews agreed to fund the program for the first three years of the national scheme however this funding is set to expire at June 2013. The Medical Board of Australia has allocated some interim funding of \$350,000 for its continuation over 2013-14 but this is only while it determines a long-term

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<sup>227</sup> AMA (Vic), Submission No. 18, p. 3.

<sup>228</sup> AMA Victoria, *Transcript of Evidence*, 29 May 2013, p. 51.

<sup>229</sup> MPBV and Board of VDHP, 'The future of the Victorian Doctors Health Program', February 2009, p. 3.

<sup>230</sup> AMA (Vic), *Transcript of Evidence*, 29 May 2013, p. 51.

<sup>231</sup> HSC, Submission No. 5, p. 4. Cf. AMA (Vic), Submission No. 18, p. 3.

policy position on doctors' health programs. The Board has so far given no guarantee that it will provide long term support to the program.<sup>232</sup>

In addition to the MBA's funding of \$350,000 for 2013-14, the VDHP has been required to secure additional funding from the Victorian Medical Benevolent Association and from three Victorian universities in order to continue with existing services.<sup>233</sup>

In its evidence to the Inquiry, the Victorian Department of Health considered that there is not the same impetus for continuing the health programs (including the Nursing and Midwifery Health Program) as there was under the previous state-based system.<sup>234</sup>

The Medical Board of Australia advised that it is not appropriate for the National Scheme to fund a service for doctors in one jurisdiction only:

The Board does not believe that it is equitable to fund a service for doctors in only one jurisdiction, given that all medical practitioners have to pay the same registration fee. There is significant variation in the type and level of service offered by the existing programs around Australia from, at one extreme, a model based on volunteers providing telephone advice, through to the VDHP model. As a prerequisite to determining what model of external health services it will fund, the Board has defined its role and responsibilities in relation to managing impaired practitioners under the National Law. This is to ensure that there is clear delineation between the role of the Board in managing impaired practitioners and the related risk to the public, and the role of an external health program. This clear differentiation is critical to reduce risk to the public and avoid confusion for practitioners.<sup>235</sup>

A discussion paper was prepared in February 2009 on behalf of the AMA (Vic), MPBV and VDHP on the future of the Victorian Doctors Health Program. The paper considered various options including a national doctors program, continuation of individual state programs and funding options such as practitioner levies, funding from government and from medical indemnity organisations.

The MPBV and the Board of VDHP have argued that a VDHP program or similar service is essential in all States and Territories and that the cost should be borne by the entire medical profession. They suggest the simplest way that this could be achieved is by implementing the Victorian funding model in the other jurisdictions.<sup>236</sup> Victoria is the only State in which such a comprehensive support service for health practitioners exist. While there are health services particular to doctors in some of the other States, they are generally unfunded voluntary organisations.<sup>237</sup>

Two possible national models for the future have been considered by MPBV and the Board of VDHP. Firstly, within the National Scheme, a health program could be equitably funded in each jurisdiction

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<sup>232</sup> AMA (Vic), Submission No. 18, p. 3.

<sup>233</sup> VDHP, *Transcript of Evidence*, 4 September 2013, p. 161.

<sup>234</sup> Department of Health, *Transcript of Evidence*, 12 December 2012, p. 4

<sup>235</sup> MBA, Submission no. 42, p. 7.

<sup>236</sup> MPBV and Board of VDHP, 'The future of the Victorian Doctors Health Program', February 2009, p. 1.

<sup>237</sup> *Ibid.*

with each jurisdiction determining its own model. Alternatively, an Australian Doctors Health Program could be funded with offices in every capital city. The MPBV and VDHP considered the former proposal would have the advantage of allowing for differences inherent in different jurisdictions and may therefore be more readily accepted; however the latter model would bring an ‘enormous boost’ to research capacity and has the advantage of ‘bureaucratic neatness’ and consistency with the aims of the National Scheme.<sup>238</sup> The MPBV and VDHP review of the health program noted that:

Given the considerable funding provided by COAG to establish the new national registration process, Victoria (via its Health Minister ideally) might wish to seek bridging funding for the VDHP until a national approach to doctors health services is agreed and in place.<sup>239</sup>

Evidence highlights that the existing program within Victoria is considered the most comprehensive in Australia and should be maintained:

By comparison with other models in other states of Australia I think it is the Rolls Royce version of health care in terms of protecting the public, identifying problems that the medical profession may have, and hopefully nipping many of them in the bud before they become a problem.<sup>240</sup>

Dr Parnis stated that if the VDHP does not continue in its current form it would be a ‘tragedy’.<sup>241</sup> Similarly, Dr Jenkins from the VDHP, warned against allowing a service that constitutes the ‘lowest common denominator’, such as merely a telephone counselling service and a national website. Dr Jenkins advised that a decrease in funding would see the discontinuation of the VDHP’s primary preventative approach with its educational initiatives as well its case management of doctors with mental health issues, substance use disorder or physical health problems. Dr Jenkins submitted that analysis of outcomes of the VDHP case management program shows results comparable with world’s best practice.<sup>242</sup>

Further evidence, including from the Acting Health Services Commissioner, opposed the notion that AHPRA would manage any future health programs:

I think because AHPRA is the regulator and manager of the system, having them manage a health program is very difficult. I am not sure whether if I was a registered practitioner who was having some health issues, I would want to go to a service that was funded by the person who I rely on for my livelihood. The registered practitioners have invested in them enormous amounts of money to practice. That seems to me to be an important aspect in supporting them. Part of the issue for me is also encouraging practitioners to seek help. There should not be impediments for practitioners to seek help, and having AHPRA run those programs may well be an impediment.<sup>243</sup>

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<sup>238</sup> *Ibid.*, p. 9.

<sup>239</sup> *Ibid.*

<sup>240</sup> AMA (Vic), *Transcript of Evidence*, 29 May 2013, p. 51

<sup>241</sup> *Ibid.*

<sup>242</sup> VDHP, Submission No. 15, p. 1.

<sup>243</sup> HSC, *Transcript of Evidence*, 26 June 2013, p. 89; HSC, Submission No. 5, p. 4. Cf. MBA, Submission No. 42, p. 7.

When asked at a public hearing whether AHPRA or the Boards would operate future programs, the Chair of the Medical Board of Australia, Dr Joanna Flynn, advised this would not be the case.

Let me be very clear about this: we would not run the doctors health program; it would be completely at arm's length. Part of the preparatory work the medical board has done is to try and articulate very clearly our regulatory role in relation to impaired practitioners and public protection, which is quite separate from a whole range of things about access to health services and support that a range of doctors need. We need to be very clear about the thresholds for reporting to the board and the board taking action, but the whole sort of nurturing, pastoral care, support, triage, education and prevention is in the hands of a separate body, which would be funded by medical registration fees and run at arm's length from the board and from AHPRA.<sup>244</sup>

Dr Flynn stated that the Board is currently focussing on what model it would fund and 'does not foresee the need to increase registration fees for this purpose.'<sup>245</sup> Dr Flynn also stated that the MBA is committed to establishing a health program for doctors in Australia and that the Board is 'now starting the planning and thinking to make this happen and will keep the profession informed about progress in the months ahead.'<sup>246</sup> This commitment follows a request to the MBA from the Australian Health Workforce Ministerial Council to consider continuing the VDHP and to expand it nationally.

In response to this AHWMC request, in 2012 the MBA consulted with stakeholders on whether it should be funding doctors' external health programs. The feedback indicated there was general support that the MBA support such health services, but there was no agreement on what services should be funded. In addition, there was a widespread view that such a program should be funded from within the current registration fees, rather than causing a specific fee increase.<sup>247</sup> The AMA (Vic) is also strongly opposed to any further medical registration fee increases to fund the VDHP.<sup>248</sup>

According to the AMA (Vic), the announcement of ongoing funding for the doctors health program is positive, but 'the details really matter':

The fear is... that the quantum allocated will not be enough to support the service in the form that it currently exists.<sup>249</sup>

AHPRA has informed the Committee that the MBA has appointed a consultant 'to provide advice to the Board on the governance of external health program/s for medical practitioners and to provide information on the scope of the work required to establish this service.'<sup>250</sup>

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<sup>244</sup> AHPRA, *Transcript of Evidence*, 11 December 2013, p. 292.

<sup>245</sup> Medical Board of Australia, 'Media Release: Medical Board to fund health program/s for doctors', 6 March 2013, p. 1. Dr Flynn again reiterated that the doctors health program would be funded by the Medical Board at a public hearing on 17 April, 2013. See AHPRA, *Transcript of Evidence*, 17 April 2013, p. 24.

<sup>246</sup> MBA, 'Media Release: Medical Board to fund health program/s for doctors', 6 March 2013, p. 1.

<sup>247</sup> *Ibid.*, p. 2. See <http://www.medicalboard.gov.au/News/Past-Consultations/2012/Consultation-February-2012.aspx> for the submissions received. Accessed 7 August, 2013.

<sup>248</sup> AMA (Vic), Submission no. 18, p. 4. Cf., AMA (Vic), *Transcript of Evidence*, 29 May 2013, p. 52.

<sup>249</sup> AMA (Vic), *Transcript of Evidence*, 29 May 2013, p. 52.

At the final public hearing on 11 December 2013, the Chair of the Medical Board of Australia reaffirmed its commitment to a future national health program specific to the needs of doctors:

...the medical board is strongly convinced of the need for a national doctors health program, and that belief has only been supported by the recently published study done in cooperation with the board by beyondblue, which surveyed nearly half of all Australia's medical practitioners, got a high response rate and found very significant levels of current and past mental health problems and distress amongst the medical profession.

The board has currently commissioned a piece of work to look at what that model should look at, what the governance model should be and what the accountability should be, and has set aside funding to fund a national doctors health program in all states and territories. How that will work structurally with the current state programs is an issue on the table for us to work through in conjunction with the profession, but we have a strong commitment to an equitable offer of delivery of doctors health programs around the country.<sup>251</sup>

## 5.2 Nursing and Midwifery Health Program

Beginning its operation in 2006, the Nursing and Midwifery Health Program (NMHP) is an independent Victorian support service for nurses, midwives and students of nursing and midwifery experiencing health issues related to their mental health or substance use concerns. The NMHP was an initiative of the previous Nurses Board of Victoria, the Australian Nursing Federation (Victoria Branch) and dedicated individual nurses. Although the program has been funded through the former Nurses Board of Victoria, it is a fully independent legal entity.<sup>252</sup> The NMHP provides screening, assessment, referrals, individual support sessions and groups to all nurses, midwives and students of nursing and midwifery in Victoria.<sup>253</sup>

The Program has been funded by Victorian nurse registration through the former Nursing Board of Victoria (AHPRA now administers these funds) with funding equating to \$5.69 per registrant annually.<sup>254</sup>

Approximately 600 nurses accessed NMHP in the first five years of its existence, and of those, at least 63 per cent have either returned to work or have been able to stay at work while being supported by the program.<sup>255</sup> Similarly to the VDHP, demand for the services of the NMHP has grown substantially, from 20 cases in the first year to 117 cases in 2010-11.<sup>256</sup>

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<sup>250</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 5.

<sup>251</sup> AHPRA, *Transcript of Evidence*, 11 December, p. 292.

<sup>252</sup> [http://www.nmhp.org.au/NMHP/About\\_NMHP.html](http://www.nmhp.org.au/NMHP/About_NMHP.html), accessed 13 August, 2013.

<sup>253</sup> *Ibid.*

<sup>254</sup> Siggins Miller, *Evaluation of Health Programs for Managing Impaired Nurses and Midwives: Report to the Nursing and Midwifery Board of Australia*, April 2012, p. 19.

<sup>255</sup> ANF (Vic), *Transcript of Evidence*, 29 May 2013, p. 43.

<sup>256</sup> Bridget Hamilton & Rachel Duncan (2012), *Evaluation of the Nursing and Midwifery Health Program: Final Report – December 2012*. Melbourne: The University of Melbourne, p. 34.

The NMHP claims that the program has positive impacts in the following areas: public safety, by assisting impaired nurses to regain optimal health; workplace productivity, by supporting nurses to remain in the workforce or assisting them back to work; and, individual nurse health and wellbeing.<sup>257</sup>

The NMHP argues that the case management support available to impaired nurses is 'essential' and 'integral' to the return to work for many, and that it is a role that compliments the regulatory role of the Nursing and Midwifery Board of Australia. Furthermore, it states:

The majority of the nurses and midwives under the care of the NMHP have experienced or are experiencing health challenges that, when appropriately treated, managed and monitored, can be prevented from reaching a level where action by the regulatory authority is required.<sup>258</sup>

The NMHP advised that one of the benefits of the Program's model is that the service is run by nurses and midwives. This means that there is an immediate understanding between the impaired nurses and NMHP staff that does not need to be built up over numerous sessions.<sup>259</sup>

The only alternative health support model available to nurses and midwives are the employment assistance programs (EAPs). These are contracted by particular health service employers, are time limited and the service is not usually provided by a nurse.<sup>260</sup>

The ANF (Vic)'s submission highlighted the importance of the program for the practitioners and protection of the public:

It is clear that the provision of this service for Nurses/midwives and students of nursing and midwifery and employers of nurses and midwives not only benefits the individuals utilising the service, and employers of nurses and midwives, but more importantly this service helps to provide protection to the Victorian public. This provides the benefit/protection to the Victorian Public in that practitioners are supported through these processes in a way that allows them to either continue to practice or facilitates the return to practice (including supervised and limited practice) once that they have been cleared to return to practice. The information about the service is provided by employers, the ANF (Vic Branch) as well as AHPRA staff, to nurses and midwives.<sup>261</sup>

Consistent with concerns raised by medical practitioners, the NMHP asserts that numerous members are aggrieved that their registration fees have almost doubled since the move from State registration to National registration. As noted earlier, NMHP members believed that despite the fee increase, they are receiving fewer services, including the prospect of no health program.<sup>262</sup>

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<sup>257</sup> NMHP, Submission no. 9, p. 2.

<sup>258</sup> NMHP, Submission no. 9, pp. 2-3.

<sup>259</sup> Nurses and Midwives Health Program, *Transcript of Evidence*, 4 September, pp. 169-70.

<sup>260</sup> *Ibid.*, p. 170.

<sup>261</sup> ANF (Vic), Submission No. 21, p 9

<sup>262</sup> NMHP, Submission No. 9, p. 3.

In 2012, AHPRA and the NMBA, engaged consultants to examine services offered to nurses and midwives in Victoria, including the NMHP, and those available in other jurisdictions.<sup>263</sup>

The report found that the NSW, Queensland, South Australia, ACT and Victorian branches of the ANF were very supportive of a NMHP-style national program being implemented. However, contributors to the report in Tasmania and the ACT were not convinced that such services were needed over and above what already existed in those jurisdictions. Some respondents questioned the return on investment and were not convinced about the overall benefits. The federal ANF was concerned over any possible increase in fees to support a national health program.

A Victorian response to the review concluded that the large number of nurses and midwives in Australia meant that any increase in fees to support the program would be relatively small. Further it was considered that the potential savings to the health system in lost time, productivity and replacement costs far outweighed the cost of subsidising the health program.<sup>264</sup>

An analysis of the economic benefits of the NMHP, sponsored by the NMHP and the ANF, in which the cost was calculated of lost productivity for an impaired nurse with time off work to be between \$52,000 and \$70,000. Time off work ranged from two months to two years. For the 60 per cent of impaired nurses who did not have time off, the cost to the system was calculated to be between \$38,000 and \$40,000. Using these figures, the study estimated that the NMHP contributed a saving to the health sector of \$7.23 million.<sup>265</sup>

The ANF (Vic) canvassed its members in early 2013 regarding the possibility of a fee increase to partially fund a future health program. Members were asked if they would contribute an extra \$3.00 per year (taking their annual registration from \$160 to \$163) on the basis that the NMBA would also contribute \$3.00 per registrant. Almost three-quarters of ANF members indicated they would be willing to contribute the extra \$3.00. The ANF (Vic) considers that \$6.00 per registrant per year would enable the program to be ongoing.<sup>266</sup>

On 16 November 2012 the Nursing and Midwifery Board of Australia announced that it would not continue to fund the NMHP for Victorian nurses and midwives nor would it establish a national health program. In making this decision, the Board indicated that it had considered the core regulatory function of the National Board under the National Law in relation to impairment, which is to 'manage practitioners' when their health is impaired and their practice may place the public at

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<sup>263</sup> Siggins Miller, *Evaluation of Health Programs*, pp. 1-2.

<sup>264</sup> *Ibid.*, pp. 25-6.

<sup>265</sup> P. Lorgelly (2011), *Estimated economic benefits of the Nursing and Midwifery health Program Victoria*. Melbourne: University of Melbourne, cited in Siggins Miller, *Evaluation of Health Programs for Managing Impaired Nurses and Midwives: Report to the Nursing and Midwifery Board of Australia*, April 2012, p. 20. Cf. Hamilton & Rachel, *Evaluation of the Nursing and Midwifery Health Program*, pp. 44, 46.

<sup>266</sup> Australian Nursing Federation (Vic), *Transcript of Evidence*, 29 May 2013, p. 43.



risk. The Board also took into account potential duplication of existing services; ‘fairness’ to all nurses and midwives of continuing to fund a service only available in Victoria, and; funding implications of establishing and implementing a national health program that provides equitable services across metropolitan and rural areas of Australia.<sup>267</sup>

The Board then stated that it ‘would welcome the continuation of a health program for Victorian nurses and midwives’, claiming that it would participate in work by AHPRA, with the National Boards, ‘to explore a possible cross-profession approach to external health programs that could complement the National Boards’ core statutory role in relation to impairment.’<sup>268</sup> In response, the NMHP declared that the NMBA ‘has failed to understand the enormous benefits the NMHP provides the industry.’<sup>269</sup>

However, in contrast to its statement on 16 November 2012, in August 2013 the National Board decided to extend the funding to the NMHP to 30 June 2016 while it ‘examines best practice in the role of national and international regulators in relation to referral, treatment and rehabilitation programs for health practitioners with a health impairment’, which will include an analysis of recommendations made in the consultant’s report.<sup>270</sup> The NMBA further explained that the Board will work with AHPRA and the other National Boards in the National Scheme to undertake this exploratory study. Furthermore, this study will involve the development of a comprehensive business case followed by a tender process that AHPRA will manage on behalf of the National Board.<sup>271</sup>

The Board of NMHP would like to see its health program continued under the National Board, through some mechanism so that a portion of Victorian registration could continue to fund the program.<sup>272</sup>

Earlier in this Chapter, evidence from the Medical Board of Australia stressed the importance of a health program specifically tailored to the needs of medical practitioners. At the public hearing on 11 December 2013, AHPRA’s CEO could not give the same commitment to a similar profession-specific health program to support nurses and midwives:

The board did not believe that there was sufficient support or evidence to establish a national health program on the basis of the Victorian model; however, what they have agreed to do, working with AHPRA, is some further work, looking in a sense more widely than just in Australia, because there is very little experience, apart from Victoria and internationally, on models of health programs. In that

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<sup>267</sup> NMBA, ‘Explanatory Notes: Management of nurses, midwives and students with impairment’, 16 November, 2012, p. 2. Cf., NMHP, Submission No. 9, p. 3.

<sup>268</sup> NMBA, ‘Explanatory Notes: Management of nurses, midwives and students with impairment’, 16 November, 2012, p. 3.

<sup>269</sup> NMHP, Submission No. 9, p. 2.

<sup>270</sup> Nursing and Midwifery Board of Australia, Media Release 4 September 2013, p. 1.

<sup>271</sup> *Ibid.*

<sup>272</sup> NMHP, *Transcript of Evidence*, 4 September 2013, p. 172.

context there is also an interest in looking at whether there may be scope for something that is multi-professional. For example, you might have a portal where a range of professions could potentially go, and then there might be more profession-tailored specific advice depending on what the issue is.<sup>273</sup>

AHPRA confirmed the NMHP has a further two years funding and in the interim period work will be done to examine a future model and funding options:

The board have agreed to work with AHPRA in regard to how that model might work. As you are aware, given that work occurring, the board have agreed to provide an additional two years funding to the program here in Victoria so that there is time for that work to occur, for there to be appropriate consultation on that and to develop what the longer term direction might be for a program that might be supported by the board.<sup>274</sup>

## **FINDINGS**

- 5.1** *The Victorian Doctors Health Program and Nursing and Midwifery Health Program are important Victorian initiatives established prior to the implementation of the National Scheme to provide support services for the health and well-being of doctors, nurses, midwives and students. The continuation of these programs is vital to maintain productivity and well-being in the workplace and therefore plays an important role in the protection of the Victorian public.*
- 5.2** *The long term future funding and nature of these programs is uncertain. Evidence suggests the Victorian health programs should continue in their current form and that any proposed nationally focussed cross-discipline programs would be considered a retrograde step for Victorian doctors, nurses and midwives.*

## **RECOMMENDATION**

- 7.** *That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that AHPRA be required to provide on-going funding for the continued operation of the Victorian Doctors Health Program and Nursing and Midwifery Health Program to support Victorian registered practitioners in these professions. That such funding be provided without increasing health practitioner registration fees in real terms.*

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<sup>273</sup> AHPRA, *Transcript of Evidence*, 11 December 2013, p. 292.

<sup>274</sup> *Ibid.*

## Chapter Six: Health Practitioner Complaints Process

As noted throughout this Report, the key focus of the Committee's Inquiry was the extent to which the Australian Health Practitioner Regulation Agency and the National Registration and Accreditation Scheme is protecting the Victorian public through the health practitioner complaints process.

AHPRA acknowledges the protection of the public underpins the role and performance of the National Scheme. In AHPRA's 2012-13 Annual Report, its Chief Executive Officer, Mr Martin Fletcher, emphasised the importance of public protection:

The past decade has seen a greater emphasis on safety and quality across the Australian health system. Well-regulated practitioners are the foundation of a healthcare system which provides safe, high-quality healthcare. The National Registration and Accreditation Scheme focuses squarely on public protection and patient safety in regulating more than 590,000 health practitioners across 14 health professions.<sup>275</sup>

The Chair of AHPRA's Agency Management Committee, Mr Peter Allen, further noted:

For the community, the National Scheme delivers more robust and transparent protection of public safety than existed previously in any one state or territory regulation system.<sup>276</sup>

Further, the Committee notes AHPRA's 2012-13 Annual Report carries the heading: *'Regulating health practitioners in the public interest.'*

Evidence received by the Committee and recent developments in Queensland have questioned the view that the current National Scheme provides greater protection than previous state-based complaints handling processes. The Committee notes that the developments in Queensland have prompted the Medical Board of Australia to question the extent to which it is meeting its main obligation in protecting the public. Dr Joanna Flynn, Chair, Medical Board of Australia, notes in the Agency's current Annual Report:

The question of the appropriateness and effectiveness of decision-making by the Queensland Board or any other Board is a question that all members conscientiously ask themselves at every meeting when they weigh up the evidence before them. The challenge for AHPRA and the Medical Board in the next 12 months is to develop better performance indicators for timeliness and monitor them closely, to reflect on what may be learned from these events, and to continually ask: Are we achieving our primary purpose of public protection?<sup>277</sup>

The Committee acknowledges that the National Scheme has implemented a number of new measures aimed at improving public protection, such as national registration standards, mandatory

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<sup>275</sup> AHPRA, *Annual Report 2012-13*, p. 12.

<sup>276</sup> *Ibid.*, p. 10.

<sup>277</sup> *Ibid.*, p. 43.

reporting, criminal history checking, and student registration. However, questions remain over whether the existing complaints process under the National Scheme is the most appropriate.

Evidence highlighted in this Chapter analyses the extent to which the existing arrangements are providing sufficient public protection and whether improvements can be made to ensure greater protection. This Chapter refers to a number of submissions made to the Inquiry that raise concern with the current complaints (notification) systems including:

- delays with the notification process;
- inadequate communication between AHPRA and consumers involved in a notification;
- confusion over the roles of AHPRA, the Boards and the Office of the Victorian Health Services Commissioner;
- inadequate rights of notifiers;
- lack of consumer confidence in the notification processes, systems and decision making; and
- inability of the Victorian Minister of Health and Victorian Parliament to monitor and oversee the health complaints performance of AHPRA and the Boards.

This Chapter will also highlight developments in Queensland regarding the health complaints management process in that State. Problems experienced in Queensland, such as consumer confusion and delays in the complaints process, were consistent with evidence put to the Committee with respect to Victoria.

Importantly, despite the aim of the National Scheme to protect the public and the desire of AHPRA and the Boards to achieve national consistency in the regulatory framework, the decision of New South Wales in 2010, and Queensland in 2013 to become co-regulatory jurisdictions and manage their complaints process separately from AHPRA, has raised the issue about whether the public will be better protected under either a national system or a state-based complaints system.

Most significantly, with New South Wales and Queensland managing their own health practitioner complaints, there is no longer national consistency in this critical element of the National Scheme. Of the 8,648 total notifications made in Australia in 2012-13, almost 60 per cent were from NSW (3,041) and QLD (2,042). Further, almost half of the total registered health practitioners throughout Australia are from these two States.

## 6.1 Registration of Practitioners

### 6.1.1 Registration Process

Before examining the complaints process, it is necessary to firstly outline the health practitioner registration process, standards and safeguards aimed at protecting the public.

AHPRA's Annual Report notes that:

The core role of AHPRA and the National Boards is to protect the public and facilitate access to health services. One of the ways we do this is by making sure that only those practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.<sup>278</sup>

Under the National Law, each Board may determine the types of registration for that profession. The majority of practitioners across all professions are classified as holding 'general registration'. Most Boards will have other registration categories such as specialist registration, limited registration, student registration, and provisional registration.<sup>279</sup>

As at 30 June 2013, the total number of Victorian health practitioners registered under the National Scheme was 153,774, an increase of approximately 10,000 from the previous year. Victoria makes up just over 25 per cent of the total number of registered practitioners throughout Australia, being 592,470. Three-quarters (74.78%) of the total number of Victorian practitioners are from the medical and nursing/midwifery professions. A breakdown of Victorian registered practitioners for each profession is provided in Table 6.1.

Each Board also establishes registration standards to ensure practitioners are fit to practice. These standards include:

- English language skills
- Proof of identity
- Continuing Professional Development (CPD)
- Recency of practice
- Professional indemnity insurance
- Criminal history
- Supervised practice for limited registration of overseas practitioners

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<sup>278</sup> *Ibid.*, p. 121

<sup>279</sup> *Health Practitioner Regulation National Law 2009*, ss. 52-61.

**Table 6.1: Victorian Registered Health Practitioners – 2011/12 to 2012/13**

<b>Profession</b>	<b>2012-13</b>	<b>2011-12</b>
Aboriginal and Torres Strait Islander Health Practitioner	7	-
Chinese Medicine Practitioner	1,151	-
Chiropractor	1,260	1,202
Dental Practitioner	4,633	4,358
Medical Practitioner	23,402	22,365
Medical Radiation Practitioner	3,528	-
Midwife	747	747
Nurse	82,196	80,982
Nurse and Midwife (dual registration)	8,654	10,297
Occupational Therapist	3,634	-
Optometrist	1,199	1,163
Osteopath	915	843
Pharmacist	6,815	6,578
Physiotherapist	6,166	5,904
Podiatrist	1,247	1,195
Psychologist	8,220	8,009
<b>TOTAL</b>	<b>153,774</b>	<b>143,643</b>

(Source: AHPRA Annual Report 2012-13)

AHPRA’s submission to the Inquiry notes that ‘the National Scheme has delivered benefits both in terms of public protection and improvements for practitioners and their practice of the profession.’

AHPRA highlights that improvements to public safety include:

- national registers of health practitioners and specialists;
- mandatory identity checking;
- mandatory criminal history checking;

- mandatory reporting of 'notifiable conduct' by health practitioners;
- mandatory professional indemnity insurance arrangements;
- student registration; and
- a national notifications (complaints) system for consumers.

With respect to improvements for practitioners, with public benefit in mind, AHPRA points to:

- ability to register once (annually) and practise anywhere in Australia;
- consistent national registration standards, codes and guidelines;
- consistent national standards for continuing professional development;
- greater collaboration and learning between professions that are part of a single national scheme; and
- more flexible options for dealing with notifications, particularly managing impairment.

In addition to ensuring registered practitioners are suitably trained and qualified to provide safe healthcare, the National Scheme has a responsibility to investigate concerns about health practitioners and to manage the implications for registration of health practitioners.<sup>280</sup> The following section describes the notification process in the National Scheme and its operation in Victoria.

### **6.1.2 Registration and Supervision of International Medical Graduates**

As mentioned above, there are specific guidelines and standards for the registration of international medical graduates. The Committee received evidence that the protection of the public in rural Victoria may be jeopardised due to inadequate supervision of these overseas trained doctors.

The registration standards for limited registration state that supervision is a requirement for all international medical graduates (IMGs) who are granted limited registration to practice in Australia. The purpose of the supervision is to provide 'assurance to the Medical Board of Australia and the community that the registrant's practice is safe and is not putting the public at risk.'<sup>281</sup>

A principle of supervision is that the Board 'will not normally approve any practitioner to have direct supervisory responsibility for more than four doctors.' However, exceptions can be made to this rule, as the Board advises: 'Any prospective supervisors who are proposing to supervise more than four doctors must provide a proposal to the Board about how they will provide supervision to each registrant.'<sup>282</sup>

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<sup>280</sup> AHPRA, Submission No. 40, p. 7.

<sup>281</sup> Medical Board of Australia, 'Guidelines: Supervised practice for limited registration', 1 May 2012, p. 1.

<sup>282</sup> *Ibid.*, p. 2.

There are four levels of supervision, ranging from level one, with supervision provided primarily in person to level four which is more flexible and less prescriptive.<sup>283</sup>

The Committee received evidence from the Rural Doctors Association of Victoria (RDAV), which was very critical of the current supervision ratios of IMGs. RDAV explained that prior to the National Scheme, in General Practice, one Fellow could supervise a maximum of two IMGs, which paralleled supervision standards for Australian GP registrars-in-training.<sup>284</sup>

At its 2011 AGM the RDAV membership voted to support a 1 to 2 supervision ratio for IMGs, in line with supervision of Australian trained graduates undergoing General Practice training. In contrast, the RDAV maintains that AHPRA/MBA ‘...has firmly committed itself to a substantial program of overseas doctor importation to General Practice set at a standard significantly below that of Australian GP training.’<sup>285</sup>

RDAV contends that distance supervision, as allowed for supervision levels 2 to 4, is inappropriate:

Distance supervision was originally introduced, in Victoria with RDAV support, for isolated communities unable to recruit a doctor. It was not designed for use in training within the general medical community in a large program designed to put limited registrants into telephone supervision after very short periods of large ratio physical supervision in parent corporate practices.<sup>286</sup>

Dr Moynihan, President of RDAV, stated in evidence that supervision of four IMGs by telephone is inappropriate and that he has anecdotal evidence to suggest that even such minimal supervision is not occurring.<sup>287</sup>

Dr Peter Radford, a Benalla GP, was also critical of the supervision ratios and English language testing for overseas trained doctors in rural Victoria. Dr Radford believed active supervision is effectively non-existent in many regional locations and highlighted an example where an overseas trained doctor in one region is working on their own but receiving telephone supervision from a region hundreds of kilometres away.<sup>288</sup>

The Victorian Board of the Medical Board of Australia (VBMBA) informed the Committee that supervision ratios of IMGs should not be compared to that of local graduates:

I think it is important to understand that local graduates almost invariably have full or general registration and, by definition, are not subject to supervision. That is a hallmark of general registration. Certainly when they first come to our country, international medical graduates almost invariably have limited registration, which by definition requires supervision. So they are two fundamentally different states. A limited registrant — that is, an international medical graduate — needs to have a full registrant to offer that supervision.<sup>289</sup>

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<sup>283</sup> *Ibid.*, p. 4.

<sup>284</sup> RDAV, Submission No. 22, p. 1.

<sup>285</sup> *Ibid.*, pp. 3, 4.

<sup>286</sup> *Ibid.*, p. 5.

<sup>287</sup> RDAV, *Transcript of Evidence*, 9 August 2013, p. 109.

<sup>288</sup> Peter Radford, Submission No. 1, p. 1.

<sup>289</sup> Victorian Board of the Medical Board of Australia, *Transcript of Evidence*, 27 November 2013, p. 277.



In follow-up material supplied to the Committee following its hearing, the VBMBA explained that every time it grants limited registration to an IMG it assesses their specific skills, qualifications and experiences in order to determine the correct supervision level. As such, the VBMDA advised:

There is no formal limit on the number of IMGs who can be supervised by one supervisor and models do exist where a principal supervisor might be supervising a number of IMGs but the direct supervision is provided by an on-site co-supervisor.<sup>290</sup>

There is further concern that IMGs working in Australia do not have to inform their patients of their registration status although patients must be notified when an Australian-trained registrar-in-training is attending them.<sup>291</sup> Dr Moynihan stated:

With respect to the situation of overseas trained doctors, overseas trained doctors are not obliged to advertise their status. All Australian trained doctors in general practice training are obliged to state their training status; overseas doctors are not obliged. We made representations to the medical board that they were being advertised as providing equal levels of service — actually, levels of service at or above that of the training providers and that of the RACGP — and we pointed out that this was advertised on the website. We received a reply that any doctor registered with the medical board is entitled to make such claims. That appeared to me to be a forthright declaration, and I have this in writing too, that the medical board believed that this was a new standard of general practice.<sup>292</sup>

Dr Radford wrote of his confusion at the processes of AHPRA and the MBA in regards to supervision of IMGs:

Foreign graduates are given various levels of need for supervision- though the system by which this is worked out is unclear to me, and to the learned Colleges. It appears that there is no supervision of the adherence to these restrictions and supervision requirements. Indeed AHPRA has acknowledged that it has no way of ensuring their restrictions are being adhered to.<sup>293</sup>

In evidence to the Committee, Dr Dohrmann, Chair of the Victorian Registration Committee of the VBMBA, explained how each supervision level is determined:

The issues that the registration committee regard as paramount in sorting out what is an appropriate level of supervision relate particularly to familiarity with the Australian health-care system, especially in recently arrived practitioners, and familiarity with general practice as a discipline. There is also a common issue that we have to grapple with, which is recency of practice. Many international medical graduates may not have practised for some years.

All those factors will determine the level of supervision that the registration committee will require in an individual case. We rely considerably upon assessments by general practice panels that interview international medical graduates and make recommendations to the registration committee about the level of supervision. We may accept the recommendation, but we will frequently increase the level of required supervision because of our concerns about those particular features.<sup>294</sup>

The Australian Medical Council was asked by the Committee for its views on the supervision of overseas trained doctors, Mr I. Frank, Chief Executive Officer, explained that it is a complicated issue:

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<sup>290</sup> Victorian Board of the Medical Board of Australia, Response to questions on notice at public hearing, 9 December 2013, pp. 6-7.

<sup>291</sup> Peter Radford, Submission No. 1, p. 1.

<sup>292</sup> RDAV, *Transcript of Evidence*, 9 August 2103, p. 111.

<sup>293</sup> Peter Radford, Submission No. 1, p. 1.

<sup>294</sup> VBMBA, *Transcript of Evidence*, 27 November 2013, p. 277.

The issue of supervision I think is always a difficult one. People in limited registration are not legally qualified to practise without oversight, so they have to have some form of oversight, but it is also true to say that there is a significant variation in the standard of people that have limited registration. They may range from people who are freshly out of a medical school in an overseas country and not familiar with Australian health practice who need very close supervision and, in theory, should not be out in general practice positions, to people who have had extensive experience in general practice, albeit that they are not fully qualified as specialist general practitioners. There is a wide range of people in that area.<sup>295</sup>

## **FINDING**

**6.1** *The Committee received evidence that there has been an effective reduction in the levels of supervision of international medical graduates since the National Scheme commenced which may adversely impact upon the protection of the public. This is particularly the case in some parts of rural Victoria where there is a higher prevalence of overseas trained doctors.*

## **RECOMMENDATION**

**8.** *That the Victorian Minister for Health recommend to the the Australian Health Workforce Ministerial Council that it undertake a review to ascertain the appropriate ratio of supervisors to International Medical Graduates.*

## **6.2 Notification Process**

A complaint about the conduct of a registered health practitioner is referred to as a notification. The National Law requires that complaints or concerns over health practitioner conduct be formally notified to AHPRA which manages the notification on behalf of the Boards. AHPRA's Annual Report states:

The role of the National Boards and AHPRA is to protect the public, including by managing notifications about health practitioners and, when necessary, restricting their registration and their practice in some way.<sup>296</sup>

There are a number of stages in the notification process from initial lodgment through to a possible tribunal hearing. The process will vary according to each notification with many cases being closed after initial assessment. The process is outlined below:

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<sup>295</sup> RDAV, *Transcript of Evidence*, 12 June 2013, p. 62.

<sup>296</sup> AHPRA, *Annual Report 2012-13*, p. 135.

### **1. Lodgement**

A complaint or concern about a registered health practitioner is lodged with AHPRA who makes a preliminary assessment within 30 days to determine if the concern relates to a registered practitioner and is a ground for notification. If these initial criteria are met, the matter becomes a formal notification and is referred to a National or State Board. Otherwise, AHPRA can close the matter.<sup>297</sup>

### **2. Assessment**

Once a complaint has been formally lodged as a notification, AHPRA may, within 60 days, gather further information to assist Boards in their assessment. When making a decision after assessing a notification, a National Board has to decide if it raises issues of professional misconduct, unprofessional conduct, unsatisfactory professional performance or impairment of a registered practitioner.<sup>298</sup>

After an assessment, a Board can determine no further action is required, it may seek additional information, or it may proceed with an investigation.

### **3. Investigation**

A National Board may decide to investigate a registered practitioner or student if it believes that:

- the practitioner or student has, or may have, an impairment; and/or
- the way the practitioner practises is, or may be, unsatisfactory; and/or
- the practitioner's conduct is, or may be, unsatisfactory.

A National Board assesses the risk to the public when considering whether or not to investigate. Not every notification lodged is investigated and not every investigation arises from a notification. A National Board has the power to initiate an investigation (called an 'own motion' investigation in the National Law). It might do this when it becomes concerned about a practitioner through information that is in the public domain, or when information about a practitioner is revealed in an investigation about another practitioner.

In almost every case, practitioners and students who are being investigated are aware of the investigation, as they are given notice of the investigation and information about what is being investigated. Notifiers are also advised that an investigation will be conducted. The issues being

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<sup>297</sup> AHPRA website, <http://www.ahpra.gov.au/Notifications/The-notifications-process/Lodgement.aspx>, accessed 19 November 2013.

<sup>298</sup> AHPRA website, <http://www.ahpra.gov.au/Notifications/The-notifications-process/Assessment.aspx>, accessed 19 November 2013.

investigated will be set out in written advice from AHPRA. AHPRA provides practitioners or students being investigated, and notifiers, with three-monthly updates on the progress of the investigation. The only exceptions are when the Board believes that giving notice to the practitioner may:

- seriously prejudice the investigation;
- place someone's health or safety at risk; or
- place someone at risk of harassment or intimidation.

After analysing the issues raised and facts of the case, the investigator prepares a report for a National Board to consider. The report informs the Board's decision about what, if any, action to take next.

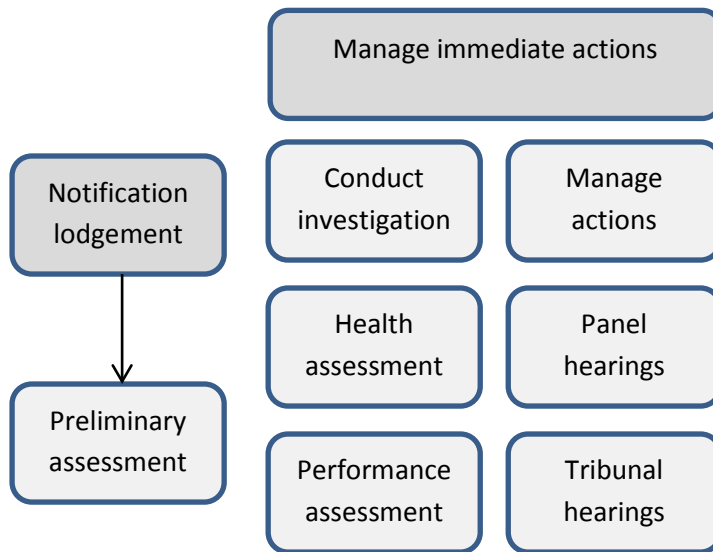
The length of the investigation depends on a number of issues, including how long it takes to gain access to the relevant records or information. The National Law requires the investigation to be conducted in a timely way. As will be outlined later in this chapter, the Act does not define 'timely way' and there are no statutory timelines for completion of an investigation.

As a result of an investigation a National Board can make the following decisions based on the allegations, facts and evidence:

- take no further action;
- refer the practitioner for a health assessment;
- refer the practitioner for a performance assessment;
- refer the matter to a health panel;
- refer the matter to a performance and professional standards panel;
- impose conditions on/accept an undertaking from the practitioner;
- caution the practitioner;
- refer the matter to a tribunal; or
- refer the matter to another entity.<sup>299</sup>

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<sup>299</sup> AHPRA website, <http://www.ahpra.gov.au/Notifications/The-notifications-process/Assessment/Investigation.aspx>, accessed 16 November 2013.

**Figure 2: Notification process stages**

*The stages in the notification process do not necessarily apply to all notifications and are not completed in a linear sequence. In complex cases, a notification can be involved in more than one stage at the same time.*

(Source: AHPRA, *Annual Report 2011-12*)

### 6.2.1 Notifications made in 2012-13

In 2012-13, there was a total of 8,648 notifications about health practitioners throughout Australia, including NSW. Victoria had the third largest number of notifications, behind NSW (3,041) and QLD (2,042). Victoria's total of 1,844 notifications is illustrated in Table 6.2.

Consistent with the professions with the largest registrations, the medical and nursing/midwifery professions were subject to the highest number of notifications in 2012-13. However, dentists were the subject of the highest proportion of notifications as a percentage of total registered practitioners per profession. In Victoria, 4.1 per cent of registered dentists were the subject of a notification, followed by 3.6 per cent of medical practitioners. Less than 1 per cent of nurses and midwives were subjected to a notification.

AHPRA's 2012-13 Annual Report highlights just over half of the notifications (53%) were in relation to the conduct of health practitioners while over a third (38%) related to the performance of practitioners. A small number of notifications (8%) were received about the health of practitioners.<sup>300</sup>

<sup>300</sup> AHPRA, *Annual Report 2012-13*, p. 142.

**Table 6.2: Health Practitioner Notifications in 2012-13**

Profession	2012-13 Victorian Total	2012-13 National Total
Aboriginal and Torres Strait Islander Health Practitioner	Nil	4
Chinese Medicine	6	30
Chiropractor	26	72
Dental Practitioner	223	1,052
Medical Practitioner	989	4,709
Medical Radiation Practitioner	7	26
Midwife	8	69
Nurse	330	1,528
Nurse and Midwife	Nil	1
Occupational Therapist	5	50
Optometrist	15	42
Osteopath	2	8
Pharmacist	93	429
Physiotherapist	15	83
Podiatrist	10	44
Psychologist	114	471
<b>Totals</b>	<b>1,844</b>	<b>8,648</b>

(Source: AHPRA, *Annual Report 2012-13*)

AHPRA's Annual Report does not contain specific data on notification outcomes for each State and Territory, however information is published at a national level. Of the total notifications closed during 2012-13, excluding New South Wales, 60 per cent were closed at the 'no further action' stage. One-fifth (24.78%) were referred to a health complaints entity (such as the Office of the Health Services Commissioner) and approximately 10 per cent resulted in a caution or reprimand. A breakdown of notification outcomes is provided in Table 6.3.

**Table 6.3: Notification Outcomes in 2012-13**

<b>Outcome</b>	<b>Total</b>
No further action	3,026
Refer all or part of notification to another body	43
Health complaints entity to retain	1,019
Accept undertaking	174
Caution or reprimand	522
Impose conditions	228
Cancel registration	3
Accept surrender of registration	14
Suspend registration	5
Fine registrant	7
<b>Totals</b>	<b>5,041</b>

(Source: AHPRA, *Annual Report 2012-13*)

### 6.3 Mandatory Notifications

Under the National Scheme, new reporting obligations apply to all registered health practitioners and employers of registered health practitioners. Section 140 of the National Law requires that a registered health practitioner or employer notify the appropriate National Board if they form a reasonable belief that another registered health practitioner has behaved in a way that constitutes 'notifiable conduct'. Such notifiable conduct is defined as: practising intoxicated by alcohol or drugs; engaging in sexual misconduct; placing the public at risk due to an impairment; or placing the public at risk because of a significant departure from professional standards. Any registered practitioner who fails to report notifiable conduct on the part of another registered health practitioner may be the subject of disciplinary action by their National Board.<sup>301</sup>

<sup>301</sup> AHPRA, 'Fact Sheet: New Reporting Obligations', 20 April 2010, p. 1; AHPRA website, 'Mandatory Notifications', <http://www.ahpra.gov.au/Notifications/Who-can-make-a-notification/Mandatory-notifications.aspx>, accessed 19 November 2013.

In addition, education providers have an obligation to make a mandatory notification if they have formed a reasonable belief that a student undertaking clinical training has an impairment that may place the public at substantial risk of harm.<sup>302</sup>

Prior to the implementation of the National Scheme, in Victoria, there was already a requirement for medical practitioners to report the ill-health of registered health practitioners.<sup>303</sup>

AHPRA states that the strengthened mandatory reporting requirements in the National Scheme increase public safety across all the regulated professions. In 2012, almost 10 per cent of notifications were mandatory reports.<sup>304</sup> Since the commencement of the National Scheme, mandatory reporting has increased in Victoria from 164 in 2010/11 to 200 in 2012/13. Nationally, a mandatory report is three times more likely to result in immediate action than a voluntary notification.<sup>305</sup>

Evidence put to the Committee raises questions over the mandatory reporting requirements under the National Scheme. Firstly, not all jurisdictions have adopted the mandatory reporting requirements. Concerns were also raised over the reporting thresholds and many practitioners opposed mandatory reporting on the grounds that it may inhibit a practitioner from seeking help.

Western Australia decided not to adopt the mandatory requirements when transitioning to the National Scheme in 2010 and, as such, there is no legal requirement in that State for treating practitioners to make mandatory notifications about patients (or clients) who are practitioners or students in one of the regulated health professions.<sup>306</sup> However, AHPRA explains that practitioners in Western Australia 'continue to have a professional and ethical obligation to protect and promote public health and safety. They may therefore make a voluntary notification or may encourage the practitioner or student they are treating to self-report'.<sup>307</sup>

The recently passed Queensland *Health Ombudsman Act 2013* changes the way mandatory reporting operates in that State, introducing an exemption from mandatory notification requirements. According to this law, an exemption to this requirement only applies if the matter relates to an impairment, does not relate to professional misconduct, and the treating practitioner forms the reasonable view that the other practitioner does not pose a serious threat to the public.<sup>308</sup>

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<sup>302</sup> AHPRA website, 'Mandatory Notifications', <http://www.ahpra.gov.au/Notifications/Who-can-make-a-notification/Mandatory-notifications.aspx>, accessed 19 November 2013.

<sup>303</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 15.

<sup>304</sup> AHPRA, Submission No. 40, p. 2.

<sup>305</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 16.

<sup>306</sup> AHPRA website, 'Mandatory Notifications', <http://www.ahpra.gov.au/Notifications/Who-can-make-a-notification/Mandatory-notifications.aspx>, accessed 19 November 2013.

<sup>307</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 15.

<sup>308</sup> *Ibid.*



On consideration of the various mandatory reporting requirements across Australia, AHPRA claimed that it and the National Boards are concerned that:

...state-by-state variations create confusion for practitioners about their reporting obligations and risk reducing compliance with this important public safety obligation.<sup>309</sup>

In its evidence, AHPRA explained the purpose for mandatory reporting:

Mandatory notification is about making very clear the circumstances in which people are required to advise of a concern about a practitioner. In the national law that applies to a health practitioner, it applies to an employer and, in some circumstances, for students it applies to an education provider as well. We are looking very closely at the data on mandatory notifications, and we report that as a separate category in our annual report. We are particularly wanting to make sure what we are seeing in that category of notifications.<sup>310</sup>

Some evidence, including that from ANF (Vic), the Victorian Department of Health, and Southern Health, expressed the view that mandatory reporting is a positive step and has strengthened public protection.<sup>311</sup> The Victorian Doctors Health Program had initial concerns over the effects of mandatory reporting when it was first introduced but can now see the benefits and importance of the requirement. The Chief Executive of VDHP noted:

We are bound by the same mandatory reporting regulations as any other health professional. We were very concerned about that when the national scheme came about, that the mandatory reporting would deter people who really needed help from seeking help. I have looked closely at our figures over the past three years and that does not appear to be the case. Since reporting has been mandatory, the number of people I have reported to the medical board has not increased, because with or without mandatory reporting one still has an ethical obligation to report if you felt somebody was going to harm their patients. --- There are times when actually reporting somebody to the medical board may be the sort of step you need to take in order to get that doctor to get help. In the long run that is more helpful than less helpful.<sup>312</sup>

However, further evidence received has not been in favour of mandatory reporting. Avant, the largest medical indemnity organisation in Australian, stated that Victoria should adopt an exemption from mandatory reporting requirements as in WA because it can 'seriously inhibit health practitioners obtaining the care they need.'<sup>313</sup> Similarly, the AMA (Vic) has been concerned, since the introduction of the National Law, that mandatory reporting stops doctors from seeking help:

The AMA has opposed that process because we felt that it would undermine the potential for doctors to self-refer to another medical practitioner. What we sought at the time was a specific exemption, which is in place in Western Australia, where a doctor treating a medical practitioner is not legally bound to report on a mandatory basis from those categories if they felt that in the context of that

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<sup>309</sup> *Ibid.*

<sup>310</sup> AHPRA, *Transcript of Evidence*, 17 April 2013, p. 25.

<sup>311</sup> Southern Health, Submission No. 10, p. 5; ANF (Vic), Submission No. 21, p. 8; Department of Health, Submission No. 50, p. 21.

<sup>312</sup> VDHP, *Transcript of Evidence*, 4 September 2013, p. 162.

<sup>313</sup> Avant, *Transcript of Evidence*, 9 August 2013, p. 129.

therapeutic relationship they were able to treat, seek improvement or avert the risk of harm to the public and also see that the health issues that that doctor was experiencing—and an example may be alcohol addiction—could be addressed and dealt with. Because the other issue was, of course, that since 2010 as a doctor, if they go to a colleague—and we encourage all members of the profession to have their own medical care, particularly via a GP—and if they feel that that doctor is going to report them, the instant reaction will be to not seek that help. We are concerned about the net effect.<sup>314</sup>

The Australian Doctors Fund concurred, arguing similarly that mandatory reporting inhibits practitioners from seeking advice and treatment, while Professor Paddy Dewan asserted that the requirement creates a culture of vindictiveness.<sup>315</sup>

The Committee received further evidence that questioned the threshold for mandatory reporting, including from the ANF (Vic) and the Australian Doctors Fund. The ADF is concerned that mandatory reporting is being over-utilised for issues that need not be reported:

Although AHPRA declares that the threshold for mandatory reporting is high, that is not how the regulation is interpreted by the medical profession or indeed other health practitioners. The nature of good medical practice is to be risk averse, and thus reporting tends to occur at what would seem a low threshold to the layperson.<sup>316</sup>

The ANF (Vic) has been concerned about what could be seen as an inappropriately low threshold around mandatory reporting but believes AHPRA has gone some way to dealing with this problem:

We are aware of a number of nurses who have been reported under mandatory reporting because they have been seen at a party with too much alcohol on board. AHPRA are now taking the approach that if a nurse is out on Saturday night and not at work, and it is not work related, whether or not they have had too much to drink is really not a matter for AHPRA. AHPRA is concerning itself with matters around conduct at work. Some of those distinctions with mandatory reporting are being worked on, and we see that as a significant improvement.<sup>317</sup>

AHPRA responded to these concerns by confirming that under the National Law, the threshold for mandatory notifications is high:

Mandatory notifications are an important public safety mechanism of the scheme. Given this is a new regulatory requirement in many jurisdictions, there has been some misunderstanding of these thresholds among practitioners. In response, AHPRA and National Boards have conducted a range of educational and awareness raising activities, and each National Board has – since the start of the National Scheme – published approved Guidelines for mandatory notifications. These guidelines are consistent and common to all 14 boards and professions regulated under the National Scheme.<sup>318</sup>

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<sup>314</sup> AMA (Vic), *Transcript of Evidence*, 29 May 2013, p. 51.

<sup>315</sup> Prof. Paddy Dewan, *Transcript of Evidence*, 21 August 2013, p. 156.

<sup>316</sup> ADF, *Transcript of Evidence*, 26 June 2013, p. 75.

<sup>317</sup> ANF (Vic), *Transcript of Evidence*, 29 May 2013, p. 41. COP also agrees that while there were some teething problems with the way that mandatory reporting first functioned, and they were concerned about vexatious claims, it is now not a problem from an organisational psychologist's perspective. COP, *Transcript of Evidence*, 18 September 2013, p. 185.

<sup>318</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 15.

## **FINDINGS**

**6.2** *Mandatory reporting of notifiable health practitioner conduct is an important initiative under the National Scheme aimed at protecting the public. The Committee shares AHPRA's concerns that there is no longer a nationally consistent approach to mandatory reporting.*

**6.3** *Evidence suggests that some confusion exists as to the circumstances which are required to be mandatorily reported.*

## **RECOMMENDATION**

**9.** *That the Victorian Minister for Health recommend to the Australian Health Workforce Ministerial Council that mandatory notification provisions under the National Law be specifically considered in the forthcoming three-year review of the National Scheme with the aim of achieving greater national consistency.*

## **6.4 Communication and Time Delays**

The Committee's evidence highlighted lengthy time delays in the notification process together with, at times, inadequate communication and information from AHPRA to notifiers, practitioners and health service providers.

Section 148 of the *Health Practitioner Regulation National Law Act 2009* states the National Agency must refer a notification to a National Board 'as soon as practicable after receiving a notification.' Section 149 requires a Board to conduct a preliminary assessment within 60 days. However, with respect to the conduct of an investigation, section 162 makes a reference to it being conducted in a 'timely manner':

The National Board must ensure an investigator it directs to conduct an investigation conducts the investigation as quickly as practicable, having regard to the nature of the matter to be investigated.<sup>319</sup>

AHPRA's information guide to notifiers indicates the length of time for an investigation is influenced by a number of issues including:

- how much evidence is available;
- whether there is a need to receive other expert opinions; and

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<sup>319</sup> *Health Practitioner Regulation National Law Act 2009*, s. 162.

- whether there is a need to rely on information being provided by other people or organisations.

The guide states '[m]ost straightforward investigations are completed within nine to 12 months.'<sup>320</sup> However, in evidence to the Committee, AHPRA suggests the median length of time for an investigation is around seven months.<sup>321</sup>

Evidence from the Royal Australian College of General Practitioners summarises the concerns of many practitioners. The College advised that it continues to receive concerning feedback from general practitioner members regarding the AHPRA complaints process, including:

- unnecessarily lengthy complaint processes; and
- poor/delayed communication of investigation and hearing outcomes, including the outcomes of panel and tribunal hearings.<sup>322</sup>

RACGP further observed:

Investigations into the professional conduct of a health practitioner can often be a stressful period for the health practitioner involved. Feedback from RACGP members indicates that it is not uncommon for investigations into the professional conduct of general practitioner to exceed 6 months, even when there is little substance to the allegations.

It is therefore important that all investigations, and outcomes of hearings, are completed in a swift and timely manner to reduce stress and uncertainty for those health practitioners involved, and to ensure that the investigation itself, rather than any alleged notified behaviour,<sup>323</sup> does not become a safety concern for the health practitioners and the communities they serve.

The Victorian Chapter of the Australian Nursing Federation supports the National Scheme and commented positively that 'to date AHPRA is responsive to changing needs and implements actions as needed in order to provide regulatory efficacy, to protect the public and hopefully within a cost effective framework.'<sup>324</sup> However, the ANF (Vic) maintains that AHPRA needs to continue to improve the timeliness in the notification process:

The National Law under Section 162 states that an investigation must be conducted in a timely way but does not set out a time limit. ANF (Vic Branch) submits that AHPRA has made changes that, in Victoria, have resulted in improvements in timeliness of case handling, but are yet to meet reasonable timeliness. ANF (Vic Branch) submits improvements could be made by AHPRA formulating appropriate allegations before requiring a response. Changing of allegations or amendments to allegations should not be allowed to occur once AHPRA have finished their fact finding functions. This

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<sup>320</sup> AHPRA, 'Do you have a concern about a health practitioner? A guide for people raising a concern (making a notification or complaint)', p. 14, accessed at <http://www.ahpra.gov.au/Notifications/Fact-sheets.aspx> on 19 November 2013.

<sup>321</sup> AHPRA, *Transcript of Evidence*, 11 December, 2013, p. 284.

<sup>322</sup> RACGP, Submission No. 19, p. 1.

<sup>323</sup> RACGP, Submission No. 19, p. 2.

<sup>324</sup> ANF (Vic), Submission No. 21, p. 10.

would save time in the investigation process and give the nurse certainty when responding to allegations.<sup>325</sup>

The Ambulatory and Nursing Services section of Austin Health submitted from a nurse practitioner's perspective and also noted concerns over time delays:

When a notification/complaint is made, there is a significant delay from receipt of the notification/complaint to the subsequent steps that take place, before the appropriate course of action is taken. Furthermore, there also appears to be no consistency with regards to how notifications/complaints are prioritised internally.<sup>326</sup>

Avant Mutual Group represents medical practitioners and provides assistance to its members in complaints handling of matters that are dealt with by AHPRA, the health services commission and the Victorian Board of the Medical Board of Australia. Avant is generally supportive of the National Registration Scheme, however it highlighted that its members have a number of concerns over the complaints handling process:

We have assisted members who have been subject to lengthy delays. Delays cause significant stress and disruption to the health practitioner concerned, as well as to the notifier, and risks reducing public confidence in the complaints handling system.

There have also been a number of instances when a medical practitioner has responded to a request for a response to a preliminary investigation, only to be advised some weeks or months later that the Board has determined to investigate the notification and requesting that the medical practitioner provide a "formal response" to issues he or she has already addressed. It then becomes apparent that the initial response was not considered by the Board or even misplaced or misfiled. These examples suggest that AHPRA's processes are inefficient and cumbersome.<sup>327</sup>

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) believed AHPRA's communication regarding complaints against RANZCP's fellows is inadequate. The College noted that it is sometimes informed of the outcome of an investigation, but its experience is that the process is not followed 'appropriately, correctly or consistently across the board or within investigations.' According to RANZCP there needs to be a clear process that is adhered to and relevant parties need to be informed of the process as well as the public. It states there is inconsistency in the conditions or undertakings being placed on an individual practitioner – for example, practitioners in Victoria and Queensland may be given different lengths of 'punishment' for the same boundary violation. As the notification process is very stressful for the psychiatrist, RANZCP asserts that it would be 'enormously helpful' for people to have certainty about time lines and processes.<sup>328</sup>

Similar concerns over time delays and communication were expressed by consumers. The Health Issues Centre promotes improvements to the health care system from the perspectives of

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<sup>325</sup> ANF (Vic), Submission No. 21, pp. 7-8.

<sup>326</sup> Ambulatory and Nursing Services, Austin Health, Submission No. 8, p. 1.

<sup>327</sup> Avant, Submission No. 38, p. 4.

<sup>328</sup> Royal Australian and New Zealand College of Psychiatrists, *Transcript of Evidence*, 9 August 2013, p. 127.

consumers with an emphasis on equity, and promotes and provides expertise on consumer participation in health. From a health consumer's perspective, the Health Issues Centre also advised that AHPRA needs to improve its 'timeliness and communication'.<sup>329</sup>

In its evidence at a hearing on 9 August 2013, the Health Issues Centre commented:

Similar across all health complaints, really, is timeliness — that the sooner something is resolved the better. People do not want to have this hanging around in their lives for a year, 18 months or two years. In some respects, in terms of effective complaint resolution, things that happen quickly are most effective. The second thing that people were looking for was communication.

I cannot reiterate strongly enough how much consumers, patients and families feel that they are powerless in the system, that the more involved they are, the more enmeshed in it and the more they need and rely on the system, the more they feel they do not have a voice or do not have much power, control or information. People are constantly saying, 'I didn't know what was going on; I didn't have information; I didn't know how to access information'.<sup>330</sup>

Evidence from Miss Jenny Morris indicates her notification took 13 months to complete before an outcome of no action. Miss Morris was highly critical of AHPRA's performance during this process and was particularly concerned at the time delays and poor communication:

Section 180 (1) of the National Law requires that notifiers and practitioners be informed of Board decisions "as soon as practicable". I strongly object to the notion that 40 days is "as soon as practicable" for the provision of a template letter. Indeed, I object to the nebulous, non-numerical qualifier "as soon as practicable". To avoid such blatant abuses of this imprecision, I suggest legislative change to replace "as soon as practicable" with a realistic, numerical time limit (for example 14 days).

AHPRA's failure to inform notifiers of decisions in a timely manner further compounds and exacerbates their systematic lack of communication with notifiers and appalling inefficiency. This is because, on the exceedingly rare occasions that AHPRA does concede to communicating with notifiers (in template letter form), it does so many weeks to months after the relevant event.<sup>331</sup>

Similar concerns were also raised by a health service provider. Southern Health's submission noted there is potential for improvement in communication between the Agency and the health services when a mandatory notification is made. Southern Health highlighted the need for:

- greater clarity around the process and timeline for progressing a notification; and
- the appointment of a designated AHPRA staff member for each notification to improve communication between agencies.

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<sup>329</sup> Health Issues Centre, *Transcript of Evidence*, 9 August 2013, pp. 137-8.

<sup>330</sup> *Ibid.*, p. 138.

<sup>331</sup> Jennifer Morris, Submission No. 31, p. 15.

Commenting on AHPRA's responsiveness to mandatory notifications, Southern Health observed:

The Agency is too slow to respond when a Registrant is notified under mandatory notification obligations. Investigation by the Agency takes a long time during which the health service has to implement revised practices to address the imposed conditions of practice. We acknowledge that most of the statutory powers under the National Scheme reside with the National Boards and several agencies are involved in the investigation of conduct, health or performance related matters of Registrants. However health services expect the Agency to provide them with information about the investigation and reasonable timeframes for resolution.<sup>332</sup>

The impact on hospitals as a result of delays in communication was illustrated in the case of a doctor and a regional health service. Eleven weeks passed between the time the conditions were imposed and when the hospital was notified. The regional health service considered this delay created an unnecessary clinical governance risk to the hospital.

When asked in a public hearing about the delayed communication to the hospital, the Victorian Board of the Medical Board of Australia stated:

....AHPRA and the board have had a meeting with the appropriate regional health service there and have discussed that particular matter. It was apparently an administrative oversight that the health service was not notified about those particular conditions. The circumstances surrounding that oversight have been explained to the regional health service.<sup>333</sup>

In a later hearing, AHPRA further clarified:

It is regrettable. It was just an oversight. Somebody did not send a letter, did not type it or did not have cause for it to be produced by the system. It was not discovered until some 13 weeks later, and at that stage we sent it. At the time we discovered that, we apologised the next day to Stawell Regional Health.<sup>334</sup>

In response to the broader concerns raised in evidence relating to time delays and communication, AHPRA advised:

Ensuring timely and effective responses to notifications about the conduct, health or performance of registered health practitioners is an important ongoing focus for AHPRA working with boards. Our shared priority is improving the effectiveness, timeliness and efficiency of notifications management to ensure that risks to the public are effectively managed.<sup>335</sup>

Similarly, perhaps in response to the Committee's evidence and similar concerns in Queensland, AHPRA's 2012-13 Annual Report states:

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<sup>332</sup> Southern Health, Submission No. 10, p 5.

<sup>333</sup> VBMBA, *Transcript of Evidence*, 27 November 2013, p. 273.

<sup>334</sup> AHPRA, *Transcript of Evidence*, 12 December 2013, p. 294.

<sup>335</sup> AHPRA, Correspondence received, 26 November 2013, covering letter, p. 1.

While the National Scheme has been implemented successfully, there are areas for further improvement and continuing focus. Over the past year, our top priority has been national consistency, and responsive, timely service. This remains the focus for 2013/14. In particular, AHPRA and the National Boards are attaching the highest priority to work aimed at improving consistency and timeliness in notifications management.<sup>336</sup>

AHPRA advised the Committee it is implementing key performance indicators to set benchmarks for the timeliness of notifications management and plans to publish performance data against these KPIs commencing financial year 2014/15.

There are key performance indicators for the timeliness of each stage of the notifications process. This is new and more rigorous than what has ever existed in Victoria. Performance measures such as these did not exist universally, and there was wide variation in performance across jurisdictions and professions prior to the national scheme. We will start public reporting on our performance against these KPIs from 2014–15, in addition to our annual report. This exceeds the reporting requirements of the national law, and we are also benchmarking internationally and across Australia.<sup>337</sup>

A copy of AHPRA's future notification key performance indicators is provided in [Appendix E](#). In summary, the KPIs include:

- Lodgement to assessment: 60% within 14 days and 100% within 30 days;
- Immediate action: 100% within 5 days; and
- Investigation to completion: 80% within 6 months, 95% within 12 months, and 100% within 18 months.

Responding to concerns about poor communication, AHPRA acknowledged it is important that the community has confidence in the processes in place to address their concerns about health practitioners. AHPRA advised that recent initiatives aimed at improving communication include:

- the publication of separate guides to notifiers and practitioners on AHPRA's website;
- publication on the website of additional clear information about its notifications management process, including a fact sheet on how it works with health complaints entities; and
- the establishment of a Community Reference Group to provide feedback on how it can improve community knowledge about health practitioner regulation.

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<sup>336</sup> AHPRA, *Annual Report 2012-13*, p. 10.

<sup>337</sup> AHPRA, *Transcript of Evidence*, 11 December 2013, p. 282.



## **FINDINGS**

- 6.4** *There is evidence of lengthy time delays in the National Scheme's notification process together with, at times, inadequate communication and information from AHPRA to notifiers, practitioners and health service providers.*
- 6.5** *There are no current statutory timeframes prescribed under the National Law for completion of an investigation process. The Committee does not consider the proposed key performance indicators established by AHPRA commencing from 2014-15 are sufficient in comparison with statutory timelines now in force in the co-regulatory jurisdictions of New South Wales and Queensland.*

## **6.5 Rights of Notifiers**

A key concern raised in evidence is the lack of rights afforded to notifiers, particularly when an initial decision is made not to undertake an investigation or, after assessment, a Board decides to take no further action. Evidence indicates notifiers have fewer rights to have decisions reviewed under the current system than were afforded under the previous Victorian *Health Professions Registration Act 2005*. Further, evidence indicates that notifiers are not provided with sufficient information, evidence and feedback as to reasons why their cases result in 'no further action'.

Notification statistics referred to early in this chapter illustrate that the majority of notifications result in no further action. In 2012-13, two-thirds (1,031 out of a total 1,552) of National Law notifications in Victoria were closed with no further action after preliminary assessment. The Committee is in no position to question these outcomes, other than to highlight there are a large number of complaints that are dismissed with no further action and no recourse of appeal. The Committee believes it is important that these complaints are handled in a fair and equitable manner from a notifier and practitioner point of view.

Miss Jennifer Morris, a notifier, believes that:

Contrary to HSC complainants, AHPRA notifiers are... disposable nobodies. [Notifiers] have no right to know the evidence collected, no right to know the processes undertaken, no right to participate, no right to seek conciliation or recourse, no right of appeal and no right to know the reasons for any outcome... [AHPRA] continue to treat us [notifiers] in this unconscionable manner and the system will collapse catastrophically.<sup>338</sup>

The Victorian Department of Health's submission to the Inquiry listed provisions of the *Health Professions Registration Act 2005 (Vic)* that were not carried forward into the *Health Practitioner*

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<sup>338</sup> Jennifer Morris, Transcript of Evidence, 9 August 2013, p. 98.

*Regulation National Law Act*. Under section 60 of the previous Victorian legislation, notifiers were able to apply to the responsible Board to establish an investigation review panel to review a decision of the responsible Board if:

- a) the responsible Board has determined not to conduct an investigation; or
- b) the responsible Board has decided to take no further action after an investigation; or
- c) the responsible Board after the investigation of a matter has decided to refer the matter to a professional standards panel.<sup>339</sup>

The Department noted:

Under previous Victorian arrangements, the bulk of grievances brought to the attention of the Minister and the Department were from complainants (notifiers) who were aggrieved about how their complaint against a registered practitioner was handled arose. Most of these related to board decisions to close a matter with no further action, or to conduct a hearing in house rather than external to the board.<sup>340</sup>

As part of the review into the regulation of Victorian health professions in the early 2000s that led to the *Health Professions Registration Act 2005* (Vic), the Department commissioned an independent assessment of the complaints process titled *Bringing the Consumer Perspective: Consumer Experiences of Complaints Processes in Victorian Health Practitioner Registration Boards*. Among its many findings, the review made the following observations with respect to the rights of notifiers:

- The complainant's lack of status in Board investigation and disciplinary processes was an issue for many interviewees.
- Many interviewees reported no opportunity to review the response of the health professional to their complaint allegations, to reply to this, and to be able to correct what they perceived to be factual errors, misconceptions and untruths, before the Board made a decision.
- From a complainant perspective, consideration could be given to affording them the legal opportunity to present whatever evidence they wished at a hearing. At the very least, reforms to the legislation could entitle them access to the health practitioner's evidence/statements if they wished it, and guarantee them an opportunity to present their own versions/refutations in hearings.
- Complainants could also be able to exercise this right before the end of the preliminary investigation, and before the Board decided whether to proceed or not. Legislation could require a Board to offer the complainant the chance to review the health practitioner's statement and reply to it before making a decision.

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<sup>339</sup> *Health Professions Registration Act 2005*, s. 60.

<sup>340</sup> Department of Health, Submission No. 50, p. 30.

- There are a number of complainants' issues identified by interviewees that potentially would be addressed if their legal status as participants in the proceedings were clarified and, where useful, enhanced.<sup>341</sup>

The Victorian Department of Health notes that 'in responding to these concerns, the *Health Professions Registration Act 2005 (Vic)* was framed to make provision for a notifier to have an internal right of review for certain decisions by the Board, but with a fresh panel of persons, including a nominee of the Health Services Commissioner'.<sup>342</sup> The Department acknowledged that 'although this presented an additional cost to the scheme, it provided additional checks and balances on board disciplinary processes'.

The Department commented that:

The Committee may wish to consider whether there is a need to strengthen the entitlement of notifiers to seek a review of decision by a National Board to close a matter following investigation, or to deal with a matter through internally constituted and closed to the public Performance and Professional Standards Panels, rather than through referral for hearing by an externally constituted tribunal where hearings are open to the public.<sup>343</sup>

In its written response to the Committee's evidence, AHPRA advised:

One submission to the Committee proposed the consideration of a review process for notifiers. This was in place in Victoria under the *Health Professions Registration Act 2005* before the National Scheme. The Act allowed review, in limited circumstances, of a finalised notification by an independent review panel. The outcomes of the review process reported by the Victorian state boards between 2005-2010 showed that a significant proportion of the notification outcomes were upheld. In only a small number of matters did the review panels recommend reconsideration of matters. In addition, the review processes added additional costs to state boards. This independent review process, as well as other external oversight models, was considered and publicly consulted on in developing the National Law. They were not supported by the jurisdictions in the final development of the National Law.<sup>344</sup>

The Committee is concerned that AHPRA would suggest that only 'one submission' highlighted this issue. However, the Committee received several submissions that raised the issue of a lack of review process for notifiers.

The Health Issues Centre, while supporting the National Scheme, stressed the complaints process should ensure there 'is consumer confidence that in making a complaint their individual concerns

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<sup>341</sup> Resolution Resource Network and Health Issues Centre, *Bringing in the Consumer Perspective*, October 2004, p. 9.

<sup>342</sup> Department of Health, Submission No. 50, p. 30.

<sup>343</sup> *Ibid.*, p. 31.

<sup>344</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 19.

and expectations will be addressed.’<sup>345</sup> Ms Susan Biggar, Senior Project Officer with the Centre, observed:

I think one of the difficult things is that if no further action is taken—if you go to the health services commissioner, you are moved over to AHPRA and no further action is taken—that is really the end of the road for your complaint. There is nothing else you can do, and that might not have been what you wanted anyway. So you have ended up in a place where there is no opportunity for reconciliation, there is no opportunity for sitting down and there is no further process, and I think that is difficult. I think also, in the view of appearing fair, that is not the same with a practitioner. They can appeal a judgement; a notifier cannot. There may be good reason for that, but I think from the perspective of being seen to be fair it might feel a little bit for the consumer like it is not weighed in their favour or is not moving in their favour.<sup>346</sup>

Mr Jim Boyle provided a submission to the Inquiry outlining his negative experiences as a notifier. Mr Boyle believes it is unfair that notifiers are denied an appeal mechanism while practitioners maintain a right of appeal:

It is an important consideration that decisions on complaints by AHPRA are not subject to any effective appeal mechanism by a complainant in regard to the actual decision. Otherwise, via the Health Industry Ombudsman, only a review of procedural issues is available to a complainant, though reconsideration of a decision is available, by appeal, to a professional against whom AHPRA has made an adverse decision.<sup>347</sup>

Miss Morris believes ‘the rights, status and consideration afforded to practitioners in AHPRA cases grossly outweighs the meagre role afforded to notifiers. This results in flagrant perversions of justice.’<sup>348</sup> Miss Morris commented:

Contrary to HSC complainants, AHPRA notifiers, as I had now unwillingly become, are disposable nobodies. We are deemed to be not a party in our own notifications. We have no right to know the evidence collected, no right to know the processes undertaken, no right to participate, no right to seek conciliation or recourse, no right of appeal and no right to know the reasons for any outcome. Indeed we have no right to know more than a person on the street, which is effectively nothing. It was the antithesis of what I had been promised.<sup>349</sup>

Miss Morris’ comments above, and further evidence, highlight a secondary concern over the rights of notifiers in terms of a lack of information provided to them during this process. The Committee heard examples where notifiers, in making a complaint, are advised no further action will be taken but are not informed of the reasons for such decisions.

As noted later in this Chapter, the Victorian Office of the Health Services Commissioner, plays an integral role in the health complaints process. The OHSC noted:

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<sup>345</sup> Health Issues Centre, Submission No. 35, p. 2.

<sup>346</sup> HIC, *Transcript of Evidence*, 9 August 2013, p. 141.

<sup>347</sup> J. Boyle, Submission No. 54, p. 1.

<sup>348</sup> J. Morris, Submission no. 31, p. 25.

<sup>349</sup> J. Morris, *Transcript of Evidence*, 9 August 2013, p. 99.

Another aspect of AHPRA's operations which has an effect on the way in which the OHSC deals with complaints is the way AHPRA informs Notifiers following conclusion of a matter. The National Law mandates the Notifier is provided with information about the decision made by the Professional Standards Panel but only to the extent the information is available on the National Board's Register. This means the Notifier is not provided with an adequate statement of reasons. They are not told why a matter has been concluded. The only information provided to the Notifier is the outcome of the notification, whether that is a 'no further action' outcome or a limitation to registration.<sup>350</sup>

The OHSC believed the lack of information or statements of reason provided by AHPRA has led to further consumer confusion and has impacted upon the OHSC in dealing with complaints:

With limited information, Notifiers are put in the same category as the general public which is unreasonable if they are patients/consumers and leads them to pursue other avenues to pursue their grievances with other bodies like the OHSC. On occasion, AHPRA refers a dissatisfied Notifier to the OHSC following their conclusion of the matter. When the Notifier contacts the OHSC with minimal information, the OHSC seeks additional information from AHPRA (such as the Reasons document) to assess whether there are any unresolved or unaddressed issues. The HSCRA prohibits the OHSC from accepting an issue already determined by another body such as AHPRA. This leaves the consumer further aggrieved and dissatisfied whereas had AHPRA provided an adequate statement of reasons, it may have discouraged the consumer from lodging a complaint with the OHSC. It is necessary for the OHSC to be routinely supplied with this information (reasons, provider response etc) so it can determine whether there are issues which may be addressed through OHSC processes.<sup>351</sup>

The Health Issues Centre stressed the importance of ensuring health consumers are provided with sufficient timely information during a complaints process and be provided with a reason why a Board decides to take no further action:

I cannot reiterate strongly enough how much consumers, patients and families feel that they are powerless in the system, that the more involved they are, the more enmeshed in it and the more they need and rely on the system, the more they feel they do not have a voice or do not have much power, control or information. That comes out very strongly through the review. People are constantly saying, 'I didn't know what was going on; I didn't have information; I didn't know how to access information'. That is something you hear people say in hospitals when they are just trying to deal with their own care and even more so once they have had a negative experience. Whether it was legitimate or not, they feel they were harmed, and it is even more important that the process be seen to be fair, open and that they be informed.

The Chief Executive Officer of the Health Issues Centre, Ms Mary Draper, observed:

I think quite a high proportion of the referrals to AHPRA do not go past the first stage, and they are the ones where you do sometimes wonder, in a sense, if they really need to go down that track. Somebody will just get back something that says, 'No further action'; it does not actually say why there is no further action. I think we have focused, in a way, on perhaps the end that might be well addressed by apology and acknowledgement, but we also need to remember that at the heavy end, as it were, there are serious issues of practitioner behaviour and conduct and serious issues of harm to consumers. Particularly that end, I think, is probably the end at which there most needs to be...

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<sup>350</sup> Health Services Commissioner, Submission No. 5, p. 3.

<sup>351</sup> *Ibid.*

really good communication about what is happening here, what the decisions are and why the decisions go that way.<sup>352</sup>

The Committee received evidence from Queensland Parliament's Health and Community Services Committee which undertook a review of the Health Ombudsman Bill in that State. The Queensland Committee Members stressed upon the Legal and Social Issues Committee the importance of ensuring health consumers are provided with information on decisions.

Dr Alex Douglas, a member of the Queensland Committee, highlighted the need for transparency in the process:

...the problem with the AHPRA model currently is that unless it is referred to the tribunal, people do not know what the outcomes are if it is not known. It actually becomes a secret, and that is really what has happened with regards to that matter that I raised earlier on.<sup>353</sup>

Miss Morris, in her submission, recommends 'legislative changes be implemented to afford basic rights of due process and procedural fairness to notifiers.'<sup>354</sup> Miss Morris suggests such changes include the following for notifiers:

- due recognition as a party in notification proceedings;
- right to information on the progress of a notification (this is already legislated for, but not enforced);
- right to know beforehand of any hearings to take place;
- right to attend hearings;
- right to give evidence and be questioned at hearings if desired;
- right to provide a submission to the panel conducting a hearing;
- right to see a transcript of any hearings; and
- right to a duly detailed summary of the proceedings and outcomes of any hearings.<sup>355</sup>

In its response to the Committee's evidence, AHPRA advised that 'it has recently established a Community Reference Group to provide feedback on how it can improve community knowledge about health practitioner regulation.' Furthermore, 'a current focus of the Community Reference Group is to review and improve the information we provide to notifiers.' AHPRA stated:

Improved community engagement has been a significant focus for AHPRA during 2013. We have established a Community Reference Group. We have worked nationally in partnership with the Consumers Health Forum to increase community engagement. We have published new, clear

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<sup>352</sup> HIC, *Transcript of Evidence*, 9 August 2013, p. 6.

<sup>353</sup> Health and Community Services Committee, *Transcript of Evidence*, 22 November 2013, p. 229.

<sup>354</sup> J Morris, Submission No. 31, p. 4.

<sup>355</sup> *Ibid.*

information for consumers about how we manage their concerns. We are establishing a partnership with the Health Issues Centre in Victoria to advise on opportunities to improve confidence, transparency and understanding of the joint consideration process in Victoria.<sup>356</sup>

## **FINDINGS**

### **6.6 Notifiers in Victoria have limited ability to appeal or seek review of a notification assessment decision. Notifiers have:**

- ***fewer rights than they were previously afforded under the Victorian Health Professions Registration Act 2005;***
- ***fewer rights to appeal a decision than the practitioner involved; and***
- ***limited appeal and review rights compared to what exist in the co-regulatory jurisdictions of New South Wales and Queensland.***

### **6.6 Interaction with the Victorian Health Services Commissioner**

The Committee's evidence highlighted some concern over the dual roles of AHPRA (the Boards) and the Office of the Health Services Commissioner in the health complaints process. Rather than having one clear pathway, consumers are faced with a process that involves three separate entities working in partnership to handle complaints. Evidence suggests this creates confusion from a health consumer point of view and can lead to delays in the notification process.

The National Law requires that the Boards and health complaints entities (HCEs) share complaints and notifications and agree on how to deal with each complaint or notification.<sup>357</sup> In Victoria, the HCE is the Office of the Health Services Commissioner (OHSC) which was established through Victorian legislation, the *Health Services (Conciliation and Review) Act 1987*. Under a Memorandum of Understanding, AHPRA and the OHSC are required to notify each other about receipt of complaints/notifications, and consult about who is responsible for managing the complaint. AHPRA notes the process is called 'joint consideration' and is designed to avoid double handling and ensure that legislative requirements are met.<sup>358</sup>

AHPRA's Annual Report sets out the roles of the three entities in the complaints process:

The role of HCEs is to resolve complaints or concerns, including through conciliation or mediation.

The role of the National Boards and AHPRA is to protect the public, including by managing notifications about health practitioners, and when necessary restricting their registration and their

<sup>356</sup> AHPRA, Correspondence received, 26 November 2013, covering letter, p. 2.

<sup>357</sup> AHPRA, Submission No. 40, p. 41.

<sup>358</sup> *Ibid.*, p 9.

practice in some way. AHPRA and the National Boards have no power to resolve complaints. Its focus is on managing risk to the public.<sup>359</sup>

In short, AHPRA and the National and State Boards deal with concerns about practitioners' conduct, health and performance. The Office of the Health Services Commissioner deals with concerns relating to health systems, health service providers, fees and charge.

AHPRA's submission commented that:

A strength of the current processes is that the HCEs can focus on an individual's complaint and seek resolution. By contrast, as regulators, the National Boards must focus on action that might be needed to address the health, conduct or performance of individual practitioners to protect the public.<sup>360</sup>

The Committee appreciates the National Law and the Victorian *Health Services (Conciliation and Review) Act 1987* sets out separate and distinct roles for AHPRA and the OHSC respectively. However, evidence would suggest the nature of health complaints will vary and it is not always clear which entity should take responsibility.

Furthermore, evidence indicates the actual day to day managing of complaints can be time consuming and public confusion remains about the roles of the entities involved. AHPRA acknowledges such in its submission:

This difference in focus is not always readily understood by consumers, and can lead to a gap between what the person making a complaint is seeking, and what the National Scheme can deliver.<sup>361</sup>

Chair of the Victorian Board of the Medical Board of Australia, Dr Laurie Warfe, further commented on the extent of confusion:

There is no doubt there is confusion about the public finding out which way to send their complaints. They are uncertain about the role of the health services commissioner and the limitation of that — that the health services commissioner can only receive complaints from consumers — that they do have a role in conciliation and perhaps directing compensation, and they do have a role in looking at the provision of health services in general, particularly from the state health services, whereas the national board and the state board do not have that role. They have no role or power for compensation or for conciliation, and they have no role beyond that protection of the public regarding regulation of individual practitioners. They have no role about implementation of health service delivery, in a general sense, from a health service, and they also have no role with the non-regulated practitioners. The public does not appreciate that in many respects.<sup>362</sup>

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<sup>359</sup> AHPRA, *Annual Report 2012-13*, p. 137.

<sup>360</sup> AHPRA, Submission No. 40, p 41.

<sup>361</sup> *Ibid.*

<sup>362</sup> Victorian Board of the Medical Board of Australia, *Transcript of Evidence*, 27 November 2013, p. 269.



However, the Committee notes it is not just the public that may be confused over the shared complaints handling roles. Health practitioners may also be uncertain. The Royal Australian and New Zealand College of Psychiatrists spoke of the dilemma they are faced with when determining which body a patient can be referred to if they have a complaint:

We are very aware that we do not have the investigative powers to be able to investigate matters such as those involving patients or the practice of an individual doctor, so we do refer them either to the appropriate health services commissioner in the state or to AHPRA, but there is a little bit of confusion, both for the college and for patients, as to which of those two bodies — or sometimes three — each individual complaint should be referred to. We are trying to refer each individual complainant to the appropriate body because we are aware that these processes are quite cumbersome and tedious and stressful for the public, so we do try to refer those complaints to the most appropriate body each time.<sup>363</sup>

The Australian Dental Association also referred to the confusion over the roles of AHPRA and the Health Services Commissioner:

An issue that continues to be brought to the attention of the ADAVB is public misunderstanding about the role of AHPRA, and confusion about the distinction between the HSC and AHPRA. This misunderstanding is relevant to both health professionals and members of the public. There is a misconception that AHPRA is a consumer complaints entity, rather than a professional standards body. Whilst AHPRA is responsible for managing notifications, they do not resolve complaints about health systems or investigate concerns about health service providers. This is the role of Health complaints entities in each state and territory. There needs to be consistent, clear communication about the roles of each body and why a notifier should contact one in preference to the other.<sup>364</sup>

The Australian Psychological Society's submission commented on areas of overlap between the processes of AHPRA and state-based health complaints entities such as the Victorian Office of the Health Services. The Society believes the areas of overlap have the potential to create confusion for both consumers and registered practitioners:

The processing of complaints and points of cross referral between the OHSC and AHPRA needs to be consistent and streamlined for the NRAS to achieve regulatory efficacy and effective protection of the Victorian public. The aim of the NRAS was to ensure that AHPRA complimented and not replicated other State and Territory complaints processes, however, it is evident there are differences in investigative processes and overlap of complaints. As such, it is inefficient that depending on which entity a complaint is lodged, the powers of investigation and their scope are different.<sup>365</sup>

The dual handling of complaints is illustrated in AHPRA's data on notifications. AHPRA's initial submission indicates that in 2012, a total of 533 notifications (32%) were received on behalf of the community of Victoria through the Office of the Health Services Commissioner.<sup>366</sup> In its supplementary submission dated 26 November 2013, AHPRA advised that in 2012-13, 28 per cent of Victorian notifications were the subject of the joint consideration process with the OHSC. Further,

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<sup>363</sup> Royal Australian and New Zealand College of Psychiatrists, *Transcript of Evidence*, 9 August 2013, p. 126.

<sup>364</sup> Australian Dental Association, Submission No. 27, p. 5.

<sup>365</sup> APS, Submission No. 24, p. 8.

<sup>366</sup> AHPRA, Submission No. 40, p. 25.

AHPRA data indicates that of the 1,552 total National Law notifications closed in Victoria during 2012-13, the OHSC retained 296 or 19 per cent.<sup>367</sup>

Analysis of the past three AHPRA annual reports illustrates the number of notifications received from health complaints entities throughout Australia (excluding New South Wales) is on the rise. In 2010-11 there were 1,401, or 26 per cent of notifications received from HCEs. The following year there was 27 per cent. In 2012-13, the number of notifications received from HCEs had risen to 1,857 or 33 per cent of the Australian total.<sup>368</sup> So at a national level, excluding NSW, one-third of notifications about health practitioners managed under the National Law were initially referred to health complaints entities.

AHPRA suggested the comparatively large number of notifications received by HCEs, together with the large proportion retained by the OHSC, 'illustrates the joint consideration of notifications between the National Boards and health complaints entities in the National Scheme.' And further that:

The relatively higher percentage of referrals received through the Office of the HSC may be attributable to the well-functioning relationship with the HSC in Victoria.<sup>369</sup>

In terms of the communication between AHPRA and OHSC, the OHSC advised:

AHPRA representatives regularly participate in the meeting where views are exchanged and processes refined. Consistent with the previous state based arrangements, each body is to consult on notifications (in the case of AHPRA) and complaints (in the case of the OHSC) where they fall within the respective jurisdictions. Agreement is then reached on which body is best placed to handle the matter. This process works well from the OHSC's perspective, with one or two issues still being addressed, chief among them the timeliness of advice from AHPRA.<sup>370</sup>

The Committee's view is that the large number of notifications initially referred to HCEs and jointly considered by AHPRA and the Health Services Commissioner is an illustration of a system with overlapping responsibilities which has the potential for time delays and public confusion.

Despite AHPRA's claim of a 'well-functioning relationship' and clear responsibilities set out in legislation, further evidence from AHPRA suggests it is not always obvious internally as to which body should take responsibility for a complaint. AHPRA's evidence refers to 'debate on matters where opinion may differ', and that 'joint consideration contributes to a robust, quality decision making process.'<sup>371</sup>

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<sup>367</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 2, p. 2.

<sup>368</sup> See AHPRA, *Annual Report 2010-11*, p. 61; AHPRA, *Annual Report 2011-12*, p. 159; AHPRA, *Annual Report 2012-13*, p. 247.

<sup>369</sup> AHPRA, Submission No. 40, p. 25.

<sup>370</sup> HSC, Submission No. 5, p. 2.

<sup>371</sup> AHPRA, Submission No. 40, p. 42.

One of the main concerns about the overlap in the dual handling of complaints by AHPRA and the OHSC is the additional time delays arising. The OHSC stated:

While most advice is received within four weeks, it can sometimes be four to eight weeks before a decision is made by the respective registration board to accept or not accept a matter. These delays occurred more frequently at the commencement of the National Scheme and occur infrequently now. During this time, a complaint is not progressed at the OHSC awaiting that decision. The OHSC has 84 days to assess the complaint and attempt to resolve it prior to either closing the complaint or referring it into conciliation. Over half of that time may be expended awaiting a decision by the registration board and is an erosion of the OHSC's capacity to resolve complaints as informally and in as timely a manner as possible. If a consumer makes a complaint to the OHSC and AHPRA simultaneously, comments may not be received for some time since AHPRA has 60 days under the National Law to assess the matter and provide comments to the OHSC.<sup>372</sup>

The OHSC advised that under the previous state-based arrangements, it engaged directly with each of the Boards around delays which mitigated against timelines not being met. Under the current arrangements, AHPRA is an additional layer between the OHSC and the relevant Board.

The Victorian Board of the Medical Board of Australia advised:

There was another perceived delay between dealing with matters that have come via the health services commissioner, and the Office of the Health Services Commissioner suggested that we should look at ways of improving our handling of those matters. They were determined originally to go to the notification committee in the appropriate time frame, and each one met fortnightly, alternately, so occasionally a matter would come from the health services commissioner and sit for a fortnight before it became actioned by the next sitting notification committee.<sup>373</sup>

The Board advised that it has made internal adjustments to its processes in order to expedite these delays.

The Committee questions the merits of a system where two separate entities, with separate complaints handling responsibilities set out in separate laws, are required to regularly meet, consult, engage in robust decision making, and at times not initially agree on who should manage a complaint.

It is noted that the Victorian Government is currently reviewing the *Health Services (Conciliation and Review) Act 1987*, the legislation which established the role of the Health Services Commissioner (the Commissioner) in Victoria. The review's terms of reference are to examine whether changes are required to the Act to:

- reflect best practice in health complaints resolution for all health service users;
- strengthen the Commissioner's role in improving the health system and the patient experience;

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<sup>372</sup> HSC, Submission No. 5, p. 2.

<sup>373</sup> VBMBA, *Transcript of Evidence*, 27 November 2013, p. 268.

- respond to a changing health service environment and changes in related federal and State legislation; and
- address any scope, policy or operational issues in the current legislation.

The Department's website states 'the review aims to ensure that the Act reflects best practice and provides a prompt, responsive and cost-effective system for resolution of health complaints. It also aims to help achieve the government's health reform priorities.'<sup>374</sup>

The Australian Psychological Society advised the Committee that in its submission to the State Government review of the *Health Services (Conciliation and Review) Act 1987*, it made several recommendations relating to collaboration between agencies, minimising cross-referrals and effective information provision. Those recommendations were:

- That the OHSC and AHPRA work to collaborate and clearly delineate their functions, roles and responsibilities (including issues that overlap for both organisations) in handling complaints from the public.
- That the OHSC, in collaboration with AHPRA and other complaint handling entities, develop a program to continually inform and educate the public, health practitioners and health services of their organisations' roles and responsibilities, including their powers, decision making process and points of escalation for complaints.
- That the OHSC, in collaboration with AHPRA and professional associations, develop and disseminate information on the process and points of cross referral of complaints between the three entities.
- That the OHSC and AHPRA jointly commission research into complaints lodged with the two entities, focusing particularly on systemic issues that can be resolved over time to increase their respective system's efficiency and effectiveness.

The APS contended that greater cooperation between AHPRA and OHSC would optimise compliance handling for both agencies, and provide consumers with greater certainty and prompt pathways to resolution.<sup>375</sup>

AHPRA and the National Boards have also provided a submission to this review. The submission noted:

AHPRA and the National Boards support current complaints handling processes and agree that good working relationships combined with established referral pathways between the Commissioner and most possible first points of contact by health consumers allows the majority of complaints to be referred in an appropriate and timely way and results in a complaints process that is responsive to people's needs.<sup>376</sup>

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<sup>374</sup> Department of Health website, <http://www.health.vic.gov.au/hscrareview/>, accessed 16 November 2013.

<sup>375</sup> APS, Submission No. 24, pp. 2-3.

<sup>376</sup> AHPRA. Correspondence received, 26 November 2013, Appendix 1, p. 5.

AHPRA noted that implementing recommendations to this review ‘may constructively address some of the issues raised to this Committee (LSIC) in this inquiry, in a Victoria-specific context.’<sup>377</sup>

AHPRA and some other evidence suggests a parallel handling of complaints could be a means to avoid delays and confusion. AHPRA’s submission stated:

With the Health Services Commissioner, AHPRA is exploring whether there are opportunities to better use existing powers in the National Law to run parallel processes. This would allow, in appropriate cases, the HSC to review systems issues or progress towards conciliation, while AHPRA and the National Boards concurrently pursue appropriate regulatory action. This parallel investigative approach requires careful thought to prevent duplication of effort or unwise use of resources.<sup>378</sup>

A submission from the Health Issues Centre (HIC) also argued for a parallel handling of complaints with both AHPRA and HSC managing the process rather than consideration being put on hold until a decision is made as to which entity should take responsibility. The HIC noted:

At the moment if somebody comes through the health services commissioner and they decide there is a professional issue, they will refer it to AHPRA, the complaint goes on hold, and it might stay like that for quite a long time. We argue that the health services commissioner should continue to manage the complaints process. That would go quite a long way to addressing this confusion in the role, because the boards do have a role—that is their role—but there is still a complaint.<sup>379</sup>

The HIC further stated that even if there is a parallel process, with both AHPRA and OHSC, there should be one source of information to the consumer, that being the Health Services Commissioner whose focus is on the consumer, whereas AHPRA’s focus is on the practitioner. Ms Biggar observed:

I still wonder whether or not, even if there is a parallel process, there should be one source of communication to the consumer—that it just be the health services commissioner—and that this process should run its course. It seems to me that one of the things about mixed expectations is that the first focus for AHPRA is not about that particular consumer; it is about the practitioner, but the consumer comes into it assuming that it is about them and their experience. With the health services commissioner it is a bit more about the consumer and their experience. I think it is tricky. It is a very hard thing for someone from the outside to understand.<sup>380</sup>

Miss Morris was very critical of AHPRA’s complaints handling processes and recommended the Office of the Health Services Commissioner be the one body responsible for all health complaints in Victoria. Miss Morris’ submission recommended:

Legislative changes be made to strip AHPRA of jurisdiction over the handling of complaints/notifications by the public about practitioners in Victoria, and all administrative and investigative powers and responsibilities thereto attached.

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<sup>377</sup> *Ibid.*, p. 10.

<sup>378</sup> AHPRA, Submission No. 40, p. 41.

<sup>379</sup> HIC, *Transcript of Evidence*, 9 August 2013, p. 139.

<sup>380</sup> *Ibid.*

Legislative change be made to bestow upon the Victorian Office of the Health Services Commissioner (OHSC) the above-mentioned jurisdiction over complaints/notifications by the public about practitioners in Victoria, and resourcing of that office be increased accordingly.<sup>381</sup>

## **FINDING**

**6.7** *Approximately one-third of all notifications about health practitioners managed under the National Scheme were initially referred to health complaints entities. Evidence indicates this is an illustration of the confusion surrounding the respective roles of AHPRA and the Health Services Commissioner which can lead to delays and lack of public confidence in the complaints handling process in Victoria.*

## **6.7 Co-regulatory Jurisdictions**

Under the National Law, there is scope for States and Territories to be co-regulatory jurisdictions with respect to the health practitioner complaints process. This means the jurisdiction will not participate in the health, performance and conduct process provided by Divisions 3 to 12 of Part 8 of the National Law.

New South Wales and more recently Queensland are both co-regulatory jurisdictions under the National Law with respect to the health complaints process. When Queensland's new Health Ombudsman commences in 2014, almost half of all registered practitioners and 60 per cent of total notifications in Australia will be managed by state-based health complaints processes. For this important regulatory function, the National Scheme is no longer consistent, and indeed was not consistent for all States and Territories at the commencement of the Scheme in 2010.

### **6.7.1 New South Wales**

AHPRA's 2010-11 Annual Report states that 'the National Law was adopted in NSW on 19 November 2009, except for:

- definitions of health assessment, performance assessment, professional misconduct, unprofessional conduct and unsatisfactory professional performance; and
- mechanisms for dealing with complaints, investigations, health and performance assessments, disciplinary proceedings and mandatory notifications.'<sup>382</sup>

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<sup>381</sup> J. Morris, Submission No. 31, p. 4.

<sup>382</sup> AHPRA, *Annual Report 2010-11*, p. 26.

In the first half of 2010, prior to the commencement of the National Scheme in July that year, New South Wales amended the uniform National Law to become a co-regulatory jurisdiction with respect to complaints, performance and disciplinary processes. This enabled that State to maintain its existing complaint handling arrangements involving:

- the government-funded Health Care Complaints Commission;
- instead of existing boards, a council for each of the 10 professions registered under the National Law; and
- a tribunal for each profession with a permanent chair, members appointed as required by the councils and registry support provided by the staff supporting the councils.<sup>383</sup>

During passage of the Health Practitioner Regulation Amendment Bill in New South Wales Parliament in 2010, the then Health Minister, the Hon Carmel Tebbutt, spoke of the 'unique' health care complaints system in that State and emphasised the importance in maintaining the State-based complaints process:

....there are some areas where compromises have been made to reach agreement on a national system. However, there are some areas where the protection of the public demands that compromise is not possible. For this reason the Government has argued consistently that there can be no compromise in ensuring the maintenance of a strong, accountable and transparent disciplinary and complaints systems in New South Wales.<sup>384</sup>

The New South Wales Health Care Complaints Commission (HCCC) was established in 1994 as an independent body to deal with complaints about health service providers in NSW, including:

- registered health practitioners, such as doctors, nurses and dentists;
- unregistered health practitioners, such as naturopaths, massage therapists and alternative health care providers; and
- public and private hospitals, and medical centres.<sup>385</sup>

The Commission works in conjunction with ten professional Councils which cover the same professions covered by the initial ten National Boards under the National Scheme. The NSW Councils are supported to perform their regulatory and legislative functions under the National Registration and Accreditation Scheme by the Health Professional Councils Authority, an administrative unit of the Health Administration Corporation.

All complaints about NSW health practitioners are passed on to the Health Care Complaints Commission, even where the complaint is made to a Registration Board or Council. Under the

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<sup>383</sup> *ibid.*

<sup>384</sup> NSW Legislative Assembly, *Hansard*, 20 May 2010, p. 23210.

<sup>385</sup> Health Care Complaints Commission, 2012-13 Annual Report, p. 3.

National Law, all mandatory notifications must be made to AHPRA, however if they relate to a practitioner in NSW, AHPRA will forward them to the Commission.

The process for handling a health practitioner complaint in New South Wales can involve the following:

- Refer the complaint to the Commission's Resolution Service.
- Refer the complaint to the relevant professional Council for their management. This can lead to the Council disciplining, counselling or re-educating the practitioner involved.
- Refer the complaint for formal investigation where it raises a serious issue of public health and safety or may result in disciplinary proceedings.
- Take no further action regarding the complaint.
- Refer the complaint to a more appropriate agency (for example the Office of Aged Care Quality and Compliance).
- Refer the complaint to the relevant public health organisation to resolve the complaint directly with complainant.<sup>386</sup>

In 2012-13, the Commission assessed 4,544 complaints:

- 2,148 (47.3%) were discontinued – with the Commission taking no further action
- 887 (19.5%) were referred to the relevant professional council to take appropriate action regarding a registered health practitioner
- 714 (15.7%) were referred to the Commission's Resolution Service
- 252 (5.5%) were referred to the relevant public health organisations to try to resolve the complaint locally
- 240 (5.3%) were successfully resolved during the assessment process
- 209 (4.6%) were referred for formal investigation by the Commission
- 94 (2.1%) were referred to another more appropriate body for their management.<sup>387</sup>

Features of the NSW complaints process that illustrate the success of the model in comparison with the process managed by AHPRA and National Boards include:

Faster assessment and resolution time frame - in 2012-13, the Commission received 4,554 complaints (highest in Australia), of which 94.5% were assessed within the 60 day statutory timeframe. On average, complaints were assessed within 40 days. Where a complaint was not assessed within the statutory timeframe, an extension was approved in 99.2% of cases (target

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<sup>386</sup> Health Care Complaints Commission, *2012-13 Annual Report*, pp. 13-15.

<sup>387</sup> *Ibid.*, p.29



100%). This is a significant improvement on the previous year, when 88.1% were assessed within the 60-day timeframe, in an average of 43 days (statutory timeframe - target 100%).

Greater communication - When the Commission has completed the assessment of a complaint, all parties are informed in writing about the outcome and reasons for the decision. In 2012-13, 99.4% of decision letters were sent within 14 days of the decision being made.

Rights of notifiers - unlike under the National Scheme, in NSW complainants have a right to review a decision. People who made the complaint can request a review of the Commission's assessment decision within 28 days of being notified of the decision. A review must include any new or additional information that may alter the initial assessment decision. In 2012-13, 389 requests for a review of the assessment decision were received, which represents 8.6% of all assessments finalised during the year. In the vast majority of cases (93.2%), the original assessment decision was confirmed. However, in the past year there were 25 cases (6.8%), where the initial decision was changed as result of the review. Such rights to review a decision are not afforded to Victorians under the National Scheme.

Ministerial direction- The HCCC is subject to the control and direction of the Minister, except in respect of the assessment, investigation and prosecution of a complaint or the terms of any recommendation or report of the Commission including the annual report. The Commission provides quarterly reports on its complaint-handling performance to the Minister for Health and a Parliamentary Committee on the Health Care Complaints Commission (see below). In Victoria, the Minister for Health has no individual control or direction over AHPRA and the 14 National Boards and only has the power to appoint members to three State Boards.

Parliamentary oversight - a joint NSW parliamentary committee, the Committee on the Health Care Complaints Commission, has a statutory role to monitor and review the Commission's functions, annual reports and other reports it makes to Parliament. The Committee is not authorised to re-investigate a particular complaint; or to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

## **FINDING**

**6.8** *The health practitioner complaints process managed by the NSW Health Care Complaints Commission and State-based professional councils is considered to be a highly successful and well established model. The NSW system provides a number of key features that differ from the National Scheme including improved timelines and communication, rights of review for notifiers, and enhanced accountability and oversight to the Minister for Health and to Parliament.*

### **6.7.2 Queensland**

During the course of this Inquiry, the Committee noted legislative changes in Queensland which will result in that State becoming a co-regulatory jurisdiction for Part 8 (health, conduct and performance matters) of the National Law.

On 20 August 2013, the Queensland Parliament passed the Health Ombudsman Bill 2013 which reforms the system for managing health complaints in Queensland. Those reforms include abolishing the existing Health Quality and Complaints Commission and creating the statutory position of Health Ombudsman as the single agency which receives health service complaints. Additional monitoring, oversight and review functions have been afforded to the Health Ombudsman, the Minister for Health, and Queensland Parliament.

The Health Ombudsman is expected to commence operation by the middle of 2014. In the interim, health practitioner complaints will continue to be managed by the outgoing Health Quality and Complaints Commission (HQCC), together with AHPRA and the National and State Boards.

The Health Ombudsman Bill follows a public interest disclosure to the Queensland Crime and Misconduct Commission in April 2012 about the conduct, registration and discipline of medical practitioners in Queensland. The Commission subsequently appointed retired Supreme Court Judge, Mr Richard Chesterman AO RFD QC to undertake an independent assessment of the allegation. One of the recommendations from Chesterman's Report was that there be a review of all the cases of misconduct or alleged misconduct by medical practitioners dealt with by the Queensland Board of the Medical Board of Australia (QBMA) or in which AHPRA has recommended disciplinary action against a medical practitioner, including cases in which the Notification Advisory Committee and/or QBMA rejected a recommendation by AHPRA to take disciplinary action.<sup>388</sup>

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<sup>388</sup> Forrester K, Davies E and Houston J, *Chesterman Report Recommendation 2 Review Panel (The Forrester Report)*, 5 April 2013, p. i.

Arising from this disclosure, the Queensland Minister for Health appointed a panel, led by Dr Kim Forrester, to review files of the former Medical Board of Queensland (MBQ), the Queensland Board of the Medical Board of Australia and AHPRA. The purpose of the review was to determine whether the MBQ and QBMBA were achieving their primary objective of protecting the public by ensuring that medical practitioners are competent to practice. On 5 April 2013, the panel reported their findings to the Minister. The panel found:

- delays in the timeliness of notifications progressing from receipt through the various assessment and disciplinary processes to a final decision by the Board;
- a lack of consistency and predictability of outcomes in the Board's decisions across notifications of a similar nature; and
- considerable delays and inconsistencies in a significant number of files due to cross-jurisdictional referral, consultation and information sharing obligations imposed under the then legislation.<sup>389</sup>

In evidence to the Committee, Dr Forrester explained why a state-based complaints system, in her opinion, is more efficacious than a national one. She claimed that a health complaints process is:

...more manageable within a state based system, so that as I said, you are case managing; the timelines are clear; you are able to identify where that complaint is in the process. There is an obligation for the Health Ombudsman to be notifying the complainant and the registrant as to what is actually going on, so that the process itself is more contained, that has to be an advantage.<sup>390</sup>

The reports by Chesterman and Forrester, together with a third report by Mr Jeffrey Hunter SC into possible criminal offences by certain medical practitioners, led to the Health Ombudsman Bill being introduced into Queensland Parliament on 4 June 2013.

Under the new arrangements, the Health Ombudsman will initially receive all complaints about registered health practitioners in Queensland, but will only retain and investigate the most serious complaints, some of which are currently investigated by the National Boards. All other, less serious complaints will be referred on to AHPRA and the National Boards for action. In this way, the Queensland model differs from the New South Wales HCCC/professional councils model which does not deal with AHPRA and National Boards (see above).

The Health Ombudsman's functions under the Act are to:

- receive health service complaints and take *relevant action*;

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<sup>389</sup> *Ibid.*, p. 74.

<sup>390</sup> Dr K Forrester, *Transcript of Evidence*, 22 November 2013, p. 239.

- identify and deal with health service issues by undertaking investigations, inquiries or other relevant action;
- identify and report on systemic issues in the way health services are provided, including issues affecting quality;
- monitor the National Boards and AHPRA's performance in relation the health, conduct and performance of Queensland health practitioners;
- provide information about providing health services in a way that minimise complaints and resolving complaints;
- report to the Minister and parliamentary committee about the administration of the health complaints system, the performance of the Health Ombudsman's functions, the National Boards and AHPRA's performance in relation to the health, conduct and performance of Queensland health practitioners; and
- publish reports about the health complaints system.

Following the first reading of the legislation in the Queensland Legislative Assembly, it was referred to the Parliament's Health and Community Services Committee for consideration and report back to the Legislative Assembly by 12 August 2013. The Committee received 29 written submissions and took public hearing evidence from several key stakeholders. The Committee subsequently recommended the Bill be passed. Two non-Government Members of the Committee submitted 'Statements of Reservation' regarding the Committee's report and indicated they shared the concerns of some organisations, such as AHPRA and the AMA (QLD), over the Bill and its implications for the National Scheme.

Overall, organisations representing the interests of Queensland's health practitioners acknowledged that problems existed in the State's health complaints system, but were opposed to the legislation on several grounds. The Parliamentary Health and Community Services Committee noted that 'submissions from medical and other health profession representative bodies expressed support for maintaining the current National Scheme, and considered that the Bill, while well intentioned, would have negative impacts on health care in Queensland.'<sup>391</sup>

The key concerns raised by practitioners in relation to the new health complaints system were:

- the Health Ombudsman is not independent from Government and should be accountable directly to the Parliament;
- the Minister for Health has increased powers including the power to direct the Health Ombudsman to conduct an Inquiry;

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<sup>391</sup> QLD Health and Community Services Committee, *Health Ombudsman Bill 2013, Report No. 27, August 2013*, p. 8.

- the Health Ombudsman does not need to be a suitably qualified and experienced medical practitioner; and
- the Health Ombudsman is not required to seek clinical advice before taking immediate action to suspend or place conditions on a practitioner's registration.

There were also wider concerns as to the implications of the Queensland changes on the National Scheme. AHPRA considers that there should be a national examination of the appropriate arrangements for health care complaints as part of the three-year review of the Scheme.<sup>392</sup>

Given that the Queensland Health Ombudsman is yet to commence operation, the Committee is not in a position to comment on the success or otherwise of the new health complaints process. The basis for the changes, to protect the health and safety of the public, has much merit. The Committee also considers there are many potential benefits arising out of the new arrangements including:

- Creation of one single entry point for all health practitioner complaints, rather than being split between AHPRA, National Boards and the Health Quality and Complaints Commission;
- Independent arbiter - decisions are made by persons who do not face the potential conflict of being a member of any health profession;
- More stringent statutory timelines for dealing with complaints and greater public reporting of delays in investigations;
- Improved communication with notifiers and practitioners during the investigation process;
- Greater transparency and accountability to Parliament and the Minister for Health; and
- Ability of the Health Ombudsman to take immediate action where the public may be at serious risk from a practitioner.

However, the Committee also notes there will be initial issues to overcome when the Health Ombudsman commences operation, not the least being to ensure practitioners are confident with the system. There remains some confusion as to how the Health Ombudsman and the National Boards (and AHPRA) will work together when considering complaints, particularly those deemed to be serious matters. There are further concerns over the potential powers of the Minister to direct and control complaint assessments and investigations. The Committee further notes concerns expressed by the Queensland Opposition that there is no longer a legislative requirement for health care safety and quality improvement that existed under the repealed *Health Quality and Complaints Commission Act*.

AHPRA wrote to the Committee in November 2013 responding to a number of matters including the implications of the new system in Queensland. AHPRA commented:

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<sup>392</sup> AHPRA, Correspondence received, 26 November 2013, Appendix 1, p. 6.

Having carefully reviewed our work across Australia, we believe that the issues in Queensland that have led to legislative change and the planned creation of a Health Ombudsman are largely specific to Queensland. They reflect unique features of the transition to the National Scheme in Queensland including limited transition of staff from the former Medical Board of Queensland, a relatively large number of ongoing open matters, much less clarity about roles and responsibilities among related complaint handling bodies, and a continuously changing environment for practitioner regulation. The establishment of a Health Ombudsman in Queensland by 1 July 2014 will be the fourth major change to medical regulation in that state in seven years. This level of change has not been a feature of the environment in Victoria and many aspects of the National Law build on the previous arrangements and legislation in Victoria.

There are many examples from around the world of different models of complaint handling and there is no international consensus about the right balance of professional and community involvement in decision making. The scheduled three-year review of the National Scheme commissioned by Health Ministers is an important opportunity for a considered review of performance and debate about the need for further legislative or structural change to Australia's regulatory arrangements. There are a number of improvements to the transparent operation of the scheme, particularly for those making complaints about health practitioners, for which AHPRA and National Boards will continue to advocate during the review.

Given the ambitious regulatory reform introduced in 2010, we see the outcomes of the three year review as an important opportunity for Ministers to make national changes to the operation of the scheme where required, informed by three years experience and learning. Any major legislative change on a state-by-state basis risks the fragmentation of the National Scheme and may increase risk to the public, while decreasing the return on government investment now resulting from the major transition in 2010.<sup>393</sup>

It is acknowledged that Queensland has been the subject of several high profile health practitioner complaints, however concerns over time delays, public confusion with dual complaints handling, and lack of transparency and accountability are common throughout both Queensland and Victoria.

The Committee does agree that it is now timely for the Ministerial Council to review the implications of Queensland and New South Wales being co-regulatory jurisdictions for health complaints and consider the merits of enabling all States and Territories to adopt similar state-based systems.

## 6.8 Conclusions on Health Complaints Process

The Committee's evidence highlights a number of problems with the health complaints process managed under the National Scheme. These include:

- confusion and inconsistencies with the mandatory notification process throughout Australia;
- time delays and inadequate communication during investigations;

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<sup>393</sup> AHPRA, Correspondence received, 26 November 2013, covering letter, p. 2.

- delays associated with, and confusion with respect to, the roles of AHPRA, the Boards and the Health Services Commissioner;
- inadequate rights of notifiers;
- lack of consistency across all jurisdictions with New South Wales and Queensland now managing their complaints processes independent to the National Scheme; and
- inadequate ministerial and parliamentary accountability and oversight.

In its final deliberations, the Committee considered two options with respect to the preferred future model for health practitioner complaints in Victoria. The first option would be to continue with the current health complaints process under the National Scheme jointly managed by AHPRA, the Boards and the Office of the Health Services Commissioner. In maintaining the existing system in Victoria, the Committee would expect that the three year review of the Scheme considers a number of legislative and management changes to address the numerous problems mentioned above; such as rights of notifiers, reducing time delays and greater accountability.

The alternative option would be for Victoria to join New South Wales and Queensland in becoming a co-regulatory jurisdiction for the health, conduct and performance matters under the National Law. Under this option, Victoria could be guided by models in New South Wales and Queensland and establish a health complaints process model that best suits Victorian health consumers and practitioners.

In considering both options, the Committee considered the weight of evidence throughout the Inquiry that undeniably indicates health complaints are best managed at a local level. Furthermore, the Committee is conscious that there is no longer national consistency in the health complaints processes, with 60 per cent of notifications now being managed by co-regulatory jurisdictions in New South Wales and Queensland. The Committee is therefore conscious that the three year review of the National Scheme being commissioned by the Australian Health Workforce Ministerial Council will inevitably be required to review the future of the health complaints under the National Scheme in view of the recent changes in Queensland, the existing system in New South Wales and the concerns raised in this Inquiry.

As outlined in Chapter Three, the Committee is satisfied that, despite initial problems, the national registration and accreditation processes are working well and the Scheme, in these respects, has the potential to create benefits.

However, the Committee is of the view that the current health complaints process has numerous problems. Again, evidence indicates this aspect of the National Scheme is best managed at a local level with direct accountability to the Victorian Minister for Health and Victorian Parliament, and most importantly, with the main aim of protecting the Victorian public. Accordingly, the Committee

believes it is timely for the Victorian Minister for Health to consider the option of Victoria joining New South Wales and Queensland as a co-regulatory jurisdiction with respect to Part 8 (health, conduct and performance matters) of the National Law.

## **RECOMMENDATIONS**

**10. That the Minister for Health advise the Australian Health Workforce Ministerial Council that there are numerous problems with the existing health complaints process in Victoria including:**

- **confusion and inconsistencies with the mandatory notification process throughout Australia;**
- **time delays and inadequate communication during investigations;**
- **delays associated with, and confusion with respect to, the roles of AHPRA, the Boards and the Health Services Commissioner;**
- **inadequate rights of notifiers;**
- **lack of consistency across all jurisdictions with New South Wales and Queensland now managing their complaints processes independent to the National Scheme; and**
- **inadequate ministerial and parliamentary accountability and oversight.**

**11. That the Minister for Health advise the Australian Health Workforce Ministerial Council that Victoria will consider amending the Health Practitioner Regulation National Law (Victoria) Act 2009 to become a co-regulatory jurisdiction for Part 8 (health, conduct and performance matters) of the National Law.**

**12. That the Victorian Department of Health examine the co-regulatory models of New South Wales and Queensland and consult with key stakeholders when reviewing a complaints process for the Victorian public which would ensure that:**

- **rights of notifiers to appeal decisions are enshrined in legislation;**
- **the Minister for Health has overall responsibility for the system;**
- **performance is monitored by Parliament; and**
- **time frames for dealing with complaints are set out in legislation.**

**Committee Room  
25 February 2014**



## Appendix A – List of Written Submissions

1. Peter Radford
2. Australian Doctors' Fund
3. Australian Association of Surgeons
4. Dr Norman Castle
5. Health Services Commissioner
6. Health & Care Professions Council (UK)
7. The Royal College of Pathologists of Australia
8. Austin Health (Ambulatory and Nursing Services)
9. Nursing and Midwifery Health Program
10. Southern Health
11. Royal Australasian College of Surgeons
12. Australian Medical Acupuncture College
13. Australian College of Nurse Practitioners
14. Australian College of Nursing
15. Victorian Doctors Health Program
16. Australian Nursing Federation
17. Consumers Health Forum of Australia
18. Australian Medical Association (Victoria)
19. Royal Australian College of General Practitioners
20. Tasmanian Government
21. Australian Nursing Federation (Victoria Branch)
22. Rural Doctors Association of Victoria
23. Australian Society of Orthopaedic Surgeons
24. Australian Psychological Society
25. Victorian Medical Directors Group
26. Health Professions Accreditation Councils' Forum
27. Australian Dental Association Victoria
28. Julie Phillips
29. Dr Rob McEvoy, Medical Forum WA
30. Patricia Reid
31. Jennifer Morris
32. Australian Senior Active Doctors Association Inc

33. Australian Medical Council
34. Health Rights & Community Action Inc
35. Health Issues Centre
36. College of Organisational Psychologists, Victorian Section
37. Melbourne Medical Deputising Service
38. Avant Mutual Group Limited
39. Australian Society of Ophthalmologists Inc
40. Australian Health Practitioner Regulation Agency
41. AHPRA Joint National Boards
42. Medical Board of Australia
43. Dianne Perret-Abrahams
44. Norma Barton
45. Stawell & District Healthcare Watch Inc.
46. Margaret Lorang
47. Michelle Clague & Steven Barnett
48. Australian Osteopathic Association
49. Australian Physiotherapy Association
50. Victorian Department of Health
51. Royal Australian and New Zealand College of Psychiatrists
52. David Lindsay
53. Gwen Woodford
54. Jim Boyle
55. Prof. Paddy Dewan

# Appendix B – Witnesses at Public Hearings

## 12 December 2012

### Victorian Department of Health

- Mr Peter Fitzgerald, Executive Director, Strategy and Policy
- Ms Anne-Louise Carlton, Health Practitioner Regulation

## 17 April 2013

### Australian Health Practitioner Regulation Agency

- Mr Peter Allen, Chair, Agency Management Committee
- Mr Martin Fletcher, Chief Executive Officer, AHPRA
- Mr Richard Mullaly, AHPRA State Manager (Vic)
- Dr Joanna Flynn, Chair, Medical Board of Australia
- Mr Steve Marty, Chair, Pharmacy Board of Australia

## 29 May 2013

### Australian Nursing Federation (Victorian Branch)

- Ms Lisa Fitzpatrick, State Secretary
- Ms Pip Carew, Assistant Secretary

### Australian Medical Association (Victoria)

- Dr Stephen Parnis, President
- Mr Bryce Prosser, Director of Policy and Public Affairs

## 12 June 2013

### Australian Medical Council

- Professor Robin Mortimer AO, President
- Mr Ian Frank, Chief Executive Officer
- Ms Theanne Walters, Deputy Chief Executive Officer

### Health Professions Accreditation Councils' Forum

- Dr Nicholas Voudouris, Chair
- Ms Lyn LeBlanc, Deputy Chair
- Ms Peggy Sanders, Forum Secretariat

**26 June 2013**

Australian Doctors' Fund

- Mr Stephen Milgate, Executive Director
- Dr John Buntine, Committee Member
- Dr Shirley Prager, Committee Member
- Dr Richard Prytula, Committee Member

Office of the Health Services Commissioner

- Dr Grant Davies, Acting Health Services Commissioner
- Ms Angela Palombo, Legal and Policy Officer

**9 August 2013**

Royal Australian College of General Practitioners

- Associate Professor Christopher Hogan

Ms Jennifer Morris

Rural Doctors Association of Victoria

- Dr Michael Moynihan, President

Australian Society of Ophthalmologists

- Dr Andrew Atkins, Vice President
- Mr David Russell

Royal Australian and New Zealand College of Psychiatrists

- Professor David Castle, Chair, Victoria Branch
- Ms Callie Kalimniou, Legal Officer
- Ms Joanne Cox, Project Officer

Avant Mutual Group Limited

- Ms Georgie Haysom, Head of Advocacy
- Mr John Arranga, Head of Claims (Vic, Tas)
- Ms Kate Hughes, Head of Practice (Vic, Tas)

Health Issues Centre

- Ms Mary Draper, Chief Executive Officer
- Ms Susan Biggar, Senior Project Officer

Australian Association of Surgeons

- Mr John Buntine, President

**21 August 2013**

Professor Paddy Dewan

**4 September 2013**

Victorian Doctors Health Program

- Dr Kym Jenkins, Medical Director

Nursing and Midwifery Health Program

- Mr Glenn Taylor, Chief Executive Officer
- Assoc. Prof. Denise Heinjus, Director of Nursing, Royal Melbourne Hospital

**18 September 2013**

College of Organisational Psychologists (Victoria Section)

- Ms Gina McCredie, Lead, Strategic Relations
- Dr Ern Green, Victorian State Chair
- Ms Rachael Palmer, Past Victorian State Chair

**22 November 2013, Brisbane**

Australian Medical Association (Queensland)

- Dr Christian Rowan, President
- Ms Emily Cotterill, Senior Policy Officer

Queensland Department of Health

- Dr Michael Cleary, Deputy Director General
- Ms Rachel Welch, Director, Regulatory Instruments Unit
- Ms Jan Phillips, Executive Director, Health Systems Innovation Branch

Health and Community Services Committee, Queensland Parliament

- Mr Trevor Ruthenberg, Chair, Member for Kallangur
- Mr Dale Shuttleworth, Member for Ferny Grove
- Mr John Hathaway, Member for Townsville
- Dr Alex Douglas, Member for Gaven

Dr Kim Forrester, Associate Professor, Faculty of Health Science and Medicine, Bond University

Australian Health Practitioner Regulation Agency, Queensland and Queensland Medical Interim Notifications Group (QMING)

- Mr C. Robertson, Director, National Boards Queensland, AHPRA
- Mr M. Hardy, Director, Regulatory Operations, AHPRA
- Ms S. Gallagher, Chair, QMING
- Dr M. Waters, Practitioner and Member. QMING

**27 November 2013**

Victorian Board of the Medical Board of Australia

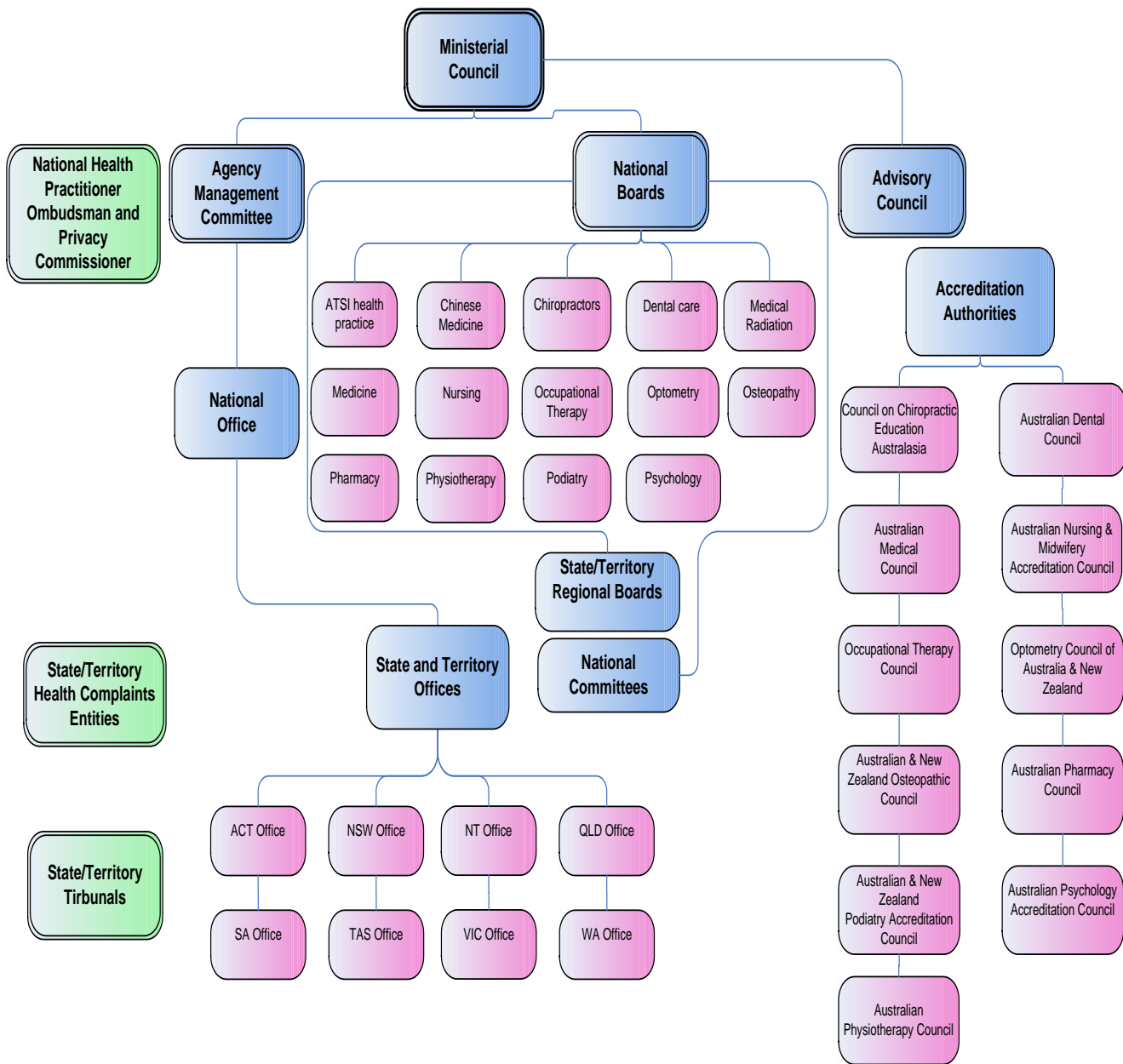
- Dr Laurie Warfe, Chair
- Dr Peter Dohrmann
- Dr Bill Kelly
- Mr Kevin Ekendahl
- Mr Richard Mullaly, AHPRA State Manager (Vic)

**11 December 2013**

Australian Health Practitioner Regulation Agency

- Mr Peter Allen, Chair, Agency Management Committee
- Mr Michael Gorton, Member, Agency Management Committee
- Dr Joanna Flynn, Chair, Medical Board of Australia
- Mr Martin Fletcher, Chief Executive Officer, AHPRA
- Mr Richard Mullaly, State Manager Victoria, AHPRA

# Appendix C – Structure of the National Scheme



Source: Department of Health, Presentation slides, 12 December 2012

## Appendix D – Structure of National Boards and Committees

National Board	National Committees	Regional Boards	State and Territory Boards	State and Territory /Regional Committees
Aboriginal and Torres Strait Islander Health Practice Board of Australia	Registration and Notification Committee	None	None	None
	Communications Committee			
Chinese Medicine Board of Australia	Accreditation Committee	None	None	None
	Communications Committee			
	Policies, Standards and Guidelines Advisory Committee			
	Registration Committee			
Chiropractic Board of Australia	Accreditation, Assessment and Education Committee	None	None	None
	Communications and Relationships Committee			
	Continuing Professional Development Committee			
	Governance, Finance and Administration Committee			
	Immediate Action Committee			
	Registration, Notification and Compliance Committee			
	Standards, Policies, Codes and Guidelines Committee			
Dental Board of Australia	Accreditation Committee	None	None	Immediate Action Committee (excluding New South Wales)
	Administration and Finance Committee			
	Registration and Notification Committee			
Medical Board of Australia	Finance Committee	None	All states and territories (except Queensland at 30 June 2013)  (corrected 14	Health Committee (excluding New South Wales)
	National Specialist International Medical Graduate Committee			Immediate Action Committee (excluding New South Wales)



			November 2013)	Notifications Assessment Committee (excluding New South Wales) Performance and Professional Standards Committee (excluding New South Wales) Registration Committee
Medical Radiation Practice Board of Australia	Communications Committee Finance, Risk and Governance Committee Immediate Action Committee Notifications Committee Overseas Qualifications Assessment Committee Policy, Research and Standards Committee Professional Capabilities Working Group Registration Committee Supervised Practice Committee Workforce Innovation and Reform Working Group	None	None	None
Nursing and Midwifery Board of Australia State and Territory Chairs' Committee (corrected 14 November 2013)	Accreditation Committee Finance and Governance Committee Policy Committee	None	All states and territories (corrected 14 November 2013)	Immediate Action Committee (excluding New South Wales) Notification Committee (excluding New South Wales) Registration Committee
Occupational Therapy Board of Australia	Communications Committee Finance and Governance Committee Immediate Action Committee Registration and Notifications Committee Registration Standards, Codes and Guidelines Committee	None	None	None
Optometry Board of Australia	Continuing Professional Development Accreditation Committee	None	None	None

Inquiry into the Performance of the Australian Health Practitioner Regulation Agency

	Finance and Risk Committee			
	Immediate Action Committee			
	Policy, Standards and Guidelines Advisory Committee			
	Registration and Notification Committee			
	Scheduled Medicines Advisory Committee			
Osteopathy Board of Australia	Finance Committee	None	None	None
	Registration and Notification Committee			
Pharmacy Board of Australia	Compounding Working Party	None	None	None
	Finance and Governance Committee			
	Immediate Action Committee			
	Notifications Committee			
	Policies, Codes and Guidelines Committee			
	Registration and Examinations Committee			
Physiotherapy Board of Australia	Continuous Improvement Committee	None	All states and Territories  (corrected 10 January 2014)	None
Podiatry Board of Australia	Finance Committee	None	None	None
	Immediate Action Committee			
	Registration and Notification Committee			
	Scheduled Medicines Advisory Committee			
Psychology Board of Australia	Finance and Management Committee	Australian Capital Territory, Tasmania and Victoria South Australia, Northern Territory and Western Australia	New South Wales Queensland	Immediate Action Committee
	Internship Review Working Party			Registration and Conduct Committee (excluding New South Wales)
	National Examination Committee			
	Supervisor Training Working Party			

Source: AHPRA, *Annual Report 2012 -13*

## Appendix E – AHPRA’s Notifications Key Performance Indicators

Notifications Key Performance Indicators			
No.	Key Performance Indicator	Definition	Target
1	<b>Lodgement to Assessment</b>	The time taken from the date of an enquiry up until the start of the assessment. This covers the activities for evaluating the initial risk presented, determining whether particulars have been provided and following up where they have not been.	60% within 14 days
			100% within 30 days
2	<b>Lodgement to Closure</b>	The time taken from the date of an enquiry up until to closure at lodgement stage. This covers the activities as described above however represents those matters which are closed as enquiries due to the lack of particulars being established.	100% within 30 days
3	<b>Initial Risk Evaluation</b>	The time taken to complete triage and initial risk evaluation. NB: use of the word evaluation is to address issues raised by the Risk Manager with respect to what meaning is conveyed by the term "risk assessment" (being a formal analysis using a framework of likelihood and consequence).	100% within 3 days
4	<b>Immediate Action Convened</b>	The time from receipt of notification to Immediate Action being convened, where Immediate Action followed Assessment.	100% within 5 days
5	<b>S149 Completion</b>	The time from the receipt of the notification to the completion of the preliminary assessment (s149). This covers the activities of performing a preliminary assessment in accordance with s149 only.	100% within 14 days
6	<b>Assessment to Completion</b>	Time from receipt of notification to completion of assessment stage. This covers the activities of performing a preliminary assessment in accordance with s149, seeking practitioner responses, assessing and developing recommendations for boards and consulting with health complaints entities. (excludes s178 matters)	100% within 60 days
7	<b>S178 Completion</b>	If s178 proposed, the time from Board decision to end of assessment stage.	60% within 60 days
			100% within 110 days
8	<b>Investigation to Completion</b>	The time from the beginning of the investigation stage to the completion of investigation stage.	80% within 6 months
			95% within 12 months
			100% within 18 months
9	<b>Appointment of Investigator</b>	The time from the decision to direct an investigation to the appointment of an investigator.	100% within 5 days
10	<b>Health Assessment Completion</b>	The time from the decision to conduct a health assessment to completion of the health assessment.	90% within 3 months
			100% within 6 months
11	<b>Performance Assessment Completion</b>	The time taken from the decision to conduct a performance assessment to completion of the performance assessment.	90% within 6 months
			100% within 12 months
12	<b>Establishment of Panel Hearing</b>	The time from the decision to conduct the panel hearing to establishment of the panel.	80% within 3 months
			100% within 6 months
13	<b>Panel Hearing to Completion</b>	The time from the decision to conduct the panel hearing to the completion of the panel hearing.	80% within 4 months <del>100% within 6 months</del>
14	<b>Establishment of Tribunal Hearing</b>	The time from the decision to go to the tribunal hearing to the date of file letter of referral.	95% within 3 months
			100% within 4 months
15	<b>Tribunal Hearing to Completion</b>	The time from the decision to go to the tribunal hearing to the completion of the tribunal hearing.	Average time in months

Source: AHPRA, Correspondence received, 26 November 2013, Appendix 3



# Extracts of the Proceedings

Legislative Council Standing Order 23.27(5) requires the Committee to include in its report all divisions on a question relating to the adoption of the draft report. All Members have a deliberative vote. In the event of an equality of votes, the Chair also has a casting vote.

The Committee divided on the following questions during consideration of this Report, with the result of the divisions detailed below. Questions agreed to without division are not recorded in these extracts.

## 25 February 2014

### Chapter Six, page 111

#### Finding 6.5

*There are no current statutory timeframes prescribed under the National Law for completion of an investigation process. The Committee does not consider the proposed key performance indicators established by AHPRA commencing from 2014-15 are sufficient in comparison with statutory timelines now in force in co-regulatory jurisdictions of New South Wales and Queensland.*

Ms Mikakos moved, That the second sentence in Finding 6.5, page 111, Chapter Six, be omitted and that the following new recommendation be inserted after Finding 6.5:

‘That the Victorian Minister for Health recommends to the Australian Health Workforce Ministerial Council that the National Law be amended to introduce statutory timeframes for the completion of an investigation.’

Question put.

The Committee divided.

#### **Ayes 3**

Mr Elasmarr  
Ms Hartland  
Ms Mikakos

#### **Noes 4**

Ms Crozier  
Mr Elsbury  
Mrs Millar  
Mr O’Brien

Question negated.

**Chapter Six, page 117**

Ms Mikakos moved, That the following new finding be inserted after Finding 6.6 on page 117 in Chapter Six:

‘The Committee received evidence that between 2005-2010 a significant proportion of the notification outcomes of Victorian State Boards were upheld. Similarly, in NSW in 2012-13, 93.2 per cent of the original assessment decisions were confirmed.’

Question put.

The Committee divided.

**Ayes 3**

Mr Elasmr  
Ms Hartland  
Ms Mikakos

**Noes 4**

Ms Crozier  
Mr Elsbury  
Mrs Millar  
Mr O’Brien

Question negated.

Ms Mikakos moved, That the following new recommendation be inserted after Finding 6.6 on page 117 in Chapter Six:

‘That the Victorian Minister for Health recommends to the Australian Health Workforce Ministerial Council that the National Law be amended to introduce a right of review of a notification assessment decision for notifiers.’

Question put.

The Committee divided.

**Ayes 3**

Mr Elasmr  
Ms Hartland  
Ms Mikakos

**Noes 4**

Ms Crozier  
Mr Elsbury  
Mrs Millar  
Mr O’Brien

Question negated.

**Chapter Six, page 124**

Ms Mikakos moved, That the following new recommendation be inserted after Finding 6.7 on page 124 in Chapter Six:

'That the Victorian Minister for Health recommends to the Australian Health Workforce Ministerial Council that the National Law be amended if required and that the Memorandum of Understanding between AHPRA and the Office of the Health Services Commissioner to facilitate the OHSC becoming the single entry point for all health consumer complaints in Victoria.'

Question put.

The Committee divided.

**Ayes 3**

Mr Elasmr  
Ms Hartland  
Ms Mikakos

**Noes 4**

Ms Crozier  
Mr Elsbury  
Mrs Millar  
Mr O'Brien

Question negated.

**Chapter Six, page 134**

*Recommendation 11*

*That the Minister for Health advise the Australian Health Workforce Ministerial Council that Victoria will consider amending the Health Practitioner Regulation National Law (Victoria) Act 2009 to become a co-regulatory jurisdiction for Part 8 (health, conduct and performance matters) of the National Law.*

Ms Mikakos moved, That Recommendation 11 page 134 in Chapter Six be omitted with a view of inserting the following recommendation in its place:

'That the Victorian Minister for Health wait for the completion of the three-year review of the National Scheme before considering opting out of Part 8 of the National Law and that the Minister call for this national review to commence as a matter of urgency.'

Question put.

The Committee divided.

**Ayes 3**

Mr Elasmr  
Ms Hartland  
Ms Mikakos

**Noes 4**

Ms Crozier  
Mr Elsbury  
Mrs Millar  
Mr O'Brien

Question negated.

*Recommendation 12*

*That the Victorian Department of Health examine the co-regulatory models of New South Wales and Queensland and consult with key stakeholders when reviewing a complaints process for the Victorian public which would ensure that:*

- *rights of notifiers to appeal judgements are enshrined in legislation;*
- *the Minister for Health has overall responsibility for the system;*
- *performance is monitored by Parliament; and*
- *time frames for dealing with complaints are set out in legislation.*

Ms Mikakos moved, That Recommendation 12 on page 134 in Chapter Six be omitted.

Question put.

The Committee divided.

**Ayes 3**

Mr Elasmarr  
Ms Hartland  
Ms Mikakos

**Noes 4**

Ms Crozier  
Mr Elsbury  
Mrs Millar  
Mr O'Brien

Question negatived

**Chapter 6: Health Practitioner Complaints Process**

Ms Crozier moved, That Chapter 6: Health Practitioner Complaints Process (including findings 6.1 to 6.8 and recommendations 8 to 12), as amended, stand part of the Report.

Question put.

The Committee divided.

**Ayes 4**

Ms Crozier  
Mr Elsbury  
Mrs Millar  
Mr O'Brien

**Noes 3**

Mr Elasmarr  
Ms Hartland  
Ms Mikakos

Question agreed to.



## **Report Adoption**

Ms Crozier moved, That the Report into the Performance of the Australian Health Practitioner Regulation Agency (as amended) be adopted as the Report of the Committee.

Question put.

The Committee divided.

### **Ayes 4**

Ms Crozier

Mr Elsbury

Mrs Millar

Mr O'Brien

### **Noes 3**

Mr Elasmr

Ms Hartland

Ms Mikakos

Question agreed to.



## Minority Report – Ms Mikakos and Mr Elasmar

### Background

Ensuring that Australian Health Practitioner Regulation Agency (AHPRA) is able to undertake its role effectively and that it protects members of the public, that is, patients, is critically important.

At the outset, it was clear to the Committee that this inquiry is to be followed by two further national inquiries.

The Intergovernmental Agreement for a National Registration and Accreditation Scheme for health professions requires the Australian Health Workforce Ministerial Council (AHWMC) to initiate an independent review of the scheme following three years of operation (from July 2013). The details of the review need to be announced without further delay.

In addition, the Productivity Commission is reviewing its 2005 report on issues impacting on the health workforce.

In light of these two imminent reviews (discussed in Chapter 2 of this Report) and the 2011 Senate Committee review (discussed in Chapter 3 of this Report), which had already documented initial implementation problems with the establishment of AHPRA, it was curious that the Legal and Social Issues Legislation Committee (the Committee) was given this inquiry in the first place.

That the Committee was tasked to review a national body was particularly curious in light of the current crisis in Victoria's health system at present. The emergency departments in our hospitals are unable to cope, the Government's broken election promise to deliver 800 additional beds, more than 10,000 additional patients are facing delays in receiving elective surgery and our ambulance system has many problems, including ramping of patients at hospitals. It is therefore curious to say the least that the Committee was not tasked to look at any of these issues facing our health system.

Every reference to the Committee initiated by non-government members has been rejected by the government which currently has a majority in the Legislative Council. To date there have been 24 references rejected.

We draw attention to this issue in the hope that the Committee can be able to undertake its proper role of scrutiny of Victorian government departments and agencies as set out in the Legislative Council's Standing Orders (SO 23.02(3)), which states that the Committee "will inquire into and report on any proposal, matter or thing concerned with community services, education, gaming, health, and law and justice". To date, references by non-government members to inquire into the Department of Health's Annual Report have been rejected, contrary to Standing Order 23.02(4).

### Chapters 1-5

We agree with the findings and recommendations contained in Chapters 1 to 5 of the Report. The thrust of those recommendations was to accept that a national registration and supervision of health practitioners and students should be retained. A national registration scheme is important to avoid health practitioners who have faced disciplinary sanction moving interstate to avoid detection.

The Committee found that there was scope for further streamlining of the accreditation authorities (finding 2.8 and recommendation 1 in Chapter 2).

The recommendations in Chapters 2 to 5 called on the forthcoming national review to address certain issues and current problems within the AHPRA framework, which we support.

### Chapter 6

We support the majority of the findings and recommendations contained in Chapter 6 of the Report which relates to the health practitioner complaints process. Where we have disagreed with findings and recommendations, these are outlined below.

#### *Time Delays*

Getting the complaints process correct is critical both from the perspective of ensuring patient safety but also public confidence in our health practitioners.

We are concerned at the lengthy time delays in the notification process as well as evidence of inadequate communication and information from AHPRA to notifiers (patients), health practitioners and health service providers.

As there are currently no statutory timeframes prescribed under the National Law for the completion of an investigation process, we support the Victorian Minister for Health recommending to the Australian Health Workforce Ministerial Council (AHWMC) that the National Law be amended to introduce statutory timeframes for the completion of an investigation.

In light of the imminent National review there is therefore an opportunity for all jurisdictions to consider this and our other recommendations.

#### **Recommendation:**

**That the Victorian Minister for Health recommends to the Australian Health Workforce Ministerial Council that the National Law be amended to introduce statutory timeframes for the completion of an investigation.**

*Notifiers' Right to Review*

We are also concerned that notifiers (patients) have limited ability to appeal or seek a review of a notification assessment decision.

We note that having such a right will not necessarily result in a 'win' for the notifier.

In fact, evidence to the Committee found that between 2005-2010, a significant proportion of the notification outcomes of State Boards were upheld. Similarly, in NSW in 2012-13, 93.2% of the original assessment decisions were confirmed.

Nevertheless, we support that the Victorian Minister for Health recommended to AHWMC that the National Law be amended to introduce a right of review of a notification assessment decision for notifiers.

**Finding:**

**That the following new Finding be inserted after Finding 6.6 on page 117 in Chapter Six:**

**The Committee received evidence that between 2005-2010 a significant proportion of the notification outcomes of Victorian State Boards were upheld. Similarly, in NSW in 2012-13, 93.2 per cent of the original assessment decisions were confirmed.**

**Recommendation:**

**That the Victorian Minister for Health recommends to the Australian Health Workforce Ministerial Council that the National Law be amended to introduce a right of review of a notification assessment decision for notifiers.**

*Office of the Health Services Commissioner*

The clearest source of confusion for the public is the respective role of AHPRA and the Office of Health Services Commissioner (OHSC).

The Committee received evidence as to the dual handling of complaints. In 2012, 32% of notifications to AHPRA were received through the OHSC. The overlap of responsibilities can lead to both delays and public confusion.

AHPRA's role should primarily be a professional standards body and that of OHSC, a complaints body.

We note that the Government is currently reviewing the Health Services (Conciliation and Review) Act 1987, which establishes the OHSC in Victoria. It is surprising that this Committee was not tasked with this review as part of its terms and reference given the similarity of the subject matter.

We recommend that the OHSC become the single entry point for all consumer complaints in Victoria. This could occur through the Victorian Minister for Health recommending to the AHWMC

that the National Law be amended if required and amending the Memorandum of Understanding between AHPRA and the OHSC.

**Recommendation:**

**That the Victorian Minister for Health recommends to the Australian Health Workforce Ministerial Council that the National Law be amended if required and that the Memorandum of Understanding between AHPRA and the Office of the Health Services Commissioner to facilitate the OHSC becoming the single entry point for all health consumer complaints in Victoria.**

*Co-regulatory Jurisdictions*

Chapter 6 of the Report discusses the co-regulatory jurisdictions of NSW and Queensland, who have opted out of Part 8 of the National Law. NSW opted out from the outset when the National Law commenced. We note that the Committee did not visit NSW nor take direct evidence relating to the operations of its complaints system, therefore we are not in a position to comment on its efficacy.

We note however that it is our understanding that in NSW complaints are referred to the Health Care Complaints Commission but that the relevant professional Council can also be referred complaints for the purpose of disciplining a health practitioner.

The Committee did take one day's evidence in Brisbane on the Health Ombudsman Act which passed the Queensland Parliament in August 2013.

We believe that the unique nature of well-publicised cases of medical malpractice on a significant scale was the impetus for Queensland's legislative changes. It is too early to tell what impact Queensland's new Health Ombudsman will have in receiving health complaints as it has not yet commenced operating.

We note however that the new Health Ombudsman will only investigate the most serious complaints and that other complaints will continue to be referred to AHPRA.

Conclusion

On balance, we believe that making the OHSC the single entry point for health complaints would not require Victoria becoming a co-regulatory jurisdiction for Part 8 of the National Law. We therefore disagree with recommendation 11 and recommendation 12 is consequently not required. Starting from "scratch" rather than improving what we already have would only lead to further delays and problems.

**Recommendation 11 be omitted and substituted with the following:**

**That the Victorian Minister for Health wait for the completion of the three-year review of the National Scheme before considering opting out of Part 8 of the National Law and that the Minister call for this national review to commence as a matter of urgency.**

**Recommendation 12 be deleted.**

We take this opportunity to thank all the individuals and organisations for their submissions and correspondence to the Committee. We also thank the Deputy Chair of the Committee, Mr Matt Viney, for his participation in this inquiry and note that he was unable to participate in the final deliberations on the Report due to illness.

**Jenny Mikakos MLC**

**Nazih Elasmr MLC**





## Minority Report – Ms Hartland

While I acknowledge the hard work of the Chair, Ms Georgia Crozier, for this Committee, I am very concerned about the political nature of this reference.

While we found serious flaws in the complaints mechanism, as was highlighted by Ms Jenny Morris in her evidence, I believe that these problems can be overcome by AHPRA. I do not believe there is a need to go back to a state based complaints mechanism.

My major concern about this referral is that the Victorian Health Minister knew that there would be a national Ministerial Council review conducted three years after the commencement of the National Scheme, however, the Minister failed to inform the House when he put forward this reference.

It was revealed by Mr Allan, Chair of the Agency Management Committee, during his testimony that this review would soon be taking place. I do not understand why it is that the Minister thought it was appropriate for this Victorian Parliamentary committee to take this reference when he knew a national review would be taking place.

My other concern is the treatment of the Legislative Council parliamentary committees. In this Parliament, the Government has rejected 40 referrals to these committees. Only 11 referrals have been passed. If the Government believes in transparency and accountability, it would allow the committees to do the work they were set up to do.

Colleen Hartland MP

Committee Member