Australian Doctors’ Fund Submission

Review of the National Registration and Accreditation Scheme for Health Professions

“The idea for a national registration and regulation of all healthcare professionals was always loopy, a solution in search of a problem and one of the poorer ideas of the Productivity Commission” – Professor Judith Sloan 2 Feb 2011

1. The Australian Doctors’ Fund (ADF) maintains that the so-called ‘Review of the National Registration and Accreditation Scheme for Health Professions’ is neither an independent nor an objective review. It is in fact the health bureaucracy reviewing itself. The review assumes that the National Registration and Accreditation Scheme (NRAS) as established is at best in need of refinement. As such, the review lacks the courage to challenge the questionable way in which national registration was implemented and hence the defects of NRAS are likely to be perpetuated to the detriment of the Australian public.

2. The ADF has always maintained that the NRAS is a triumph of bureaucratic power over the legislature, of complexity over simplicity, of ideology over necessity. There are two basic processes involved in the regulation of professions: the administration of a register and the discipline of registrants who are no longer fit for practice.

3. Historically, registration of medical practitioners has been undertaken by state and territory governments. Doctors would register with their state or territory government registration agency, and would be disciplined by a state medical board if their conduct and/or state law warranted it. Each State Health Minister undertook responsibility to ensure that registration and discipline met acceptable standards. The Australian public had direct representation to the State Health Minister through their local State Member. This system served Australia well. It ensured direct parliamentary accountability for both registration and discipline. Under this system, and in conjunction with a high quality system of medical education, the Australian medical profession developed an enviable international reputation for safety and competency.

4. The registration of medical practitioners is but one of the risk management processes used to protect the public and maintain confidence in the Australian medical profession. Others include: a public complaints system, accreditation of doctors at hospitals, defined scopes of practice, professional codes of ethics, accountability before the law, and a referral system based on reputation and outcomes. Doctors are also required to participate in continuing medical education and most importantly, be an acceptable risk to a medical indemnity organisation, which maintains an accurate history of their practice profile, incidents and claims history. No doctor can practise without medical indemnity insurance.

5. The backstory outlined in AHPRA’s inaugural annual report (2009/10) claimed that “national registration will bring substantial benefits to the community, individual practitioners and to the health profession, including: mobility: practitioners with general registration can register once and practise in any participating jurisdiction in Australia; uniformity: there are consistent national standards in relation to registration and professional standards for each profession; efficiency:

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less red tape associated with registrations and notifications, over time, processes will be streamlined and there will be considerable efficiencies of scale; collaboration: sharing, learning and understanding of innovation and good regulatory practice between professions; and transparency: national online registers displaying all registered health practitioners, including current conditions on practice (except health-related conditions).

6. The ADF maintains that the above so-called benefits were a solution in search of a problem. Doctors have always had mobility and have not been restricted in times of medical emergency from working interstate. For those doctors who worked in more than one jurisdiction (border towns), the issue was simply an extra form and fee. These fees were approximately half the current registration fees. Furthermore, state-based registration acted as a risk management device to prevent doctors, who may have developed bad reputations in one state, practising in another state before disciplinary issues were resolved. Under the Mutual Recognition Act 1992, a medical practitioner registered in one state could gain registration in another state provided they submitted satisfactory notice that they were “not the subject of disciplinary proceedings in any State (including preliminary investigations or action that might lead to disciplinary proceedings) in relation to those occupations”2. Hence mutual recognition of registration was available for a decade prior to the Productivity Commission’s 2005 report, which made the unsubstantiated claim that state based systems “can impede the movement of health workers across jurisdictions (notwithstanding the operation of mutual recognition)”3. The ADF maintains that with mutual recognition, the issue of medical workforce mobility was never an issue requiring the creation of NRAS. (The biggest criticism was that it required some practitioners to pay an extra registration fee.) The majority of doctors practise in settled locations where they develop clinical reputations and referral networks. Few doctors practise simultaneously in several states. Hence, simultaneous registration was not a problem crying out for NRAS or AHPRA as its solution.

7. Another myth is the proposition that the Australian medical profession did not have consistent national standards until the arrival of NRAS. Australian doctors must meet qualification standards issued by national colleges (including in many cases New Zealand), which in turn have international recognition. The proposition that cancer, heart disease, depression or fractured limbs were being treated differently depending on state boundaries is ludicrous. Australian surgeons and physicians have always been able to walk into any hospital in Australia (and many overseas) and immediately relate to the treatment protocols which, as best practice, have been well promulgated by their national colleges and training bodies. Australian GPs are also trained to internationally recognised standards. NRAS has no role to play in the development and maintenance of uniform clinical standards. Medicine is a dynamic and changing science. Its practices, protocols, results and methods are constantly under challenge by itself, the growth of knowledge and the available medical evidence.

8. The claim that NRAS will result in ‘less red-tape’ and efficiencies over time was another spurious and untested claim that has been clearly contradicted by the increased registration fees that have followed the introduction of NRAS. Rather than update the previous National Compendium of Medical Registries, which held computerised registration data for ten years prior to NRAS, a new computer system was developed and the administrative debacle that followed was subject to a Senate Inquiry. Furthermore, paperwork has not been diminished for many doctors. As a Queensland doctor recently told the ADF, “My biggest gripe at this time is the multiple registrations required by many doctors ... now we have almost every hospital asking for what

3 Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra, page xxv
amounts to “original” AHPRA type registration processes as part of so-called recertification or recredentialing. Some hospitals are actually asking for us to provide certified copies of original certificates of training as well as certified copies of passports or birth certificates. For those of us that work for Statewide service entities and are credentialed at multiple hospitals, we end up doing this every few months for someone. Someone needs to rationalise this. It’s vastly worse than what we had with State based registration.” Registrants under NRAS find themselves dealing with an impersonal computer program which allows little scope for the variations that often occur in medical practice and has no direct personal knowledge of their practice history. With the NRAS covering all registrable health professions, there are now over 600,000 health professionals subject to the idiosyncrasies of a poorly designed computer program.

9. Perhaps the most fanciful claim is that NRAS would deliver collaboration, sharing and learning between professions. This claim is based on assumptions that somehow, the professions don’t work together in practice and that NRAS was required to get them to talk to each other. Doctors have a long history of working with other professions and there is nothing that prevents meetings and work groups of multiples professions from being formed at any time, be it for research or treatment. The ‘egalitarian ethos’ behind this claim however should be taken seriously. It displays the real purpose of NRAS, which is a political and ideological desire to have a multi-tasked and uniform health workforce. In this Utopian vision, medical practitioners, who have traditionally been the experts in whole body systems, will be cut down to size (deconstructed) and their tasks reassigned to a variety of other groups in changed scopes of practice. This ‘attack on elites’ is well defined by Prof Stephen Duckett in his two papers on health workforce⁴. Hence, the ADF maintains that NRAS is part of a three-pronged social engineering strategy with the Productivity Commission report of 2005 as its implementation vehicle. This strategy involved changing the medical registration system (to align it with other health professionals), the medical education system and the Medical Benefits Schedule (MBS) to create a ‘21st Century Health Workforce’ shaped and controlled by health bureaucrats. Interestingly, the Productivity Commission qualified its 2005 report by stating that the report was written “in parallel with a review by COAG senior officials”⁵ and that “currently available information does not support the full assessment of health sector productivity and hence the efficiency of health service provision.”⁶ The concerning aspect is just how quickly and easily State Health Ministers and Opposition Leaders uncritically surrendered their legislative authority to an unaccountable bureaucracy, hence reducing the protection of their constituents. To their credit, the NSW Labor government refused to surrender its healthcare complaints system to this process and the Queensland Liberal government has since taken the complaints process back under its direct jurisdiction. Furthermore, the Victorian Office of the Health Services Commissioner (OHSC) has implemented a process where “work on a complaint that the OHSC believes is within its remit is commenced within days of the correspondence being sent to AHPRA”.⁷ Perhaps the greatest example of the failure of collaboration between professions has been the battle between the Optometry Board of Australia (OBA) versus the Australian Society of Ophthalmologists (ASO) and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) over the treatment of glaucoma. Why does this matter end up in the Supreme Court of Queensland if AHPRA is able to deliver such great collaboration? The answer is clearly that under NRAS, any board (with AHPRA Board approval) can introduce a scope of practice for any procedure without any direct

⁵Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra, page xv
⁶Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra, page 387
legislative scrutiny. Since there is no hierarchy of boards, each board is free to license its own practitioners in any scope of practice it believes they should be entitled to undertake (or have lobbied to be granted). Hence, a major public safety issue is now being ruled on by the Supreme Court of Queensland.

10. Finally, the claim that NRAS was needed in order to deliver a publically available register of medical practitioners defies common sense. Producing an updated website of registered medical practitioners could have been undertaken by the then Joint Medical Boards Advisory Committee (JMBAC) a national entity comprising the Presidents of all State and Territory Medical Boards within the Australian Medical Council by updating the National Compendium of Medical Registries. The fact that JMBAC and the AMC were ignored in the NRAS process is clear evidence that the purpose of NRAS was to obliterate existing structures and substitute for them a new, more ideologically driven NRAS health bureaucracy.

11. In summary:
   a. NRAS was a bureaucratic solution to a non-problem and hence has added to complexity and cost whilst weakening legislative oversight and public protection through removal of direct parliamentary accountability.
   b. A national database for medical registration is an administrative reform that could have been conducted without NRAS.
   c. Simultaneous registration is an administrative issue which was achievable without NRAS.
   d. The claim that NRAS has created specific independent national boards responsible for regulating their own professions, is false. In reality, all boards report to AHPRA and the CEO of AHPRA has authority over 600,000 health professionals without any direct accountability to any particular Minister or jurisdiction. The NRAS system is run by bureaucrats and all professions report to and are guided by them. This alone should send shivers up the spines of all legislators, both state and federal.

12. Recommendations:
   a. That the Australian Medical Profession be removed from NRAS.
   b. That State Medical Boards be responsible for registration and discipline of medical practitioners in their state jurisdictions under the direct responsibility of the respective State or Territory Minister for Health.
   c. That a National Medical Board, consisting of the Presidents of State and Territory Medical Boards be formed to consider matters referred to them by State and Territory Boards which may require national attention, and that this board work cooperatively with the Australian Medical Council.
   d. That other professions be given the opportunity to leave the NRAS.

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