The Senate

Finance and Public Administration References Committee

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

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ABBREVIATIONS

ACMHN	Australian College of Mental Health Nurses
ACNP	Australian College of Nurse Practitioners
ACT	Australian Capital Territory
ADA	Australian Dental Association
ADF	Australian Doctors' Fund
ADTOA	Australian Doctors Trained Overseas Association
AHMAC	Australian Health Ministers Advisory Council
AHWMC	Australian Health Workforce Ministerial Council
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
AMC	Australian Medical Council
ANF	Australian Nursing Federation
APA	Australian Physiotherapy Association
APS	Australian Psychological Society
ASIM	Australian Society of Independent Midwives
AWRGNP	Albury Wodonga Regional GP Network
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CPD	Continuing Professional Development
DOHA	Department of Health and Ageing
DVA	Department of Veterans Affairs
EN	Enrolled Nurse
FAQs	Frequently Asked Questions
GP	General Practitioner
ICT	Information and Communication Technology
ID	Identification
IGA	COAG Intergovernmental Agreement
IMG	International Medical Graduate
IT	Information Technology
MABEL	Medicine in Australia: Balancing Employment and Life
MBA	Medical Board of Australia
MMDS	Melbourne Medical Deputising Service

NHPOPC	National Health Practitioner Ombudsman and Privacy Commissioner
NMBA	Nursing and Midwifery Board of Australia
NP	Nurse Practitioner
NRAIP	National Registration and Accreditation Implementation Project
NRAS	National Registration and Accreditation Scheme
NSW	New South Wales
OTD	Overseas Trained Doctors
PBA	Psychologist Board of Australia
PESCI	Pre-employment structured clinical interviews
PHI	Private Health Insurance
PRG	Professions Reference Group
PSA	Pharmaceutical Society of Australia
QA	Quality Assurance
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RANZCR	Royal Australian and New Zealand College of Radiologists
RDN	Rural Doctors Network
RWA	Rural Workforce Agency
RWAV	Rural Workforce Agency Victoria
SA	South Australia
SCI	Structured Clinical Interview
Stat Dec	Statutory Declaration
UK	United Kingdom
US	United States
WA	Western Australia

RECOMMENDATIONS

Recommendation 1

6.11 The committee recommends that AHPRA should issue a letter of apology to practitioners who were deregistered because of the problems revealed by the inquiry and, where it is established a lapse or delay in registration took place, AHPRA should reimburse practitioners for any loss of direct Medicare payments.

Recommendation 2

6.12 The committee recommends that AHPRA should rectify any situation where a practitioner is left liable due to their professional indemnity insurance lapsing, or being voided, during a period where they were deregistered by AHPRA's administrative failings.

Recommendation 3

6.17 The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to undertake a regular review of the registration of overseas trained health practitioners.

Recommendation 4

6.18 The committee recommends that AHPRA establish Key Performance Indicators in relation to the registration of overseas trained health practitioners and provide detailed information on this matter in its annual report.

Recommendation 5

6.20 The committee recommends that complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners.

Recommendation 6

6.22 The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to identify and establish mechanisms to improve the accountability of AHPRA to the parliaments of all jurisdictions and the Australian public.

Recommendation 7

6.24 The committee recommends that AHPRA, as a matter of urgency, establish consultative groups with professional organisations and health providers.

Recommendation 8

6.26 The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to amend the National Law to provide AHPRA with a discretion to grant a grace period where a health practitioner faces deregistration as a result of administrative error by AHPRA.

Recommendation 9

6.28 The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to amend the National Law to provide further practicing classifications for practitioners in academic institutions and for those who practise in a limited manner.

Recommendation 10

6.30 The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to implement a review of the mandatory notifications requirements and in particular take into account the Western Australia model of mandatory reporting.

Chapter 1

Introduction

Terms of reference

1.1 On 23 March, the Senate referred to the Finance and Public Administration References Committee for inquiry and report by 13 May 2011:

> The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA) and related matters, including but not limited to:
>
> (a) capacity and ability of AHPRA to implement and administer the national registration of health practitioners;
>
> (b) performance of AHPRA in administering the registration of health practitioners;
>
> (c) impact of AHPRA processes and administration on health practitioners, patients, hospitals and service providers;
>
> (d) implications of any maladministration of the registration process for Medicare benefits and private health insurance claims;
>
> (e) legal liability and risk for health practitioners, hospitals and service providers resulting from any implications of the revised registration process;
>
> (f) liability for financial and economic loss incurred by health practitioners, patients and service providers resulting from any implications of the revised registration process;
>
> (g) response times to individual registration enquiries;
>
> (h) AHPRA's complaints handling processes;
>
> (i) budget and financial viability of AHPRA; and
>
> (j) any other related matters.

1.2 The reporting date of the report was subsequently extended to 3 June 2011.

Conduct of the inquiry

1.3 The inquiry was advertised in the *Australian*, and through the Internet. The committee invited submissions from the Commonwealth and State and Territory Governments and interested organisations.

1.4 The committee received 232 public submissions and 52 confidential submissions. The committee also received 394 form letters in relation to the registration of homebirth midwives. A list of individuals and organisations that made

public submissions to the inquiry together with other information authorised for publication by the committee is at appendix 1. The committee held two days of public hearings in Canberra on 4 May and 5 May 2011. Appendix 2 lists the names and organisation of those who appeared. Submissions, additional information and the Hansard transcript of evidence may be accessed through the committee's website at www.aph.gov.au/senate/committee/fapa_ctte/index.htm

1.5 Many of the submissions from individuals contained details of particular cases in relation to health practitioner registration. The committee noted the circumstances of these cases and used them to build a picture of the problems facing health practitioners in relation to their dealings with AHPRA. However, the committee is unable to recommend remedies for any particular person.

Attendance of Commonwealth officials at the hearing

1.6 The Department of Health and Ageing (the department) did not provide a written submission to the inquiry. The committee therefore invited representatives of the department to appear before the committee. The department declined the invitation and in doing so stated that:

> The Department took the decision to decline the invitation on the basis that the National Registration and Accreditation Scheme (NRAS) is a national scheme, not a Commonwealth scheme, and is legislatively based in the Parliaments of the states and territories. The Australian Health Workforce Ministerial Council (AHWMC) took a decision to make a written submission to the Inquiry. It would be inappropriate for the Department to appear as a representative of the governments of all jurisdictions and it could not properly represent their views.[1]

1.7 In replying to the department's response to its invitation, the committee acknowledged that NRAS is a national scheme, but it is one in which the Commonwealth has an interest. The committee noted that it was not seeking representation on behalf of other jurisdictions. Rather, it is seeking evidence on matters within the terms of reference that go to Commonwealth areas of interest. These matters included the impact on the health workforce in Australia, the delivery of health services and Medicare issues. In addition, the terms of reference include 'any other related matters' and it is for the committee to determine what falls within this term of reference. The committee therefore did not accept that all matters related to the terms of reference fell outside the Commonwealth's responsibility and again invited representatives of the department to appear.

1 Letter to from Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, dated 4 May 2011.

1.8 The department agreed to appear and give evidence on 5 May on the basis that it would only provide evidence on the matters that fall within the responsibility of the Commonwealth Government.[2]

1.9 Initially, Medicare Australia also declined the committee's invitation to provide evidence. However, following a further invitation from the committee, officials made themselves available for the hearing on 5 May.

1.10 The committee acknowledges that it is not appropriate that a Commonwealth official should give evidence on behalf of the states or territories. However, the matters raised in the terms of reference for this inquiry went to areas where the committee considered that the Commonwealth had a direct interest. As such, the committee considered that Commonwealth officials, as representatives of the Commonwealth Government, were in the best position to assist the committee. The committee considers that the department's initial approach was less than helpful. The committee is also disappointed that the Chair of the committee was required to write to the department while hearings were taking place, in order to ensure that the committee received all the evidence required to undertake its deliberations on the matters before it.

Acknowledgment

1.11 The committee thanks those organisations and individuals who made submissions and gave evidence at the public hearings.

2 Letter from Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, dated 4 May 2011.

Chapter 2

Background

Introduction

2.1 This chapter provides an overview of the National Registration and Accreditation Scheme (NRAS) and the operation of the Australian Health Practitioner Regulation Agency (AHPRA).

The National Registration and Accreditation Scheme (NRAS)[1]

2.2 In 2006, the Productivity Commission reported on its examination of issues impacting on the health workforce and solutions to ensure the continued delivery of quality healthcare over the next decade. The Commission recommended the establishment of a single national registration and accreditation scheme to enable the Australian health workforce to deal with shortages and associated pressures; to increase its flexibility, responsiveness, sustainability and mobility; and to reduce red tape.[2]

2.3 The Council of Australian Governments (COAG) considered the Productivity Commission's recommendation and on 14 July 2006, COAG agreed to establish the NRAS, with the nine health professions (later increased to 10) registered in all jurisdictions at that time. COAG envisaged the scheme being implemented in July 2008.[3] The intention was to ensure that all health professionals were 'registered against the same, high-quality national professional standards' and would allow 'doctors, nurses and other health professionals to practise across State and Territory borders without having to re-register'.[4]

2.4 The Australian Health Workforce Ministerial Council (AHWMC) submitted that the objectives of the NRAS are to:

- provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
- facilitate workforce mobility across Australia;

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1 A detailed account of the history of the NRAS is provided in Australian Health Workforce Ministerial Council, *Submission 70*, pp 4–8.

2 Productivity Commission, *Australia's Health Workforce*, Research Report, January 2006.

3 COAG *Communique*, 14 July 2006; www.coag.gov.au/coag_meeting_outcomes/2006-07-14/index.cfm#health

4 COAG *Communique*, 13 April 2007.

- facilitate the provision of high quality education and training of health practitioners;
- facilitate the rigorous and responsive assessment of overseas trained health practitioners;
- facilitate access to services provided by health practitioners in accordance with the public interest; and
- enable the continuous development of a flexible, responsive and sustainable health workforce and enable innovation in the education of, and service delivery by, health practitioners.[5]

2.5 AHWMC went on to state that:

> The greater consistency in registration and accreditation across states and territories under NRAS 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. If a health practitioner is deregistered or has conditions placed on the registration, this now automatically applies across all states and territories, as a result of the new national scheme.[6]

2.6 The implementation of the NRAS was delayed until March 2008 when COAG signed the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions. The agreement aimed to 'help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce'. The agreement included a national register to ensure health professionals banned from practising in one place would be unable to practise anywhere else in Australia.[7]

2.7 The Intergovernmental Agreement was to be implemented on 1 July 2010 and would consist of 'a Ministerial Council, an independent Australian Health Workforce Council, a national agency with an agency management 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'.

2.8 The national agency as described in the agreement would have the following role:

- maintain up-to-date and publicly accessible national lists of accredited courses and registered practitioners with entries relating to individuals to include any conditions or restrictions on professional practice;

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5 Australian Health Workforce Ministerial Council, *Submission 70*, p. 3.

6 Australian Health Workforce Ministerial Council, *Submission 70*, p. 3.

7 COAG *Communique*, 26 March 2008.

- administer the resources of the scheme and ensure the scheme is as efficient as possible;
- act in accordance with any policy directions from the Ministerial Council;
- report annually to the Ministerial Council;
- following agreement with the boards, set fees, and where there is no agreement, this will be referred to the Ministerial Council;
- at its discretion, contract or delegate functions, excluding registration and accreditation functions, with any delegations reported to the Ministerial Council;
- in consultation with the boards, develop and administer procedures and business rules for the efficient and quality operation of the registration and accreditation functions and the operation of the boards and their committees, consistent with ministerial policy direction and the objects of the legislation;
- in accordance with the objects of the legislation and any policy directions of health ministers, set frameworks and requirements for the development of registration, accreditation and practice standards by the national boards to ensure that good regulatory practice is followed;
- advise the Ministerial Council on issues relevant to the scheme; and
- establish a national office.[8]

2.9 The national agency would maintain the national registers of health practitioners and lists of accredited courses; provide secretariat support for the agency management committee and boards, and any other committees constituted under the scheme; and establish at least one presence in each state and territory.

2.10 As the Commonwealth does not have the power to regulate health professionals, the legislative framework for implementation of the NRAS was enacted by the state and territory legislatures. The initial legislation was passed by the Queensland Parliament in November 2008. This legislation set up interim administrative arrangements for the Scheme.

2.11 Consultation with stakeholders took place through the National Registration and Accreditation Implementation Project (NRAIP). Following this consultation, in May 2009 the AHWMC announced changes to the Scheme as originally proposed. These changes included ensuring that accreditation functions are independent of government; establishing both general and specialist registers for professions, as well as separate registers for nurses and midwives; and requirements for continuing professional development in relation to annual renewal of registration.[9]

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8 Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, pp 12–13.

9 Australian Health Workforce Ministerial Council, *Communique*, 'Design of New National Registration and Accreditation Scheme', 8 May 2009.

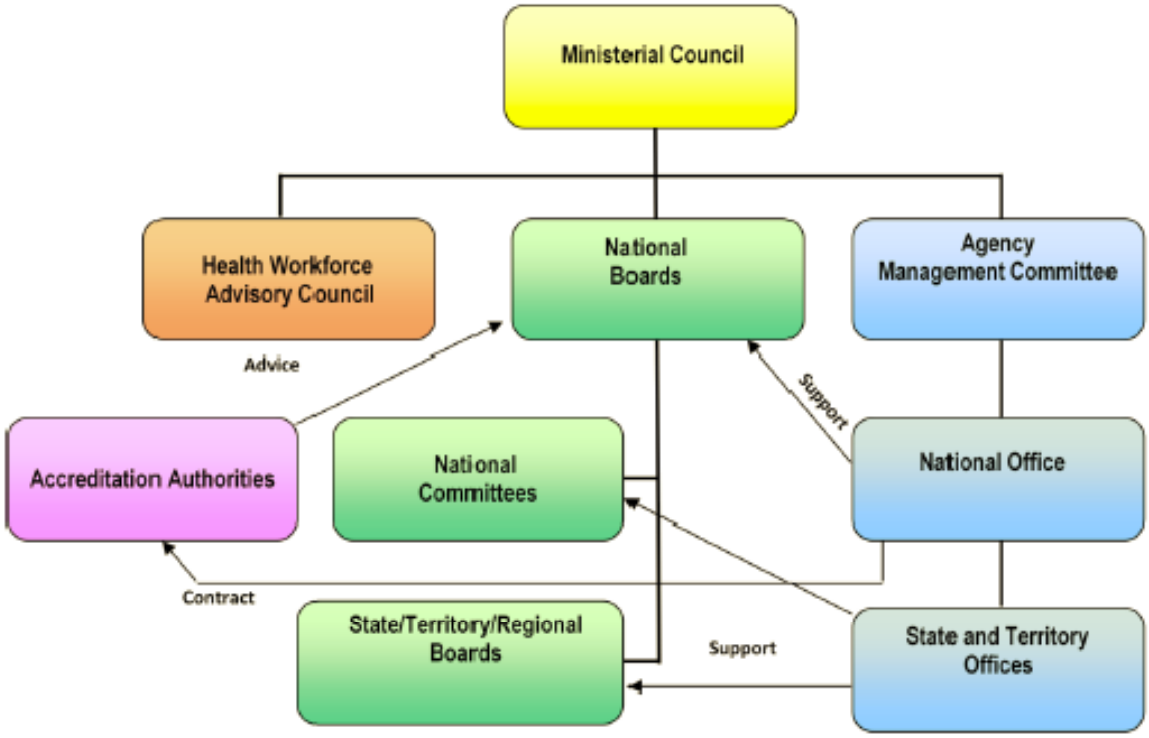
2.12 The *Health Practitioner Regulation National Law Act 2009* (Qld) (National Law) received Royal Assent on 3 November 2009. It details the substantive provisions for registration and accreditation and replaced the initial legislation passed in 2008. Other states and territories passed similar legislation to the National Law and jurisdiction-specific consequential and transitional provisions.[10] The NRAS legislation replaced 65 Acts across the jurisdictions and the bodies established replaced 80 state and territory boards. Several jurisdictions made amendments to the National Law, including New South Wales which opted for retaining its own complaints system.[11]

2.13 The Commonwealth also passed consequential and transitional amendments to Commonwealth legislation required to recognise and support the NRAS.

2.14 The NRAS commenced on 1 July 2010 for all States and Territories except Western Australia which joined the NRAS on 18 October 2010.

Structure of the NRAS

2.15 AHPRA provided the following diagram to show how the scheme operates:



Source: Australian Health Practitioner Regulation Agency, *Submission 26*, p. 5.

10 For further details of the legislation passed by each jurisdiction, see Australian Health Workforce Ministerial Council, *Submission 70*, p. 7.

11 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 5.

- Ministerial Council: AHWMC comprises the health ministers of each state and territory and the Commonwealth. The functions of the Ministerial Council are set out in the National Law and include:
    - appointing the National Board members and the Agency Management Committee;
    - giving direction to AHPRA and the Board about the policy they must apply in exercising their functions; and
    - approving registration standards, lists of specialities and specialist titles and endorsements in relation to scheduled medicines and areas of practice;
- Health Workforce Advisory Council: provides independent advice to the Ministerial Council about matters related to the national scheme;
- National Boards: established under the National Law for each of the regulated health professions with members appointed by the Ministerial Council. Functions are set out in the National Law and include:
    - responsibility for registering health practitioners who meet the requirements of the approved registration standards (English language skills, professional indemnity insurance, recency of practice, continuing professional development and criminal history);
    - investigate and manage concerns (notifications) about performance or conduct of practitioners;
    - develop standards, codes and guidelines; and
    - set national fees;

    The functions of the National Boards can be delegated and many are delegated to AHPRA and Board committees; and
- Agency Management Committee: effectively the board of AHPRA with functions including policy development and ensuring that AHPRA performs its functions in a proper, effective and efficient manner.

2.16 The AHWMC described its role as:

> The AHWMC has an ongoing and defined role but had not intended or expected continued administrative involvement except at the 'lightest touch' level. Under the National Law, Ministers are responsible for approving registration and accreditation standards put forward by the National Boards, approval of specialist registration and approval of areas of practice for the purposes of endorsement. Ministers can only give directions to National Boards or the national agency under limited circumstances specified in the legislation.[12]

12 Australian Health Workforce Ministerial Council, *Submission 70*, p. 4.

Inquiries into the NRAS

2.17 The Senate Community Affairs Legislation Committee conducted two inquiries into the NRAS. The first, *National registration and accreditation scheme for doctors and other health workers*, made three recommendations:

- providing a safeguard against the potential misuse of power by the Ministerial Council in relation to accreditation standards (Recommendation 1);
- introducing a requirement into the NRAS that the reasons for the Ministerial Council issuing a direction in relation to an accreditation standard be made public (Recommendation 2); and
- that the AHWMC ensure that the NRAS contains sufficient flexibility for the composition of National Boards to properly reflect the characteristics and needs of individual professions (Recommendation 3).[13]

2.18 In May 2010, the Community Affairs Legislation Committee tabled its report on the Health Practitioner Regulation (Consequential Amendments) Bill 2010. In addition to recommending that the bill be passed, the committee also recommended that AHPRA place information on protected titles and roles, including for nurses and specialists, on its website to ensure clarity around definitions for the community.[14]

Australian Health Practitioner Regulation Agency (AHPRA)

2.19 AHPRA was established on 1 July 2010 as part of the National Registration and Accreditation Scheme to regulate 10 health professions. The ten health professions regulated by AHPRA are:

- chiropractors;
- dental practitioners (including dentists, dental specialists, dental hygienists, dental prosthetists and dental therapists);
- medical practitioners;
- nurses and midwives;
- optometrists;
- osteopaths;
- pharmacists;
- physiotherapists;
- podiatrists; and
- psychologists.

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13 Senate Community Affairs Legislation Committee, *National registration and accreditation scheme for doctors and other health workers*, August 2009, p. vii.

14 Senate Community Affairs Legislation Committee, *Health Practitioner Regulation (Consequential Amendments) Bill 2010 [Provisions]*, May 2010, p. vii.

2.20 The AHPRA annual report for 2009–10 indicated that from July 2012, a further four health professions are planned to join the scheme:

- Aboriginal and Torres Strait Islander health practitioners;
- Chinese medicine practitioners;
- medical radiation practitioners; and
- occupational therapists.[15]

2.21 AHPRA supports the nation boards to perform their functions. AHPRA staff exercise functions delegated by each of the National Boards in relation to registration of health practitioners and investigation of notifications. The following provides an overview of the establishment of AHPRA.

Staff

2.22 Timetable for the appointment of staff:

March 2009	Agency Management Committee members appointed
Dec 2009 – Jan 2010	AHPRA CEO and national management team in place and receive handover from project team
February 2010	AHPRA State and Territory managers on board and recruiting senior staff
March 2010	Most eligible staff accept offer to transfer to AHPRA
July 2010	Over 400 staff transfer to AHPRA AHPRA offices open in all states and territories

Source: Australian Health Practitioner Regulation Agency Annual Report 2009–10, p. 9.

2.23 AHPRA has a staff of around 510 full-time and part-time staff. More than 80 per cent of staff from the previous boards joined AHPRA. Most state and territory managers were recruited from previous chief executive officers of state and territory boards.

Offices

2.24 AHPRA has offices in all states and territories and a national office co-located with the state office in Melbourne.

Financial arrangements

2.25 The Ministerial Council established the financial principles for the transfer of assets and liabilities for state and territory boards. All funds deriving from the state

15 Australian Health Practitioner Regulation Agency, *Annual Report 2009-10*, p. 6.

and territory boards of each profession were to be pooled at a national level and held for the benefit of the national board of that profession.

2.26 The Australian Health Ministers Advisory Council (AHMAC) agreed that boards were required to transfer funds to cover:

- prepaid fees held at 20 June 2010;
- funds to cover transferring liabilities; and
- reserve funds equivalent to one year's operating, or if not available, all reserve funds.[16]

2.27 In addition, $19.8 million (and subsequently additional funds) were provided by the Commonwealth and state and territory governments for project costs before implementation commenced.

2.28 AHPRA is now funded solely by the registration and renewal fees paid by health practitioners. AHPRA noted that in some cases transition and implementation costs have been higher than expected. Further, renewal dates for health practitioners differ across the states and territories. It was noted that it will take up to 17 months before the new national fees can be applied uniformly to all registrants.

2.29 AHPRA also commented that if more resources are required, additional revenue can only be raised by increasing registration fees, in agreement with the National Boards. It was stated that 'it is not expected that fees should increase by more than the inflation rate on an annual basis'. The Ministerial Council will be advised if the fee rise is to be greater than the inflation rate.[17]

Information and communication technology

2.30 The 2009–10 AHPRA Annual Report provides an overview of the information and communication technology (ICT) system implemented. Following review of the existing ICT capability of boards, it became clear that greenfields ICT would be required by AHPRA with only limited re-use likely of existing systems and infrastructure.

2.31 Data migration of more than one million names and addresses from 42 databases located within state and territory registration boards. A key element of the data migration was a mailing to registrants which commenced in April 2010 to:

- confirm registrant details;
- confirm principle place of practice;
- advise registrants of their new registration types; and

16 Australian Health Practitioner Regulation Agency, *Annual Report 2009-10*, p. 11.

17 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 24.

- advise registrants of the conditions that would appear on the public register.[18]

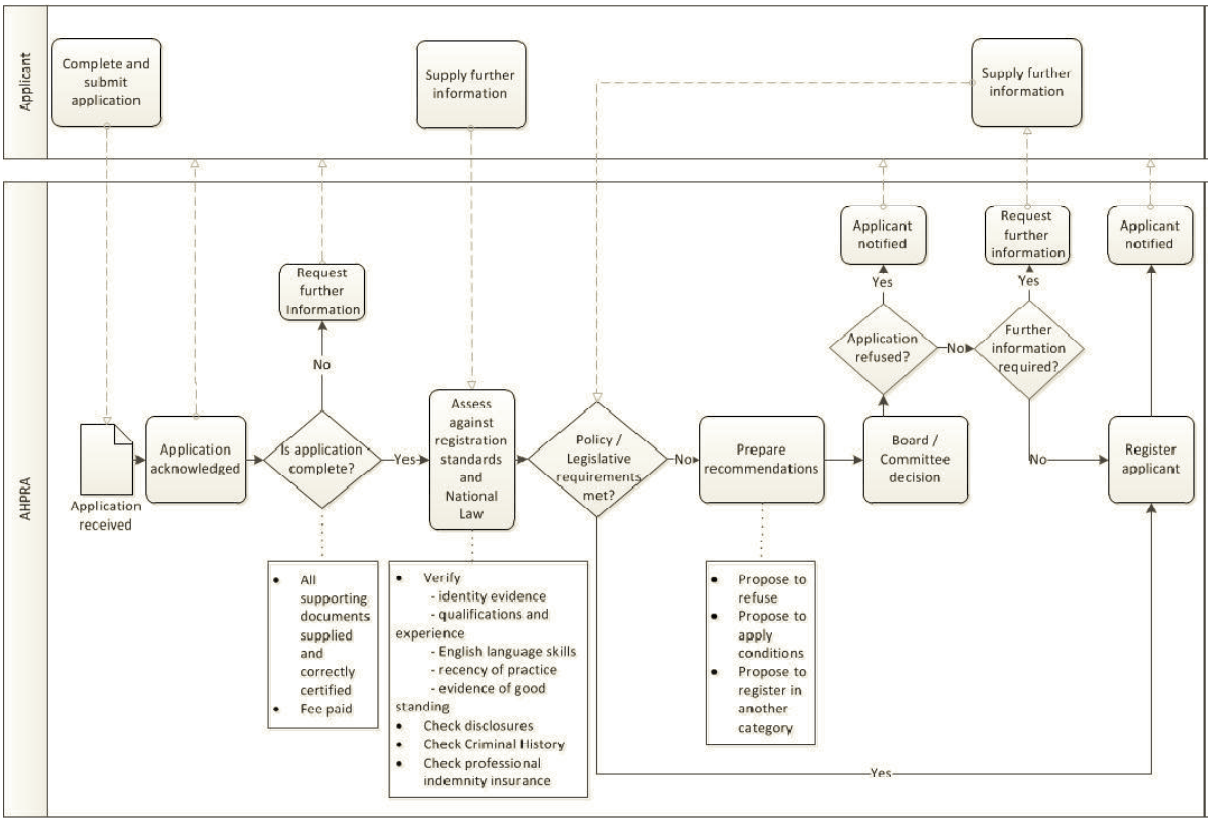
Registration by AHPRA

2.32 There are over 528,000 health practitioners on the national registers across 10 professions with just over half of those being nurses and midwives (288,861) and 87,984 medical practitioners.[19]

Application for registration

2.33 The National Law sets a maximum 90 day timeframe to assess an initial application for registration. If a National Board does not decide an application for registration within 90 days of its receipt, or a longer period agreed between the Boards and the applicant, the failure by the Board to make a decision is taken to be a decision to refuse to register the applicant.

2.34 AHPRA provided the following flowchart of the registration process:



Source: Australian Health Practitioner Regulation Agency, *Submission 26*, p. 26.

18 Australian Health Practitioner Regulation Agency, *Annual Report 2009–10*, p. 12.

19 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 26.

2.35 AHPRA noted that the registration process now includes additional requirements that 'stem from the core principle of public safety'. These new requirements are as follows:

- English language skills registration standard;
- criminal history registration standard;
- recency of practice registration standard;
- continuing professional development registration standard;
- automatic expiry of registration; and
- new common renewal date.[20]

2.36 AHPRA has instituted special procedures for the graduate registration process which allows graduates to pre-apply for registration.

Renewal of registration

2.37 All health practitioners must renew their registration annually. If practitioners do not renew their registration by the end of the late period (one month after their registration expiry date), their registration will lapse and they will need to make a new application for registration.

2.38 AHPRA stated that the National Law does not set a time period for a decision on an application for renewal, as section 108 enables a practitioner to remain registered after he or she has made an application for renewal until the Board decides to renew or refuse to renew the registration. AHPRA stated that in most cases, where practitioners renew online and make no adverse declarations, their registration is updated within hours.[21]

2.39 AHPRA provided the following flow chart of the renewals process:

20 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 12.

21 Australian Health Practitioner Regulation Agency, *Submission 26*, pp 13–14.

Source: Australian Health Practitioner Regulation Agency, *Submission 26*, p. 43.

APHRA's response to service delivery problems

2.40 In response to service delivery problems, AHPRA indicated that it had instituted measures to improve service delivery. These include:

- contacting AHPRA: boosted resources for customer services teams, management of calls directly by experienced staff and established new backup and peak demand capacity;
- lapsing of registrants: established a fast track application process for registrants who miss the renewal deadline, to streamline their re-registration, with no late or application fees in the first year. The fast track is open for one month after the end of the late period; and
- improved online services: implemented enhancement of the online applications and tracking process.[22]

2.41 In addition, AHWMC announced that the Commonwealth will consider ex gratia or act of grace payment for a period of time so that patients are not disadvantaged by lapsed registration of their health care practitioner who is still practising.[23] See chapter 4 for further details.

22 Australian Health Practitioner Regulation Agency, *Submission 26*, pp 15–17.

23 Australian Health Workforce Ministerial Council, *Communique*, 17 February 2011.

Chapter 3

Implementation of the National Registration and Accreditation Scheme by the Australian Health Practitioner Regulation Agency

Introduction

3.1 The introduction of the National Registration and Accreditation Scheme (NRAS) was a very complex task: it brought together 10 health professions from eight jurisdictions into one national registration and accreditation scheme. The Australian Medical College noted that it is a common misconception that 'the NRAS project is a straightforward transfer of existing registration functions and activities from the State and Territory regulatory bodies to the National Board and AHPRA'. In addition to registration functions, the 10 health professions are required to develop, and maintain both registration standards and standards for the accreditation of programs of study and the institutions providing these programs. The College commented that:

> ...development of these standards is complex and there are high-stakes for the educational institutions that provide the programs, the professions, health jurisdictions and the community. It requires careful consideration and stakeholder input. The consultation requirements, while essential to achieving national consistency, add to an already complex system and have contributed to time delays in other AHPRA processes. Again, there were no precedents for these in the legacy systems that were inherited by AHPRA from the State and Territory regulatory processes.[1]

3.2 The size and complexity of the task, as many witnesses noted, was well recognised by stakeholders from the inception of the scheme. Dr Kay Sorimachi, Pharmaceutical Society of Australia, stated:

> We did foresee problems, given the complexity of the transition. This was not simply amalgamating a number of organisations into one. It consisted of 10 diverse health professions being brought together. The number of registrants and therefore the accompanying data that needed to be put together was considerable.[2]

3.3 The Australian Medical Association in particular pointed to Australian Health Practitioner Regulation Agency's (AHPRA) lack of understanding of the core business requirements for registering health professionals and the impact on the health system. As a consequence, there was no strategic planning to ensure that all aspects of the

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1 Australian Medical College, *Submission 13*, p. 4.

2 Dr Kay Sorimachi, Policy and Regulatory Affairs, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 10.

registration and renewal processes were addressed, resulting in significant delays and disruption for the profession, employees and patients.[3]

3.4 Submitters were of the view that there appeared to be a lack of recognition of the nature and extent of difficulties that were likely to arise and as a consequence, AHPRA was provided with inadequate resources.[4] Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia commented that 'it would seem to us that, given the scope, the resources were not adequate to cope with the merging of the 10 professions into a new database and a new entity with new people'.[5] This view was supported by other organisations including the Australian College of Rural and Remote Medicine.[6]

3.5 Some submitters commented that it had been a mistake to transition all 10 professions as the same time. The Australian Psychological Society, for example, commented that 'in hindsight it is obvious that many of the problems encountered could have been managed if the task involved a step-wise introduction of professions into the scheme instead of ten at once'.[7]

3.6 It was generally agreed by submitters that insufficient planning had been undertaken by AHPRA and therefore a lack of adequate resources were committed to the implementation process. As a result, unrealistic timeframes for transition were set. The lack of resourcing was in seen in:

- AHPRA offices and state and territory boards;
- inadequate call centre and website processes;
- inadequate training of staff; and
- lack of liaison with key stakeholders including large commercial entities.

3.7 There were also concerns that the implementation process had not taken advantage of the expertise available in state and territory boards. Dr Sorimachi commented:

> We were also aware that, because pharmacy as a profession had been operating under state and territory legislation in terms of registration for many years, the state entities, our pharmacy boards, had considerable experience in this. We were concerned that in the transition some of this expertise would be lost. So even as early as October 2006 we had suggested that perhaps in the initial stages the state and territory pharmacy boards remain as organisations whilst the transition was made. In April 2009, I

3 Australian Medical Association, *Submission 23*, p. 4.

4 See for example, Optometrists Association of Australia, *Submission 37*, p. 4.

5 Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 11.

6 Australian College of Rural and Remote Medicine, *Submission 59*, p. 3.

7 Australian Psychological Society, *Submission 36*, p. 3.

> think, we reiterated that position. We were concerned that in looking forward to the 2010 implementation that aspect had not been taken into consideration and that in simply dismantling all the state and territory pharmacy boards we would lose all the benefits that resided in those entities.[8]

3.8 Concern about the loss of expertise was also raised by Dr Steve Hambleton, Vice President, Australian Medical Association (AMA), who also put the view that the process had not been well-handled by AHPRA:

> There was lots of expertise available. We know the complexity of medical registration, and state boards know the complexity. I guess AHPRA, which took on that role, should have done a better job. It is unacceptable in these days that they should not have done a better job, and if they were not resourced to do so then they should have been.[9]

3.9 The Australian College of Mental Health Nurses (ACMHN) also commented on the failure of AHPRA to call upon those organisations with expertise and strong communication links with their members to assist during the transition period. The ACMHN considered that 'if the information and communication channels of the nursing organisations across Australia had been used in the absence of robust communication mechanisms of the AHPRA/NMBA [Nursing and Midwifery Board of Australia], there would have been a reduction in confusion among the nursing profession about administration changes and impacts on individual obligations to renew their registration'.[10]

3.10 Another problem identified was the loss of many experienced and knowledgeable members of former state boards and councils. The Australian College of Rural and Remote Medicine commented:

> From a professional college perspective effective working relationships that had been cultivated over many years were entirely lost when AHPRA commenced. Many of the experienced people in previous state medical boards did not transition to state AHPRA and it has taken a long time for the responsibilities and names of new staff members to be shared with the College–even in those portfolios where there was active, weekly, communication required for activities such as communication about results of overseas trained doctor assessments.
>
> This has led to a general decline in efficiency within the system and confusion and lack of confidence in the new system. It has also meant that

8 Dr Kay Sorimachi, Policy and Regulatory Affairs, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 10.

9 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 55.

10 Australian College of Mental Health Nurses, *Submission 58*, p. 4.

> many policy and administration issues have needed to be discussed again and reconfirmed. This has unnecessarily wasted time and resources.[11]

3.11 The Australian Medical Council stated:

> Experience with the implementation of new regulatory legislation in medicine, as occurred in Victoria, New South Wales and Queensland over recent years, has demonstrated the need for effective communication within the regulatory authority itself, as well as with key stakeholders and members of the profession. In the past major changes in processes or policy have been assisted by the presence of existing reporting channels, experienced personnel and established infrastructure and IT systems. However, in the case of the national registration projects and AHPRA, there has been a complete change of senior management with an unfortunate loss of expertise at both the state and national level. AHPRA staff now find themselves working under new reporting and management structures, dealing with health professions and issues which they have not previously encountered, operating under newly developed and unfamiliar legislation and navigating totally new and equally unfamiliar business processes and IT systems. Any one of these factors alone would have represented a significant challenge to a well established organisation, let alone to a new body with no corporate memory or established administrative practice and communication structures.[12]

3.12 Overall, submitters concluded that the implementation process was flawed, that significant problems that should have been identified before 1 July 2010 had not been addressed and as a result the registration of the 10 major health professions was put at risk. This had the potential to significantly undermine the provision of health services in Australia because, as stated by the AMA, 'the management of the transition from state based registration to national registration has been an absolute debacle'.[13]

3.13 The following provides an outline of the difficulties that arose during the implementation period.

Timeframe for implementation

3.14 The timeframe for the implementation of the scheme was criticised by submitters both in terms of moving from state-based registration boards to National Boards and the practical issues such as data system testing. Professor Richard Smallwood, Forum of Australian Health Professions Council, commented:

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11 Australian College of Rural and Remote Medicine, *Submission 59*, p. 6.

12 Australian Medical College, *Submission 13,* p. 3.

13 Australian Medical Association, *Submission 23*, p. 2.

> I think that, throughout the development of NRAS and its implementation, there has been unease about the time lines and the speed with which it was required to go ahead, particularly with some delay in the bills.[14]

3.15 The Australian Medical Council provided these comments which pointed to the effect of the short timeframes on planning for the implementation of the NRAS:

> The requirement to maintain the momentum of the regulatory reform agenda necessitated short timelines on key consultations and review of key documents in support of the new initiatives. It is likely that longer timeframes in the consultation processes would have added insight and opportunity to anticipate and prevent some of the problems that have subsequently emerged from the implementation. This remains a concern in the roll out of the new Scheme, since the National Law requires consultation on a range of complex matters relating to the operation of the legislation.[15]

3.16 The complexity of the situation was not only due to establishing a national register, but also to the new accreditation requirements which the Council of Australian Governments (COAG) had agreed would be undertaken by the one national entity. Mr Gavin O'Meara, Ramsay Health Care Australia, outlined this issue:

> It is not just a centralisation of registration function but a whole new raft of rules, guidelines, and standards associated with it that everybody has to get used to, so I think that a softer start—just making sure that the resources were there, the systems and procedures worked and everybody was clear about that—would have been a much more acceptable way of doing it. I think that is something that you see frequently in something like this, where there is perhaps a political imperative to get something up and running. But it is a tremendously big task, and I think that starting more slowly and implementing bit by bit as you learn is a better way of doing it.[16]

3.17 The Optometrists Association of Australia pointed to the effect of the short timeframe on AHPRA's internal processes:

> The current problems reflect the ambitious implementation timetable which apparently limited the time available for stress testing of systems, staff training and other preparations for commencement.
>
> With the benefit of hindsight, the design and implementation of the national scheme was such a major enterprise that difficulties such as those experienced should have been anticipated. If there were such risk

14 Professor Richard Smallwood, Forum of Australian Health Professions Councils, *Committee Hansard*, 4 May 2011, p. 3.

15 Australian Medical Council, *Submission 13*, p. 3.

16 Mr Gavin O'Meara, Manger, People and Culture, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p. 50.

> assessments undertaken or contingency provisions put in place Optometrists Association does not know about them.[17]

3.18 Other submitters such as the Australian Psychological Society also supported this assessment.[18]

3.19 The committee was informed that prior to the implementation of the NRAS, consultations took place in 2008 and 2009. During the consultations, issues around the time lines and the need for a focus on data transfer, training and the complexity of melding the legislation were identified. Mr Ian Frank, Forum of Health Professions Councils, commented:

> There were concerns expressed that this was a very complex exercise...because we were dismantling so many existing structures to create a new one. I think pretty much all of the submissions that came in to the implementation team—the project team that was looking at it—raised issues about the complexity of the time lines, the data quality and the need for training et cetera.[19]

3.20 Other witnesses drew the committee's attention to the implementation of the 1992 mutual recognition scheme. This scheme was much less complex, retained the existing jurisdictions and organisational structures and had an appropriate lead in time, still took two to three years to fully bed in.[20]

3.21 The views of many submitters was summed up by Ms Elizabeth Spaull, Ramsay Health Care Australia, who commented:

> Many in the industry, many of whom I respect as senior members of our industry community, said it was too much, too soon, too quick. That is the general opinion in the industry.[21]

Committee comment

3.22 Establishing the NRAS was always going to be a difficult task: there were delays in passing legislation, more than 500,000 health practitioners were covered by the new scheme; large amounts of data had to be migrated from a range of databases; new offices had to be established and staff employed and trained. Coupled with the establishment of the national accreditation system, it is apparent to the committee that the timeframe for the implementation of the NRAS was significantly underestimated.

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17 Optometrists Association of Australia, *Submission 37*, p. 3;

18 Australian Psychological Society, *Submission 36*, p. 4.

19 Mr Ian Frank, Member, Forum of Australian Health Professions Councils, *Committee Hansard*, 4 May 2011, p. 4.

20 Australian Medical Council, *Submission 13*, p. 3.

21 Ms Elizabeth Spaull, National Workforce Planning and Development Manager, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p. 51.

3.23 The committee considers that the problems with the timeframe should not have come as a surprise: major stakeholders were raising concerns during the consultation period and the implementation of the 1992 mutual recognition scheme pointed to the complexities inherent in amalgamating state and territory systems into a national scheme.

Data quality

3.24 Much was made during the inquiry about the problems faced by AHPRA because of the quality of the data received from the state and territory organisations. Again, submitters commented that this should have been recognised, and planned for, in the implementation process.

3.25 The Australian Medical Council commented that data migration was one of the most significant challenges facing the NRAS. Not only were there problems with the quality of the data transferred to the national registers from the existing state and territory registers but also with the IT infrastructure to support the registration activities of the National Boards. The Council noted that the experience with the implementation of the 1992 mutual recognition scheme for medicine indicated that approximately 10 per cent of the data collected from the state and territory medical registers contained duplicate entries as a result of incorrect matching of the data held on individual practitioners on the separate state registers.

3.26 The Australian Medical Council was of the view that since the introduction of mutual recognition, considerable efforts have been made to improve the quality of data on the state and territory medical registers. However, it appears that the quality of data varies considerably across the different professions that are now part of the national registration system. The Council concluded:

> Addressing this variability would require very thorough data cleansing procedures prior to the transfer to the AHPRA-administered national registers. Since the AHPRA data set was a compilation of data drawn from the State and Territory registers, a significant number of the data quality problems experienced by AHPRA were inherited from these systems.[22]

3.27 Mr Ian Frank, Forum of Australian Health Professions Councils, also pointed to the implementation of mutual recognition in 1992 and commented:

> So when the national registration scheme was implemented we expected that something of that order could be expected in transmitting the data across into the new national system.
>
> That process usually requires cleansing the data well beforehand. With mutual recognition we had about a year or two to do that, but in this particular instance they did not. They could not transfer the data until bills

22 Australian Medical Council, *Submission 13,* p. 3.

> B and C were both implemented. There was a very short timeframe to get that across and get it up by 1 July.[23]

3.28 While noting that the quality of the data had improved since 1 July 2010, Mr Frank commented that systems were not properly implemented or tested in the lead up to AHPRA taking over. Further, before the bills were passed by the states and territories, there was no legal authority to provide the data to AHPRA, so no live testing could take place.[24] AHPRA confirmed this and stated:

> In the transition period, issues with data AHPRA has received from some previous state and territory boards has affected the initial renewal process for some health practitioners. Until the National Scheme started on 1 July 2010, all data about health practitioners was held by state and territory registration boards, not by AHPRA. In the first months of operation, AHPRA has had to rely on these data, which were migrated to AHPRA, including the contact details of health practitioners.[25]

3.29 AHPRA also stated:

> The National Scheme began full operation from 1 July 2010, the day immediately following cessation of operation of over 80 state and territory boards. As such, there was no break between the start of the National Scheme and the end of previous state and territory-based regulation. This meant there was no opportunity to run or test new systems in parallel for any time.[26]

Case study 3.1

My registration details were incorrectly translated from the Dental Board of Queensland (DBQ). Initially AHPRA staff tried to tell me that one of my Dental Specialties did not exist and could not be registered and that I am entitled to be registered in two specialities was beyond the understanding of the staff I dealt with. Then later with the renewal forms two specialties were not accommodated with space on the generic renewal form sent November 2010.

Over the last 20 years I have had no problems with the Dental Board of Queensland. I estimate about 10 phone calls and 5 emails to sort this.

Source: Name withheld, *Submission 211*, p. 1.

3.30 In addition, AHPRA stated that it had established its own ICT system as 'the work made it clear that, greenfields ICT would be required for AHPRA with only

23 Mr Ian Frank, Member, Forum of Australian Health Professions Councils, *Committee Hansard*, 4 May 2011, p. 3.

24 Mr Ian Frank, Forum of Australian Health Professions Councils, *Committee Hansard*, 4 May 2011, p. 3.

25 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 14.

26 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 14.

limited re-use of existing systems and infrastructure likely'.[27] Mr Peter Allen commented that:

> The judgement about the preferred platform for the new national scheme was made well before the start-up of the scheme. It was made sometime I think in 2009; that was when the decision was made to go with the Pivotal system as opposed to any of the existing state or territory systems.[28]

3.31 The Australian Psychological Society summed up the problems with migration of data as follows:

> The enormity and complexity of providing appropriate services to half a million registrants, while inheriting a mishmash of databases and previous Registration Boards' processes, is acknowledged. However, AHPRA should have had an awareness of the likelihood of difficulties arising in transitioning database information which should have been grounds for caution and considerable care. There appears to have been insufficient planning for the transition from jurisdictionally-based registration to one that is nationally based, and the necessary risk management strategies to mitigate against possible glitches in the new system.[29]

Committee comment

3.32 The committee considers that there were pointers, for example, the difficulties experienced with the 1992 mutual recognition scheme, which should have alerted AHPRA to likely problems with data migration. However, this appears not to have been the case and as a result there was inadequate planning and provision of resource.

3.33 The committee has noted AHPRA's comments about the delays in passing the state legislation and the inability of AHPRA to access the data. However, the committee considers that this is a somewhat disingenuous argument. The committee does not believe that such a large undertaking would have been planned without scrutiny of the databases which were to compromise the new national register. Therefore, the committee, while acknowledging the size of the task, does not believe that the fault lies with the former state boards, rather it lies with AHPRA. AHPRA was able to quantify beforehand the number of databases and the number of registrants. The Agency Management Committee was appointed in March 2009. With AHPRA commencing on 1 July 2010, the committee considers that there was more than adequate time to identify issues and to implement action to ensure a smooth transition of data.

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27 Australian Health Practitioner Regulation Agency, *Annual Report 2009–10*, p. 12.

28 Mr Peter Allen, Chair, Agency Management Committee, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 5 May 2011, p. 26.

29 Australian Psychological Society, *Submission 36*, pp 4–5.

Contacting AHPRA

3.34 One of the major difficulties identified by submitters was the difficulty in contacting AHPRA and accessing advice and the quality of that advice. While AHPRA had established a 1300 local call number, many submitters stated that accessing advice from AHPRA through the telephone help service was at best problematic and at worst non-existent.[30] Ms Melissa Locke, Australian Physiotherapy Association, commented that there was a fault with the 1300 number and it was some time before it was fixed.[31] When it was working, the committee heard evidence of very long delays on the 1300 number with one witness stating that a practitioner had waited for five hours to have their call answered.[32]

3.35 Mr Stephen Milgate, Australian Doctors Fund, also commented on the difficulties and noted that 'the process was [circular], with 1300 numbers going to websites going to 1300 numbers going to websites'.[33]

3.36 The alternative way of contacting AHPRA is through its website. AHPRA submitted that it had established 11 websites (one for AHPRA and one for each of the national boards). However, evidence received by the committee again pointed to significant problems: there were delays in responding to emails or, in many cases, no response was received at all. In addition, the AHWMC commented that on 5 July 2010 the online registers for each profession went live.[34]

3.37 The Australian Psychological Society (APS) provided the following evidence of the problems encountered:

> From July 1 2010, the APS was repeatedly informed of overwhelming difficulties in accessing AHPRA staff either by telephone or e-mail. Beside phone lines being continually engaged (and in Queensland initially being diverted to an oil company) and the website frequently being offline, the online website enquiry system also experienced significant delays, resulting

30 See for example, Society of Hospital Pharmacists of Australia, *Submission 6*, p. 6; Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 8; Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, p. 40; Australian Association of Psychologists, *Submission 60*, p. 11; Australian Physiotherapy Association, *Submission 54*, p. 4; Rural Workforce Agency Victoria, *Submission 50*, p. 8; Royal Australian College of General Practitioners, *Submission 46*, p. 4; Optometrists Association of Australia, *Submission 37*, p. 3; Australian Dental Association, *Submission 34*, p. 2;

31 Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 3.

32 See for example, Australian College of Mental Health Nurses, *Submission 58*, p. 5; Ramsay Health Care Australia, *Submission 35*, p. 4.

33 Mr Stephen Milgate, Executive Director, Australian Doctors Fund, *Committee Hansard*, 4 May 2011, p. 17.

34 Australian Health Workforce Ministerial Council, *Submission 70*, p. 8.

> in delayed registration of health professionals. Another Victorian psychologist trying to renew her registration was reportedly standing in a queue at AHPRA on January 31 (last day of grace period) having failed to make contact with AHPRA staff by either phone or email since mid-December.[35]

3.38 Ramsay Health Care Australia provided extensive assistance to its staff who experienced difficulties with contacting AHPRA with registration inquiries. Ramsay Health reported the following statistics:

- on average, for 234 employees seeking assistance and advice it took AHPRA 29 days to return calls/emails if at all;
- 178 employees never received a response and we assisted to seek resolution/answers by phoning policy officers directly on their behalf; and
- the National Workforce Planning arm, Ramsay Health Care Australia, placed on average 107 calls/emails a month to AHPRA seeking clarification and assistance. Of the 107 calls/emails lodged only 10-12 of them would yield a response in the form of a return email or adequate verbal instruction.[36]

3.39 The Royal College of Pathologists of Australasia provided the following example:

> Communication with AHPRA has been very bad, in particular, time spent on the phone awaiting service and not being able to speak to the appropriate people when they finally get through. One example of poor communication is a Fellow returned a phone call from someone in the Sydney AHPRA office, got put through to the Melbourne switchboard and was told that no-one of that name worked in the organisation.[37]

3.40 Mr Robert Boyd-Boland, Australian Dental Association, commented:

> ...at some point in the process, when it became clear to ADA and its branches that there was an issue with the new registration process, at times branches approached AHPRA directly for confirmation and information about what is going on and did not receive any correspondence back. That was in the form of letters, telephone calls and emails, and there was no response from AHPRA, which indicates systemic lack of communication not only with those registrants but also with their professional bodies.[38]

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35 Australian Psychological Society, *Submission 36*, p. 5.

36 Ramsay Health Care Australia, *Submission 35*, p. 4.

37 Royal College of Pathologists of Australasia, *Submission 24*, p. 2.

38 Mr Robert Boyd-Boland, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 70.

Case study 3.2

NURSE C

- October 2010 – applied for registration No acknowledgement of her application was ever received. Emails to AHPRA seeking a progress update on the following dates:

- 15 December 2010
- 6 January 2011
- 21 February 2011
- 3 March 2011
- 7 March 2011

On all but 2 occasions, Nurse C was given the following standard response:

"Thank you for contacting AHPRA. Your enquiry has been escalated to a information/registration specialist who will advise you via email accordingly."

Nurse C never received a response from AHPRA. On the other occasions she received the standard response that applications are assessed in date order and they could not give her any idea on how long her application would take

- In Nurse C's email of 7 March, she advised AHPRA that their non-responsiveness and the time taken to process her application was insufficient and inadequate. She notified them of her intent to make a formal complaint. She received a response to this email to say that all her emails had been forwarded on and that they were receiving a high volume of emails and therefore applicants were waiting "a little longer than usual" for a response.
- Nurse C also made several phone calls over this period, all with the same answer – "your application is in the system to be looked at". March 2010 – she received a letter to say that she needs a letter from her College showing that her education was in English.
- Nurse C's application has taken 5 months and she has still not been granted registration. Nurse C was expected to start with RHC in January 2011, but the hospital is still waiting for her to join them. Nurse C has come to Australia on a working holiday visa and is working as an Assistant in Nursing whilst she continues to wait for her registration to be granted.

Source: Ramsay Health Care Australia, *Submission 35*, p. 9.

3.41 The ACMHN commented that the website is not user friendly and lacks even some basic information such as the different types of registration.[39] One nurse, after waiting for five hours to speak to an AHPRA operator was told the information was on the website. A thorough search for details revealed that no such information existed on the AHPRA website.[40] The website is also not updated on a timely basis.[41]

39 Australian College of Mental Health Nurses, *Submission 58*, p. 6; see also Rural Workforce Agency Victoria, *Submission 50*, p. 9.

40 Ramsay Health Care Australia, *Submission 35*, p. 4.

3.42 Concern was expressed that in the case of a health practitioner who is not able to provide a work address, the registrant's home address is listed on the website. Both the ACMHN and the Royal College of Nursing Australia pointed to privacy and safety concerns.[42]

3.43 It was noted that the delays caused took health practitioners away from their primary task of providing health care or they had to try to fit the calls in between patients or during breaks in shifts. This situation was exacerbated as AHPRA did not make arrangements for after hours or weekend phone contact arrangements for practitioners. Some submitters, for example, Specsavers suggested that AHPRA should provide these facilities, particularly at peak times.[43]

3.44 Submitters generally agreed that the systems within AHPRA were unable to cope with the volume of queries through the 1300 number or lodged through the website. Health practitioners have become so frustrated with this situation that they have sought intervention from the National Health Practitioner Ombudsman who then provided the contact details for specific AHPRA staff.[44] Other practitioners have resorted to going to AHPRA offices to lodge their paperwork in person. Mr Stephen Milgate, Australian Doctors' Fund commented:

> Our doctors will not work without registration, so they are spending enormous amounts of time on this. One doctor as recently as two weeks ago fronted the office of AHPRA with all her paperwork. Doctors are now physically having to go in to do it. This is not the system that we were promised.[45]

3.45 Attempts to escalate problems to more senior officials in AHPRA proved to be a particular problem. The Australian Physiotherapy Association commented that the AHPRA website did not provide phone, fax or email contact details for branch offices. The Association stated that 'AHPRA wished to discourage direct calls to branch offices while there was a functioning call centre'. However, given the difficulties being experienced with the 1300 number, the lack of alternative contact details contributed to the issues experienced by health practitioners.[46] The Royal Australian College of General Practitioners (RACGP) commented:

> It has proved almost impossible to access state or territory offices of AHPRA, except through a central number, which is always engaged. No

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41 Royal College of Nursing Australia, *Submission 62*, p. 4.

42 Australian College of Mental Health Nurses, *Submission 58*, p. 6; Royal College of Nursing Australia, *Submission 62*, p. 4.

43 Specsavers, *Submission 61, p. 1*.

44 Australian and New Zealand Association of Physicians in Nuclear Medicine, *Submission 43*, p. 3.

45 Mr Stephen Milgate, Executive Director, Australian Doctors Fund, *Committee Hansard*, 4 May 2011, p. 17.

46 Australian Physiotherapy Association, *Submission 54*, p. 5.

> local contact persons are detailed on the AHPRA website, and RACGP staff have resorted to sourcing email addresses through networking.[47]

3.46 Ramsay Health also commented that it was, and remains, very difficult to contact key people within AHPRA who may be able to solve problems. All contact with AHPRA is through a 1300 number so that large organisations like Ramsay Health were not able to contact more senior personnel to address significant problems.[48] The AMA also commented that during the transition relationships with health facilities appeared to instantly cease, restricting the ability of employers to assist medical practitioners through the registration process.[49]

3.47 The Australian College of Rural and Remote Medicine provided similar comments and stated that:

> The most significant issue that has impacted the perception of AHPRA's performance has been its decision to severely restrict access for individuals and organisations to contact appropriate AHPRA officers personally to discuss new processes or status related issues. There has generally been an absence of personal contact and, by extension, a perceived absence of care and responsibility within the system.[50]

Committee comment

3.48 The committee considers that the difficulties experienced in contacting AHPRA were unacceptable and point to inadequate planning and resourcing. The task which AHPRA is to undertake underpins the efficient provision of health services within Australia. If health practitioners cannot access the body which is to process their registration and to provide advice, the committee considers that health services could be significantly compromised. This is unacceptable.

Provision of advice

3.49 When health practitioners were able to get through to AHPRA, they often found that staff were unable to respond to their inquiry or just provided generic advice.[51] For some members of the ADA, clarification of advice was never provided.[52]

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47 Royal Australian College of General Practitioners, *Submission 46*, p. 3.

48 Mr Gavin O'Meara, Manager, People and Culture, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, pp 50-51.

49 Australian Medical Association, *Submission 23*, p. 4.

50 Australian College of Rural and Remote Medicine, *Submission 59*, p. 4.

51 See for example, Melbourne Medical Deputising Service, *Submission 28*, p. 8.

52 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 70.

3.50 AHPRA staff were also unable to provide updated information on the status of applications which pointed to problems with internal information systems. Practitioners who were required to call AHPRA more than once, found that staff appeared not to be able to access records of previous enquiries.[53]

3.51 Professor Lyn Littlefield, Executive Director, Australian Psychological Society, commented that 'you just could not get good answers from AHPRA, with staff not understanding the scheme and actually giving inaccurate information. So I think the situation was really quite bad.'[54] Ms Wett, Pharmaceutical Society of Australia, argued that 'staff that were obviously new being under-resourced or untrained to respond to straightforward queries'.[55]

3.52 This view was supported by other submitters including the Royal College of Nursing Australia which stated that AHPRA staff handling customer enquiries do not have the knowledge, skills and expertise to respond to enquiries specifically relating to nursing and midwifery registration.[56] Melbourne Medical Deputising Service (MMDS) also commented on lack of basic knowledge of the registration process:

> On more than one occasion, when necessary information was not available from the AHPRA website, MMDS personnel have experienced 'I can't give you that information because of privacy reasons' – central call centre staff did not seem to know that a doctor's registration status is public information.[57]

3.53 The Albury Wodonga Regional GP Network provided this comment:

> The 1300 call centre personnel are unable to answer queries despite asking the detail of your enquiry. Not once was a telephone call from this office transferred to a knowledgeable staff member.
>
> The website email enquiry option provided the same result as the 1300 number. Not once has a website email enquiry from this office been responded to since 1 July 2010.[58]

3.54 The AMA added its concern about the lack of follow-up by AHPRA when practitioners sought advice:

> The feedback was that they made the phone call. They often waited on the line for extended periods of time to be answered. When they were answered

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53 The Pharmacy Guild of Australia, *Submission 53,* p. 4. See also Optometrists Association of Australia, *Submission 37*, p. 3.

54 Professor Lyn Littlefield, Executive Director, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 63.

55 Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 8.

56 Royal College of Nursing Australia, *Submission 62*, p. 1.

57 Melbourne Medical Deputising Service, *Submission 28*, p. 8.

58 Albury Wodonga Regional GP Network, *Submission 30*, p. 2.

> they did not receive return phone calls. When they rang back they got someone else and they often had to start the process again. They did not receive return phone calls for extended periods and often after a couple of attempts they would call the AMA and say, "Please, do something; we're not getting anywhere."[59]

3.55 This example provided by the ACMHN illustrates some of the difficulties faced by health practitioners:

> I had to visit the AHPRA office on a few occasions because they refused faxes, mailed documents and because they kept forgetting I needed certain documents despite me asking several times "Are you sure there is nothing else left for me to sign." This carried onto a rather discomforting phone call where the administration asked me to send in proof of my high school education (this is about a month after I had already applied for registration). When I engaged her in conversation on the phone she commented on my English saying "Oh my god your English is really good!" Considering it's the only language I spoke I was confused and she explained, "Oh I assumed from your name you were a foreigner and that's why we wanted to check your education status." Now I am fully aware it was compulsory to prove you went to high school in Australia, but you can understand how inappropriate her comment was, and how unprofessional. In my application it was very clear I was born and raised here, yet this lady couldn't check this basic inquiry and decided to judge me by my name.[60]

3.56 Of significant concern to submitters was the provision of inconsistent or incorrect advice by AHPRA staff. The AMA provided the example of registrants being told to fill in the incorrect form:

> As well as that, people were sent the wrong forms and when they rang up they were told, "Just fill it out, everything will be fine" and in fact it was not. I have had doctors tell me personally that provisional registrants, who expected to be fully registered at the end of their intern year, found that when they filled out the wrong form, after being told to fill out the wrong form, maintained provisional registration not full registration...[61]

3.57 The Pharmacy Guild of Australia commented that AHPRA had stated in its media releases of 20 January and 25 January 2011 that practitioners whose registration application has been received by AHPRA could continue to practice while their application was being processed, even after the conclusion of the one month grace period. However, the Guild indicated that it received anecdotal reports that AHPRA

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59 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 57.

60 Australian College of Mental Health Nurses, *Submission 58*, p. 9.

61 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 57.

phone operators were advising pharmacists that until their application was processed, they were not registered and could not practice.[62]

3.58 Other evidence of inconsistent advice was also provided to the committee. For example, the Australian Nursing Federation (ANF) stated that some nurse members were told they could not renew as an Enrolled Nurse if they were applying for registration as a Registered Nurse. Consequently, due to delays in processing they were unable to work as an Enrolled Nurse while waiting for their registration as a Registered Nurse. The ANF reported that other Enrolled Nurses were advised by AHPRA to do exactly this.[63]

3.59 The Australian and New Zealand Association of Physicians in Nuclear Medicine also provided an example of inconsistent advice provided to a practitioner in relation to specialist radiology. AHPRA initially advised the individual, who holds a Fellowship of the RANZCR but has limited registration as a radiologist, that they could practice in nuclear medicine as it is part of radiology. On this basis the specialist accepted a position and commenced working as an advanced trainee (registrar) in an accredited nuclear medicine training position. However, the specialist was informed by AHPRA that their initial advice was incorrect and that the current registration limited the specialist's practice to radiology only and that this would not include nuclear medicine. To work in nuclear medicine, the specialist would have to lodge a new application with supporting documents from RANZCR confirming his eligibility for Fellowship in the speciality of nuclear medicine. The Australian and New Zealand Association of Physicians in Nuclear Medicine commented that in rescinding its initial advice, which in fact turned out to be the correct advice, AHPRA provided no option for this specialist to continue to work while the matter was resolved. The specialist was unable to practice for several months until the matter was resolved. The Association called for a mechanism to allow for temporary registration in such circumstances.[64]

3.60 In relation to training of staff, AHPRA submitted:

> The staff members AHPRA needed to run the new National Scheme were focused until the last minute on winding up old boards. With more than 80% of staff from the previous boards joining AHPRA, the requirements of the implementation timetables and legislative uncertainty in some states up to the final moment of changeover, opportunities for staff training and preparation were very limited before 1 July 2010.[65]

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62 The Pharmacy Guild of Australia, *Submission 53,* p. 3.

63 Australian Nursing Federation, *Submission 57*, p. 4.

64 Australian and New Zealand Association of Physicians in Nuclear Medicine, *Submission 43*, p. 4.

65 Australian Health Practitioner Regulation Agency, *Submission 26,* p. 3.

Committee comment

3.61 The committee was very disturbed by evidence that practitioners were provided with vastly different advice from different AHPRA staff on the same question. This points to extremely poor training being provided by AHPRA to its staff. The committee finds this yet another example of poor planning: surely AHPRA could have negotiated with the former state boards to allow training of those staff who were transferring to AHPRA before the 1 July commencement date to ensure that they were able to provide appropriate advice on the new scheme.

Registration processes

Initial registration and re-registration

3.62 Many of the problems experienced by health professions related to the registration process. These problems identified included:

- lack of notification of renewals;
- unacceptably long delays in processing registration renewals;
- inconsistent or incorrect advice given by call staff in relation to requirements for registration;
- lack of updating of AHPRA internal processes so that incorrect information, including lack of registration, remained in databases; and
- loss of vital documents by AHPRA relating to payment and registration.

Lack of notification of renewal

3.63 Submitters commented that one of the problems experienced by health practitioners was the lack of renewal notices from AHPRA. This was, in part, due to poor data contained in databases with the committee hearing of one instance where a letter was addressed to a medical practitioner as 'Dr Jack Smith, Adelaide'.[66]

Case study 3.3

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

Source: Australian Doctors' Fund, *Submission 52*, p. 7.

66 Professor Claire Jackson, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 30.

3.64 As a consequence of the problems being experienced, many of the professional organisations stepped in to inform their members of the changes to the renewal process. Submitters commented that members were very used to an efficient system of receiving renewal notices under the old registration system, and the poor AHPRA processes caused many late applications.

3.65 As AHPRA was focussed on a web-based registration process, registrants needed a User ID and Password to submit applications. Those registrants who did not receive notification did not have access to their User ID and Password to enable online renewal.[67] Even when a User ID and Password had been provided, some registrants still could not use the online system as the system did not recognise this information.[68] The Australian Psychological Society noted that contacting AHPRA in these circumstances was almost impossible.[69]

3.66 Even after the initial problems with issuing renewal notices, Ramsay Health Care Australia submitted that the process is still not working efficiently:

> The mailing of letters (for 31st May 2011 national renewal) for nurses and midwives continues to be an issue (in that staff are not receiving them and therefore cannot access the online renewal details without the code provided for them in the letter). When discussed with AHPRA we were advised that "There was [a] stuff up at the mail distribution centre in Melbourne and that only some got away". No advice could be offered on when these replacement letters will be issued.[70]

3.67 The ACMHN also commented that it had continuing concerns with the registration process. Nurses will renew their registration in May 2011 and the ACMHN stated that:

> The uncertainty and apprehension within the nursing profession about renewals in May 2011 is well founded. This date is not far away, and some nurses still have not been notified of their renewal requirements while others have received two emails.[71]

Processing applications

3.68 The major problem with the registration process was the length of time taken to process applications. The Pharmacy Guild of Australia, for example, commented that some registrants had to wait up to three months for their applications to be processed.[72] The ACMHN provided this response from an individual nurse who came

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67 Australian Psychological Society, *Submission 36*, p. 6.

68 Ramsay Health Care Australia, *Submission 35*, p. 5.

69 Australian Psychological Society, *Submission 36*, p. 6.

70 Ramsay Health Care Australia, *Submission 35*, p. 5.

71 Australian College of Mental Health Nurses, *Submission 58*, p. 6.

72 The Pharmacy Guild of Australia, *Submission 53*, p. 3.

to Australia in October 2010 and is still unable to work as a nurse as AHPRA has not processed her registration application:

> I have also been met with poor case management, where my documents have been lost or not internally sent as promised between Melbourne and Brisbane office, information provided is not followed up or shared between the team members who assess so info gets lost and not taken into consideration of the assessment, The screening staff on the phone seems tired and untrained, so it is always very unhelpful to telephone (both to main number and locally in Brisbane), and the general unwillingness to guide and assist when I asked (nearly begged) for assistance to understand why they aren't approving me.[73]

Case study 3.4

An Australian graduate and specialist who worked overseas for four years applied for registration on December 22 2010, received an email on February 22, 2011 from someone who was doing 'an initial assessment' of his application for re-registration

Source: Royal College of Pathologists of Australasia, *Submission 24*, p. 1.

3.69 The applications of health practitioners wishing to register for the first time including overseas trained practitioners have taken inordinate amounts of time to be processed. In a case provided to the committee by the MMDS, an overseas trained doctor applied on 5 August 2010 for registration. As at 14 April 2011, registration had not been finalised. A particular concern, as a result of the inordinate amounts of time taken to process applications, is that the Certificate of Good Standing, a requirement for overseas doctors, expires after three months. MMDS noted that in many parts of the world obtaining another is 'both difficult and dangerous' and adds to costs and further delays.[74]

3.70 This situation was exacerbated by registrants not being provided with confirmation that their registration documentation had been received and/or confirmation that it had been processed.[75] Many registrants were forced to ring AHPRA, which added to the delays at call centres, in an attempt to ascertain if their applications had been received and processed. The ACMHN commented that the lack of confirmation of registration also created a situation where some nurses believed that they had successfully renewed their registration when AHPRA had failed to receive the renewal application. The ACMHN noted the case of a nurse who had posted her renewal and assumed that it had been received by AHPRA; she became

73 Australian College of Mental Health Nurses, *Submission 58*, p. 10.

74 Melbourne Medical Deputising Service, *Submission 28*, p. 8; see also Rural Workforce Agency Victoria, *Submission 50*, p. 7.

75 See for example, Australian Dental Association, *Submission 34*, p. 2.

aware that the renewal had not been received when her employer advised that her employment was to be terminated because she was not registered.[76]

3.71 A further matter raised by the Royal College of Nursing Australia is the delay in providing a hardcopy certificate of registration. This can take more than four weeks and as noted by the Royal College of Nursing Australia, casual employees are particularly affected when no hardcopy certificate has been issued. In this case, pages from the AHPRA website must be printed off and then certified as a true copy for provision to employers.[77]

Case study 3.5

My name is Pharmacist No.7. I forwarded my registration renewal in October 10. In February 11 I had received no response. When I checked the website my date registration date had expired. I filled out another application and paid again only to be contacted a few weeks later to say they had received my application in October 10 but were still processing it and now no longer required my second application. Then late March I was notified that my credit card payment was declined because the card date had expired at the end of February 2011. I was required to submit a new payment before my registration would be processed. My credit card was fine in October 2010, Nov, Dec, Jan and all of February but because of AHPRA's delay of more than four months in processing the payment when they finally did my card had expired. So for the third time I have sent in information to try to re-register. To date I still have no confirmation of registration. As the owner of a pharmacy this is unacceptable.

Source: The Pharmacy Guild of Australia, *Submission 53*, Attachment A, p.22.

3.72 The delays experienced by registrants pointed to fundamental problems in AHPRA's systems. The problems ranged from the online registration system using the American dating system for recording the date of birth (mm/dd/yy);[78] to poor internal processes which resulted in loss of renewal applications;[79] loss of documents provided with applications;[80] and loss of cheques for the payment of registration.[81] The AMA also pointed to the use of generic application forms 'that were not fit for purpose, which added to the difficulty and time for registrants to complete forms correctly and for AHPRA staff to process the applications'.[82]

3.73 Dr Sorimachi, Pharmaceutical Society of Australia, provided this example:

76 Australian College of Mental Health Nurses, *Submission 58*, p. 5.

77 Royal College of Nursing Australia, *Submission 62*, p. 3.

78 The Pharmacy Guild of Australia, *Submission 53*, p. 3.

79 Australian College of Mental Health Nurses, *Submission 58*, p. 9.

80 Optometrists Association of Australia, *Submission 37*, p. 3; Ramsay Health Care Australia, *Submission 35*, p. 5.

81 Australian Nursing Federation, *Submission 57*, p. 4.

82 Australian Medical Association, *Submission 23*, p. 4.

> We had one example where two pharmacists in a pharmacy practice together lodged and paid on the same day. One received documentation and one did not. That one contacted, did not get any feedback and then went back to pay again and was asked, 'Why are you paying again?'
>
> So I think there is a gap in the processes at AHPRA in making sure that there is a consistent delivery to the professions.[83]

3.74 The ANF also provided examples of poor internal processes. These included letters being sent to individuals informing them that they would be deregistered as they were not renewed, when in fact they had renewed their registration but AHPRA had not updated the register. The ANF stated that this caused distress for nurses in this situation.[84]

3.75 Evidence provided by Ramsay Health gives an indication of the size of the problem. Ramsay Health employs approximately 22,000 nurses across 66 hospitals. 234 nurses and midwives reported, since 1 July 2010, that they did not know whether or not they were registered. While registration fees had been paid, and receipts provided, their names did not appear on AHPRA's website. Ramsay Health noted that these were the cases which had been escalated to the central office, other cases may have been dealt with at a local level. Ramsay Health indicated that these nurses and midwives could not be employed in this capacity and were employed in other capacities within the organisation until the registration issues were finalised.[85] Ms Spaull, Ramsay Health, commented that at the time of registrations in Victoria, she committed more than 89 hours in one week to deal with problems arising from the registration process.[86]

3.76 The Royal College of Nursing Australia noted that while it may take a significant period of time to confirm registration, the fees are deducted from registrants' accounts soon after lodging their registration or renewal applications.[87]

3.77 The AHPRA processes were so flawed that operators could not provide an accurate update on the status of applications, to the extent that some pharmacists were unable to confirm if their paperwork had been received by AHPRA.[88]

3.78 Mr David Stokes, Australian Psychological Society, summed up the failures of the registration system as follows:

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83 Dr Kay Sorimachi, Director, Policy and Regulatory Affairs, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 9.

84 Australian Nursing Federation, *Submission 57*, p. 4.

85 Ms Elizabeth Spaull, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p. 47.

86 Ms Elizabeth Spaull, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p. 49.

87 Royal College of Nursing Australia, *Submission 62*, p. 3. See also The Pharmacy Guild of Australia, *Submission 53*, p. 3; Ramsay Health Care Australia, *Submission 35*, p. 4.

88 The Pharmacy Guild of Australia, *Submission 53*, p. 3.

> I guess the renewal process really highlighted their unpreparedness for this process. We had some gross injustices on both our members and our members of the community that followed on as a consequence. Perhaps the worst was experienced in Queensland. We did manage to rescue a renewal phase in Victoria and Tasmania—it could have been a bit more than it needed. The issues that really came up in that renewal process were the failure of members to receive a registration renewal form through any of the multiple ways that they attempted to send these out; they just never received any of them. Not only was that failure very potent for many of them but also there was a strong implication that it was a failure of the registrant and not of the process. [89]

Case study 3.6

I am one of the many pharmacists who were completely frustrated by the inadequacy of AHPRA. Copies of my email enquiry and consequent emails follow.

As you are no doubt aware, the 1300 419 495 phone enquiry line was unavailable for enquiries during January 2011 and communication could only be made by the online enquiry email. Although the "customer service team" advised me on January 19th my enquiry would be escalated, I had no further communication from them until 18th February 2011.

In early February I eventually had an answer on the 1300 number and was put through to the NSW office and was told "yes" my application had been received and would be processed shortly.

Are we to go through the same thing again in December 2011? Copies of emails sent to and from AHPRA:

18th January 2011 via Online Enquiry Form

Registration application posted XXXX P.O. 6/12/2010. Phoned 1300 419 495 23/12/2010 and again 13/01/2011. Spoke to XXXX. She informed me I would have received an SMS or email if Pharmacy Board had not received my application-none received. Still currently listed as registered till 31/12/2010. Please confirm by email current status of my application As 31/01/2011 is fast approaching I am concerned about my status as a registered pharmacist

19th January 2011 Reply from AHPRA to Online enquiry

Dear Pharmacist 4

Thank you for contacting AHPRA. Your enquiry has been escalated to an information/registration specialist who will advise you via email accordingly.

Regards

The Customer Service Team, AHPRA Enquiry Contact Centre

18th February 2011 Email from AHPRA

Dear Pharmacist 4

This email is to advise you that your application to renew your registration has been finalised by AHPRA.

89 Mr David Stokes, Senior Management, Professional Practice, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 62.

You will receive a tax receipt and a certificate of registration from AHPRA within 4 to 6 weeks. In the meantime, if you need to confirm your registration status, you can search the public register at…etc

Source: The Pharmacy Guild of Australia, *Submission 53, Attachment A, p. 20.*

Fast track procedures

3.79 Following the issues with the registration process, AHPRA established a 'fast track' system to enable health practitioners to be restored to the register without going through an entirely new registration process. However, it appears that AHPRA staff were not fully trained in these procedures and the Australian Physiotherapy Association commented that 'communication with health practitioners around the procedures was flawed' and the 48 hour turn-around time was a minimum with some fast track procedures taking significantly longer.[90] The Australian Psychological Society also commented that 'they instituted a fast track system which for many people was in no way fast tracked; it still took a month to get a renewal through even on the fast-track system'. [91]

Errors in registration information

3.80 The Australian College of Rural and Remote Medicine commented on the lack of quality control of data resulted in the registers containing inaccurate and/or missing information about their qualifications and status, despite accurate information being provided by the health practitioner and the College concerning fellowship status. This was particularly the case where registrants were described as 'general' rather than 'specialist'. The College concluded:

> Data discrepancies such as these also have the potential to substantially undermine the professional standing of the doctor with patients and amongst the profession (e.g. when agencies check the register to validate credentials as part of employment, teaching or other professional applications).[92]

3.81 The problems of incorrect listing of qualifications was also noted by the RACGP. The RACGP further commented that the register listed some practitioners as lapsed when in fact they had renewed their registration while other who had not renewed their registration remained registered on the public database.[93] The Australian and New Zealand Association of Physicians in Nuclear Medicine also raised this matter and noted that when an error is pointed out to AHPRA it requires

90 Australian Physiotherapy Association, *Submission 54*, p. 5. See also The Pharmacy Guild of Australia, *Submission 53*, p. 4; Royal college of Pathologists of Australia, *Submission 24*, p. 1.

91 Mr David Stokes, Senior Management, Professional Practice, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 62.

92 Australian College of Rural and Remote Medicine, *Submission 59*, p. 6.

93 Royal Australian College of General Practitioners, *Submission 46*, p. 3.

resubmission of paperwork that has already been provided and therefore the medical practitioner is unable to renew registration online, thereby creating further delays and continuing inaccuracy of the online registration record.[94]

3.82 Ramsay Health Care Australia reported that up to 30 staff received incorrect registration types in their certificates. Seven of these staff were told by AHPRA staff 'not to worry about what it says on the public register or certificate'.[95]

3.83 The AMA also provided evidence of inadequate advice from AHPRA in relation to incorrect information on the register:

> To add to the problem, AHPRA's on line register lists medical practitioners who have made the applications for renewal, but have expiry dates well before the current date. Employers are informed to ignore the expiry date and that if the medical practitioner appears on the register, they can be taken as being registered.
>
> This has been counter intuitive for hospitals and other employers who have been advised to check against the medical register.[96]

3.84 The AMA concluded that 'the integrity of the register has been corrupted and employer confidence in the information on the public register is significantly diluted'.[97]

Case study 3.7

Dr C - Vocationally Registered doctor providing 35 years medical service in solo rural GP practice was very anxious that registration renewal was paid, however, was stated as 'expired' on the AHPRA website for months after payment had been made. This doctor was taking leave and was very concerned regarding registration status upon return from leave.

Source: Albury Wodonga Regional GP Network, *Submission 30*, p. 2.

3.85 Dr Hambleton, AMA, noted the problems arising from the flawed registration process: many hours of health professionals' time have been devoted to dealing with the problems, rather than direct patient care. The biggest concern has however, been the uncertainty over registration status. Dr Hambleton commented:

> Even today some people appear on the national register with expired registration dates but are told as long as they are on the register everything

94 Australian and New Zealand Association of Physicians in Nuclear Medicine, *Submission 43*, p. 5.

95 Ramsay Health Care Australia, *Submission 35*, p. 4.

96 Australian Medical Association, *Submission 23*, p. 7.

97 Australian Medical Association, *Submission 23*, p. 7.

> is okay. This is certainly counterintuitive to a modern, efficient registration system.[98]

3.86 For many, the first indication that they were not registered came when Medicare informed the health practitioner that they were no longer registered.[99] Ms Locke, Australian Physiotherapy Association, provided the details of one such case:

> A Queensland member received a call from Medicare on 14 January to advise that she was not currently registered and that Medicare was aware there was a problem. They were making a number of these phone calls, and said that they would hold her provider number until she could get her registration fixed. She received a letter from AHPRA advising that registration had lapsed on the same day even though she had a facsimile transmission record of her renewal notices being sent in November.[100]

3.87 AHPRA indicated that of the registrations due between 1 July 2010 and 31 March 2011, the registration of approximately 24,894 practitioners lapsed.[101] Mr Martin Fletcher, Chief Executive Officer, AHPRA, indicated that:

> We write to the practitioner to advise them that their registration has lapsed. So, just to reiterate, there is a registration expiry date; the practitioner then has a month after the expiry date called 'the late period' to submit their application, and provided they have submitted their renewal application in that period, they can continue to practise. If they have not submitted, we write to the practitioner to advise them that their registration has lapsed and we also have at the moment a protocol where we, on a regular basis, transfer those data to Medicare...
>
> One of the things we did was set up a hotline so if Medicare contacted them and they said they had not heard from AHPRA, they had a dedicated hotline that they could ring.[102]

Students/graduates

3.88 Difficulties have arisen with the processing of registrations for new graduates. The ANF commented that the processing of applications takes place in the state or territory where the course leading to initial registration was undertaken. This is irrespective of where the person was living whilst completing the course and where

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98 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 54.

99 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 56. See also Specsavers, *Submission 61*, p. 1.

100 Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 2.

101 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 18.

102 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 5 May 2011, p. 28.

they are living at the time of their application for registration. This has caused delays in the registration process and in many instances new graduates were unable to commence graduate programs. The ANF commented that both graduates and employers were considerably compromised and in some cases the offer of employment was withdrawn due to the graduate's inability to provide evidence of registration.[103]

3.89 The Royal College of Nursing Australia also noted that newly graduated nurses who attempt to enrol in post graduate courses are unable to do so without proof of their registration.[104]

3.90 Another matter of concern in relation to new graduates was the lack of a pro rata fee for registration. This matter was raised by the ANF which stated that initially there was a provision for a pro rata fee. However, on 1 November 2010, 'without consultation or notice', pro rata fees were no longer allowed. This meant that if an initial applicant finished their course at the end of the year they pay an application fee in addition to a full 12 month registration fee despite the fact that they will only be registered for a part period. The ANF provided the following example:

> An ANF member has lodged a written complaint with AHPRA as they had to pay $115 to apply, then $115 for registration as a nurse, and another $115 for registration as a midwife. Although the ANF member was registered on 3 February 2011 which meant they would be required to renew by 31 May 2011 (four months), they were charged for 12 months.[105]

3.91 The ANF commented that the AHPRA website indicates on initial registration both an application fee and a fee for annual renewal of registration apply. 'Annual' by definition, means a year or returning once a year. The ANF went on to state that it acknowledged that the process for pro rata fees is only until all states are in line with the same national annual review date. However, the processing for pro rata fees should have been straight forward.[106]

3.92 AHPRA has made changes to the registration process and these are outlined in this chapter. AHPRA also commented:

> A core challenge in health practitioner regulation is balancing the at times competing priorities of workforce supply and the safety and quality of health services delivered to the Australian public. Assessing and making determinations about eligibility for registration is not just an administrative process. To undertake its statutory role responsibly, AHPRA makes sure its operational processes support a thorough assessment of applications for registration. It also aims to do this in a timely way, noting that there are no

103 Australian Nursing Federation, *Submission 57*, p. 5.

104 Royal College of Nursing Australia, *Submission 62*, p. 2.

105 Australian Nursing Federation, *Submission 57*, p. 5.

106 Australian Nursing Federation, *Submission 57*, p. 5.

externally agreed performance benchmarks for registration processes beyond the maximum period specified in the National Law.[107]

Committee comment

3.93 The committee again reiterates the importance of efficient registration processes to the provision of health care to the Australian public. The evidence points to extremely poor processes, in particular, the lack of confirmation of receipt of applications. It is normal business practice to acknowledge receipt of applications and payments. The committee considers that this matter should not have been overlooked when processes were established. In addition, the deregistration of practitioners without notification was unacceptable and pointed to significant system failures.

3.94 The committee also notes the comments made by AHPRA about balancing workforce supply and protection of the public. However, the committee considers that in the transition period, the reduction in workforce supply was not a function of protection of the public but of AHPRA's system breaking down.

Funding of AHPRA

3.95 A significant concern raised in the evidence was the issue of the funding of AHPRA. Professor Smallwood, Forum of Australian Health Professions Council, commented that under the previous accreditation scheme government provided funding assistance. However, the NRAS, following initial funding by the Commonwealth, is a user pays scheme. Professor Smallwood went on to comment 'the issue of any immediate change of government support will really mean that registration fees and accreditation fees may need to rise sharply'.[108]

3.96 The Australian Dental Association indicated that fees for its members had increased.[109] Professor Jackson, RACGP, also commented that fees had increased. Professor Jackson went on to state that these extra costs were 'for what is far less effective registration work than we have had previously is also an ongoing problem as those costs will have to be passed on to our patients'.[110] The AMA also supported this view and stated that registration is costing more and 'has not delivered an efficient system to justify the increase'.[111]

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107 Australian Health Practitioner Regulation Agency, *Submission 26,* p. 7.

108 Professor Richard Smallwood, Chari, Forum of Australian Health Professions Councils, *Committee Hansard*, 4 May 2011, p. 2.

109 Mr Robert Boyd-Boland, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 69.

110 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 28.

111 Mr Francis Sullivan, Secretary General, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 59.

3.97 The AMA went on to comment:

> No economies of scale has been identified. Under the previous State and Territory boards there was a surplus of funds despite the registration fees being approx 50 per cent less than they are now. Despite this surplus being transferred to AHPRA as part of the national contribution, the registration fees for medical practitioners increased significantly.
>
> The medical profession will not tolerate any further increase in the registration fees to cover the increasing costs of the scheme. AHPRA must now perform its functions within the existing budget by working with the respective professions to identify the efficiencies of each of the registration processes and develop business protocols to ensure consistency around the country.[112]

3.98 Submitters stated that if AHPRA requires more resources, then the initial estimates for the funding needs of the NRAS were unrealistic.[113] Mr Ian Frank added that funding for similar bodies overseas is much higher:

> It is perhaps worth noting that, if you take all the 10 health professions together that are involved in bringing together the scheme and you look at the 85...different regulatory bodies that existed across the states and territories to look after those, none of those could be described as being flush with resources. We work with colleagues in Canada and the US and we know that the resourcing of the regulatory process in Australia is significantly lower than it is in those two countries alone. So the resources that already existed on the ground prior to NRAS were probably fairly thin, you might say.
>
> To then create something on the scale that they have talked about here by simply saying, 'Oh, well, we'll take all of the resources that currently raise the registration fees, assets et cetera and bring them across into the new system but to a completely different new system,' I think suggests that perhaps that had been underestimated to start with, because if you try to build something totally new from the ground up it is going to be more expensive than just finetuning existing systems that are already out there. As Professor Smallwood has already said, for those of us who have worked with mutual recognition and worked in IT systems before, the thought that $19 million was the seeding funds for this would probably not even cover the costs of IT consultants doing this sort of development work. So we had concerns from the outset that that was probably a bit of an underestimate of the complexity and of the need that would be required to support this exercise.[114]

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112 Australian Medical Association, *Submission 23*, p. 8.

113 Mr John Low, Member, Forum of Australian Health Professions Councils, *Committee Hansard*, 4 May 2011, p. 5.

114 Mr Ian Frank, Member, Forum of Australian Health Professions Councils, *Committee Hansard*, 4 May 2011, p. 7.

3.99 It was argued that health practitioners should not be asked to provide additional funding, however, as the AMA commented 'in the event that AHPRA requires even more resources, we believe the Health Ministers will not provide the additional funding required, but instead seek to increase registration fees to cover this'.[115] The Optometrists Association of Australia were also of the view that any additional funding should be provided by government:

> Similarly, if additional resources are needed from time to time to establish the national scheme as intended then those resources should be provided by governments as agreed originally when the decision to proceed with national registration was announced. While ongoing operations were to be funded from registration fees the costs of establishing the scheme were to be met by governments and resolving start-up problems such as experienced thus far should be accepted as part of establishment.[116]

AHPRA's response

3.100 In evidence, AHPRA acknowledged the issues that had arisen since 1 July 2010. Mr Martin Fletcher, CEO, AHPRA commented:

> AHPRA has recognised that there have been shortfalls in our service to practitioners in the early days of the scheme. We are now embedding robust systems which are getting stronger all the time and of course our systems not only need to work well from an administrative point of view, but they also need to make sure that we are discharging the objectives of the national law around public protection and patient safety.[117]

3.101 AHPRA's submission provided details of the initiatives it had taken to address the problems experienced during the implementation phase of the NRAS, and these include:

- *data:* 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;[118]
- *service delivery:* improvements in service delivery have been made through:

115 Australian Medical Association, *Submission 23*, p. 4.

116 Optometrists Association of Australia, *Submission 37*, p. 3.

117 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 5 May 2011, p. 16.

118 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 14.

- addressing problems with contacting AHPRA, for example, through boosting resources for customer service teams and establishing new back-up and peak demand capacity;
- improving the renewal system to decrease the incidence of lapsing of registration, for example, through establishing a fast track application process;
- improving practitioner awareness of new registration and renewal requirements through work with professional associations, employers, education providers and students;
- addressing delays in providing certificates for example, through establishing an online process to enable registrants to request a certificate;
- developing and embedding standard operating processes;
- improving services for employers checking employee registration online; and
- improving online services including a registration tracking process and expanding the range of online services.[119]

3.102 In particular, AHPRA noted that it has implemented a fast track application process for registrants whose registration has lapsed but who wish to remain in practice. This fast track process is open for one month after the end of the late period. In the first year of the NRAS, there are no additional registration fees for the fast track registration process. Because these practitioners have been registered until very recently, the fast track process does not require proof of identity; does not require verification of qualifications (if this was recorded as part of previous registration); does not require verification of English language skills; and does not require registration history or work history. The process does require practitioners to make declarations about their continuing professional development and criminal history. AHPRA indicated that these applications are usually finalised within 48 to 72 hours of receipt of a complete application, provided that the practitioner has not made an adverse criminal history declaration.[120]

3.103 AHPRA also provided information on how it is approaching the renewal process for the 330,000 health practitioners who are renewing in May and June:

> We have substantially ramped up our communications and approach to renewals, so we are looking at renewals in the form of a campaign. 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

119 Australian Health Practitioner Regulation Agency, *Submission 26*, pp 15–16. See also Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 5 May 2011, pp 17–18.

120 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 19.

> 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 email 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.[121]

3.104 In evidence AHPRA also indicated a number of additional matters it has addressed. In relation to registration certificates, AHPRA stated that from the middle of the year a new online service will be introduced so that a practitioner can log on to the AHPRA website and print their own registration certificate. Graduates, from approved programs of study, will also be able to register online from the middle of 2011.[122]

3.105 In order to address criticisms concerning lack of national consistency, Mr Martin Fletcher, AHPRA, provided examples of the work being undertaken by AHPRA:

> ...we have developed standard operating procedures in all of the key areas around both management of registrations and notifications, and we would be more than happy to table information about that if that would be of interest to the committee. 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. We have the business processes clear around how we manage our business of registration and of course we invest in things like staff training and the like.
>
> 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 of notification around things like standard templates, standard letters, forms 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.[123]

3.106 AHWMC commented that since its formal establishment on 1 July 2010, AHPRA has reviewed and improved its capacity and ability to undertake its key functions. An example of this is the recent appointment of a Director of Business

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121 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 5 May 2011, p. 17.

122 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 5 May 2011, p. 17.

123 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 5 May 2011, p. 18.

Improvement and Innovation in acknowledgement of the need for AHPRA to build its capacity in business improvements.[124]

3.107 In addition, AHWMC informed the committee that at ts meeting of 17 February 2011, the AHWMC agreed that action needed to be taken to address the concerns being raised about registration processes during the transition to the new Scheme. It was agreed to provide additional support and expertise to assist AHPRA in managing the registration function. Additional monitoring of AHPRA has been introduced and AHPRA will be required to report to future meetings of health ministers.[125]

3.108 The AHWMC concluded that:

> Whilst it is clear that there have been some operational difficulties in the establishment of NRAS, these have largely been the result of bringing 10 professions across eight jurisdictions into a system that was to be operational from day one without any interruption to service provision...
>
> Any difficulties in bringing these systems together should not overshadow the importance of this key health workforce reform and the role of AHPRA in achieving a national scheme with a focus on the health and safety of the public and nationally consistent standards for health practitioners. 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.[126]

3.109 The Department of Health and Ageing also indicated that the Commonwealth had offered support to AHPRA: the chief nurse is available to AHPRA to discuss nursing issues; Medicare has offered to pick up call centre overflows; and assistance has been offered with the integrity of AHPRA's IT systems.[127]

3.110 In relation to funding, AHPRA commented:

> The intent into the future is that AHPRA is funded entirely from registration fees. The space we are in now is the issues associated with start-up and government has both provided money and accepted a qualified broader responsibility to assist AHPRA where it is agreed that it needs that assistance in dealing with the start-up costs.[128]

3.111 The AHWMC also commented on the funding issue and stated:

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124 Australian Health Workforce Ministerial Council, *Submission 70*, p. 9.

125 Australian Health Workforce Ministerial Council, *Submission 70*, p. 10.

126 Australian Health Workforce Ministerial Council, *Submission 70*, p. 14.

127 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 May 2011, pp 20–21.

128 Mr Peter Allen, Chair, Agency Management Committee, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 5 May 2011, p. 25.

While governments support NRAS and some have provided additional financial support to AHPRA in the establishment phase NRAS should become self sufficient and there should not be an ongoing reliance on Commonwealth, state and territory government funding. This means that the financial obligations of AHPRA and the National Boards need to be fully considered when setting registrant fees.

As has been noted above, AHPRA and the National Boards are reliant on registrant fees for funding, and at the present level AHPRA has resource constraints which limit capacity and performance. It is important that financial sustainability is an element in all decisions about the structure and scope of NRAS.[129]

129 Australian Health Workforce Ministerial Council, *Submission 70*, p. 14.

Chapter 4

Effect of implementation difficulties on health practitioners

Introduction

4.1 This chapter details the practical effects of the difficulties that health practitioners, patients and service providers experienced in dealing with the Australian Health Practitioner Regulation Agency (AHPRA) since it took over registration on 1 July 2010. These difficulties were experienced by all 10 of the health professions regulated under the National Law and resulted in concerns about financial and legal implications, impact on resourcing of the health workforce, provision of health services, and access to Medicare and other health claims. In addition, the effects on individual practitioners were substantial and ranged from anxiety and emotional distress to loss of income and in some cases loss of employment opportunities.

4.2 The effects of the implementation difficulties of the National Registration and Accreditation Scheme (NRAS) were not limited to health practitioners: the committee received evidence from large health providers and from organisations in rural areas which clearly identified that access to health services had been compromised during the implementation period. CRANAplus commented:

> The impact on the individual practitioner as a result of the inefficient delivery of process has a cascading effect on the health service they work for and then potentially consumers of that service...Ultimately, the discovery that staff are not registered, with the resultant legal implications of that, the impact is felt by the service providers, particularly in the remote context where they have a very limited workforce pool. This then impacts on consumers when the health service is unavailable due to an unregistered Health Professional.[1]

4.3 The Australian Medical Association (AMA) provided the following comment on the considerable problems experienced with the registration system:

> The cost shift is to the professions, the burden shift is to the professions, the anxiety shift is to the professions and it does not take much to work out how people have lost confidence.[2]

4.4 The problems caused by the issues with the registration process, and the resulting implications, were acknowledged by the Australian Health Workforce Ministerial Council (AHWMC):

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1 CRANAplus, *Submission 47*, pp 2-3.

2 Mr Francis Sullivan, Secretary General, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 60.

> Some delays in registration have had an impact upon practitioners and heath [sic] services. In some instances the time taken to process registration applications, particularly for overseas applicants, has resulted in delays in the commencement of employment for and for others has delayed the establishment of private practice. Some patients have also had appointments cancelled or rescheduled.[3]

4.5 The committee heard that the impact of the issues experienced under the registration system were immediate and wide ranging. Witnesses explained to the committee that the effects of the registration process became apparent from July 2010, as soon as registration fell due:[4]

> This started mid last year, with great concern from members about the length of time in accessing the medical board to find out if they were registered or not, and the problem snowballed from there.[5]

4.6 Not all organisations were aware of the problems at the same time. The Australian Physiotherapy Association (APA) for example, commented that it became aware of the issues with the registration process in early January 2011.[6]

Quantifying the impact

4.7 The issues arising from AHPRA's administration of the registration system affected large numbers of practitioners from across a range of professions. Witnesses quantified the number of their members impacted by the registration difficulties for the committee, as follows:

- Royal Australian College of General Practitioners (RACGP): over 100 members contacted the RACGP following the difficulties they were having with their registration and the problems they encountered in contacting AHPRA, and an estimated several hundred of their members were not informed of their registration renewal;[7]

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3 Australian Health Workforce Ministerial Council, *Submission 70*, p. 10.

4 Mr Stephen Milgate, Executive Director, Australian Doctors' Fund, *Committee Hansard*, 4 May 2011, p. 16; Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, pp 40 and 42; Dr Kay Sorimachi, Director Policy and Regulatory Affairs, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 11.

5 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 33.

6 Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, pp 1-2 and 4.

7 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, pp 30-32.

- MDA National Insurance: 15-20 of their members approached them directly about registration issues;[8]
- Australian Dental Association (ADA): over 500 members experienced difficulties communicating with AHPRA to check the status of their registration, and members who were sent the wrong information about their registration, even though they had put in paperwork and paid fees, numbered 'in the 20s';[9]
- Ramsay Health Care Australia: 234 employees (207 nurses and midwives, 25 allied health staff and 2 medical practitioners) were unsure if they were able to practice, as although they had submitted their registration, their names did not appear on AHPRA's register, and 34 of these employees (all nurses) had to cease practice for a period of between 3 days to 5 weeks until their registration was reinstated; [10]
- APA: 60 members responded to a survey by the APA, of which 30 per cent stated that they did not get a renewal notice, 60 per cent said that they had paid renewal fees but which were not processed by AHPRA, and a quarter said that they had made an online query but got no reply from AHPRA;[11]
- Australian Private Midwives Association: an estimated 50 members in Queensland were not notified or were given incorrect paperwork, and approximately another 30 or 50 in Victoria were not notified;[12]
- Australian Psychological Society (APS): an estimated 500 members in Victoria alone failed to renew their registration, with between 50 to 100 members from Victoria contacting the APA with their concerns about the registration process, and, in addition, a further 30 members from Queensland had not registered and had not received any communication from AHPRA;[13] and

8 Associate Professor Julian Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 10.

9 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, pp 70-71.

10 Ms Elizabeth Spaull, National Workforce Planning and Development Manager, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p.47; Ramsay Health Care Australia, *Submission 35*, p. 3.

11 Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, pp 1-2 and 4.

12 Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, pp 40 and 42.

13 Mr David Stokes, Senior Management, Professional Practice, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 65.

- Australian Association of Psychologists (AAP): 570 psychologists were deregistered in Victoria and 130 were deregistered in Queensland.[14]

4.8 However, witnesses explained that the figures provided were only indicative, as concerns regarding registration may have been voiced with other membership organisations, or with state branches as opposed to national offices. Further, the volume of those affected varied based on the state based composition of their membership, with some states being more heavily affected than others.[15] Associate Professor Rait commented that:

> ...out of the other organisations we have a disproportionate number of West Australians. As a result of that, I believe we have had fewer problems, because as we have heard the system as it was introduced was delayed because the government of West Australia wished to further modify the legislation. As a result, some of the issues were improving in Western Australia and the registration problems were not as paramount or as problematic.[16]

4.9 AHPRA also provided the committee with the number of registration renewals across all professions under the NRAS, noting that 7.2 per cent of registrations which were due to be renewed, lapsed:

> Since 1 July 2010, AHPRA has finalised approximately 370,000 renewal applications, with 345,000 renewals due by 31 March 2011. In the period between the start of the National Scheme and 31 March 2011, the registration of approximately 24,894 practitioners lapsed. This represents 7.2% of all practitioners who were due to renew their registration in that period. While comparative performance information is patchy, AHPRA has found no evidence that there are more practitioners not renewing their registration than was the case in the past.[17]

4.10 While the APS noted that according to the Psychology Board of Australia, the number of practitioners affected by registration issues under AHPRA are similar to the number of those affected in the past, the majority of witnesses across a number of professions explained to the committee that in the past it was unusual for practitioners to have issues with registration. It was argued that the volume of difficulties

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14 Mr Paul Stevenson, President, Australian Association of Psychologists, *Committee Hansard*, 4 May 2011, p. 66.

15 Associate Professor Julian Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 10; Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, pp 1-2 and 4; Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, pp 30-32.

16 Associate Professor Julian Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 10; Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, pp 30-32.

17 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 18.

experienced with the registration under the new system is unprecedented.[18] Professor Claire Jackson, RACGP, stated:

> The amount of time and the degree of angst that this registration this year has caused our members and the number of phone calls and requests for us to intervene that have come through from our members are of unparalleled proportions.[19]

4.11 This was supported by Avant Mutual Group Limited, who submitted:

> Whilst the majority of doctors seek assistance in relation to complaints and the investigation process relating to complaints, since 1 July 2010 there has been a substantial increase in the number of doctors who have sought assistance in relation to registration issues.[20]

4.12 As further evidence of the number of health practitioners affected by the implementation problems, representative organisations provided evidence of the considerable increases in their workload, particularly in negotiating and liaising with AHPRA on behalf of their members. As a result, practitioners, service providers and representative bodies have had to divert a significant amount of time and resources to deal with arising difficulties.[21] Professor Littlefield told the committee that the APS had to employ extra staff to handle all of the extra enquiries and concerns generated in response to the difficulties experienced with the registration system:

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18 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, pp 30-32. See also Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 58; Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, pp 70-71; Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, pp 40 and 42; Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 4; Ms Elizabeth Spaull, National Workforce Planning and Development Manager, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p. 49; Professor Lyn Littlefield, Executive Director, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 67; Mr Paul Stevenson, President, Australian Association of Psychologists, *Committee Hansard*, 4 May 2011, p. 67.

19 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, pp 30-32.

20 Avant Mutual Group Limited, *Submission 12*, p. 2.

21 Mrs Elizabeth Foley, Federal Professional Officer, Australian Nursing Federation, *Committee Hansard*, 4 May 2011, p. 22; Mr Stephen Milgate, Executive Director, Australian Doctors Fund, *Committee Hansard*, 4 May 2011, p. 17; Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 10; Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 4; Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, pp 54 and 59.

> ...AHPRA were referring them all to us. So they did refer these inquiries to us and the impact of that was enormous. We had to put on 13 staff for six months to handle the inquiries...[22]

4.13 While the Australian Osteopathic Association noted that their members have been affected by organisational and administrative problems since the implementation of the NRAS, they submitted that most of their members had not experienced delays or errors with their registration under the new system.[23]

4.14 However, AHPRA informed the committee that it is not possible to directly compare the extent of problems arising out of the NRAS registration process with the state and territory based schemes in place before 1 July 2010, as 'key features are different'.[24]

4.15 Mr David Stokes of the APS noted that that there were certainly differences between the previous systems and current registration processes, which may have affected the number of practitioners who did not re-register, stating 'in previous stages there was a three-month period of grace, if we can use that term, while the matter could be sorted out. This was a one-month period only'.[25] Professor Littlefield further qualified that:

> I think it is not to do with number, it is due to the impact of what has happened. It is these people who were totally unaware that they were unregistered and the huge impact of that. So impact is enormously different to previous years even if numbers are not so different.[26]

Committee comment

4.16 The number of registrants adversely affected by problems in the registration process undertaken to date by AHPRA is significant and far exceeded anything experienced under the old registration system. The committee considers that the number of health practitioners facing problems with the registration process had the potential to severely compromise the delivery of health services across Australia.

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22 Professor Lyn Littlefield, Executive Director, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 62.

23 Australian Osteopathic Association, *Submission 56*, p. 1.

24 Australian Health Practitioner Regulation Agency, Answer to question on notice, p. 1.

25 Professor Lyn Littlefield, Executive Director, and Mr David Stokes, Senior Management, Professional Practice, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 67.

26 Professor Lyn Littlefield, Executive Director, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 67.

The effect of poor administration on individual practitioners

4.17 Mr Robert Boyd-Boland, ADA, summed up the impact on practitioners:

> We have all been affected. We have all been required to undertake the registration process. It was a new process. It was a process that they were not familiar with. It was a process that a reasonable percentage of them struggled with. They were all affected.[27]

4.18 The committee received evidence that as a result of the poor processes under the NRAS, many practitioners experienced loss of income, damage to reputation, inconvenience and stress.[28] Ms Liesel Wett, Pharmaceutical Society of Australia, explained that the registration of health practitioners affects both the livelihood of practitioners and service delivery to patients, and therefore it is imperative that the current issues be addressed.[29]

4.19 In many cases practitioners were not informed of their registration renewals, received misinformation about their registration even when paperwork had been completed and fees had been paid, and also had difficulty contacting AHPRA to renew or check the status of their registration.[30] The Australian College of Rural and Remote Medicine submitted that delays in medical registration renewals under AHPRA:

> ...created a high level of anxiety and stress for the doctors generally as well as adversely affecting their ability to see patients and generate income during the relevant period. Employers of those doctors who had experienced delays in registration renewals were also impacted adversely.[31]

4.20 The AMA submitted that in their view, it is unacceptable the AHPRA's poor administration and processes have had such devastating impacts on practitioners:

> The impact of non-registration as a result of poor administration, or administrative failure by AHPRA is very significant. Once a medical

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27 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 69.

28 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 54; Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, pp 30-32; Catholic Health Australia, *Submission 44*, p. 4; Ms Julianne Bryce, Senior Professional Officer, Australian Nursing Federation, *Committee Hansard*, 4 May 2011, p. 21; Society of Hospital Pharmacists of Australia, *Submission 6*, pp 1 and 9; Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, pp 70-71.

29 Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 8. See also Chiropractors' Association of Australia (National) Limited, *Submission 29*, p. 2.

30 Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 2; Royal Australasian College of Physicians, *Submission 22*, p. 2.

31 Australian College of Rural and Remote Medicine, *Submission 59*, p. 6.

> practitioner learns they are not registered they cannot practice medicine. If a change in registration category was delayed i.e. provisional registration to general or specialist registration, the medical practitioner could not commence in their new position. In both cases the doctor cannot earn an income, and there are fewer medical practitioners available to provide medical care to patients...it is unacceptable that even one practitioner who met all of the registration requirements and application deadlines was unable to work as a result of administrative delays or failures.[32]

4.21 A number of witnesses told the committee that a significant issue has been the deregistration of practitioners without notification.[33] The committee was informed that in the case of optometrists, registration difficulties resulted in the registration of a number of optometrists lapsing, which prevented them from practicing and impacted on patient care, the optometrists themselves and of course their practices.[34] The Optometrists Association of Australia explained that where possible, optometrists tried to ameliorate the effects of this on their patients, however, the only way to address the problems faced by the practitioners was to try to re-register:

> ...optometrists affected sought to minimise the impact on patients by rescheduling appointments with other optometrists in their practices or even by sending them to competitors. While they could assist patients where possible, the only remedy for the optometrists themselves was to get back on the register as fast as possible.[35]

4.22 The committee also heard that the delay in processing applications has had a very real impact on practitioners. Before the introduction of the NRAS, the assessment of applications by nurse practitioners was assessed by state and territory nursing boards. The Australian College of Nurse Practitioners (ACNP) submitted that when the NRAS commenced on 1 July 2010, no guidelines had been made available to the AHPRA branches detailing how to process the applications for nurse practitioners (NP). As a consequence, some applications have sat for over eight months with no assessments occurring. The effect on nurses waiting for their applications to be processed so that they could gain endorsement and commence work as a nurse practitioner has been significant both financially and professionally. The ACNP stated:

> The lengthy delay has taken a heavy professional and personal toll on the NPs who have had to wait extended periods for the applications to be processed as they were unable to practice and function at the level they were qualified and experienced to perform.[36]

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32 Australian Medical Association, *Submission 23*, pp 5-6.

33 Ms Marie Heath, National President, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, p. 41.

34 Specsavers, *Submission 61*, p. 2; Optometrists Association of Australia, *Submission 37*, p. 3.

35 Optometrists Association of Australia, *Submission 37*, p. 3.

36 Australian College of Nurse Practitioners, *Submission 3*, p. 1.

Case study 4.1

I am a trauma specialist. I was for 21 years registered as a psychologist and I was on-site at the Bali bombings and the Port Arthur shootings. I was a prime ministerial adviser to John Howard during the Indian Ocean tsunami and many other major international disasters around the world. You mentioned the floods in Brisbane. I turned up at the royal national association evacuation centre during the floods to see the 1,300 or so evacuees who were staying there. I came in as a volunteer to assist as a trauma expert and was welcomed by people who knew me and knew of me. Within an hour of my volunteering to assist, I was asked to leave the premises because a screening was done and I was found to be deregistered. I had no knowledge of that at all. So this very humiliating situation impacted on me professionally and also upon thousands of people who were in the evacuation centre because I had to leave the premises and was not able to offer any services at all.

I spent the rest of that day on the phone to AHPRA and the PBA to try and work out why I was not on the register. I had looked at the register, I saw that I was not there but I had heard nothing from them. I knew that the renewal date had passed because in fact I wrote to AHPRA two weeks before the renewal date to tell them that I had not received a renewal notice and to ask if they could please send it in a timely manner. I heard nothing from them. Then we got involved in the floods and I did not follow it up, only to find that I was deregistered. I got a letter that was dated some eight days earlier, which may have been held up in the floods, and so I had been working for eight days unregistered without knowing about it. Of course, I would have had legal liability because my professional indemnity insurance would have been null and void.

Because I do not do a lot of work for Medicare, I did not have a Medicare problem at that time, but I do do some work for Medicare. So what I had to do was cease work immediately because I was threatened with a $30,000 fine if I worked. Then I found out that my Medicare provider numbers had been cancelled. I asked AHPRA if they would please take responsibility to reinstate that. They refused outright and said it would be my responsibility to do so. I was able to get back on the PBA register by sending an article to the Courier-Mail and explaining my plight in relation to the people at the evacuation centre. Within half an hour of the Queensland psychologists board being interviewed by the Courier Mail journalist, the Queensland psychologists board rang me and said they would fax out a fast-track renewal. I cleaned that up pretty quickly. I got that back to them and I got back on the register...Anyway, I was back on the register but I still could not do any Medicare work because it took a month to be reinstated back into Medicare...the effect on people's livelihoods and their reputations is unquantifiable in lots of respects. You do not just lose the money for that period of time; you lose the next six to 10 or further sessions that you might have with a patient. You lose up to 18 Medicare sessions for the next year for every Medicare client that you lose under those circumstances. AHPRA has not reinstated me as a registrant from 1991. My date of first registration now reads 27 January 2011, and that is not satisfactory either. But I do not know how much this is going to come to in terms of cost. I am yet to talk to my lawyer bout how to quantify that kind of cost.

Source: Mr Paul Stevenson, President, Australian Association of Psychologists, *Committee Hansard*, 4 May 2011, pp 66-67.

4.23 MDA National Insurance explained to the committee that some of the new requirements of the registration system have resulted in significant delays in the processing of registration applications, to the detriment of the medical practitioners involved who are unable to work until their registration is confirmed:

> ...members attempted to register on time, but their applications were delayed impeding investigation following self-disclosure of past health issues. Investigations did not commence until after the members were due to commence their employment, leaving them unable to work. This was obviously an unexpected and unfortunate outcome for those practitioners affected.[37]

4.24 The committee also heard that AHPRA's poor administration and communication has caused significant frustration and distress for a number of practitioners. The Australian Nursing Federation(ANF) explained:

> Letters were sent to nurses and midwives informing them that they would be deregistered as they were not renewed, when in fact they had renewed their registration but AHPRA had not updated the register. This caused distress to members as nurses and midwives take their right to hold registration seriously and will not work without registration.[38]

4.25 These issues were reflected across a series of professions, and the committee heard a number of examples similar to that provided by the Pharmaceutical Society of Australia (PSA) in relation to the experience of pharmacists who were trying to have their queries and concerns addressed by AHPRA:

> They could not get through on the 1300 number. There was no answer. Their emails remained unanswered...Even when they did finally manage to get through on the numbers, because the operators were unable to assist them they were then asked to lodge email queries instead, which then went unanswered.[39]

4.26 The committee heard that even representative bodies and healthcare service providers had significant difficulty contacting AHPRA, indicating a 'systemic lack of

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37 Associate Professor Julian Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 8. Regarding the impact of new requirements on the registration process, see also Ms Julianne Bryce, Senior Professional Officer, Australian Nursing Federation, *Committee Hansard*, 4 May 2011, p. 23.

38 Australian Nursing Federation, *Submission 57*, p. 4.

39 Ms Liesel Wett, Chief Executive Officer, and Dr Kay Sorimachi, Director Policy and Regulatory Affairs, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 9; Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, p. 40; Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 30; Professor Lyn Littlefield, Executive Director, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 62; Royal College of Pathologists of Australia, *Submission 24*, p. 2; Mr Paul Stevenson, President, Australian Association of Psychologists, *Committee Hansard*, 4 May 2011, p. 63.

communication not only with those registrants but also with their professional bodies'.[40] Witnesses explained that there was only one contact point, 'an e-mail or a 1300 number', regardless of the seniority of the person contacting, or whether they were an individual or organisation. Ramsay Health Care Australia elucidated:

> We feel that we did not as an organisation have an 'in' to somehow get into those more senior levels when we are looking at quite significant impact across healthcare service provision.[41]

4.27 Ms Spaull informed the committee that Ramsay Health Care Australia has had to institute its own mechanisms for ensuring it has correct and up-to-date information regarding the registration of their employees, as it is not readily or reliably provided by AHPRA:

> Also, just to further your understanding when we talk about lost shifts and lost hours, whenever we had someone who was struck off the register—in, I would have to say, nearly 100 per cent of the cases—this became known to us through our multiple registration track. Through our internal mechanisms of communication, we actually encouraged every nurse and every allied health professional to log on for themselves and see where they were at, and often that would reveal problems: 'Oh my gosh! I've paid but I'm not registered.' So it would come about almost by accident that we would find out. They did not receive letters willingly from AHPRA. You will see in our folder that we actually had to draft letters with legal to create a sense of communication and documentation around these serious incidents where people had been practising and were not aware that they were not registered. We pulled them off the ward immediately.[42]

4.28 The committee received evidence that the communication and accessibility issues that many organisations and individuals experienced with AHPRA have not been addressed. Mr Gavin O'Meara explained, 'It is still difficult to get in contact with key people, and it is difficult to get in contact with people who have the knowledge to solve the problems'.[43]

4.29 In a similar vein Ms Liz Wilkes, Australian Private Midwives Association, explained to the committee that the difficulties experienced with the registration process have been significant, and the issues that most of the Association's members are having with AHPRA remain outstanding:

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40 Mr Alex Chapman, Manager, Government and Public Affairs, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 70.

41 Ms Elizabeth Spaull, National Workforce Planning and Development Manager, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p. 51.

42 Ms Elizabeth Spaull, National Workforce Planning and Development Manager, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, pp 48 and 50.

43 Mr Gavin O'Meara, Manager, People and Culture, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p. 50.

> Only 30 people have actually managed to get through the process. There would be at least another 70 or so seeking eligibility who are in some part of the process. There are another 38 in Queensland that are in some way along the track of the process. We find that they submit their application and they are then required to submit more information. We have got a huge email trail around what is being required in addition to what they have already submitted...there does not seem to be any single point of accountability, or it is very difficult to find a single point of accountability around eligibility notation.[44]

4.30 Dr Hambleton noted that the AMA's members now have little confidence in the registration system:

> I can tell you that the confidence of the members from Queensland is very low that, when they put their forms or dollars in, they will actually get actioned in an appropriately reasonable time frame.[45]

Impact on practitioners' reputation

4.31 The committee heard that one of the most concerning effects of the problems with the registration system is the deregistration of practitioners and the impact this has on the practitioner's reputation, which can be very distressing for those affected. This was evidenced by the ADA's submission:

> In some instances, some practitioners, thinking that they had correctly followed the registration process, found that through delays occasioned at AHPRA with their registration process, they were in fact not registered and thus had claims made on Private Health Insurers and Medicare refused. Whilst AHPRA has since attempted to deal with this issue, severe reputational damage has been suffered by the dental practitioner.[46]

4.32 MDA National Insurance informed the committee that five of their members had been deregistered, and all but one have now been successfully re-registered.[47] Dr Hambleton described the impact that deregistration can have on a practitioner:

> As a medical practitioner, I cannot overstate how devastating it can be when you find yourself not registered and not being able to practise medicine and

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44 Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, p. 40; see also Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, p. 42.

45 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 57.

46 Australian Dental Association, *Submission 34*, p. 3. See also Dr David Hoffman, *Submission 205*, p. 2.

47 Associate Professor Julian Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 8.

> earn a living. There is devastation for the doctor's family...The fact that many doctors found themselves in this very situation is appalling.[48]

4.33 The committee received evidence that physiotherapists also had concerns about how their deregistration by AHPRA had affected their reputation as practitioners:

> Other physios have been concerned that there was a perceived loss of reputation, that new patients were cancelled and went elsewhere and wondered why this person was not registered.[49]

4.34 The committee was further informed that the deregistration of practitioners also affects the patients, in particular, it can have a deleterious impact on a patient's confidence in their practitioner:

> One impact is not being able to see a particular doctor or the waiting times increasing substantially. The second impact is the decrease in confidence in the practitioner that they are seeing. A lot of the time we have international medical graduates. We need to maintain confidence in our colleagues from overseas to make sure that they can do the job that they are brought here to do. If an international graduate is deregistered and the patients find out, they come back and say, 'How come he was not registered last week, he is registered this week and he was the week before?' So the confidence in the practitioner is almost as disturbing as the fact that they could not see anyone.[50]

4.35 The APS explained to the committee that practitioners had to explain their deregistration to clients:

> Being characterised as 'unregistered' is damaging to a practitioner's reputation and not meaningfully understood by clients. It was necessary for the full explanation to be given to all clients to explain the cancellation of services. No offer to remedy this slur on the reputation of the psychologists was ever made by AHPRA.[51]

Committee comment

4.36 The committee acknowledges the devastating impact of AHPRA's administration of health practitioner registration on the livelihoods of health practitioners, on the operation of practices and health service providers, and also on patients. Further, the committee notes the detrimental impact to the reputation of

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48 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 54. See also Royal Australasian College of Practitioners, *Submission 22*, pp 2-3.

49 Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 3.

50 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 57.

51 Australian Psychological Society, *Submission 36*, p. 8.

practitioners and patient confidence in practitioners due to AHPRA's substandard management of the registration process. The committee is concerned that AHPRA's poor administration has led to delays in the processing of registrations, the deregistration of practitioners, the provision of incorrect information, and the provision of insufficient support for practitioners, which have had a very real impact on the lives of practitioners and their patients.

Financial and economic loss

4.37 Once of the more serious issues arising out of the difficulties with the registration process was that due to delays in the processing of registration, the deregistration of practitioners or the amount of time taken to follow up registration issues with AHPRA, a number of practitioners across all professions found themselves unable to work and earn an income.

4.38 Dr Hambleton explained to the committee that the financial implications of a practitioner not being able to work for a period of time can be 'devastating', as often, general practices 'run very close to the financial line', so even having one practitioner who is unable to work for several weeks can have serious financial consequences.[52] The evidence provided by MDA National Insurance supported these comments, and further stated:

> While we were not able to quantify the potential actual economic loss that practitioners suffered, we were aware that some practitioners have ceased practising until such time as their insurance and registration requirements were finalised.[53]

4.39 The committee received evidence that due to the delays in registration processes, some nurses and midwives were unable to work and therefore unable to receive a wage:

> Some nurses and midwives subsequently had to forgo shifts as they could not provide evidence of registration to their employer and therefore were financially compromised. [54]

4.40 For the committee's information, the APA provided an example of how the registration issues have impacted practitioners in a financial sense:

> One private practitioner in Queensland was removed from the register. She received no correspondence from AHPRA. She checked the online register when the APA notified our members that there were problems. She is a

52 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 57; Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 31.

53 Associate Professor Julian Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 8.

54 Australian Nursing Federation, *Submission 57*, p. 4; Mrs Elizabeth Foley, Federal Professional Officer, Australian Nursing Federation, *Committee Hansard*, 4 May 2011, p. 22.

> small business owner with 20 or so clients per day. She was forced to cancel three days worth of clients because of the issue. She had been indirectly affected by the Queensland floods and she had already lost thousands due to closure and power failure. She was worried that if this were not rectified her business would not survive the loss of thousands of dollars more from cancellation of clients.[55]

4.41 The committee was told that as a result of the registration issues experienced, some psychologists were unable to work and some even lost patients, to their financial detriment:

> So those people could not see any patients for quite some time, until they got back on the register. A lot of them lost income and lost their patients, although a number of them continued to just work—or not work, because they were not registered, but support somehow their patients by trying to get them somewhere else.[56]

Case study 4.2

Avant assisted a doctor, whose registration incorrectly contained an entry indicating that he was subject to conditions on his registration. This was pointed out to AHPRA and was eventually corrected, but this took a number of days. This had a particularly significant impact upon the doctor concerned who had developed a locum business. With remote locum positions the communities require doctors to be available at the earliest possible time and the doctor loses substantial amounts of income for each day he/she is unable to work. The doctor concerned was unable to apply for locum positions whilst there was a suggestion that his registration was subject to conditions.

It was therefore harmful not only to the doctor, but also likely caused inconvenience to patients in the areas where he could have worked but for the conditions. In another case, it took several weeks to correct the register of details for a locum physician.

Source: Avant Mutual Group, *Submission 12,* pp 5–6.

4.42 The Optometrists Association of Australia submitted that practitioners whose registration had lapsed suffered significant loss of income, with over 100 optometrists remaining unemployed until they were re-registered. The Optometrists Association of Australia acknowledged that the fast track re-registration system had the potential to mitigate loss of income, however, stated that it is unclear to what degree this was taken up, or how effective it was in practice:

> Where a lapsed registrant applied immediately for Fast Track re-registration and was restored to the register within 48 hours, the loss of income was limited to just a few days. However, we do not have statistics about how long re-registrations actually took and of how many lapsed registrants did

55 Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 3.

56 Professor Lyn Littlefield, Executive Director, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 65.

> not seek Fast Track re-registration because they did not realise it was an option available to them.[57]

4.43 Mr Boyd-Boland also explained to the committee that the financial impact of the registration issues is not quantifiable, as it has been absorbed by individual practices. However, he provided the committee with a description of the practical implications of the registration difficulties experienced by dental practitioners, who practice in:

> Largely office based practice, single or two-person practices so, when problems arose and there needed to be clarification through AHPRA, it took the dentist out of circulation insofar as provision of treatment was concerned for the duration of the inquiry that was made to AHPRA. From the accounts that I have received the length of time that it took to obtain clarification varied from hours to never...I am sure when the problem crystallised they were able to deal with a lot of it perhaps out of hours but the office hours of AHPRA coincided with surgery hours, so when there was direct communication with AHPRA the dentist was out of circulation.[58]

4.44 The delays in the processing of registration applications also affected the wage which those practitioners completing their intern year, were able to be paid. Some provisional registrants were unable to obtain full registration because they were told to fill out the incorrect form and consequently 'they were employed as interns on intern pay not on PGY2 pay'.[59]

4.45 Ms Wett, PSA, explained that the delays in processing registration applications and renewals has had considerable impact on both pharmacists and intern pharmacists:

> 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.[60]

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57 Optometrists Association of Australia, *Submission 37*, p. 3.

58 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 70.

59 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 57.

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

4.46 The committee further heard that currently there do not seem to be any suggestions on how to address this loss of income for practitioners who were unable to practice due to AHPRA's administrative failures:

> ...individuals rely on their ability to generate an income. There was a gap for a lot of individuals where they were not generating income. We certainly know about doctors who are misclassified in the public sector whose income is down. I do not think there is any remedy at this stage for any of that.[61]

4.47 The AMA suggested that a compensation scheme for any future events should be considered:

> While it would be difficult to set up a scheme to retrospectively provide compensation for financial loss as a result of non-registration because of the transition to the national scheme, consideration should be given to establishing a scheme for future events.[62]

4.48 The committee was told that Ramsay Health Care have extrapolated the costs of the registration issues to the health industry between 1 July 2010 and 1 January 2011 to amount to 'in excess of half a million of dollars of labour'. However, Ms Spaull noted that this figure is not inclusive of all of the impacts, 'I do not think we can measure the toll on committed healthcare professionals supporting their colleagues and the organisation in the interests of patient safety, but nevertheless it is ever present'.[63]

Cost of registration

4.49 Witnesses also told the committee that a further financial implication for practitioners under the new registration system is the increase in the cost of registration, which could also affect patients. The RACGP noted concerns regarding increased registration costs, with doctors now paying 20 to 60 per cent more for registration. Professor Jackson explained:

> It has become a far more expensive system and, as I said, we are worried that we are going to have to pass those costs on to our patients. There are no part-time opportunities to reduce costs. Most organisations charge far less for doctors with family responsibilities who are doing two or three sessions a week than they do for full timers, but medical registration is not like that.[64]

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61 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 58.

62 Australian Medical Association, *Submission 23*, p. 7.

63 Ms Elizabeth Spaull, National Workforce Planning and Development Manager, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, pp 48-49.

64 Professor Claire Jackson, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 28.

4.50 Mr Boyd-Boland informed the committee that dental practitioners have also been impacted financially by the substantial increase in registration fees:

> They have all been affected, quite simply, in a financial sense in that the registration fees have significantly increased. In our submission we quoted that it was $250 for registration in Western Australia and it has increased to $545.[65]

4.51 The committee heard that this financial impact will have significant implications for academics in the field of dentistry:

> There is a significant shortage of academic staff in universities training dentists. I have an instance of one member who sought to register. He lectures two days a week and, for first-year students in a pre-clinical area, there is not a patient to be seen. He is required to register. His existing registration fee is $101. He had to reapply, so that is $275, and then apply for registration, $545. In an environment in which we are struggling to get academics into the universities that is a big negative for that person. I am sure there are other academics in a similar situation.[66]

4.52 The AMA further pointed out:

> ...I would stress the point that we were given every indication there would not be an increase in personal fees. So if the budget of $20 million was inadequate then I hope we are not working on an assumption that there will be a continued cost shift to the professionals in order to crank that budget up.[67]

Committee comment

4.53 The committee is of the view that the exposure of practitioners to loss of income and financial risk due the inability of the national health practitioner registration authority, AHPRA, to adequately perform its functions, is deplorable.

4.54 The committee notes the estimated financial impact for six months of this debacle exceeds $0.5 million in labour, and is concerned that there do not appear to have been any support systems put in place for those practitioners and service providers who suffered loss of income.

4.55 The committee is very concerned that on top of the financial risk already faced by many practitioners, practitioners are also facing substantially increased registration fees. The committee notes the impact that this may have on academic staff and the consequent possible implications for the training of practitioners.

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65 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 69.

66 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 72.

67 Mr Francis Sullivan, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 61.

4.56 The committee particularly notes comments by the AMA and agrees that any shortcomings in the projected budget for the NRAS should not be recovered through increases in registration fees.

Implications for Medicare benefits and private health insurance claims

4.57 The committee received evidence that the deregistration of practitioners also affects the ability of patients to claim Medicare benefits.[68] MDA National Insurance explained to the committee those practitioners who are not registered will have their Medicare provider number cancelled:

> We were also given to understand that AHPRA has advised Medicare of those practitioners who had not reregistered and Medicare has cancelled their provider number, which removes the entitlement to remuneration. It is not clear at this stage to us if Medicare will seek reimbursement of these billings. In respect of dentists it is unclear to us whether health funds will similarly demand reimbursement for payment made while a practitioner was unregistered.[69]

4.58 The Australian Private Midwives Association further noted that the delays in processing registrations have left midwives without Medicare provider numbers, and consequently their clients have been unable to claim Medicare rebates:

> Around the eligibility component there are at least 20 to 30 practices that have been significantly impacted by delays. These have been when midwives have expected to have eligibility so that they could get their provider numbers and they have met all the criteria but were not processed. So the women who were seeking care were expecting a Medicare rebate and were unable to get it for their care. It would be $700 to $1,000 per birth package. If you had 30 midwives that had delays and they are all taking 40 women a year, you do the maths. It is fairly significant.[70]

4.59 The committee received evidence stating that as some practitioners were deregistered without notification, and therefore continued to practice without registration, their patients were not able to claim Medicare benefits. Professor Littlefield explained to the committee that many psychologists and their patients were exposed in this manner:

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68 See for example: Avant Mutual Group Limited, *Submission 12*, pp 3-4; Australian Medical Association, *Submission 23*, p. 6; Name Withheld, *Submission 9*, p. 1; Dr Anne Etchells, *Submission 190*, p. 1; Dr David Hoffman, *Submission 205*, p. 2; Dr Marion Yeadon, *Submission 211*, p. 3; Name Withheld, *Submission 214*, p. 3; Royal Australasian College of Physicians, *Submission 22*, p. 2.

69 Associate Professor Julian Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 8.

70 Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, p. 41.

> There has been a shocking impact because many of those psychologists did not know they were not registered, so they continued to see their patients and then when the patients went to Medicare to claim the rebate they discovered that the psychologist they were seeing was not any longer registered. So the patient was impacted on by not being able to get the rebate. There was an enormous impact on the patient in how they viewed the psychologist and then they had to tell the psychologist that they were not registered.[71]

4.60 This situation was also detrimental to the treatment of patients. For example, the APS stated:

> Clients with serious mental or physical health issues without warning were no longer eligible for Medicare rebates and in most cases their treatment was disrupted. In Queensland this error occurred in the midst of the devastating January floods, which meant traumatised clients could not access treatment from psychologists affected by the registration renewal debacle.[72]

4.61 Further, the committee heard that there is 'potential for other claims for payment being affected, such as WorkCover or motor accident insurance rebates, and definitely health fund rebates'.[73] In particular the committee was told that physiotherapists were concerned that private health funds and other payment claims would be affected:

> There have been concerns about the fact that private health funds would not rebate once they found out that the treating therapists were not registered in that time, and who would repay what had already occurred with our HICAP system where it automatically goes into the practitioner's bank account when the patient is refunded at the point of service.
>
> There are issues around workers comp, Department of Veterans' Affairs, and other mechanisms where there are third-party payers. For example, if I treat children, trust funds might pay the amount but will request refunds if they find that you are deregistered.[74]

4.62 This was validated by AHWMC who submitted that:

> Because claims for benefits through the Department of Veterans Affairs (DVA) and private health insurers rely on data from Medicare Australia,

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71 Professor Lyn Littlefield, Executive Director, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 65. See also Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, pp 1 and 3.

72 Australian Psychological Society, *Submission 36*, p. 9.

73 Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 1.

74 Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 3.

> there was potential for DVA and private health insurance (PHI) claims to also be affected.[75]

4.63 Mr Stokes elaborated that even under the fast track renewal process, it took a number of weeks to be able to re-register and then reactivate a Medicare provider number:

> We had people who even with a fast-track renewal, as was mentioned, took three weeks, and all that time they are unable to practise, essentially, and they are certainly unregistrable with Medicare. Not until you are fully reregistered can you go back to Medicare and say, 'May I have my provider number reactivated?' That was reasonably efficient once you got AHPRA to do its work. So it was a pretty critical situation.[76]

4.64 The APA explained that they had:

> ...been assured or given some undertaking that there will be a period of grace or if it is seen that it was definitely not the registrant's fault that rebates through Medicare would be reintroduced, et cetera.[77]

4.65 While Dr Hambleton noted that the minister had 'thankfully indicated that she would support act of grace payments for patients', Ms Kerry Flanagan, Department of Health and Aging, noted that there are some Constitutional considerations around the Commonwealth's ability to make ex gratia or act of grace payments:[78]

> As I understand it, this is a Constitutional issue in that the power to regulate health professions actually resides with the states and territories and not the Commonwealth. The legislation to set up this national scheme was passed in each parliament across the nation. There have been discussions, and again I can provide more detail on notice in terms of what the issues are around ex gratia and act-of-grace payments and whether there is redress at the Commonwealth level considering the makeup and the legislation which governs this particular scheme.[79]

4.66 However, Ms Flanagan explained to the committee that the Commonwealth has identified a different approach to ensuring that Medicare claims can be reimbursed, which does not involve ex gratia or act of grace payments.[80] AHPRA

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75 Australian Health Workforce Ministerial Council, *Submission 70*, p. 11.

76 Mr David Stokes, Senior Management, Professional Practice, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 67.

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

78 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 58.

79 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 May 2011, p. 21.

80 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 May 2011, p. 21.

submitted that, where a practitioner has experienced administrative difficulties in renewing their registration which has resulted in their registration lapsing, and continuity of registration status can be established, AHPRA will 'adjust the date of the practitioner's new registration so that it begins immediately after his or her previous registration lapsed'.[81] Ms Flanagan informed the committee that 'in effect the consequence of it is that there is no lapse in registration, which means that Medicare can then pay benefits'.[82]

4.67 The AHWMC further elaborated on how the problems regarding Medicare benefits were being addressed:

> AHPRA established a fast-track process to assist practitioners to return to the register as quickly as possible. In addition, a procedure was established to address registration issues for practitioners whose registration was affected by transitional issues (such as incorrect address details held on the AHPRA database). AHPRA has written to practitioners who fast tracked their registration because they had missed their renewal deadline in November and December 2010 due to the new arrangements. These practitioners are now able to complete a statutory declaration up until Monday 2 May 2011, if they believe that their registration has been incorrectly dealt with.
>
> AHPRA will advise Medicare Australia directly that the provider is registered and Medicare Australia will then seek to process the practitioner's record within two days of receipt of this updated information, allowing patients to resubmit outstanding or rejected bulk bill claims. This procedure has ensured continuous registration and the payment of Medicare and DVA benefits to affected practitioners and their patients.
>
> ...Where the AHPRA procedure addresses registration issues for a practitioner for the purposes of Medicare, it also addresses registration issues for associated PHI claims.[83]

4.68 Associate Professor Rait noted that only a few practitioners may have claimed Medicare benefits for the period that they were no longer registered. Of the cases that he was aware of, Associate Professor Rait noted that Medicare had honoured the payments and backdated the registration of all cases but one. He further stated:

> As far as I am aware, only one person potentially could be asked by Medicare to repay those payments...As far as we see, it has only affected one member potentially. Obviously we would be anxious that they were not subject to any sanctions, particularly repayment of benefits, and the

81 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 20.

82 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 May 2011, p. 21.

83 Australian Health Workforce Ministerial Council, *Submission 70*, p. 11.

inconvenience to patients that that would cause. If the Commonwealth could be flexible that would be appreciated.[84]

Case study 4.3

The following account was provided by a medical practitioner who had been deregistered without her knowledge, due to AHPRA's failure to process her application in a timely manner:

On 1/3/2011, staff at the medical practice at which I work received a phone-call from a clerk at the local Medicare office to notify us that a Medicare claim for one of my patients, whom I had seen in late February, could not be processed because I had been deregistered. The staff member contacted me, but as I was out of the office doing home and hostel visits that afternoon, I did not follow it up till the next morning when our senior office staff member contacted AHPRA and confirmed that I was indeed deregistered. Patients with appointments for that week were contacted to make other arrangements. Some patients were able to see other doctors in our practice and others were able to take appointments at a later date. There were some patients who had complex and urgent needs that I wished to follow up. I also am responsible for the care of nearly 60 residents of aged care facilities...Normally, if the nursing home or hostel staff have any concerns with these residents, they contact me directly, day or night, seven days a week. Being unregistered I was unable to give any direction on the care of these patients.

I did not have any difficulty contacting AHPRA staff by telephone...They also advised me that I should write on the fax cover note a request for backdating of my registration to cover the period of my deregistration. Backdating of registration is not automatic in the situation of deregistration and would only be considered on receipt of a request in writing and under certain circumstances like my own and would take longer than 48 hours to process. On 2/3/2011 with the cover note as advised, I faxed the fast track renewal application to AHPRA...

After raising her concerns with AHPRA, the doctor received the following correspondence from AHPRA:

Thank you for your time on the telephone this morning. I appreciate you confirming for me the issues in your contact with AHPRA. I confirm my apology for the human error within our office which led to your registration lapsing and for the very significant consequences of that error for you, your practice and your patients.

I also confirm that advice was provided to Medicare Australia on 9 March 2011 that your registration had been lapsed in error and had been reinstated without any gap in registration dates. I trust this will enable you and your patients to follow up any outstanding matters with Medicare.

Whilst I sincerely hope your future contacts with AHPRA enable seamless continuation of your registration, you should not hesitate to contact me if you wish to discuss this or any other matter.

Source: Dr Sandra Gaffney, *Submission 210,* pp 3–5.

84 Associate Professor Julian Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 14.

4.69 The AMA noted the measures instituted to address the issue of reimbursing Medicare claims, however, remained concerned that 'there is no guarantee that all patients who should have received their benefits will in fact receive them.' Further, the AMA emphasised the fact that the problems with Medicare claims, and the subsequent mechanism to address the problems, have culminated in a significant burden for practitioners:

> The mechanism requires the medical practices to resubmit rejected claims. Practices will also have to tell their patients that they can resubmit their claims for benefits. We are concerned about the additional costs imposed on medical practices for having to rectify this problem on behalf of their patients, and had hoped for a more automatic solution for these practices.[85]

4.70 As a result, the AMA suggested that it is essential that communication between Medicare and AHPRA improves:

> Firstly, there must be a mechanism to ensure that medical practitioners are advised by AHPRA that they are no longer registered, and not by Medicare Australia. Secondly, there must be a sufficient period of notification before the registration is cancelled so that medical practitioners can put in place appropriate arrangements for patient care. Finally, as a stopgap measure, before cancelling access to Medicare benefits Medicare Australia should first check whether a practitioner is billing Medicare items and if so double check the registration status with AHPRA.[86]

Committee comment

4.71 The committee is dismayed that the failure of AHPRA to undertake its principal function in an efficient manner has resulted in deregistration of health practitioners and thus precluded patients being able to claim Medicare rebates. AHPRA's failure to notify practitioners that their registration had lapsed, prevented practitioners from being able to practice thereby exposing them to potential loss of patient confidence, exposing patients to an unnecessary financial impost, and in some cases, interrupted treatment.

4.72 Further the committee remains concerned that despite the mechanisms agreed to by AHPRA and Medicare Australia to reimburse Medicare claims, not all patients are guaranteed to receive these reimbursements.

Legal liability - professional indemnity insurance

4.73 The committee received evidence stating that in some instances, practitioners across all professions had continued to practice, in the belief that they were registered,

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

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

when in fact, they were no longer registered by AHPRA.[87] It was noted that this could have consequences for the legal liability of the practitioners, and also impact on patients:

> Clearly the implications of not being registered could have had a direct bearing on practitioners' indemnity, which of course is a concern to us. The respective professional indemnity insurance policies obviously cover medical and dental practitioners in our case, and each define the practitioner as being one who is registered to practise their profession. In addition, the policy excludes claims to the extent the claim arises when the insured was not registered or was prohibited from practising.[88]

4.74 In their submission to the committee AHPRA also acknowledged the potential consequences for practitioners who practice without being registered:

> Professional indemnity insurance policies held by some practitioners may limit the liability of the insurer, or exclude coverage entirely, in circumstances when the practitioner has engaged in unregistered practice.[89]

4.75 Similar concerns were expressed about the consequences of optometrists continuing to practice without being aware that their registration had lapsed, particularly how this might affect their professional indemnity insurance. Specsavers submitted that as a result, lapsed registration:

> ...could lead to professional association disciplinary actions and a lapse of professional indemnity insurance which has obvious legal liability consequences for the optometrist, their patient and their employer.[90]

4.76 The committee heard that due to concern about the possible legal implications of staff who were unaware that they had been deregistered, and therefore had continued working, Ramsay Health Care Australia have analysed and documented any possibly adverse situations on their own initiative:

> One of the reasons we captured this data—it is actually almost ironic in that we did not intuit a public hearing—is, if you like, as protection in the future should something come up. We wanted to have evidence of email trails. So it was actually done, if you like, to document evidence that we had done everything we could to be lawful in a system that was very turbulent and challenging.

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87 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 71; Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 1.

88 Associate Professor Julian Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 8. See also Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 71.

89 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 20. See also Avant Mutual Group Limited, *Submission 12*, p. 3.

90 Specsavers, *Submission 61*, p. 2.

> When one of these situations would happen, we would have a teleconference between the staff member involved, me and the CEO of the hospital; we would draft a letter and have them sign a stat dec stating that they actually got legal advice. So it was very procedural in managing this. We did not have a lot of advice from AHPRA on what to do, so we relied on our own decision.[91]

4.77 In light of this work, Mr O'Meara informed the committee that Ramsay Health Care Australia have not identified any significant outstanding issues:

> We have a fairly good idea, because I can assure you we have gone back and looked at the activity or any adverse event that might have resulted from a person working during a period of time when they were potentially not registered. So we have had a look at that. We are able to identify that at this stage, and from what we can see there are no significant outstanding issues there.[92]

4.78 The Optometrists Association of Australia noted that AHPRA has indicated their willingness to backdate registrations to the date of the lapse in circumstances in which 'AHPRA error contributed to the lapse'. While this should mitigate the insurance risks for patients and optometrists, it was noted that currently, it is unknown how many of the lapsed registrations will be able to be backdated in this manner.[93]

4.79 In addition, as a result of the current situation arising from the registration issues experienced, professional indemnity insurers have indicated that they will 'be extending indemnity to those practitioners that perform services innocently or unknowingly whilst not registered'.[94] MDA National Insurance submitted:

> In response to these unique circumstances, MDA National Insurance will hold as indemnified practitioners who have a gap in their registration due to the delays, provided registration is eventually granted. However, we will only apply this concession in this transitionary year 2010/11. This has required negotiation with our international reinsurance partners.[95]

4.80 Associate Professor Rait continued:

> 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

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91 Ms Elizabeth Spaull, National Workforce Planning and Development Manager, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p.48.

92 Mr Gavin O'Meara, Manager, People and Culture, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p. 48.

93 Optometrists Association of Australia, *Submission 37*, pp 3-4.

94 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 71.

95 MDA National Insurance, *Submission 20*, p. 2.

> that through our negotiations with our reinsurers we can indemnify all members who have so been exposed.[96]

4.81 Further, AHPRA added that it is unlikely that practitioners would be successfully prosecuted for unintentionally practicising while unregistered:

> The National Law creates an offence for a person who knowingly or recklessly holds themselves out as a registered health practitioner. Therefore, a practitioner who inadvertently fails to renew registration and continues to practise his or her profession is highly unlikely to be found by a court to be in contravention of the National Law.[97]

4.82 Witnesses noted the undertaking by professional indemnity insurers, but pointed out to the committee that it is uncertain how any such cases may be received in the court:

> We understand that the indemnity insurers have offered to support the practitioner's periods when they have been deregistered through no fault of their own; however, that has never been tested. So, if there are issues and cases that come up in the period when they were technically unregistered, we have no idea what the court's view on that will be, particularly for practitioners who continued to see patients in the belief that they had looked after all the details and subsequently found out that they had not.[98]

4.83 In addition, the AMA submitted that the legal implications of AHPRA's imprecise administration are ambiguous:

> Further, we are unclear about the legal implications for medical practitioners remaining on the public register with an expiry date on the register, even though AHPRA advice is that if a medical practitioner appears on the register, they are deemed to be registered regardless of the expiry date.[99]

4.84 The committee also heard that the professional indemnity requirements under the new system are of particular concern to self-employed midwives. Ms Wilkes of the Australian Private Midwives Association noted that under the new system AHPRA requires all health practitioners to have professional indemnity insurance – while the Association welcomes this, Ms Wilkes explained to the committee that this has created difficulties for self-employed midwives:

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96 Associate Professor Julian Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, pp 8 and 10-11.

97 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 20.

98 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 58; Mr Robert Boyd-Boland, Chief Executive Officer, and Mr Alex Chapman, Manager, Government and Public Affairs, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 71.

99 Australian Medical Association, *Submission 23*, p. 7.

> ...a significant number of our members are impacted by this change and are unable to meet the requirement. There is no satisfactory insurance product available to cover all elements of a self-employed midwife's practice. We believe that we are significantly disadvantaged by that situation at this point in time.[100]

4.85 In a similar vein, Ms Justine Caines of Homebirth Australia stated:

> Homebirth remains the only service in this country that is not afforded appropriate professional indemnity insurance. Therefore, that is obviously a double whammy as midwives do not have appropriate professional protection and homebirth consumers are the only women in Australia who do not have protection should negligence of that support be proven—and, when we are looking at lifelong care in the worst case scenario of a disabled child, that is considerable. So we are coming from a position of considerable disadvantage.[101]

Committee comment

4.86 The committee notes that due to AHPRA's failure to effectively administer practitioner registration, in some instances, practitioners have unknowingly practised without being registered, as AHPRA also failed to notify these practitioners that they had been deregistered. The committee is dismayed that practitioners have been exposed to possible legal liability as a result of AHPRA's administrative incompetence. Not only does this situation put practitioners and their practices/employers at risk, it also puts patients at risk, and the committee considers this an unacceptable situation.

4.87 The committee acknowledges the undertakings by professional indemnity insurers to cover practitioners for the period in which they were practicing while deregistered through no fault of their own. However, the committee is aware that no such case has yet been tested, and remains uneasy as to whether practitioners will be sufficiently protected in such a circumstance.

4.88 Further, the committee is concerned that there may be other, as yet unidentified, legal implications arising from AHPRA's poor administration and processes.

Impact on patients and health service provision

4.89 The committee heard that the issues with registration and the resulting effect on the time and workload of practitioners have also led to impacts on patients:

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100 Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, p. 40.

101 Ms Justine Caines, Committee Member, Homebirth Australia Inc., *Committee Hansard*, 4 May 2011, p. 34.

> Hospitals were not obviously permitting practitioners who were visibly unregistered on the record to practice or perform procedures, so they had to be abandoned and rescheduled. Treatment of patients was delayed.[102]

Case study 4.4

A nurse practitioner candidate commenced a series of education programs for the community on the role of the remote nurse practitioner in anticipation of registration as a nurse practitioner. As this candidate's registration is now in the 5th month of processing, the community is losing faith that the role will come to fruition. This candidate perceives that the general community attitude has become one of remote communities again missing out on access to an increased range of health care services.

Source: Royal College of Nursing, *Submission 62*, p. 2.

4.90 The impact this can have on both practitioners and their patients was illustrated by the RACGP, who informed the committee that about half a dozen of its members had been deregistered:

> They were informed after the date had elapsed that they were no longer registered and they had to go back and reapply for their registration, have a police check et cetera, and that created a situation where they were effectively unable to work in their practices for several weeks...As a small business person, when you are unable to make an income, there are significant financial imposts. It was a very major issue for our members, particularly elderly patients who were relying on the relationship they had with their general practitioner and the ongoing knowledge of their biopsychosocial health.[103]

4.91 Dr Hambleton described the impact that deregistration of a practitioner can have on patients:

> It is worrying for the patients. Alternative arrangements need to be made for their treatment. And it is confusing for patients about why their doctor cannot treat them.[104]

4.92 The Australian College of Rural and Remote Medicine noted that the registration delays have exacerbated long waiting periods for patients in rural and remote communities:

> The registration delays also adversely impacted patients who had no choice but to seek alternative medical care, and or wait longer for their consultations. Most of these patients would have already waited for

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102 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 71.

103 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 31.

104 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 54. See also Royal Australasian College of Practitioners, *Submission 22*, pp 2-3.

> relatively long periods for their appointment due to existing workforce shortages in rural and remote areas.[105]

4.93 Rural Workforce Agency Victoria emphasised that such delays can impact on the provision of health services to the community, particularly those more remote communities:

> Delays are both socially economically and costly to the communities and patients. This compromises the sustainability of fundamental health services to communities of high health need.[106]

4.94 Mr Stokes further explained to the committee that the registration issues regarding practitioners had deleterious impact on clients:

> Above all, it was the impact on clients in the community that was most significant from our perspective. Although it was very distressing for our members and for registrants, the impact on the continuity of care and on some of the most vulnerable members of the community was a serious consequence of this disruption.[107]

4.95 The APA further noted that the time that practitioners had to invest in following up issues with their registration also had implications for patient care:

> The head of the department spent a lot of time chasing up registration problems, as clinician certificates were needed for reaccreditation purposes for the hospital department. They did not cancel the patients in this instance, but the head of the department said that administrative issues with AHPRA took up significant amounts of time for nearly all of the physiotherapists in the department and therefore that could not be dedicated to patient care.[108]

4.96 Dr Hambleton, AMA, elucidated:

> Far from reducing red tape, the introduction of the national registration scheme has in fact diverted considerable health care delivery hours away from direct patient care. Thousands of doctors and other health practitioners, and large number of health care providers such as hospitals and member organisations like the AMA have spent countless hours and administrative resources dealing with individual and generic problems with registration.[109]

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105 Australian College of Rural and Remote Medicine, *Submission 59*, p. 6.

106 Rural Workforce Agency Victoria, *Submission 50*, p. 6.

107 Mr David Stokes, Senior Management, Professional Practice, Australian Psychological Society, *Committee Hansard*, 4 May 2011, p. 63.

108 Ms Melissa Locke, President, Australian Physiotherapy Association, *Committee Hansard*, 5 May 2011, p. 3.

109 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 54.

Committee comment

4.97 The committee points to the impact on patients and health service provision as yet another example of the serious implications of AHPRA's administrative failures. The committee notes that it has exacerbated patient waiting times, and compromised health service provision, particularly in rural and remote communities which are already particularly vulnerable.

Workforce issues

4.98 Ramsay Health Care Australia explained to the committee that access to a skilled workforce in adequate numbers is central to the provision of health care:

> Ramsay Health Care holds the view that excellent patient safety outcomes are inextricably linked to effective and efficient regulation and registration of health care practitioners alongside excellence in clinical governance and leadership. Our single greatest challenge in terms of delivering high quality care (regardless of sector and/or service) is to ensure that we can ensure access to a sufficient supply of skilled and regulated professionals.[110]

4.99 The RACGP informed the committee that 700 doctors nationally across all medical colleges (not just general practitioners) have not re-registered, and a series of practitioners have become deregistered, leading to decreased workforce capacity.[111] This has caused significant concern about the current 'very thin workforce'. Professor Jackson elaborated:

> We know that 700 doctors nationally have not reregistered. We assume they are retiring but in general practice we need every single person on deck to be able to deliver the high quality services we have traditionally delivered to 90 per cent of our population every year. We cannot afford another year like this last year, or doctors will not reregister and they will just go into early retirement. I do not believe our workforce, particularly in rural and remote areas, will recover.[112]

4.100 Dr Hambleton further explained that any disincentive to re-register could risk the loss of experienced practitioners who are valuable resources for training and teaching:

> Anything that puts a hurdle in front of people who have the option of stopping work creates a potential risk that they will not come back into the workforce. These are people at the end of their careers and we know that our senior practitioners are excellent resources for teaching and excellent

110 Ramsay Health Services Australia, *Submission 35*, p. 10.

111 Royal Australian College of General Practitioners, *Submission 46*, p. 2; Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 32.

112 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 32.

> resources for training. This is happening at a time when we need those resources to build up the numbers in the professions. If we lose them and they are deregistered and not available—doing something else—it is a tragedy going forward.[113]

4.101 The ANF further noted that while the challenge of enabling and encouraging people to re-enter the profession is ongoing, the current registration processes are causing delays which 'have quite a profound impact on those clinicians'. Ms Julianne Bryce of the ANF explained:

> ...certainly we continue to have frustrations around enabling people to work who are well able to and being able to demonstrate that and to facilitate that process so that they do not choose to work in another profession because they cannot come back into nursing...some of our most senior clinicians, our nurse practitioners, who are candidates and completed and who are ready to be endorsed as a nurse practitioner but the processes are holding them up.[114]

4.102 However, the ANF did comment that ultimately the NRAS will help increase re-entry levels for the profession:

> In fact, the National Registration and Accreditation Scheme will assist people re-entering the nursing and midwifery field in that previously there were only a small number of programs that people could do to enable them to re-enter the nursing and midwifery workforce. So we have had instances where people, for example from South Australia, might have been able to do a course only through Queensland. They had to register in Queensland, not in South Australia, and so when they wanted to work in South Australia, their home state, they had to re-register in South Australia as well, whereas now they will be able to register nationally. The other component that I want to mention is that the programs for re-entry will be accredited under national accreditation, so that will also assist people re-entering the field.[115]

4.103 Catholic Health Australia submitted evidence of significant delays in registering new graduates – in some cases up to three months. During this period the graduates were unable to work. New graduates indicated that given the problems being experienced with registration, they had decided to delay the commencement of their graduate program by several weeks. The fact that in some instances new graduates were 'not being registered until a couple of days prior to their commencement date with the facility' caused significant problems for the hospitals employing those graduates:

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113 Dr Steve Hambleton, Vice President, Australian Medical Association, *Committee Hansard*, 4 May 2011, p. 60.

114 Ms Julianne Bryce, Senior Professional Officer, Australian Nursing Federation, *Committee Hansard*, 4 May 2011, p. 24. See also Mr Gordon Blair, *Submission 71*, p. 1.

115 Mrs Elizabeth Foley, Federal Professional Officer, Australian Nursing Federation, *Committee Hansard*, 4 May 2011, p. 25.

> This caused a great deal of anxiety and stress to the new graduates, but also to the organisation as rosters were done around the fact that they were starting on a certain date.[116]

4.104 Submitters informed the committee that employers found themselves supporting employees who were unregistered and unable to work. Ramsay Health Care Australia told the committee that it provided new graduates awaiting registration alternative employment as assistants in nursing or patient care attendants so that they were able to earn an income, even if it was at a lower rate – this equated to 8,000 hours (or round 1000 shifts) of employment. Health service providers were further impacted by the delays in registration:

> The delays in rostering graduates had flow on effects such as the postponement of graduate programs, rostering and staffing implications and loss of income for those awaiting registration.[117]

4.105 Ms Spaull quantified the effect of the registration issues on work hours, and the implications this had:

> ...we know that we had around 5,500 productive hours lost on average to these periods of not being registered. Those shifts, which are hard enough to fill, were then filled with either overtime or goodwill from our existing permanent staff, from agency staff or from casual pooled nurses that would work extra shifts.[118]

4.106 Further, Mr O'Meara explained to the committee that delays in the registration process also affects recruitment timeframes:

> ...there is a workforce shortage and a skill shortage. That will get worse. The lead time for us bringing key staff from overseas, because we just do not have enough in this country, can be nine months or 12 months. We just had teams of people in the UK and Ireland recruiting for expansions in hospitals in Western Australia that will be coming online between 15 and 18 months out. We have won the tender for a hospital on the Sunshine Coast which will come online sometime near the end of 2013. We will start that process...certainly no later than the end of this year or the beginning of next year. This is because it is not just the migration time. The immigration process is quite quick. The registration processing does take a significant amount of time.[119]

4.107 Similar issues were raised by Catholic Health Australia's members, who noted the difficulties that registration delays cause in terms of recruiting staff from overseas:

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116 Catholic Health Australia, *Submission 44*, pp 3-5.

117 Ramsay Health Services Australia, *Submission 35*, p. 4.

118 Ms Elizabeth Spaull, National Workforce Planning and Development Manager, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p.48.

119 Mr Gavin O'Meara, Manager, People and Culture, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p. 49. See also Catholic Health Australia, *Submission 44*, p. 4.

> There are difficulties with the time frame it will apparently take to register specialist mental health nurses that have been recruited from the UK and Canada. The recruitment firm report it will take 6 months to register new recruits. One particular facility is in urgent need of these staff due to the difficulty of recruiting Australian nurses to these roles.[120]

4.108 These concerns were echoed by the Rural Health Workforce Australia, who noted that administrative issues have the potential to particularly affect the workforce in rural and remote communities:

> Government is investing huge amounts of money into the recruitment and retention of International Medical Graduates to provide a service to areas of our country where Australian graduates don't seem to be keen in working. Rather than put up barriers to this group of people who play a major role in looking after the health and wellbeing of our rural communities we could make them feel valued and make the "process" welcoming while retaining its rigour.
>
> Currently this valuable workforce are required to provide duplicate information to a number of bodies (the information provided to the AMC is then required by AHPRA – to what purpose?). Mostly the various players including AHPRA, registering bodies, specialist colleges and PESCI providers are blissfully unaware of the financial and personal costs incurred by doctors coming to work in Australia. Many of them have to work for years or borrow from family to save to undertake the AMC, English Language tests and PESCI interviews. To compete against other countries we must get better at these processes.[121]

4.109 This was supported by the AMA who submitted that any disincentive to the recruitment of international medical graduates would particularly impact on the health workforce in rural and regional communities:

> Poor response times and lack of assistance and advice by AHPRA have greatly impacted on International Medical Graduates (IMGs) who are offshore and attempting to register for the first time with the Medical Board of Australia. IMGs are particularly important to the medical workforce in the less populated and more remote areas. Delays in registration of IMGs have a direct impact on access to medical services by rural and remote communities.[122]

4.110 The Australian Doctors Trained Overseas Association noted that a large part of Australia's medical workforce are international medical graduates:

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120 Catholic Health Australia, *Submission 44*, p. 4. See also Australian College of Mental Health Nurses, *Submission 58*, p. 10.

121 Rural Health Workforce Australia, *Submission 49*, pp 4-5.

122 AMA, *Submission 23*, p. 7. See also Melbourne Medical Deputising Service, *Submission 28*, p. 5.

> International Medical Graduates (IMGs) currently make up the backbone of the medical workforce in rural and remote regions of Australia. Approximately one-third of the Medical workforce in Australia, and up to 50% of the doctors in rural and remote areas, are IMGs. In the past year there has been a mass de-registration of IMGs as a result of AHPRA policies/decisions which has affected tens of thousands of patients living in rural areas.[123]

4.111 The Melbourne Medical Deputising Service noted that Australia's reliance on international medical graduates is unlikely to decrease going forward, as workforce shortages are project to continue:

> There is little on the horizon to indicate that workforce shortages will ease in the future – certainly not in the provision of after-hours care. The latest MABEL Survey Report found that GPs are no longer able to provide the after-hours service themselves:
>
> - Around 50% of doctors would like to reduce their working hours.
> - Around a quarter of all doctors are very or moderately dissatisfied with their hours of work.
> - The first wave of the study's data collection completed in 2008 found that nearly 12% of the GP workforce was expected to retire within five years (MO, 1 May 2009).
> - Intentions to quit are largely driven by those over 55 years old who expect to retire, and thus reflects the loss to the workforce of the 'baby boomer' generation.[124]

4.112 Rural Health Workforce Australia further noted that AHPRA's inability to provide a timeframe for processing registrations creates significant difficulty for employing practices and for practitioners. For employing practices this uncertainty surrounding practitioner registration can hamper preparations for the arrival of new doctors, particularly plans for the arrival of doctors from overseas. It also hinders international medical graduate candidates in their plans to depart their home country and in planning their arrival in Australia. Rural Health Workforce Australia further submitted:

> The delayed arrival of a doctor in to a rural community places a strain on other medical and health practitioners in the town as they carry the burden until the arrival of the new doctor.[125]

4.113 The committee was informed of the timeframes for registration, and how this can impact on recruitment:

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123 Australian Doctors Trained Overseas Association, *Submission 63*, p. 1.

124 Melbourne Medical Deputising Service, *Submission 28*, p. 5.

125 Rural Health Workforce Australia, *Submission 49*, p. 3.

> The processing time for general registration is currently 6 weeks and limited (Area of Need) is currently taking up to 3 months. In addition, other agencies such as Medicare require one month to process provider numbers and DoHA require one month to process a 19AB Exemption, an application can sometimes take 5 to 6 months to gain approval. This often results in practices losing a candidate and potential recruitment opportunities being lost to rural general practice and communities of high health need.[126]

4.114 Rural Workforce Agency Victoria emphasised that such delays can impact on the health workforce, particularly in those more remote communities:

> Delays can result in practices losing potential recruitments and/or practices withdrawing offers of employment due to the length of time it takes the candidate to obtain medical registration. Such delays can deter potential candidates thus undermining the intention of the legislation to ensure workforce mobility and flexibility. Communities of need such as rural, remote and aboriginal communities with workforce shortages are very reliant on the recruitment of GPs, especially IMGs.[127]

Case study 4.5

Dr A – UK graduate experienced 6 month delay with registration (initial application provided to AHPRA pre July 2010). During this time AHPRA did not respond to emails or telephone calls in relation to this matter. Dr A was extremely anxious during this time and the AWRGPN and Practice employing Dr A remained in constant contact with the Dr to appease and ensure interest in relocating to Australia. The Practice was forced to close books at the Practice due to the delay in the registration application process and the pressure on existing GPs.

Source: Albury Wodonga Regional GP Network (AWRGPN), *Submission 30*, pp 1-2.

4.115 In summary Rural Workforce Agency Victoria (RWAV) submitted that:

> RWAV is concerned that a lack of a robust national approach, serious and significant administrative delays, poor communication and undue barriers to registration have impacted on the medical workforce and Australia's ability to recruit and place medical practitioners. We are also concerned that this will continue to compromise Australia's reputation as a destination of choice and hinder Australia's ability to attract crucially needed qualified medical practitioners particularly in relation to rural and remote areas of need, in a globally competitive market.[128]

Committee comment

4.116 The committee is concerned about the implications of registration difficulties on the health workforce in Australia. In particular, these difficulties appear to be

126 Rural Workforce Agency Victoria, *Submission 50*, p. 8

127 Rural Workforce Agency Victoria, *Submission 50*, p. 6.

128 Rural Workforce Agency Victoria, *Submission 50*, p. 10.

hampering the employment of qualified practitioners from overseas as well as making it difficult to retain and facilitate the re-entry of currently qualified domestic practitioners. The committee acknowledges the concerns raised in the evidence provided to the committee regarding the impact any decline in the health workforce may have on health service provision in Australia. This is a serious matter and goes to the heart of the purpose for which AHPRA was established.

Chapter 5

Related matters raised during the inquiry

Introduction

5.1 A number of related matters were raised in during the inquiry. These went to the issue of accountability of the Australian Health Practitioner Regulation Agency (AHPRA), mandatory reporting requirements, the registration of overseas health practitioners and the registration of senior doctors and academic health practitioners.

Complaints handling

5.2 Comments on complaints handling went to two areas: complaints about AHPRA itself; and the handling of complaints about health practitioners.

Complaints about AHPRA

5.3 Submitters commented that there were difficulties in attempting to complain to AHPRA.[1]

5.4 Many practitioners contacted the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC). However, submitters commented on the difficulties of contacting the NHPOPC and the lack of resources of that office to deal with the number of complaints received.[2]

5.5 The Australian Health Workforce Ministerial Council (AHWMC) commented that there was concern about AHPRA's handling of complaints about its operations. AHWMC stated:

> The scale of the issue was evident from the number of contacts made with the National Health Practitioner Ombudsman Privacy Commissioner (NHPOPC). Many of the issues raised would, under normal circumstances have been expected to have been resolved by AHPRA in the first instance. However, as a result of frustration on the part of registrants and employers unable to make contact or get satisfactory responses from AHPRA callers resorted to making contact with the NHPOPC. An indication of the improvement in AHPRA operating in this area is the significant decreases in calls to the NHPOPC in recent months about not being able to contact AHPRA.[3]

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1 Royal College of Nursing, *Submission 62*, p. 4.

2 Royal College of Nursing, *Submission 62*, p. 4; Australian Doctors' Fund, *Submission 52*, p. 7.

3 Australian Health Workforce Ministerial Council, *Submission 70*, p. 12.

Complaints about health practitioners

5.6 The AHWMC commented that a significant role for AHPRA is the management of notifications to boards regarding registrant health, conduct or performance. AHPRA inherited all open notifications and disciplinary matters from state and territory boards (other than NSW) at 1 July 2010. AHPRA is currently managing approximately 3000 notifications, including those received since 1 July 2010.[4]

5.7 The Australian Dental Association (ADA) pointed to a number of difficulties being experienced with the complaints process:

- right to respond to a complaint: there are inconsistencies between jurisdictions as to the right to respond to a complaint by a patient;
- response times in the preliminary assessment phase: the response times vary across the jurisdictions from 14 days to 28 days;
- provision of information: the level of information provided to the health practitioner who is the subject of a claim varies from only the name of the complainant or notifier to additional essential information; and
- notification form: the form is prescriptive and 'may lead a notifier to make choices which are not reflective of their actual concerns'.[5]

5.8 The Australian Medical Association (AMA) commented on the need for consistency in complaint handling and the importance of having appropriate complaint handling processes in place. The AMA stated:

> It is vital that the State AHPRA offices, in conjunction with the State Medical Boards, have clear and documented operating protocols to ensure that complaints about medical practitioners are dealt with consistently around the country. As yet, we are not aware that these protocols have been written. They should be drafted and made available for public consultation before being finalised.
>
> The importance of operating protocols is highlighted by recent matters where the AMA has evidence of administrative and bureaucratic methods significantly interfering with the normal rights of persons. We also believe that some complaints could have been resolved simply and more efficiently, but have instead been drawn out at the expense of the registrant and AHPRA resources.[6]

5.9 Avant Mutual Group commented that in its view, the complaint handling processes are working well and the processing of complaints appear to be taking no longer, and is often much quicker, than the time taken for processing complaints by

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4 Australian Health Workforce Ministerial Council, *Submission 70*, p. 12.

5 Australian Dental Association, *Submission 34*, pp 5–6.

6 Australian Medical Association, *Submission 23*, p. 8.

some of the previous state boards. However, Avant Mutual Group stated that there is concern that the approaches to complaint handling are not consistent nationally, in particular 'the willingness of some state boards/AHPRA to accept and act on notifications'. Avant Mutual Group voiced concerns that some notifications are generated in other than good faith. However, AHPRA seems to be unwilling to consider the issue of good faith. Avant Mutual Group provided the following case:

> In Queensland AHPRA has given a medical practitioner a notice of its intention to impose onerous and restrictive conditions on the doctor's practice because a current competitor of the doctor (for whom the doctor receiving the notice had once worked), had made a complaint suggesting the doctor was not competent to practice. The time given for the doctor to respond to the notice to show cause was very short. There was no supporting material provided with the complaint. After Avant became involved and senior practitioners had assessed the doctor in question, it was clear that the doctor was competent to practice. However, the expense required to respond to this complaint, which appeared to be based on anti-competitive issues, was significant.[7]

5.10 Avant Mutual Group also noted that other complaints have been made by ex-spouses of doctors during family break-ups and anonymously. Avant concluded 'the necessity for AHPRA to be take care in accepting and acting on such complaints including using its emergency powers as set out under section 156, needs to be emphasised'.[8]

5.11 The committee received a large number of submissions in relation to complaints against privately practising midwives. Homebirth Australia commented that 'the handling of those complaints by AHPRA are of grave concern'.[9] It was submitted that there are individual cases where a midwife has been suspended or had substantial limitations placed on their professional practice pending an investigation of their conduct. The Australian Society of Independent Midwives (ASIM) commented:

> ASIM is aware of a number of individual cases where a midwife has been suspended or had substantial limitations placed on her professional practice pending an investigation into her conduct. ASIM submits that taking such steps before a matter is finalised is a very serious matter and has the potential to destroy a midwife's livelihood. As the National Law recognises, such a step should only be taken when the practitioner poses a serious risk to persons and it is necessary to take immediate action to protect public health or safety. When taking such a serious step it is imperative in the interests of natural justice that the complaint then be dealt with in an expeditious manner. ASIM is aware however of at least one case where a

7 Avant Mutual Group Limited, *Submission 12*, p. 13.

8 Avant Mutual Group Limited, *Submission 12*, p. 13.

9 Homebirth Australia, *Submission 33*, p. 1.

> midwife has been suspended pending the investigation of her matter for nearly 11 months. This is simply unacceptable.[10]

5.12 It was also argued that the complaint handling processes regarding self-employed midwives are different to those which apply to medical practitioners or nurses. Ms Justine Caines, Homebirth Australia commented:

> We have one midwife who has had a complaint that is not by the current family or any person that is being cared for by her. It is by some third party. It is not based on and does not represent hospital notes that have been gathered. She was then relegated instantly to hospital-based practice, she has lost her livelihood and her clients have lost their care provider. I spoke to a director of obstetrics at a tertiary hospital in Sydney who has 27 years experience, and I said to him, 'In your experience, has this happened to an obstetrician in 27 years?' He said no. He said that the only case he knew of was after five complaints of a registrar made in quick succession; they then took out a management plan and that registrar was put under some sort of supervised practice. However, with homebirth midwives, across virtually every state, we are seeing a considerably different bar.[11]

5.13 The Australian Private Midwives Association provided further evidence in relation to this matter, noting that even if a previous complaint, of which a midwife has been absolved, is on the midwife's record, they are prevented from re-registering:

> ...where complaints have already occurred with a midwife's registration, be it 10 or 15 years ago or whenever it might have been, that triggers a process when they go to reregister, which prevents them from actually reregistering. Even if the complaint had been dealt with and put to the side and they were exonerated, they are still unable to complete a re-registration process. That creates significant difficulty.[12]

Committee comment

5.14 The committee is concerned that AHPRA's complaints handling processes were so inefficient that practitioners had no recourse but to refer matters to the Ombudsman even for matters so trivial as to find a contact number for AHPRA staff. The committee considers that a national organisation should have the highest standards and efficient processes for dealing with complaints.

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10 Australian Society of Independent Midwives, *Submission 45*, p. 3; see also Australian Private Midwives Association, Midwives in Private Practice, *Submission 21*, p. 5; Maternity Coalition, *Submission 40*, p. 3.

11 Ms Justine Caines, Committee Member, Homebirth Australia Inc., *Committee Hansard*, 4 May 2011, pp 34-35. See also Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, pp 39 and 41.

12 Ms Liz Wilkes, National Spokesperson, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, p. 40.

5.15 In relation to complaints about practitioners, the committee was provided with many examples of timeframes for resolution of complaints which were not reasonable. The committee notes that complaints are dealt with by the relevant board. However, the administration of complaints is undertaken by AHPRA (except in NSW). The committee is concerned about inconsistency in the application of complaint processes, the prescriptiveness of the application form and the way in which vexatious complaints are handled. The committee considers that further development of the complaints process is urgently required.

Accountability

5.16 The issue of accountability of AHPRA was raised in two areas: first, accountability to the Parliament and secondly, accountability to health practitioners.

5.17 The Council of Australian Governments (COAG) agreed to the provision of $19.8 million with for $12.5 million for practitioner regulation and $7.5 million for accreditation reform. The Commonwealth Government contributed $9.9 million (50 per cent of the total) which reflected the established Australian Health Ministers Advisory Council cost sharing principles.[13] The Australian Health Workforce Ministerial Council (AHWMC) is responsible for the oversight of the implementation of the National Registration and Accreditation Scheme (NRAS).[14]

5.18 The Australian Health Workforce Ministerial Council was established under the *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* following signing of, and based on, the agreement between First Ministers to the COAG Intergovernmental Agreement (IGA) for a National Registration and Accreditation Scheme for the health professions (ref. IGA Item 7). The functions of the AHWMC are also outlined in the National Law sections 11–15 of Part 2. The Department of Health and Ageing stated that 'the Ministerial Council consists of the Commonwealth, State and Territory Health ministers who remain accountable to their respective Governments'.[15]

5.19 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, explained that policy advice is provided to AHWMC by the chief executive officers of the health departments. Further, a committee of officials was set up when the NRAS was established. Ms Flanagan went on to note:

> That still exists; it has different membership but it is made up of officials of all jurisdictions in terms of providing policy advice. I would just like to clarify though that the role of the ministerial council...it has an ongoing and defined role but had not intended or expect to continue administrative involvement except as a very light touch. So under the national law

13 Department of Health and Ageing, *Answer to question on notice*.

14 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 May 2011, p. 18.

15 Department of Health and Ageing, *Answer to question on notice*.

> ministers are responsible for approving registration and accreditation standards put forward by the national boards, approval of specialist registration and approval of areas of practice for the purposes of endorsement. Ministers can only give directions to national boards or the national agency under limited circumstances specified in the legislation. So I just want to be clear that when you talk about policy, I suppose the role of this particular council in these arrangements is set out in the legislation itself.[16]

5.20 AHPRA provides its annual report to the relevant minister in each of the jurisdictions, including the Commonwealth, for presentation to their respective Parliaments. AHPRA also indicated that communication with the responsible minister in each state and territory occurs as required and primarily involves the relevant state or territory manager for AHPRA and issues of relevance to the specific jurisdiction.[17]

5.21 AHWMC has monitored the implementation process and in February 2011, AHWMC met to discuss issues arising from the move to the NRAS. The Department of Health and Ageing commented that:

> ...the workforce ministerial council discussed the issues that were being raised by the professions in February...It agreed to have an increased monitoring role over AHPRA and that AHPRA needed to report more closely. It appointed the CEO of the Victorian Department of Health, Fran Thorn, to work with AHPRA to resolve the problems. All ministers agreed that they would make a commitment to seeing what support they could provide to AHPRA through this start-up period.[18]

5.22 Some submitters pointed out that under the old system, registration was handled by state or territory boards directly accountable to the health minister. However, under the NRAS, the system is much more complex and unclear. Mr Stephen Milgate, Executive Director, Australian Doctors' Fund, commented that 'there is no one particular minister or public servant who we can actually approach who had any authority to really control the process'.[19] Mr Milgate went on to state:

> Our major focus of concern is the non-accountability to a legislature of this entire process. We are appealing to all parliamentarians. This has been created outside of the legislative process and outside direct parliamentary scrutiny.[20]

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

17 Australian Health Practitioner Regulation Agency, *Answer to question on notice.*

18 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 May 2011, p. 20.

19 Mr Stephen Milgate, Executive Director, Australian Doctors' Fund, *Committee Hansard*, 4 May 2011, pp 15–16.

20 Mr Stephen Milgate, Executive Director, Australian Doctors' Fund, *Committee Hansard*, 4 May 2011, pp 15–16.

5.23 Mr Milgate concluded that :

> ...we do not believe that any parliamentarian, of any political party in this country, wants an unaccountable organisation running 500,000 health professionals which is unreachable, has nine bosses and is virtually unaccountable by design. We do not believe that is in the national interest...But our essential concern is for public safety, the national interest and the rights of legislatures to hold people accountable for their actions.[21]

5.24 In relation to accountability to the professions within the NRAS, the committee received many comments about the lack of transparency of AHPRA and the lack of consultation with the professions about problems during the implementation phase as well as concerns about the lack of accountability for the accreditation issues.

5.25 In relation to AHPRA, Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia, commented:

> Ultimately we would like to see greater transparency and consistency in registration processes and other activities which directly affect health practitioners and the services they then provide to the community; effective and timely responses to queries and in the processing of applications; and better communication with health practitioners as well as stakeholder organisations such as ours.[22]

5.26 Dr Mukesh Haikerwal raised concerns with section 236 of the National law and its effect on accountability. Section 236 shifts liability from people working for or on behalf of AHPRA, known as 'protected persons', to AHPRA itself. Dr Haikerwal's concern was that the practical exercise of s236 will hinder accountability as 'this suggests no accountability for the work or how it is done'.[23] Dr Haikerwal was further concerned that the ministerial accountability arrangements were also unclear.

5.27 In relation to accountability of the boards set up under the NRAS, the Australian Psychological Society (APS) commented:

> It is of concern that the new registration process appears to be dictated by the National Board without due consideration of the practical consequences to health practitioners. "*Continuous development of a flexible, responsive and sustainable Australian health workforce"* has in our experience, not been contemplated in the implementation of the National Scheme. Nor does the operation of the National Scheme to date have any apparent transparency or accountability.[24]

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21 Mr Stephen Milgate, Executive Director, Australian Doctors Fund, *Committee Hansard*, 4 May 2011, pp 19-20.

22 Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 8.

23 Dr Mukesh Haikerwal, *Submission 69*, p. 5.

24 Australian Psychological Society, *Submission 36*, p. 9.

5.28 The Australian College of Mental Health Nurses (ACMHN) suggested that communications between nursing organisations and the National Nursing and Midwifery Board did not meet the standard required under the National Law when consulting on registration standards. For example, there appears to be no mechanism to inform stakeholders that a consultation is taking place other than publication on the website and 'usually this has been in association with inappropriately short periods of time for consultation'.[25]

5.29 The ACMHN went on to comment:

> This type of process limits robust consultation, reduces transparency of process and can inadvertently encourage bias.[26]

5.30 However, the Australian Doctors Trained Overseas Association (ADTOA) supported the new NRAS arrangements regarding accountability, and characterised it as a 'significant improvement':

> A significant improvement in the national scheme is that now there are standards outlined in the National Law that are supposed to guide the policies and actions of the professional boards regarding transparency, accountability and fair due process. In addition the Board's policies/action cannot breach anti-discrimination law. This is a significant improvement over the former system where there was little if no oversight of the separate Medical Boards, and minimal avenues for meaningful input from the government and other key stakeholders.[27]

5.31 Yet this support was not without criticism. The ADTOA noted that in order for international medical graduates, or IMGs, to challenge board actions where the IMG believes the board has not followed its own policy, the IMG would themselves need to pursue the matter through the courts:

> This begs the question how can the Medical Board continue to act in a manner that contravene the standards that are supposed to guide their actions? Also how is it possible for AHPRA to be able to implement policies that may be in breach of anti-discrimination law? Unfortunately the only way to challenge potentially unlawful actions/policies is through legal channels. As already mentioned, given the overwhelming costs involved, legal action is not a realistic option for most IMGs.
>
> Secondly, currently there is no mechanism in place to enforce these standards, and/or make judgments as to whether these standards have, or have not been met. This is a bit like having a speed limit but no speedometer and no police available to enforce it!

5.32 AHPRA provided the following comments about accountability:

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25 Australian College of Mental Health Nurses, *Submission 58*, p. 8.

26 Australian College of Mental Health Nurses, *Submission 58*, p. 8.

27 Australian Doctors Trained Overseas Association, *Submission 63*, p. 11.

> AHPRA and the National Boards are committed to transparency and accountability in all their functions, as well as delivering high standards of service. AHPRA, together with all National Boards, have adopted a Complaint Handling Policy and Procedure (the Complaints Policy). This formalises a process through which dissatisfied applicants and practitioners can have their concerns about AHPRA or the National Boards fairly considered and addressed. The Complaints Policy was developed to provide this mechanism and has been in effect since 14 September 2010.[28]

5.33 In order to improve accountability, health practitioner organisations suggested that more formal arrangements be put in place to ensure appropriate and timely consultation between AHPRA and organisations and between the national boards and organisations. Mrs Elizabeth Foley, Federal Professional Officer, Australian Nursing Federation (ANF), commented:

> ...the ANF wishes to take advantage of this inquiry to recommend that AHPRA establish a formal and ongoing advisory committee of the registered professions and soon to be registered groups. This committee would essentially be an expansion of the existing professional reference group, of which the ANF is a member, whose remit would include discussion of all issues pertaining to the national registration and accreditation scheme.[29]

5.34 The Australian College of Rural and Remote Medicine also called for proactive mechanisms within AHPRA to manage and encourage meaningful consultation, collaboration, communication and feedback about issues.[30] The Australian Physiotherapy Association (APA) also recommended that AHPRA increase its levels of direct communication with the professional associations through the Professions Reference Group (PRG). The APA noted that this group had been convened when the problems with the renewals process were identified. The APA recommended that AHPRA establish this group as a formal advisory committee of the currently registered professions, and soon to be registered professions, to discuss issues related to the administration of the NRAS. Further,

> The PRG has been an effective consultation and communication forum for the registered professions and the continuation of the information exchange within a formal advisory committee to the staff of AHPRA would be valuable to all concerned. The APA believes that such a body would be particularly relevant with the new professions coming into the AHPRA scheme over the next year.[31]

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28 Australian Health Practitioner Regulation Agency, *Submission 26*, p. 23.

29 Mrs Elizabeth Foley, Federal Professional Officer, Australian Nursing Federation, *Committee Hansard*, 4 May 2011, p. 21.

30 Australian College of Rural and Remote Medicine, *Submission 59*, p. 5.

31 Australian Physiotherapy Association, *Submission 54*, p. 5.

5.35 The Optometrists Association Australia proposed that AHWMC should consider establishing a standing advisory group by which advice from the professions regulated by AHPRA can be taken into consideration for the future direction of the Agency and its dealing with the regulated professions.[32]

5.36 The ACMHN recommended that consultation could be improved through the provision of mechanisms through which consultation can take place, more information about the consultations taking place, and more time for consultation.[33]

Committee comment

5.37 The evidence received highlighted a significant lack of accountability of AHPRA to the various jurisdictions and to the professions which will fund the NRAS. The committee considers that AHPRA should establish professional consultative groups. Such a mechanism would improve communications between AHPRA and professional organisations and help to quickly identify shortcomings in AHPRA processes.

Senior doctors and academics

5.38 A matter raised with the committee was the effect of the NRAS on senior doctors and academics. In relation to senior doctors, the arrangements have now changed, and any doctor retiring after the implementation of the new arrangements is unable to retain limited prescribing and referral rights, unlike doctors who retired before the new system was put in place. Professor Claire Jackson, President, Royal Australian College of General Practitioners, commented that there appeared to be no evidence why this change had been made except because such a registration category had not been allowed in some jurisdictions and stated:

> We believe that it is because in some states the legislation was to allow retired doctors very limited prescribing and referral rights and in others it was not, and so they removed the rights across the board. So we have two classes of retired doctors now. There was absolutely no evidence that the college could uncover, despite repeated requests, that there were any dangers, or safety or other related issues, with these very, very limited rights for retired doctors, for their family members only. So it was not an evidence based decision. Finally, it is very expensive for these doctors to remain in a practising category even if they are only doing occasional clinical sessions. They have to undertake a full 130 QA and CPD points, professional development points, per triennium, which will cost thousands of dollars. They need to retain their registration at a significant level.[34]

32 Optometrists Association Australia, *Submission 37*, p. 4.

33 Australian College of Mental Health Nurses, *Submission 58*, p. 8.

34 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 30.

5.39 Professor Jackson went to comment that this was a loss to the profession:

> Most of our senior doctors have said to us that this is now such a financial impost that, for the small amount of teaching and mentorship they wish to continue doing, they will not be able to sustain it. These are the giants of our profession. They have 40 years of clinical experience, which often far outstrips the sort of experience we have with all the scanning pathology and other issues available to us now, and we really, really want to strongly remonstrate that we should review this decision, acknowledge there is no evidence to it and reinstate these very senior, very experienced doctors to support us in our profession going forward.[35]

5.40 The Australian Doctors' Fund (ADF) also raised concerns in relation to the difficulties faced by senior doctors, from 55 years of age and above, who want to continue to work, but are unable to obtain an effective classification to work and are therefore 'being forced out of the profession'.[36]

5.41 Both the Medical Deans Australian and New Zealand and the Australian Dental Association (ADA) commented on the registration of academic staff. The Medical Deans noted that under the current regulations, doctors who contribute on an occasional basis to the teaching of medical students outside a clinical context are considered to be 'practising' under the interpretation of the regulations and were subject initially to full registration fees. However, after representations a voluntary agreement by the Medical Board of Australia (MBA) saw the fee reduced to $125 for doctors undertaking only teaching or examining/assessing. Further consultations by the MBA will look at the current definition of 'practice' and make a recommendation to the Ministerial Council.[37]

5.42 The ADA similarly pointed to the financial disincentives of full registration fees for dental academic staff.[38]

Committee comment

5.43 The committee is concerned that there is no flexibility for health practitioners wishing to teach and mentor students or to practise in a limited way. This will have a detrimental impact on academic institutions and the health workforce. The committee therefore considers that greater flexibility in the categories of registration is required and that the AHWMC should address this matter urgently.

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35 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 30.

36 Mr Stephen Milgate, Executive Director, Australian Doctors' Fund, *Committee Hansard*, 4 May 2011, p. 16.

37 Medical Deans Australia and New Zealand, *Submission 32*, p. 3.

38 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 72.

Mandatory notification

5.44 The National Law includes provisions for mandatory reporting of health practitioners 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.

5.45 Concern was expressed that the mandatory notification requirements were overly prescriptive and may prevent practitioners from seeking assistance.[39] The Royal Australian College of General Practitioners (RACGP), for example, argued that the mandatory reporting requirements were 'likely to have the opposite of the intended effect' in that health professionals would be more likely to conceal their impairments from colleagues:

> This will exacerbate the issues and drive them underground, rather than decrease the risks to patients, the public, the practitioners themselves, and their colleagues. Only the current system of collegiate support and peer review can ensure that impairment issues will be dealt with in the patients' interest.[40]

5.46 Dr Stanley Doumani, Australian Doctors' Fund, commented:

> One of the things that I do is carry the phone for the ACT Doctors' Health Advisory Service. I have noticed that since AHPRA and mandatory reporting commenced, there has been a dramatic fall in the number of calls that I have been getting. That troubles me because I worry about my colleagues not seeking help when they need it.[41]

5.47 Dr Mukesh Haikerwal also pointed to the requirement to notify conduct which constitutes a 'significant departure from accepted professional standards'. Dr Haikerwal argued that:

> 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.[42]

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39 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 72.

40 Royal Australian College of General Practitioners (RACGP), *Submission 46*, p. 5.

41 Dr Stanley Doumani, Director, Australian Doctors' Fund, *Committee Hansard*, 4 May 2011, p. 16.

42 Dr Mukesh Haikerwal, *Submission 69*, pp 1-2.

5.48 He went on to note that overseas trained practitioners were particularly vulnerable to such claims. Dr Haikerwal argued that the National Law 'does not offer any definition of reasonable belief or significant departure from accepted standards of professional conduct'.[43] He also stated that there are penalties for an employer not reporting an instance of notifiable conduct. Dr Haikerwal asserted that:

> These new provisions promote a culture that resorts to peer reporting for fear of legal repercussions...or as a method of filtering out those practitioners struggling to gain integration and acceptance within the profession or indeed another avenue for employers to act against an employee without first initiating normal workplace processes.[44]

5.49 Dr Haikerwal citied a case of mandatory notification where even though the practitioner had been exonerated by AHPRA, 'there was no recognition [by the agency] that this was a most distressing situation that needed to be handled with care and sensitivity'. Dr Haikerwal summarised his view of AHPRA's conduct in this particular case:

> ...the attitude has been high handed, officious, thoughtless, unprofessional, unforgiving and the principles of natural justice, access to common law rights, the presumption of innocence have been ignored. There is no respect as the notion is one of absolute power which cannot be questioned. An expectation that the high handed manner must be tolerated and there will be no detractors for fear of retribution from the Agency.[45]

5.50 Associate Professor Rait of MDA National Insurance also told the committee of his concern about a situation where a practitioner under psychiatric care was reported to AHPRA to be 'at risk' by the treating doctor. It was believed that as a consequence of this, the practitioner took his own life. Associate Professor Rait emphasised that the implications for the therapeutic relationship under the mandatory obligations are clearly very serious.[46]

5.51 MDA National's submission noted the potential for vexatious complaints under the current system and also pointed out that the mandatory reporting provisions were not included in the legislation adopted by Western Australia:

> We understand there are instances where the provisions have been interpreted or implemented in such a way to disadvantage individuals to the extent that there is potential that impaired doctors may have been reluctant to self refer for help because of the risk of being reported to AHPRA. We remain of the view that such is an unintended consequence of the legislation and yet it remains to be addressed on a national basis and yet we note that

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43 Dr Mukesh Haikerwal, *Submission 69*, p. 3.

44 Dr Mukesh Haikerwal, *Submission 69*, p. 4.

45 Dr Mukesh Haikerwal, *Submission 69*, p. 5.

46 Associate Professor Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 12.

> in Western Australia mandatory reporting of colleagues by treating doctors has been removed.[47]

5.52 Mr Boyd-Boland, ADA, suggested that an approach similar to that taken in Western Australia would be preferable:

> We are concerned that some of the mandatory reporting requirements are preventing some practitioners from seeking assistance from other health practitioners to deal with the potential for impairments. You may know that in Western Australia the legislation there is slightly different and we have sought to have that Western Australian variation adopted nationally.[48]

5.53 The RACGP went further and recommended that the National Law should be amended 'to exempt the health professional's treating doctor from mandatory reporting under section 141 of the legislation'.[49]

5.54 APS was particularly concerned about the impact of mandatory reporting requirements on psychologists who provide services for the Family Court of Australia.[50] The APS Family Law and Psychology Interest Group made similar comments, explaining that:

> Psychologists who undertake assessments in family court matters are routinely regularly reported to AHPRA following family court assessments.
>
> This has been recognised internationally in family law to be reflective of the nature of Family Law processes, and generally represent the litigant's attempt:
>
> - To invalidate the opinion of the clinician,
> - To use legal leverage by excluding the psychologist from future court proceedings, and
> - To gain revenge and retribution on the psychologist when the opinions expressed in reports do not favour them.
>
> AHPRA fails to consider the particular professional, financial and physical risks for psychologists specialising in Family Law and the potential for competing responsibilities between their duty to the court and current parameters for professional practice.[51]

5.55 While not suggesting that Family Law psychologists be exempt from complaints, it was suggested that AHPRA needed to change the way it handled the complaints process:

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47 MDA National Insurance, *Submission 20*, p. 3.

48 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 72.

49 Royal Australian College of General Practitioners, *Submission 46*, p. 5.

50 Australian Psychological Society Ltd, *Submission 36*, p. 11.

51 APS Family Law and Psychology Interest Group, *Submission 10*, p. 1.

> We submit that there needs to be some mechanism where these complaints are screened to avoid wasting time, energy and money in undertaking investigations where the litigant obviously has malicious motives.
>
> ...AHPRA also routinely ignores the rights of other parties and children involved in assessments. It is typical practice for AHPRA to rely on the complainant's view without seeking input from the other party and to demand files and reports without consideration for the other participants' rights and our ethical and legal responsibilities to them.[52]

5.56 The submission from Medical Deans Australia and New Zealand emphasised that the mandatory notification obligations also apply to education providers of medical students when it is suspected that a student's ill health may be placing the public at risk. The Medical Deans considered that an appropriate 'feedback mechanism' needs to be put in place:

> ...back to the host education provider (i.e. the institution that the student is enrolled at). The universities have a duty of care to its [sic] students and Medical Deans feel it is imperative for universities to be informed of any student reported to AHPRA to allow the university to be able to offer appropriate support and care to that student.[53]

Committee comment

5.57 The committee notes the issues raised in relation to the mandatory notification requirements. This is a difficult area of regulation and the safety of the Australian public must be paramount. However, the committee considers that there is merit in examining the operation of the mandatory notification regime in the National Law in comparison to that operating in Western Australia.

Overseas trained health practitioners

5.58 The committee received evidence of the difficulties experienced by overseas health practitioners (mainly medical practitioners and nurses) seeking registration in Australia. Some of these difficulties were similar to those experienced by other health practitioners during the registration process including inappropriate delays, inaccurate advice, and lost documentation. Rural Health Workforce Australia commented that the delays and AHPRA's inability to provide a timeframe for processing registrations, made it very difficult for IMGs to plan their arrival in Australia and also made it difficult for employing practices to plan. Such delays result in problems for both the medical practice employing the IMG and for arrangements for supervision and mentoring of the new doctor.[54]

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52 APS Family Law and Psychology Interest Group, *Submission 10*, p. 2.

53 Medical Deans Australia and New Zealand, *Submission 32*, p. 4.

54 Rural Health Workforce Australia, *Submission 49*, p. 3. See also Rural Workforce Agency Victoria, *Submission 50*, p. 8.

Case study 5.1

An overseas qualified nurse (Sweden) applied for registration in October 2010 and was informed the assessment process could take up to three months. The nurse continued to check on her application and was informed in November that the application was straightforward and was in the final stages. The nurse was told this several times, however in December was informed that AHPRA had not started the application process (at this time AHPRA indicated, assessment takes three months from when they start the process). The nurse contacted the ANF (Victorian Branch) who subsequently contacted AHPRA to be informed that overseas applications had been put on hold to deal with domestic applications. The nurse received her registration on 21 March 2011, six months after initial application.

Source: Australian Nursing Federation, *Submission 57*, p. 4.

5.59 The Melbourne Medical Deputising Service (MMDS) commented that when dealing with AHPRA nothing has been forthcoming in the way of options or possible solutions. MMDS commented that the delays may result in English tests expiring requiring IMGs to go through the process as again. The same comments were made in relation to Certificates of Good Standing required by international health practitioners.[55] The Rural Workforce Agency Victoria commented that process time for general registration is currently six weeks and limited (Area of Need) is currently taking up to three months. There are also Medicare and Department of Health and Ageing requirements which add to the time taken for IMGs to commence practice. An application can take six to eight months to gain approval and the Agency noted that by this time practices in rural areas may lose a candidate.[56]

5.60 However, there were a range of matters particular to overseas trained health practitioners which were brought to the committee's attention including the new English test and changing registration requirements.

5.61 Avant Mutual Group commented that one of the issues facing IMGs who arrived in Australia before 2007 has been the frequent changes in policy concerning demonstration of competence. Initially, the only requirements were for the practitioner to be supervised and for the supervisor to provide reports to the relevant medical board about the international graduate. In 2007 a requirement was introduced (in some jurisdictions) that IMGs pass particular Australian qualifications within four years. In 2009 (in some jurisdictions) a requirement was introduced that the IMGs had to demonstrate certain progress towards passing the Australian qualification. Then at the end of 2009 at least one jurisdiction introduced a requirement that IMGs sit the Structured Clinical Interview (SCI) if they had not passed an Australian qualification.

55 Melbourne Medical Deputising Service, *Submission 28*, p. 8; Rural Workforce Agency Victoria, *Submission 50*, p. 7.

56 Rural Workforce Agency Victoria, *Submission 50*, p. 8.

5.62 Avant Mutual Group concluded that these changes made it very difficult for many IMGs who had worked safely and competently in Australia for many years, including in areas where Australian graduates would not work, believing they met the relevant (pre-2007) requirements. However, the some IMGs are now required to invest considerable additional time in order to comply with the frequent changes post 2007. This often posed additional stresses on the doctors and their families in adjusting to their new life in Australia.[57]

5.63 The MMDS also commented on the difficulties facing IMGs and stated that IMGs face a 'maze of complex information' with each step in the process long and frustrating. The overall financial cost for IMGs is many thousands of dollars and they do not understand why everything is so hard when dealing with the relevant assessment and entry systems not the least of which is AHPRA.[58]

5.64 Another example of problems was provided by Rural Health Workforce Australia which noted that if an overseas trained doctor wishes to move from one employer/location to another they are required to submit a new registration application and fee in some jurisdictions, while in others they are only required to submit a change of circumstances form. Rural Health Workforce Australia concluded that this is 'yet another example is that the registration processes are differing in lengths of time and are differing in cost across jurisdictions'.[59]

5.65 The RACGP also noted that IMGs suffered particular consequences after the new system was introduced, and those in Western Australia and Queensland seemed to be most affected:

> These are doctors who have been on temporary registration arrangements and who, due to the new arrangements, very suddenly were informed that they could not be re-registered because they had not completed their fellowship. Fellowship exams occurs several times a year, and it did not give them time to complete their fellowship prior to the cut off. So the college has spent most of its effort around this issue working with the Medical Board of Australia to try to support our international medical graduates—particularly those in rural and remote areas, where they are 45 percent of the workforce in both those states—to get through to their fellowship as quickly as possible so that they do not miss out on registration.[60]

5.66 The Royal Australian College of General Practitioners also commented on the inconsistency of approach: in Queensland, IMGs are often subject to ongoing progress requirements on their limited registration, whereby failure to meet the progress

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57 Avant Mutual Group, *Submission 12*, p. 5.

58 Melbourne Medical Deputising Service, *Submission 28*, p. 7.

59 Rural Health Workforce Australia, *Submission 49*, p. 2.

60 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 31.

requirements can result in refusal to renew the doctor's registration. The RACGP stated that 'there are no such national requirements in place, and inconsistent processes from state to state both contradict the concept of national registration, and cause unnecessary difficulties for the profession'.[61]

English language requirement

5.67 The new English language skills registration standard introduced with the NRAS was canvassed in many submissions. The ANF for example, commented that it had 'created enormous concern, confusion and distress for those international students who had undertaken courses in Australia'. Of particular concern was the change in rules so that students, who had incurred significant cost in undertaking courses and who had expected to be registered at the completion of the course, could not do so. The ANF stated that the situation was 'compounded by inconsistent information posted on the AHPRA website in the form of the English language skills registration standard and the FAQs (frequently asked questions) section'. The ANF also noted that not only overseas students but also many Australian citizens, not having completed their secondary school education in English, were also caught up in this 'debacle'.[62]

5.68 The ANF considered that AHPRA was slow to respond to its concerns regarding inconsistencies in the English language skills registration standard and that although a review of the standard has been undertaken, AHPRA has indicated that 'the current standard would remain in place despite the review and that the outcome of the extensive consultation process remains pending'.[63]

5.69 The ADTOA argued that there are two major concerns with the English test. First, the standard of English expected of IMGs applying to work in Australia is equivalent to what would be expected of a professor teaching in an Australian university. In fact, according to a number of language instructors, many native English speakers, including health professionals, would struggle to pass the test. Secondly, the test results are only valid for two years even if the IMG has been living and working in Australia.[64]

5.70 The Medical Deans Australia and New Zealand commented on the English test in relation to students from overseas who are university-trained in Australia. The Deans were of the view that the regime is onerous for these students, given that overseas students who graduate in Australia have already faced several tests including stringent entry requirements for international students into medicine (including rigorous English skills assessment undertaken through the medical school admissions process) and the subsequent teaching and assessment in English over a 4-6 year period

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61 Royal Australian College of General Practitioners, *Submission 46*, p. 4.

62 Australian Nursing Federation, *Submission 57*, p. 6.

63 Australian Nursing Federation, *Submission 57*, p. 6.

64 Australian Doctors Trained Overseas Association, *Submission 63*, p. 2.

of the medical program. Despite the MBA partially addressing these concerns for students graduating in 2010 through a 'one-off transition process', the Deans remain concerned that the underlying problem caused by such an onerous condition remains. Consequently, 'in the longer term Medical Deans believes these regulations should be eased permanently for students undertaking their entire studies at an Australian Medical School'.[65]

Pre-employment structured clinical interviews (PESCIs)

5.71 Pre-employment structured clinical interviews (PESCIs) were introduced in 2008 as a tool to screen potential IMGs for their suitability for area of need positions prior to starting work in Australia. The PESCI involves an oral exam where candidates are asked questions about cases. Submitters voiced concerns about the PESCI in relation to efficacy, timing and portability of results.

5.72 The ADTOA commented that the PESCI should not be used for registration as this type of exam has shown to be difficult to standardise and is subject to bias. ADTOA commented that

> Despite the fact that the PESCI was never designed to be a high stakes assessment, and the fact that it had not been properly standardized on Australian trained doctors, AHPRA started to use the PESCI to assess IMGs who were already working in Australia, some of whom had worked for as long as 25 years in this country. A large number of these IMGs failed the PESCI and were subsequently de-registered.[66]

5.73 The ADTOA pointed to problems with the PESCI including frequent rule changes, procedural irregularities and inappropriate assessment, barriers to meaningful appeal and changes to timetables without explanation.[67] The ADTOA recommended that an international health professional advisory and advocacy committee be established. The committee would:

- monitor the Professional Boards and other contracted accreditation authority's adherence to standards as outlined in the national law including potential breaches of anti-discrimination law;
- gather data and provide information about the impact of Medical Board policies/decisions on IMGs as well as the potential impact on the Medical workforce particularly on rural communities;
- liaise with the Medical Board and other accreditation groups (AMC, colleges) regarding any new policies that could potentially impact on IMGs;
- provide recommendations as to how to better support IMGs in the Australian workplace;

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65 Medical Deans Australia and New Zealand, *Submission 32*, pp 1–2.

66 Australian Doctors Trained Overseas Association, *Submission 63*, p. 1.

67 Australian Doctors Trained Overseas Association, *Submission 63*, pp 3–6.

- provide information/advice/guidance to IMGs regarding registration/accreditation issues/problems; and
- provide some form of legal assistance/advice to IMGs regarding appeals.[68]

5.74 MMDS also pointed to inconsistencies in the management and scheduling of PESCIs and that there is inconsistency in the way PESCI providers ensure that interview content is relevant. For example, the RACGP (SA) is an accredited PESCI provider and the panel of assessors rightly require full information (position description, support and supervision/mentor mechanisms) about the position for which an IMG is being considered. However, this is not the case for the Health Workforce Assessment Victoria which refuses any information about the position or available support systems for which the doctor is being considered. MMDS commented that differences in the way medical registration is handled at the state level seems inconsistent with the intent of national registration.[69]

Case study 5.2

Only four applicants who were supported by the New South Wales Rural Doctors Network (the RWA in NSW) undertook an AHPRA-NSW PESCI in the 6 months from 1 July to 31 December 2010. These applicants waited an average of 6 weeks from lodging their PESCI paperwork to being notified of the PESCI date. Applicants were given an average of 2 weeks notice before the PESCI and more than 7 weeks (more accurately between 4 and 13 weeks) to be advised of the outcome; even though they were advised at the interview they will be notified within two weeks. Two other OTDs supported by NSW RDN withdrew their applications for PESCIs in NSW, citing it was too complex, frustrating and taking too long. The lack of enough sittings of a PESCI panel in NSW over this time meant that RDN was very restricted in the number of applicants it could support for registration.

Source: Rural Health Workforce Australia, *Submission 49*, p. 2.

5.75 MMDS also raised concerns about the PESCI waiting list in Victoria. MMDS has referred to the Health Industry Ombudsman the case of one IMG who lodged an application in August 2010 and who at 13 January was still 'some way down the PESCI waiting list'. The doctor then applied to sit the test in South Australia and did so in March 2011.[70]

5.76 The Albury-Wodonga Regional GP Network commented that PESCI's for limited registration doctors are non-transferrable between states contradicting a national registration system. This was of particular concern and affected GPs in the Albury-Wodonga region.[71]

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68 Australian Doctors Trained Overseas Association, *Submission 63*, p. 12.

69 Melbourne Medical Deputising Service, *Submission 28*, p. 9.

70 Melbourne Medical Deputising Service, *Submission 28*, p. 8.

71 Albury-Wodonga Regional GP Network, *Submission 30*, p. 2. See also Rural Workforce Agency Victoria, *Submission 50*, p. 10.

Committee comment

5.77 The committee notes that overseas trained practitioners form a crucial part of the delivery of health services to Australians, particularly those in rural and remote areas. The committee is therefore deeply concerned that registration processes appear not to be applied consistently and that delays by AHPRA have resulted in practitioners having to re-submit various certificates and has adversely affected their ability to commence employment.

5.78 The committee concludes that this is an area where AHPRA must significant improve its performance. Further, the committee considers that updates on the registration of overseas trained practitioners should be considered by the Australian Health Workforce Ministerial Council on a regular basis. AHPRA should also establish a Key Performance Indicator on this category of registration and report outcomes in its annual report.

Criminal history declaration

5.79 The registration process requires that health practitioners provide a criminal history declaration. Evidence provided indicated a lack of flexibility in AHPRA processes in implementing this requirement in addition to poor administrative arrangements.

5.80 The ANF, for example, provided two examples about the difficulties experienced by their members in relation to the criminal history declaration:

- a member who applied for registration as an EN in December 2010, tried many times to contact AHPRA regarding the status of their application. They were informed that AHPRA was waiting on a criminal history check (even though the applicant had no criminal history) and that they were processing hospital employed applicants before those working in aged care. The ANF commented that this determination by AHPRA that one sector was more important than another is not acceptable; and
- a nurse member was contacted by AHPRA about non-disclosure of an allegation of a criminal offence. The allegation occurred thirty years previously and was dismissed in court. The nurse was told they had to provide a statutory declaration as to why they did not disclose the allegation and a separate statement of the circumstances of the case. The nurse was told they must deliver these documents to the AHPRA office and that fax/emails were not acceptable. The nurse lives in a rural area, which led to loss of income to attend the AHPRA office.[72]

72 Australian Nursing Federation, *Submission 57*, p. 5.

5.81 While the committee is fully supportive of such a requirement, the processes implemented by AHPRA in relation to this requirement have resulted in difficulties in terms of inconsistency.

Chapter 6

Conclusions and recommendations

> From the GP perspective we are currently undergoing the worst crisis in our workforce in living memory and we have very limited capacity to respond to that. Our concerns about AHPRA's performance have been around the administrative competency. Inaccurate mail addresses for many doctors have led to significant distress and reduced patient access. There is no phone access that is timely to try to sort out problems. Many of our members waited for an hour to try to get through to have questions answered; consequently, their patients and families waited for that time as well. The internet access was of very little help to our doctors in trying to sort through the many problems of the registration and the culture of AHPRA was that it was the doctor's problem and just something they had to put up with.[1]

6.1 The committee acknowledges that the implementation of the new registration and accreditation regime for some 500,000 health practitioners was a huge undertaking. The committee also recognises that for a new organisation to take over the registration process from some 80 state and territory boards, and for that organisation to be up and fully operational on the day after those boards ceased, presented a challenge. It was a unique regulatory event, both in Australia and overseas.

6.2 However, the implementation was far from well managed. The Australian Medical Association described it as a 'debacle'. Ramsay Health Care Australia did not classify the difficulties being experienced as 'teething problems', rather it expected problems to last for the next two years.[2]

6.3 It is apparent from the evidence received that there were many stakeholders raising concerns about the implementation of the scheme from its earliest stages. These stakeholders had experience with registration within their own professions. The 1992 mutual recognition scheme also provided pointers to the possible problems that may have arisen and should have informed the setting of the timeframes and the staging of the process. The committee considers that the timeframes were inappropriate for such a complex task. Further, consideration should have been given to staging the time that the registration process for each of the ten professions was absorbed by the Australian Health Practitioner Regulation Agency (AHPRA). In addition, the timing of the changes to the accreditation process could have been managed so that a more gradual transition was facilitated. A more careful

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1 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 28.

2 Ms Elizabeth Spaull, National Workforce Planning and Development Manager, Ramsay Health Care Australia, *Committee Hansard*, 4 May 2011, p. 46.

management of the implementation process may have assisted to more accurately estimate the funds required by AHPRA to carry out its functions.

6.4 As Ramsay Health Care Australia stated, it was 'too much, too soon, too quick'.

6.5 In addition, the sheer size of the databases to be migrated should have underscored the potential for problems to arise during the data migration. AHPRA itself recognised the extent of the data problems. While AHPRA maintained that delays in passing legislation in some jurisdictions exacerbated the data migration problems, the committee considers AHPRA's risk management was clearly inadequate and it should have developed more appropriate plans to overcome these problems. In particular, the committee considers that more rigorous forward planning would have facilitated data cleansing before the transfer of the data, as well as testing of the systems to allow a smoother migration of the data, and as a result may have reduced the amount of incorrect information and communication distributed by AHPRA.

6.6 Problems with accessing AHPRA staff through the 1300 call number and the website were unacceptable. The provision of insufficient, incorrect, inconsistent and, in some cases, no advice at all because of inadequate training of staff constitutes a grave failure. The publication of registers with incorrect information was an outcome of AHPRA's flawed processes. The committee considers that these matters undermined AHPRA's ability to fulfil its primary functions: to maintain the national register and to protect the public by ensuring that only practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered.

6.7 AHPRA's failure to provide practitioners with notification that their registration needed to be renewed, and also the inordinate amount of time taken to process registration applications, demonstrated AHPRA's poor management of the registration process. As a result, the registration of a number of practitioners lapsed, and the practitioners became deregistered, a matter of significant concern. Often due to the failure of AHPRA to provide any notification, the practitioner was completely unaware that they were no longer registered. In some instances, practitioners only found out that they were no longer registered when they were contacted by Medicare. This was a significant issue as not only were practitioners concerned about the potential effect on their professional indemnity insurance, but also practitioners ceased to see patients immediately, causing a disruption to patient care.

6.8 The manner in which registrations were processed by AHPRA pointed to poor planning and a lack of understanding of basic processes to keep registrants informed, for example, lack of confirmations and the inability to track applications through processing stages. These circumstances indicate poor internal processes and document management.

6.9 The committee was provided with extensive evidence on the impact of AHPRA's flawed processes. Practitioners reported loss of income, and in some cases loss of employment. Some practitioners argued that their reputations have been

damaged as a result of incorrect registration information or deregistration through no fault of their own. They also reported added stress and anxiety as a result of their registration difficulties. Concerns were raised about the implications for legal liability when practitioners continued to practice when they did not know that they were not registered. As noted by many practitioners, these problems took them away from their core task: the provision of health services to patients.

6.10 Health providers also gave evidence of the impact on their organisations. Many reported significant time was required to access information about potential employees and to assist current employees with registration problems. Due to AHPRA's failure to support and advise practitioners during the transition, the onus has fallen on health providers and employers of health practitioners.

Recommendation 1

6.11 The committee recommends that AHPRA should issue a letter of apology to practitioners who were deregistered because of the problems revealed by the inquiry and, where it is established a lapse or delay in registration took place, AHPRA should reimburse practitioners for any loss of direct Medicare payments.

Recommendation 2

6.12 The committee recommends that AHPRA should rectify any situation where a practitioner is left liable due to their professional indemnity insurance lapsing, or being voided, during a period where they were deregistered by AHPRA's administrative failings.

6.13 The effects of AHPRA's failure to adequately perform its functions were not limited to practitioners; patients experienced financial loss as they could not claim Medicare rebates for services provided by deregistered practitioners. Patients of practitioners who were deregistered had appointments cancelled or postponed. This was of great inconvenience and concern.

6.14 The committee also notes AHPRA's poor management of the registration process has effected recruitment of overseas practitioners. This is a significant matter: many communities in rural areas rely on overseas practitioners to take up positions in local practices. The committee was provided with examples of communities losing the opportunity to employ health practitioners because of significant delays in the registration of these practitioners. In particular, the advice provided about, and the inconsistent administration of, the English test for overseas practitioners was seen as a significant concern. The committee agrees that the English language requirement is crucial; however, it should be applied in a more consistent manner.

6.15 The committee concludes that this is an area where AHPRA must significantly improve its performance. Further, the committee considers that updates on the registration of overseas trained practitioners should be considered by the Ministerial Council on a regular basis. AHPRA should also establish Key

Performance Indicators to cover registration timeframes for this category of registration and report outcomes in its annual report.

6.16 Submitters to the inquiry pointed to the lack of accountability of AHPRA. AHPRA reports to nine ministers–eight state and territory ministers and the Commonwealth minister for health. However, far from improving accountability, this appears to have resulted in fragmented responsibility and diminution of scrutiny. The committee considers that in the establishment of AHPRA, greater attention should have been paid to accountability issues. Further, that if other similar cross jurisdictional bodies are established, accountability must be clearly provided for in any establishing legislation.

Recommendation 3

6.17 The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to undertake a regular review of the registration of overseas trained health practitioners.

Recommendation 4

6.18 The committee recommends that AHPRA establish Key Performance Indicators in relation to the registration of overseas trained health practitioners and provide detailed information on this matter in its annual report.

6.19 In relation to complaints about health practitioners, the committee identified a number of areas where improvements are required including inconsistencies in application of complaint processes, the prescriptiveness of the application form and the way in which vexatious complaints are handled. The committee considers that further development of the complaints process is urgently required.

Recommendation 5

6.20 The committee recommends that complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners.

6.21 In relation to information provided to Australian Health Workforce Ministerial Council (AHWMC), the committee notes that AHPRA officials have met with AHWMC to provide briefings on the implementation of the National Registration and Accreditation Scheme (NRAS). AHPRA will now meet more regularly with the chair of the council to provide briefings on progress.[3] However, the committee is concerned that the only public reporting of the implementation of the NRAS and the work of AHPRA is provided in its annual report and occasional communiqués from AHWMC. The committee considers that better accountability

3 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioners Regulation Agency, *Committee Hansard*, 5 May 2011, p.30.

mechanisms must be established to ensure that the scheme does operate in a 'transparent, accountable, efficient, effective and fair way'.

Recommendation 6

6.22 The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to identify and establish mechanisms to improve the accountability of AHPRA to the parliaments of all jurisdictions and the Australian public.

6.23 To improve consultation with professional organisations, including provider organisations, the committee considers that AHPRA should establish professional consultative groups. Such a mechanism would improve communications between AHPRA and professional organisations and help to quickly identify shortcomings in AHPRA processes.

Recommendation 7

6.24 The committee recommends that AHPRA, as a matter of urgency, establish consultative groups with professional organisations and health providers.

6.25 A significant concern raised in evidence was that some practitioners were deregistered because of flawed administrative processes by AHPRA including loss of documents, incorrect contact data and lack of notification. The committee considers that in such circumstances that there should be a grace period so that health practitioners are not penalised for administrative errors.

Recommendation 8

6.26 The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to amend the National Law to provide AHPRA with a discretion to grant a grace period where a health practitioner faces deregistration as a result of administrative error by AHPRA.

6.27 The committee is concerned that there is no flexibility for health practitioners wishing to teach and mentor students or to practise in a limited way. This will have a detrimental impact on academic institutions and the health workforce. The committee therefore considers that greater flexibility in the categories of registration is required and that the AHWMC should address this matter urgently.

Recommendation 9

6.28 The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to amend the National Law to provide further practicing classifications for practitioners in academic institutions and for those who practise in a limited manner.

6.29 The committee received extensive evidence concerning the mandatory notification requirements under the National Law. The committee has noted that this is a difficult area of regulation and the safety of the Australian public must be paramount. However, the committee considers that there is merit in examining the operation of the mandatory notification regime operating in Western Australia.

Recommendation 10

6.30 The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to implement a review of the mandatory notifications requirements and in particular take into account the Western Australia model of mandatory reporting.

6.31 In conclusion, the committee notes that it is stated in National Law that:

> The guiding principles of the national registration and accreditation scheme are as follows–
>
> (a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;
>
> (b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;
>
> (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.[4]

6.32 The committee concludes that the mistakes, omissions and poor processes that were clearly evident from the evidence received during the inquiry calls into question the ability of AHPRA carry out its primary purpose. For AHPRA itself to be responsible for a breakdown of the entire system of registration of health practitioners in Australia is a dismal example of policy implementation and public administration.

6.33 The committee expects that the lessons learned during this phase of implementation of the NRAS will be applied to the next tranche of professions to come with the scheme. This will mean that AHPRA will need to adequately address planning, timing and resource issues. In undertaking this process, AHPRA must keep the AHWMC fully informed of developments.

Senator Mitch Fifield
Chair

4 The Schedule to the *Health Practitioner Regulation National Law Act 2009*, subsection 3(3).

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,
>
> - 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

APPENDIX 1

Submissions and Additional Information received by the Committee

Submissions

1 Mr Dechawut Boontun
2 Mr James Hill
3 Australian College of Nurse Practitioners
4 Confidential
5 Consumers Health Forum of Australia
6 The Society of Hospital Pharmacists of Australia
7 Name Withheld
8 Name Withheld
9 Name Withheld
10 Australian Psychological Society Family Law and Psychology Interest Group
11 Institute of Private Practising Psychologists
12 Avant Mutual Group
13 Australian Medical Council
14 Australian Psychological Society College of Clinical Psychologists
15 The Australian College of Specialist Psychologists
16 Homebirth Access Sydney
17 Confidential
18 Victorian Association of Maternal and Child Health Nurses
19 Australian College of Midwives
20 MDA National Insurance
21 Australian Private Midwives Association and Midwives in Private Practice
22 The Royal Australasian College of Physicians
23 Australian Medical Association
24 The Royal College of Pathologists of Australasia
25 Northern Territory Government
26 Australian Health Practitioner Regulation Agency (AHPRA)
27 Chairs of the ten national health profession boards in the National Scheme
28 Melbourne Medical Deputising Service
29 Chiropractors' Association of Australia

30 Albury Wodonga Regional GP Network
31 Association of Counselling Psychology
32 Medical Deans Australia and New Zealand
33 Homebirth Australia
34 Australian Dental Association
35 Ramsay Health Care Australia
36 The Australian Psychological Society
37 Optometrists Association Australia
38 Australian Dental Industry Association
39 Australian Sonographers Association
40 Maternity Coalition
41 Pharmaceutical Society of Australia
42 Forum of Australian Health Professions Councils
43 Australian and New Zealand Association of Physicians in Nuclear Medicine
44 Catholic Health Australia
45 The Australian Society of Independent Midwives
46 The Royal Australian College of General Practitioners
47 CRANAplus
48 Confidential
49 Rural Health Workforce Australia
50 Rural Workforce Agency Victoria
51 AMA NSW
52 Australian Doctors' Fund
53 The Pharmacy Guild of Australia
54 Australian Physiotherapy Association
55 Confidential
56 Australian Osteopathic Association
57 Australian Nursing Federation
58 Australian College of Mental Health Nurses
59 Australian College of Rural and Remote Medicine
60 Australian Association of Psychologists
61 Specsavers
62 Royal College of Nursing Australia
63 Australian Doctors Trained Overseas Association
64 Name Withheld
65 Name Withheld
66 Name Withheld

67 Name Withheld
68 Name Withheld
69 Dr Mukesh Haikerwal
70 Australian Health Workforce Ministerial Council (AHWMC)
71 Mr Gordon Blair
72 Name Withheld
73 Name Withheld
74 Ms Christine Symington
75 Mr Jamie Johnstone
76 Name Withheld
77 Ms Therese Smeal
78 Mr Anthony Lawler
79 Mr Renier Erasmus
80 Name Withheld
81 Dr Michael Free
82 Ms Maria Polymeneas
83 Name Withheld
84 Ms Fiona Stevens
85 Name Withheld
86 Ms Brigitte Kupfer
87 Name Withheld
88 Mr Adam Criddle
89 Australian College of Psychologists
89a Supplementary Submission from Australian College of Psychologists
90 Ms Karyn Matotek
91 Joyous Birth, the Australian Homebirth Network
92 Name Withheld
93 Name Withheld
94 Name Withheld
95 Name Withheld
96 Name Withheld
97 Name Withheld
98 Name Withheld
99 Name Withheld
100 Mrs Donna O'Brien
101 Dr John Jacmon
101a Supplementary Submission from Dr John Jacmon

102 Ms Jenny Corran
103 Name Withheld
104 Dr Lindsay Duncan
105 Name Withheld
106 Name Withheld
107 Ms Ratjiraporn Harnroongroj
108 Name Withheld
109 Name Withheld
110 Mr Luciano Guglielmin
111 Dr Luciana Lanza
112 Dr Neil Gilbert
113 Name Withheld
114 Name Withheld
115 Confidential
116 Confidential
117 Confidential
118 Confidential
119 Confidential
120 Confidential
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129 Confidential
130 Confidential
131 Confidential
132 Confidential
133 Confidential
134 Confidential
135 Confidential
136 Confidential
137 Mrs Chrissy Grainger
138 Ms Tass Holmes

138a Supplementary Submission from Ms Tass Holmes
139 Name Withheld
140 Ms Kathryn Bown
141 Name Withheld
142 Ms Diana Condylas
143 Mrs Gabrielle Mutton
144 Ms Clare Shamier
145 Mrs Claire Johnston-Hall
146 Ms Carolyn Hastie
147 Name Withheld
148 Mrs Fiona Clarke
149 Ms Helen Smith
150 Ms Karen Arthur
151 Mr Mark Oakley
152 Ms Nicola Dutton
153 Mrs Amy Mann
154 Ms Anne Regan
155 Ms Zoe Gordon
156 Miss Patricia Stratton
157 Ms Alicia Davey
158 Dr Brett Hill
159 Ms Melody Bourne
160 Ms Michelle Zimmerman
161 Ms Jaia Baer
162 Home Midwifery Association
163 Ms Milica Fraser
164 Ms Laura Russo
165 Ms Rebecca Jolly
166 Ms Kathryn Williams
167 Ms Pria Holmes
168 Mrs Michelle McRitchie
169 Ms Annshar Wolfs
170 Name Withheld
171 Name Withheld
172 Name Withheld
173 Name Withheld
174 Name Withheld

175 Name Withheld
176 Name Withheld
177 Ms Amanda Vella
178 Ms Cate Finch
179 Ms Chloe Coulthard
180 Ms Elizabeth Isaacs
181 Ms Heidi Hibberd
182 Ms Jacinta Cross
183 Ms Jo Hunter
184 Ms Melanie Jackson
185 Ms Binky Henderson
186 Ms Esther James
187 Ms Victoria Meadth
188 Dr Christine Sharp
189 Ms Gail Robertson
190 Dr Anne Etchells
191 Ms Anna Wiederroth
192 Dr Brendan Lloyd
193 Ms Dianne Veitch
194 Ms Angela Elia
195 Mr Henry Briffa
196 Dr Merrilly Watson
197 Ms Mimi Wellisch
198 Name Withheld
199 Ms Patricia Ryan
200 Dr Paul Campbell
201 Ms Penny Fox
202 Dr John Girardi
203 Dr Harry Mayr
204 Dr Timothy Hill
205 Dr David Hoffman
206 Dr Dianne Perrett-Abrahams
207 Mr Shayne Hanks
208 Mr Jeff Coucill
209 Dr Carin Swaddling
210 Dr Sandra Gaffney
211 Dr Marion Yeadon

212 Mr Robert Armstrong
213 Mr Patrick Barry and Mr Craig Darling
214 Name Withheld
215 Ms Linda Bruce
216 Confidential
217 Confidential
218 Confidential
219 Confidential
220 Confidential
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225 Confidential
226 Confidential
227 Confidential
228 Confidential
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236 Confidential
237 Confidential
238 Confidential
239 Mrs Hollie Singleton
240 Ms Robyn Thompson
241 Ms Robyn Burgess
242 Ms Shayla Razga
243 Mr Steven Stanley
244 Ms Sue Martin
245 Ms Suzanne Ingleton
246 Ms Vanessa Winter
247 Ms Gillian Hall
248 Ms Kirsten Adams

249 Ms Elizabeth Sheppard
250 Ms Naomi Waldron
251 Ms Rachel Pilgrim
252 Ms Lyned Isaac
253 Name Withheld
254 Name Withheld
255 Name Withheld
256 Name Withheld
257 Name Withheld
258 Name Withheld
259 Name Withheld
260 Confidential
261 Name Withheld
262 Name Withheld
263 Name Withheld
264 Name Withheld
265 Name Withheld
266 Name Withheld
267 Name Withheld
268 Name Withheld
269 Name Withheld
270 Confidential
271 Name Withheld
272 Name Withheld
273 Name Withheld
274 Name Withheld
275 Name Withheld
276 Name Withheld
277 Name Withheld
278 Name Withheld
279 Name Withheld
280 Name Withheld
281 Mr Phill Newlyn
282 Name Withheld
283 Confidential
284 Name Withheld

Form Letters

1 Form letter 1, received from 245 individuals

2 Form letter 1 with variations, received from 133 individuals

3 Form letter 2 with variations, received from 16 individuals

Additional Information

1 Document tabled by the Pharmaceutical Society of Australia at public hearing, 4 May 2011

2 Document tabled by the Australian Psychological Society at public hearing, 4 May 2011

3 Document tabled by the Australian Health Practitioner Regulation Agency at public hearing, 5 May 2011

4 Clarification to evidence given at public hearing on 5 May 2011, by Ms Malisa Golightly, Medicare Australia, provided on 23 May 2011

Answers to Questions on Notice from Public Hearings

1 Australian Nursing Federation, received 20 May 2011

2 Australian Health Practitioner Regulation Agency, received 20 May 2011

3 The Department of Health and Ageing, received 23 May 2011

4 The Department of Human Services, received 23 May 2011

APPENDIX 2

Public Hearings and Witnesses

Wednesday, 4 May 2011
Committee Room 2S1, Parliament House, Canberra

Witnesses

Forum of Australian Health Professions Councils
Professor Richard Smallwood AO, Chair
Mr John Low, Member
Mr Ian Frank, Member
Ms Lyn LeBlanc, Member

Pharmaceutical Society of Australia
Ms Liesel Wett, Chief Executive Officer
Dr Kay Sorimachi, Director Policy and Regulatory Affairs

Australian Doctors Fund
Mr Stephen Milgate, Executive Director
Dr Stan Doumani, Director

Australian Nursing Federation
Ms Julianne Bryce, Senior Professional Officer
Mrs Elizabeth Foley, Federal Professional Officer

Royal Australian College of General Practitioners
Professor Claire Jackson, President

Homebirth Australia
Ms Sonja MacGregor, Committee Member
Ms Justine Caines, Committee Member
Ms Chloe Coulthard, Consumer

Australian Private Midwives Association and Midwives in Private Practice
Ms Marie Heath
Ms Liz Wilkes
Ms Joy Johnston

Ramsay Health Care Australia
Ms Liz Spaull, National Workforce Planning & Development Manager
Mr Gavin O'Meara, Manager People and Culture

Australian Medical Association
Dr Steve Hambleton, Vice President
Mr Francis Sullivan, Secretary General

The Australian Psychological Society
Professor Lyn Littlefield, Executive Director
Mr David Stokes, Senior Management Professional Practice

Australian Association of Psychologists
Mr Paul Stevenson, President
Mr Michael Pointer, Executive Director
Ms Wendy Northey, Director

Australian Dental Association
Mr Robert Boyd-Boland, Chief Executive Officer
Mr Alex Chapman, Manager, Government and Public Affairs

Thursday, 5 May 2011
Committee Room 2S1, Parliament House, Canberra

Witnesses

Australian Physiotherapy Association
Ms Melissa Locke, President

MDA National Insurance
Associate Professor Julian Rait, President

Australian Health Practitioner Regulation Agency
Mr Martin Fletcher, Chief Executive Officer
Mr Peter Allen, Chair, Agency Management Committee
Dr Joanna Flynn, Chair of the Medical Board of Australia

Department of Health and Ageing
Ms Kerry Flanagan, Acting Deputy Secretary

Medicare Australia
Ms Sue Kruse, General Manager, Health eBusiness
Ms Malisa Golightly, Deputy Chief Executive Officer, Health and Older Australians
Ms Brenda Parkes, General Manager, Medicare and Specialists Services