Government senators' minority report

Introduction

1.1 Government senators have considered the majority report and disagree with its findings: the evidence taken during the inquiry does not support the position that Australian Health Practitioner Regulation Agency's (AHPRA) administration of health practitioner registration has been a 'debacle'. The Coalition senators on this committee make much of the transitional problems of implementing the national registration scheme for political purposes only. There was clear evidence to the committee, from a wide range of witnesses, that there is very strong support for the National Registration and Accreditation Scheme (NRAS). The NRAS will have a very positive effect on the delivery of health services for all Australians.

1.2 Government senators recognise the enormity of the task undertaken by the AHPRA to implement the NRAS. It is unsurprising that given the scale and complexity of the new system that some problems arose during the implementation stage. Not only was AHPRA establishing completely new processing systems, migrating data from a range of databases and establishing new offices, but also practitioners themselves were dealing with an unfamiliar registration system. In addition, some unforeseen transitional issues such as the delay of legislation in some jurisdictions, which held up the transfer of staff, and the poor quality of some data transferred from the state and territory registers added to the challenge of implementation.

1.3 The evidence received by the committee indicates that AHPRA moved quickly to address these deficiencies and has put in an enormous amount of work since the implementation of the scheme to improve outcomes for practitioners. AHPRA has improved its internal processes and worked with stakeholders, and continues to do so, to ensure that the issues experienced with the initial rollout of the scheme are resolved. The substantial progress made by AHPRA over a short period was recognised by many stakeholders in evidence to the committee.

1.4 Government senators note that there is overwhelming support from all sectors for this reform as the benefits of national registration are well recognised. The significant work that has been done since the implementation of the NRAS will ensure that the considerable benefits for health practitioner regulation and the Australian community will be attained. Government senators consider that the fundamentals of the scheme are sound and that AHPRA's systems are being progressively strengthened. This minority report will focus on the action taken to address the issues that have arisen during the transition process.

The scale of the reform is considerable

1.5 The scale and complexity of the task being undertaken by AHPRA to reform health practitioner regulation was acknowledged in evidence to the committee. The

National Law replaced 65 Acts of Parliament, the ten National Boards replaced over 82 state and territory registration boards and AHPRA replaced 37 organisations that supported the previous state and territory boards.[1]

1.6 The magnitude of the task was recognised in evidence with the Chairs of the ten National Health Profession Boards calling the reform 'extraordinary in its vision and scale'[2] and the Royal Australasian College of Physicians stating that the NRAS is a 'massive undertaking'.[3] AHPRA also described the reform as the 'most comprehensive and complex reform of health practitioner regulation ever undertaken in Australia' with implications for every part of the health system.[4]

1.7 Given the sheer scale of the reform many submitters recognised that there would be implementation problems. For example, the Royal Australasian College of Physicians stated that given the 'magnitude of AHPRA's responsibilities and the speed with which it has had to implement new procedures...it would be unreasonable to expect it to have been error free'.[5] The Australian Medical Council acknowledged that 'challenges associated with the implementation of new legislation often do not present until the legislation has been tested in its practical application'.[6]

1.8 Government senators agree that it would have been unreasonable to expect such a large undertaking to be without problems in its initial phase. However, Government senators consider that these problems will diminish as AHPRA institutes new processes and health practitioners become more familiar with the new scheme.

The reform process

1.9 Government senators note that the implementation of the NRAS has been a long-term process undertaken at the request of, and with support from, all jurisdictions. The Australian Health Workforce Ministerial Council (AHWMC) outlined the extensive work undertaken to ensure that the reform process met its aims and to ensure adequate consultation with the health professions affected.[7]

1.10 The impetus for the reform was the release of the Productivity Commission's 2005 report on issues affecting the health workforce and its recommendations to establish a single national registration board for health professionals as well as a single national accreditation board for health professional education and training. In July 2006, the Council of Australian Governments (COAG) agreed to establish a

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1 Chairs of the ten National Health Profession Boards, *Submission 27*, p. 1.

2 Chairs of the ten National Health Profession Boards, *Submission 27*, p. 1.

3 Royal Australasian College of Physicians, *Submission 22*, p. 2.

4 AHPRA, *Submission 26*, pp 3, 9.

5 RACP, *Submission 22*, p. 2.

6 Australian Medical Council Ltd, *Submission 13*, p. 1.

7 AHWMC, *Submission 70*, pp 4–5.

single national registration scheme and a national accreditation scheme. Final agreement by COAG on the structure of the scheme was not reached until March 2008.[8]

1.11 The decision to establish a single national scheme with a single national agency encompassing both the registration and accreditation functions was taken by the Australian Health Ministers' Conference (AHMC) in July 2007. From that time extensive consultations took place across and between all jurisdictions and with the 10 health professions. The National Registration and Accreditation Implementation Project (NRAIP) was established in May 2008. Government senators note that changes were made to the original proposal as a result of the work undertaken by NRAIP and in direct response to concerns raised by the professions.[9]

1.12 In 2008, the Queensland Parliament passed the first piece of legislation under an 'applied laws' model to establish the structure of the scheme, including the new agency itself, AHPRA; the Ministerial Council (AHWMC) to oversee AHPRA; and the National Boards. In June 2009, prior to parliamentary consideration of the second piece of legislation, the AHWMC authorised release of an exposure draft. Government senators noted that across all jurisdictions, consultation forums were held, including a national forum in Canberra, to enable practitioners and other interested parties to review the draft bill.[10]

1.13 A number of changes were made as a result of the consultation process, including in relation to accreditation functions; arrangements for smaller jurisdictions; the protection of public interest; the inclusion of partially regulated professions; transition for practitioners in occasional practice; and criminal history checks. The amended bill was then passed in the Queensland Parliament in August 2009 and became known as the 'National Law'.[11]

1.14 Government senators note that a target deadline of December 2009 was set for the passage of the National Law in each jurisdiction. However, only Queensland, Victoria and New South Wales met this date. AHPRA noted the consequences of this delay:

> The late timing of the passage of the legislation in some jurisdictions added significant uncertainty to planning for the transition to the National Scheme. Before 1 July 2010, there was limited access to the staff that would be implementing the new National Scheme, as most of them were still employed to administer the state and territory-based registration

8 AHWMC, *Submission 70*, pp 4–5.

9 AHWMC, *Submission 70*, p. 5.

10 AHWMC, *Submission 70*, p. 6.

11 AHWMC, *Submission 70*, p. 6.

> schemes and boards that needed to operate effectively until the National Scheme commenced.[12]

1.15 The remaining states and territories (except Western Australia, which later joined the scheme by passing its own corresponding or 'mirror' legislation)[13] adopted the National Law into their respective statutes, effective from 1 July 2010.[14]

1.16 Public consultation was also undertaken on the size and composition of the ten new National Boards, whose members were appointed in 2009 to enable preparatory work for the scheme's commencement on 1 July 2010. These new boards drew heavily from the existing state and territory boards to ensure the transition of expertise crucial to the new arrangements.[15]

1.17 Government senators wish to emphasise that the NRAS should not be characterised as a 'Commonwealth scheme'.[16] The National Law has been enacted in each state and territory. AHPRA is 'not a Commonwealth agency but a statutory body created by the National Law which operates in each state and territory'.[17]

Benefits of the NRAS

1.18 Government senators support the NRAS: its benefits are clear and will provide a major improvement for both practitioners and patients. For health practitioners, the old state and territory regulation systems provided limited consistency in registration across jurisdictions and while there was some mutual recognition, generally multiple registration was required if a practitioner wished to practise in more than one jurisdiction. AHPRA noted:

> Registration and practice across geographic boundaries is no longer a barrier. Health practitioners can register once and practise Australia-wide. National registration means better and more consistent data across Australia for workforce planning. There is collaboration between the ten National Boards about matters of common interest and profession-specific focus on other issues.[18]

1.19 Patients will also reap major benefits from the NRAS. Under the old system, health practitioners could move from one state to another to avoid scrutiny.[19] This will

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12 AHPRA, *Submission 26*, p. 5.

13 AHPRA, *Submission 26*, p. 5.

14 AHWMC, *Submission 70*, p. 6.

15 AHWMC, *Submission 70*, p. 6.

16 Mr Peter Allen, Chair, Agency Management Committee, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 15.

17 AHPRA, *Submission 26*, p 5.

18 AHPRA, *Submission 26*, p. 3.

19 AHPRA, *Submission 26*, p. 5.

no longer be possible. As AHPRA stated, the system has 'patient safety at its heart' with the framework provided by the *Health Practitioner Regulation National Law Act* (National Law) setting tougher standards designed for public protection.[20] In addition, the greater consistency under the scheme 'provides assurance to members of the public that all health practitioners are subject to the same high quality professional standards regardless of where the health service is accessed'.[21] For example, the scheme now requires a compulsory criminal history check, which is a new requirement in some jurisdictions.[22] Australians can now access a website showing the registration status of health practitioners within the scheme.[23] According to AHPRA, Australia's reform in this area has 'attracted a lot of international attention and, while many countries aspire to doing something similar, most recognise the difficulties of achieving it'.[24]

1.20 AHPRA summarised the benefits of the NRAS as follows:

- protecting the public by ensuring that only suitably trained and qualified practitioners are registered;
- facilitating workforce mobility across Australia;
- facilitating the provision of high-quality education and training of health practitioners;
- facilitating the rigorous and responsive assessment of overseas-trained health practitioners;
- enabling 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.[25]

1.21 The AHWMC concluded that the 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.[26]

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20 Mr Peter Allen, Chair, Agency Management Committee, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 15; AHWMC, *Submission 70*, p. 3.

21 AHWMC, *Submission 70*, p. 3.

22 Mr Martin Fletcher, Chief Executive Officer, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 16.

23 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 16.

24 Mr Allen, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 15.

25 AHPRA, *Submission 26*, pp 5–6.

26 AHWMC, *Submission 70*, p. 14.

1.22 The overwhelming majority of health profession organisations, including the Australian Medical Council (AMC), the Australian Nursing Federation and the Royal College of Nursing Australia, strongly acknowledged the benefits of national registration and accreditation in their submissions to the inquiry.[27] For example, the Australian Physiotherapy Association (APA) stated that:

> It was always going to be challenging to bring nine professions to a natural registration with more coming on board. The logistics of it are huge. I see that there were going to be problems with that. But the benefits of national registration in terms of portability of health workforce, in terms of portability of lecturers, teachers and advisers is great. The efficiencies of having a national registration outweigh these initial issues.[28]

1.23 The AMC commented that 'once the national systems have shaken down and have overcome their initial implementation problems, the Australian community will be significantly better served'.[29] Ms Melissa Locke, President of the APA, highlighted the greater workforce portability unlocked by these reforms:

> Someone who travels with an AFL team...previously had to be registered in every state to put their hands on those athletes they were caring for. A physio who lives in Albury who travelled to do a home visit in Wodonga needed to be registered in two states. For me, as well as being a leader in my area, as an example, a couple of years ago I examined in Victoria, I spoke in Western Australia and the Northern Territory and I practised in Queensland; I had to be registered in four states. With our ageing workforce and ageing population...You need that portability of workforce.[30]

1.24 In addition, the Consumers Health Forum of Australia strongly supported the introduction of the NRAS.[31]

Transitional issues

1.25 Government senators note that much evidence was provided about problems experienced by health practitioners during the start-up phase of the NRAS. These have

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27 See for example Australian Medical Council Ltd, *Submission 13*; Royal Australian College of Physicians, *Submission 22*; Royal College of Pathologists of Australasia, *Submission 24*; Ramsay Health Care Australia, *Submission 35*; Australian Dental Industry Association, *Submission 38*; Pharmaceutical Society of Australia, *Submission 41*; CRANAplus, *Submission 47*; Rural Workforce Agency Victoria, *Submission 50*; Australian Nursing Federation, *Submission 57*; Royal College of Nursing Australia, *Submission 62*. An exception is the Australian Doctors' Fund, *Submission 52*, p. 1.

28 Ms Melissa Locke, President, Australian Physiotherapy Association, *Proof Committee Hansard*, 5 May 2011, p. 6.

29 Australian Medical Council Ltd, *Submission 13*, p. 1.

30 Ms Melissa Locke, Australian Physiotherapy Association, *Proof Committee Hansard*, 5 May 2011, p. 6.

31 Consumers Health Forum of Australia, *Submission 5*, p. 1.

been acknowledged by AHPRA which stated that, since its formal establishment on 1 July 2010, there have been 'significant transitional challenges' and 'initial shortfalls in services to health practitioners'.[32] These challenges include the transition of staff, data migration and the associated issues for the registration and renewal processes, responding to individual registration inquiries and communication/education regarding the new system.

Transition of staff

1.26 It was envisaged that the vast majority of the state and territory staff would move to AHPRA bringing their knowledge and experience with them. Unfortunately the committee heard that the timing for AHPRA to commence operations meant that many of its staff were still working on the state and territory systems right up until the change-over. This left little time for staff to be trained in the new processes and to put in place standard operating procedures.

1.27 As noted earlier, this was largely due to the late passage of legislation by some jurisdictions which caused significant uncertainty about transitional arrangements for staff leading up to 1 July 2010. AHPRA explained:

> The old scheme finished on 30 June last year; the new scheme started on 1 July. The previous boards retained staff up until midnight on 30 June. The original plan was that we would have two or three months to train staff into the new requirements of the national law, but in fact there was virtually no opportunity to train staff, so we began on 1 July with the phones ringing and a responsibility to administer the national law.[33]

Data migration

1.28 In implementing the NRAS, AHPRA was required to bring together data from the existing state and territory registration boards. This was a massive undertaking with some of the data of variable quality. AHPRA described what it faced in the creation of national registers:

> ...the data migration process to create the national registers involved the translation of around 1.5 million data items from over 80 different sources into one national register, so it was a very complex undertaking. Let us be clear that the source data was variable. In some places it was very good and it is no doubt, for example, that in medicine I think we have inherited on the whole very good data, but in some of the smaller professions it was much more patchy. What we have done, though, is taken all the steps we can to make sure the data are as accurate and complete as they can be.[34]

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32 AHPRA, *Submission 26*, p. 3.

33 Mr Allen, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 15.

34 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 23.

1.29 These records were being migrated into the NRAS by staff who had been given little time to adjust to the scheme's new requirements. AHPRA commented:

> Records were inherited from the state and territory boards in a range of formats and in that context particular care was taken to ensure a safe transmission of the management of complaints from the state and territory boards into the national scheme, but we had new legislation and some quite significant new requirements in that legislation. We had a new computer system. We had some new staff. Although 80 per cent of the staff transitioned from previous state and territory boards, they were working with new systems. We were in new offices. In the new arrangements we lost some of the legacy attachments, particularly some of the personal contacts that were part of the old boards.[35]

Registration and renewals

1.30 The committee heard evidence about the problems experienced by health practitioners during the registration process. The problems are detailed extensively in the majority committee report and included practitioners not being given sufficient notice or guidance on the new registration processes, poor or inconsistent information provided by AHPRA staff about the registration process, documentation handling practices and a lack of timely response to enquiries.

1.31 Health practitioner organisations reported that, for some practitioners, there was a loss of income as practitioners were unable to work if they were not re-registered by AHPRA. For example, the Pharmaceutical Society of Australia stated:

> Many interns who were eligible to commence employment and therefore earn a living as a pharmacist were unable to do so as they experienced significant delays in their registration and their papers being processed and were left in the dark while waiting, as information from AHPRA was inaccurate, conflicting or not available. This also had a flow-on effect to other pharmacists who were unable to take leave as planned, on staff rosters et cetera. People had to reschedule their holiday leave, bring in locums and pay high fees to locum agencies to source them on short notice.[36]

1.32 The Australian Nursing Federation stated that while some of its members were 'not actually deregistered', it appeared as though they were because they had not been able to provide to AHPRA the evidence required to demonstrate that they were in fact registered.[37]

1.33 The Australian Dental Association (ADA) reported that dental professionals:

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35 Mr Allen, AHPRA, *Proof Committee Hansard*, 5 May 2011, pp 15–16.

36 Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia, *Proof Committee Hansard*, 4 May 2011, p. 9.

37 Ms Julianne Bryce, Senior Professional Officer, Australian Nursing Federation, *Proof Committee Hansard*, 4 May 2011, p. 22.

> ...found themselves unregistered through ignorance as to registration requirements (e.g. due to AHPRA's lack of communication on renewal dates or confirmation or processing the registration application submitted to AHPRA). This had the consequence that they were therefore unable to undertake procedures or prescribe treatment...As a consequence,
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> - Dentists' livelihoods were seriously impacted upon.
> - Patients found themselves unable to be treated by their dentist.[38]

Legal liability issues

1.34 A particular issue of concern for practitioners was around the consequences for practitioners whose registration had lapsed without their knowledge. In some instances, practitioners continued to practise, unaware that they had been deregistered, causing legal liability issues.

Responding to individual registration enquiries

1.35 The committee heard that AHPRA had anticipated a large number of queries and established a 1300 local call number, 11 websites (for AHPRA and each of the national boards) and an online form for questions. However, the volume of phone and email questions in the initial phase of the scheme exceeded the expected demand. AHPRA has acknowledged that 'in the first few months, too many people contacting AHPRA waited too long to speak with someone who could provide the answers they needed'.[39]

Communication and education issues

1.36 The lack of familiarity by practitioners with the new processes was raised with the committee. For example, the ADA identified one of AHPRA's shortcomings as 'the failure to create an educational program to inform practitioners as to what would be required of them in this new national registration process'.[40] In relation to complaints handling, the ADA also recommended that AHPRA provide 'faster and more reliable communications between AHPRA and practitioners' and/or establish 'practitioner bodies to ensure inquiries are dealt with in a timely manner'.[41]

Work undertaken to address transitional issues

1.37 Government senators acknowledge that there have been a number of transitional issues which unfortunately have negatively affected practitioners' experience of the new system. However, Government senators comprehensively reject the AMA's view that the management of the transition has been a 'debacle'.[42] Indeed,

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38 Australian Dental Association, *Submission 34*, p. 3.

39 AHPRA, *Submission 26*, pp 21–22.

40 ADA, *Submission 34*, p. 2.

41 ADA, *Submission 34*, p. 7.

42 AMA, *Submission 23*, p. 9.

Government senators note the comments of the ten Chairs of the National Boards who considered that already 'AHPRA has achieved extraordinary outcomes given the size and complexity of the reform initiative'.[43] Catholic Health Australia also provided this assessment:

> ...it has clearly been an effort of enormous proportions that has allowed the agency to be up and running, and when considering the large numbers of registrations processed, on the whole, the implementation, it could be argued has probably been successful.[44]

1.38 In addition, the committee received evidence that not all jurisdictions were as adversely affected as others with Western Australia and South Australia reporting no major issues regarding registration renewals processes.

1.39 However, given the nature of the experience of many health professionals, AHPRA has actively sought to overcome the deficiencies in its processes. The enormous effort that AHPRA has made in this regard was acknowledged by many organisations in evidence.[45] For example, both the Australian Physiotherapy Association and Ramsay Health Care Australia commented on the improvement since February this year.[46] The APA characterised AHPRA's initial performance as simply 'teething problems' and reported that the agency quickly responded to practitioners' concerns.[47]

1.40 Associate Professor Julian Rait, MDA National Insurance, also stated that 'there are actually some positive signs that the organisation is rapidly recovering from its mis-steps and will be on a more secure path going forward'.[48] Out of MDA National's 22,000 members, Associate Professor Rait confirmed that there were five members who were affected by the situation under inquiry, and that currently there was only one pending problem with a member's registration which was in the process of negotiation.[49]

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43 Chairs of the ten National Health Profession Boards, *Submission 27*, p. 1.

44 Catholic Health Australia, *Submission 44*, p. 2.

45 See for example, Chiropractors' Association of Australia, *Submission 29*; Australian Dental Association, *Submission 34*; Optometrists Association Australia, *Submission 37*; Forum of Australian Health Professions Councils, *Submission 42*; Catholic Health Australia, *Submission 44*; Australian College of Rural and Remote Medicine, *Submission 59*.

46 Ramsay Health Care Australia, *Proof Committee Hansard*, 4 May 2011, p. 50; Ms Locke, APA, *Proof Committee Hansard*, 5 May 2011, p. 4.

47 Senator Mark Bishop and Ms Locke, APA, *Proof Committee Hansard*, 5 May 2011, p. 5.

48 Associate Professor Julian Rait, MDA National Insurance, *Proof Committee Hansard*, 5 May 2011, p. 13.

49 Associate Professor Rait, MDA National Insurance, *Proof Committee Hansard*, 5 May 2011, p. 11.

1.41 He also affirmed his confidence in AHPRA's effectiveness in addressing the initial problems, adding that the new system was indeed a marked improvement on the old arrangements:

> ...we have been impressed that, despite unreasonable delays in processing the registration of some doctors, AHPRA's complaints handling process appears to be working well at this point, and MDA National sees that this has been in many ways superior to that which existed with the previous state boards. We are comforted that—certainly since the first few months of this year—processes seem to have improved.[50]

1.42 The Chairs of the ten National Boards have strongly expressed their full confidence in AHPRA:

> The Chairs believe is it critical to see these transition issues in the context of the wider importance of the reform as a whole and as part of the early phases of a major change process. Chairs are already encouraged by the considerable signs of improvement...AHPRA has the full confidence of the Chairs of the National Boards in administering health practitioner registration and achieving the strategic priorities of the National Scheme.[51]

1.43 The measures undertaken by AHPRA are detailed below.

Transition of staff

1.44 AHPRA informed the committee that staff training has intensified to ensure staff are well-versed in the new procedures and systems. In particular, ensuring national consistency in processes is a priority given the transition of state and territory staff who were used to different systems. AHPRA explained the challenge:

> ...we have staff who have come from very different backgrounds, very different legislation that they have worked with and different customs and practices, so a major ongoing challenge for us is to embed national consistency within the requirements of the new national law, new systems and new registration standards. To give you a couple of examples of our work in this area, we have developed standard operating procedures in all of the key areas around both management of registrations and notifications... We have invested substantially in a program of work that we call 'business improvement' led by a national director which is focusing on issues such as making sure our IT systems do what they need to do to support the work... A final example is work that we have been doing with our directors of registration, which we have in each of our state offices, and our directors notification around things like standard templates, standard letters, forms

50 Associate Professor Rait, MDA National Insurance, *Proof Committee Hansard,* 5 May 2011, p. 8.

51 Chairs of the ten National Health Profession Boards, *Submission 27*, p. 2.

> and the like, all of which are important parts of consistency, and of course we work very closely with national boards in how we do that.[52]

1.45 The need to ensure that staff are adequately trained was shown through the experience in Western Australia where there were fewer problems with the new system. AHPRA attributed this to a number of factors including additional time for staff training:

> WA's later entry into NRAS resulted in additional time for training of staff. Later entry also meant that some of AHPRA's systemic problems were already addressed. Transition of nearly 100 per cent of the previous state board staff ensured a skilled and experienced workforce and vital maintenance of corporate knowledge.[53]

Data migration

1.46 The problems with the data migration from the 42 separate databases located in state and territory registration boards inherited by AHPRA were immense. AHPRA has worked diligently to create a uniform and accurate data system and stated that:

> More than 500,000 data records were cleansed, processed and migrated as active practitioner records into the AHPRA database. Despite these efforts to establish accurate and complete records for each registered practitioner and each profession, there were a range of issues with the accuracy and completeness of the inherited data which became apparent as AHPRA renewed the registration of practitioners. AHPRA has undertaken significant work on data quality, including a data audit and continues to ask practitioners to update their information to ensure the integrity of the data AHPRA holds.[54]

1.47 AHPRA also indicated that at a conservative estimate, more than 60 per cent of registration applications are incomplete.[55] In response, AHPRA is also ensuring that the forms it provides are 'as accessible and clear as possible'. Properly completed forms ensure that there are no unnecessary delays in processing times and decisions.

Responding to individual registration enquiries

1.48 AHPRA provided evidence to the committee outlining the improvements it has made to streamline the registration and renewal process:

> In the early days of the scheme people were having the experience of having to wait too long to get the answers to the questions that they needed at a time when they had a lot of questions about the move to the national scheme, so we have completely re-engineered our approach to how we deal

52 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 18.

53 AHPRA, *Submission 26*, p. 10.

54 AHPRA, *Submission 26*, p. 14.

55 AHPRA, *Submission 26*, pp 14–15.

> with phone calls and emails. We now have customer service teams in each of our state offices and we have an office in every capital city in Australia. We have added more resources to those teams so that we can comfortably deal with 3,000 calls per day across Australia and we have put back-up arrangements in place if we get more than that.[56]

1.49 The committee heard about the substantial improvement in the wait time for phone calls to be answered. From reports of waits of up to an hour, the average phone call waiting time is now four minutes, with 92 per cent of call enquiries being finalised in one call with no call back required. However, in response to questions about whether this was still too long a waiting period, Mr Martin Fletcher, CEO, AHPRA stated:

> I think what we are continuing to do is to look at how we can improve that. As you say, they are average figures so in some state offices it is a pick-up within one minute.[57]

1.50 AHPRA assured the committee that it was looking to emulate industry best practice in terms of call wait times:

> For example, we can direct more calls to a state office that might have more capacity or we can turn on the overflow capacity if we get above a certain number of calls in a day beyond what our staffing is set up to handle in our state offices.[58]

Improvement of registration process

1.51 In response to significant concerns about the registration process, AHPRA commented that its original objectives have always been to streamline registration processes through the use of online renewal systems. AHPRA told the committee that it was 'embedding robust systems which are getting stronger all the time'. For example, in relation to renewal certificates:

> The issue of renewal certificates is another one that has been raised. We have issued 470,000 renewal certificates since the commencement of the scheme...In the early days of the scheme there was no doubt that it was taking eight to 12 weeks, on average, to get those certificates out. We have now reduced that to a four to six week cycle...[59]

1.52 AHPRA also reported that it had improved its procedures and performance in relation to registration renewals, particularly lapsed renewals:

> In the early months of the scheme what was happening was that once the registration has lapsed we were preparing the data to go to Medicare and we

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56 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 17.

57 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, pp 26–27.

58 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 27.

59 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 17.

> were also preparing the letters to go to practitioners, and Medicare would then contact those practitioners. In some cases they have said...that they did not get a letter from us or the letter may have some after the Medicare notification. One of the things we did was set up a hotline so if Medicare contacted them and they say they had not heard from AHPRA, they had a dedicated hotline that they could ring. As I said earlier, we have also got the fast track that they are able to get back onto the register. Just to say that what we are doing now, is aiming to get that notification out to practitioners 10 days before the end of the late period so that there is time for them to take steps to renew their registration prior to it lapsing if that is what they want to do.[60]

1.53 AHPRA also noted that it established a fast track application process for registrants who miss the renewal deadline, to streamline their re-registration, with no late application fees in the first year. In addition, statutory declarations from practitioners are now being accepted by AHPRA to fast track the re-registration process:

> ...we have identified the practitioners who lapsed in December and January where there were particular issues, who subsequently reapplied to be registered through our fast-track process. We have written individually to every single one of them and said that if they believe that there was a failing on our part that meant that they did not renew, they need to just complete a statutory declaration—they can provide supporting information; they do not have to but they can—and we will accept that statutory declaration. So I think we have tried to make it as streamlined as we can but with appropriate accountability and, as I say, of the 1,935 practitioners we wrote to in that circumstances, around 500 have availed themselves of that opportunity. We gave them a month, which we thought was reasonable, and so I think we have done what we can to recognise, as you say, some of these one-off issues.[61]

Addressing liability issues

1.54 AHPRA is also closely monitoring the legal liability and risk exposure issues given the penalties under the National Law for practitioners who inadvertently fail to renew their registration. The agency has established a 'special administrative procedure to address any one-off transition issues' involving statutory declarations. Noting that AHPRA is not responsible for the insurance coverage maintained by practitioners, the agency has sought to mitigate these risks through improved communication practices.[62]

60 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, pp 28–29.

61 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 30.

62 AHPRA, *Submission 26*, p. 20.

1.55 The committee also received evidence from Associate Professor Rait, MDA National Insurance, in relation to indemnity for practitioners whose registration had lapsed through no fault of the practitioner. Associate Professor Rait stated:

> Clearly if registration has lapsed through no fault of the practitioner and an incident arises, we would otherwise have been liable anyway and our reinsurers agree that that lapse is not due to any fault of the practitioner, nor should they be held accountable for that. As a result, we are quite happy that through our negotiations with our reinsurers we can indemnify all members who have so been exposed.[63]

1.56 The AMA also stated that:

> The AMA understands that medical indemnity insurers will cover their members for periods where they were not registered and for which AHPRA has backdated registration. However the legal implications for individuals will not be known unless a claim is made and the matter is brought before the courts.[64]

Communication and education issues

1.57 Government senators note that AHPRA is implementing measures to improve communication and education for practitioners regarding the new system. For example, AHPRA reported that:

> Our theme has been to renew on time, online. We are using a variety of emails, letters, working with employers and professional associations to raise awareness and understanding. I just looked at the 210,000 practitioners who are due to renew their registration by the end of May, as one example. We have email contact details for 160,000 of those practitioners. We have now sent three email reminders, which totals 350,000 emails to those practitioners. In addition, we have sent 169,000 letters where people have either not responded to the email or did not have their contact details with us, and as of yesterday more than 57,000 of those registrants have already renewed, which represents 27 per cent of those registrants, so that is a substantially ramped up approach to making sure that people understand their obligations to renew on time and have timely communication around that.[65]

1.58 AHPRA's decision to create a Practitioner Consultative (User) Group to enhance communication channels between the agency and professions was commended by the ADA. The ADA also commented that the efforts by AHPRA's CEO overall were 'greatly appreciated.'[66]

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63 Associate Professor Rait, MDA National Insurance, *Proof Committee Hansard,* 5 May 2011, p. 10.

64 Australian Medical Association, *Submission 23*, p. 6.

65 Mr Fletcher, AHPRA, *Proof Committee Hansard,* 5 May 2011, p. 17.

66 ADA, *Submission 34*, p. 6.

1.59 AHPRA also indicated that it had been working closely with the National Boards and professional associations to ensure that:

> ...its systems operate effectively, that information is clear and accessible and that work continues to help all health practitioners understand and meet their new responsibilities under the National Scheme. One example of this is the *AHPRA Report* which is a new monthly e-bulletin to interested stakeholders providing information on the implementation of the National Scheme.[67]

1.60 Government senators also wish to emphasise that the NRAS is not only a government responsibility but a profession-led scheme. The Department of Health and Ageing stated that, ultimately, AHPRA's success in administering the scheme also depends upon mutual cooperation from practitioners themselves in renewal of registration, as was the case under the previous state and territory schemes.[68]

Additional government support has been provided

1.61 The Commonwealth Department of Health and Ageing (DoHA) informed the committee that the AHWMC has agreed to have an increased monitoring role over AHPRA and more stringent reporting requirements. It has also appointed the CEO of the Victorian Department of Health to work with AHPRA to resolve problems.[69]

1.62 Mr Martin Fletcher, the CEO of AHPRA, told the committee that both he and Mr Peter Allen, Chair of the Agency Management Committee, attended the last AHWMC meeting to brief ministers on implementation:

> One of the outcomes of that was that we agreed that we would meet regularly with Minister Haynes as the chair of the ministerial council to brief him on progress and that was also when governments indicated, as was reflected in the communiqué, their offer of where there may be additional support they could provide around some of the start-up issues. We meet regularly individually with ministers to talk about the implementation of the scheme in each jurisdiction. There have been a small number of circumstances where individual ministers have written to us or contacted us about individual registrant matters and in that case we followed those up.[70]

1.63 The DoHA indicated that it had offered three assistance measures to AHPRA:

> The first is that the chief nurse, Rosemary Bryant, is available to AHPRA and has had discussions with AHPRA in terms of her network with nurses

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67 AHPRA, *Submission 26*, p. 14.

68 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, *Proof Committee Hansard*, 5 May 2011, p. 24.

69 Ms Flanagan, Department of Health and Ageing, *Proof Committee Hansard*, 5 May 2011, p. 20.

70 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 30.

> generally across Australia, because they are the majority group that need to reregister, be accredited and so on.
>
> The second is that Medicare has offered, free of charge, to pick up call centre overflows, but I understand that offer has not yet been taken up because AHPRA has put in place management arrangements to look at managing call flows as that was one of the concerns that people had in terms of contacting.
>
> The third thing that we are discussing with AHPRA is around the integrity of their IT systems. They appear to be working very well, but it was just whether there was any expert assistance that we could offer to ensure that the systems which underpin the whole process are working well and whether there was anything we could do in that area.[71]

Addressing the issue of Medicare rebates

1.64 Ms Kerry Flanagan, Acting Deputy Secretary, DoHA, also outlined to the committee that the AHWMC had been exploring ex gratia payments to those patients who have had their Medicare rebates refused due to their practitioners not being properly registered. However, Ms Flanagan advised that Medicare Australia would be applying a retrospective solution:

> ...we have found a way of redressing that which does not involve act-of-grace or ex gratia payments. What that involves is, in effect, that Medicare benefits are paid on whether people are registered or not. If they are not registered then we cannot [normally] pay Medicare benefits. A process has now been put in place—and I would need AHPRA to give the right term—and in effect the consequence of it is that there is no lapse in registration, which means that Medicare can then pay benefits.[72]

1.65 Mr Fletcher explained that the Medicare entitlements would also be reimbursed on the basis of statutory declarations provided by affected health practitioners:

> ...where it is clear that there is a problem with our systems we have put a process in place to allow a practitioner to advise us of that and on the basis of a statutory declaration we will then start their new registration immediately after the date of their registration expiry. That has the effect, as we are advised, of creating continuity for the purposes of their entitlement around MBS. That is how we have sought to discharge our responsibility where it is clear on the basis of a statutory declaration that there has been some one-off—because I think there are one-off issues around the transition—shortfall in terms of, as I say, for example, the data that we have had in our systems that may mean that the renewal notice did not, in fact, get to that practitioner.[73]

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71 Ms Flanagan, DoHA, *Proof Committee Hansard*, 5 May 2011, pp. 20–21.

72 Ms Flanagan, DoHA, *Proof Committee Hansard*, 5 May 2011, p. 21.

73 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 23.

1.66 AHPRA does not consider there has been 'maladministration' of the registration process and has continued to work closely with Medicare Australia.[74]

1.67 Government senators were reassured to hear from the Consumers Health Forum of Australia that it had received 'no reports of consumers experiencing any detriment from AHPRA's administration and processes', nor any reports of access issues to Medicare benefits or private health insurance rebates.[75]

Government senators' view

1.68 Government senators are fully supportive of the NRAS, as were the vast majority of submitters to the inquiry. The task undertaken by AHPRA was complex and unprecedented in the health sector. Government senators consider that it was almost inevitable that there would be teething problems. While there should have been better planning of the transition period, a great many of the issues could not have been anticipated. However, these problems were quickly identified and addressed by AHPRA and there is evidence of a rapid improvement of processing and other activities in the short to medium term. Many submitters now appear to be more than satisfied that AHPRA has been responsive to complaints.

1.69 AHPRA has acknowledged that the feedback from its stakeholders gathered through this inquiry process has been 'very valuable'.[76] Government senators wish to ensure that the issues raised in submissions are being adequately addressed.

Recommendation 1

1.70 Government senators recommend that the Australian Health Practitioner Regulation Agency note the issues raised in evidence to the inquiry regarding the registration and renewal processes and ensure that they are addressed in a timely manner.

1.71 Government senators consider that regular feedback to the Australian Health Workforce Ministerial Council and other key stakeholders on issues raised with the registration processes and the measures being put in place to address them should take place for the next 12 months as the system manages the next cycle of registrations.

Recommendation 2

1.72 Government senators recommend that the Australian Health Practitioner Regulation Agency provide regular detailed reports (at least every three months) to all relevant bodies including the Australian Health Workforce Ministerial Council, the National Boards, and Commonwealth and state and territory health

74 AHPRA, *Submission 26*, p. 21.

75 Consumers Health Forum of Australia, *Submission 5*, p. 1.

76 Mr Fletcher, AHPRA, *Proof Committee Hansard*, 5 May 2011, p. 16.

officers on the issues raised with the registration process and the measures put in place to address them.

1.73 Government senators also consider that a broad range of performance measures should be included in the Australian Health Practitioner Regulation Agency Annual Report to allow measurement of improvements in the registration and renewal process. These could include the number of complaints received, time taken to address them, time taken to answer phones, average time to answer queries by email.

Recommendation 3

1.74 Government senators recommend that Australian Health Practitioner Regulation Agency's Annual Report include Key Performance Indictators regarding the registration and renewal processes.

Other issues

Mandatory notification

1.75 Another issue raised by the inquiry was mandatory notification provisions in the National Law. A registered health practitioner is required to notify AHPRA of conduct by another practitioner after forming a reasonable belief that such conduct is 'notifiable'. Notifiable conduct includes practising while intoxicated by alcohol or drugs; and placing the public at risk of substantial harm because the practitioner has an impairment or the practitioner has practised in a way that constitutes a significant departure from accepted professional standards.

1.76 The effects of this provision were raised by both individual submitters and health practitioner organisations. Dr Mukesh Haikerwal AO highlighted the potential problems arising from such provisions:

> Sexual misconduct, intoxication by alcohol or drugs or mental or physical impairment are clearly defined by the Act as constituting notifiable conduct and leave little scope for interpretation. However notifiable conduct may also arise from conduct that constitutes a "significant departure from accepted professional standards". Combined with the subjective test intrinsic to the notion of "reasonable belief", the threshold for the requirement of triggering notification is low. It follows that the mandatory notification process is potentially open to abuse by claims made in bad faith with the intention of adversely affecting the registration status and the subsequent employability of a health practitioner.[77]

1.77 He noted that overseas trained practitioners were particularly vulnerable to such claims, leaving them 'potentially exposed to employers holding their visa status against them as leverage; it is trite to say that such experiences may leave the overseas trained practitioner professionally and psychologically devastated and their livelihood

77 Dr Mukesh Haikerwal AO, *Submission 69*, pp 1–2.

jeopardised'.[78] Dr Haikerwal argued that the Act 'does not offer any definition of reasonable belief or significant departure from accepted standards of professional conduct'.[79] He also stated that there are penalties for an employer not reporting an instance of notifiable conduct. Experience with one case, where the practitioner was exonerated by AHPRA, showed that 'there is no recognition [by the agency] that this was a most distressing situation that needed to be handled with care and sensitivity'.[80]

1.78 Other submitters pointed to the adverse outcomes as a consequence of the mandatory reporting requirements. The Royal Australian College of General Practitioners (RACGP) for example, commented that the provisions are likely to have the opposite effect as health practitioners are more likely to conceal their health problems. Associate Professor Rait, MDA National Insurance, emphasised that the implications for the therapeutic relationship under the mandatory obligations are clearly very serious. He pointed to a case where a practitioner under psychiatric care was reported to AHPRA to be 'at risk' by the treating practitioner. It was believed that as a consequence of this, the practitioner took his own life.[81]

1.79 In addition, the Australian Psychological Society commented on the lack of transparency of AHPRA's mandatory reporting and complaints handling processes. The Society also pointed to the lack of separation between investigation and judgment of individual cases.[82] The RACGP recommended that the National Law be amended to exempt the health professional's treating doctor from mandatory reporting.[83]

Government senators' view

1.80 Government senators consider that mandatory reporting requirements should strike a balance between patient safety and the ability for practitioners to seek appropriate therapeutic and medical assistance. Practitioners who are doing the right thing, and taking steps to address their own health issues, should be supported and not unduly penalised, either financially or professionally, for seeking assistance when they are ill or depressed. Additionally, Government senators are concerned that there are no penalties in the current legislation for vexatious notifications about practitioners. Government senators were also concerned to learn about the adverse outcomes of mandatory reporting detailed in the cases provided in evidence.

1.81 Government senators consider that the effects of the mandatory reporting provisions require close monitoring to ensure that there are no unintended adverse

78 Dr Haikerwal, *Submission 69*, p. 2.

79 Dr Haikerwal, *Submission 69*, p. 3.

80 Dr Haikerwal, *Submission 69*, p. 5.

81 Associate Professor Rait, MDA National Insurance, *Proof Committee Hansard*, 5 May 2011, p. 12. See also Royal Australian College of General Practitioners, *Submission 46*.

82 APS, *Submission 10*, p. 2.

83 RACGP, *Submission 46*, p. 5.

outcomes and that if this is the case, urgent consideration should be given to amend the provisions.

Recommendation 4

1.82 Government senators recommend that:

- **the operation of mandatory reporting requirements be closely monitored by AHPRA;**
- **AHPRA report to the AHWMC on the operation of the provision by August 2011; and**
- **the AHWMC consider the report with a view to determining whether an amendment to the National Law to revise mandatory reporting provisions is required so that the provisions do not impact adversely on health practitioners seeking assistance for health problems nor allow vexatious notifications.**

Conclusion

1.83 Government senators acknowledge the frustration experienced by some practitioners during the transition to the new national system. It is regrettable that these transitional issues have negatively affected people's experience of a new system. However, Government senators consider that enormous benefits will be provided to practitioners and the public by the NRAS.

1.84 Government senators were assured that the issues raised with the committee have been recognised by AHPRA and measures have been put in place to address them. Government senators are further reassured that these issues are transitional rather than systemic and that this will become evident as registration and renewal continue. Witnesses expressed confidence in AHPRA's response and the actions undertaken to date to address issues with the registration process and systems. It is clear that there has been rapid improvement in the response to complaints in the short to medium term.

1.85 Government senators are confident that as staff of AHPRA and health practitioners become more familiar with the new system, the benefits of the national system will be realised.

Senator Helen Polley
Deputy Chair

Senator the Hon John Faulkner

Senator Mark Bishop