AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

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AMA submission to the review of complexity within the National Registration and Accreditation Scheme — Consultation paper 1

Introduction

The Australian Medical Association (AMA) is the peak professional body representing the interests of Australia's medical practitioners and students. At the heart of doctors' interests is their own wellbeing and the wellbeing of their patients. It is imperative we promote and protect this, as well as the needs of the healthcare system and the community.

The AMA is concerned about the approach the review is taking. The primary objective of the National Scheme must be upholding the standards of our health professions, ensuring public safety through robust, independent accreditation and fair, profession-led regulation of practice.

We would like to constructively engage in this review and look forward to meeting with the review team in the near future. Noting the implications on medical practice and accreditation of medical training places, we would strongly encourage the review team to have a broader consultation process for engagement with the profession. The AMA is happy to facilitate this.

This submission provides responses to specific topics provided in the submission template.

Evidence and issues

The issue of cross-profession regulatory decision making (pages 38-39)

The AMA is not clear why the lack of cross-profession regulatory decision making is an issue for this review. There is room for greater collaboration and sharing of resources across professions led by the National Boards, but decisions about professional regulation must be led by the relevant board. Doctors want the regulatory decisions about them to be made by doctors. It would be inappropriate for a doctor to make a regulatory decision about the practice of another health professional where they have not trained in or participated in the education, training and core competencies of that profession.

Accreditation (pages 41-49)

The AMA does not support the proposals to give health ministers greater powers over accreditation.

Page 44 stipulates any reforms to the design and delivery of accreditation functions should support workforce reform and needs. The AMA sees this statement as problematic. Accreditation exists as part of a framework to ensure that Australian doctors are trained to the highest standards in the world – delivering world leading care to patients. Any introduction of a workforce focus will lower the standards of the medical professions and specialities.

It is imperative the review team consults with each specialist medical college on the proposals to change accreditation. The colleges play a vital role in upholding the quality and integrity of specialist medical education in Australia. The paper does not provide sufficient evidence the current processes are a major issue which requires a complete overhaul of the governance structures of accreditation.

Watering down accreditation standards will not solve current workforce shortages and represents short term thinking. Solving workforce shortages will require investment in the capacity of our health system including the training, recruitment and retention of practitioners and the expansion of collaborative models of care where doctors and other health professionals work together in delivering care for patients.

The AMA is concerned the health ministers' objective is to interfere with the accreditation process. Decisions by a college to remove a hospital's training accreditation are significant and are carefully considered. While we understand that such decisions can be unexpected and difficult, the appropriate response is not to increase the involvement of health ministers in the accreditation process.

Instead, the AMA would like to see a strengthening of the Accreditation Committee, with the Australian Medical Council (AMC) and other accreditation bodies brought onto the committee to engage directly. This body currently acts more as a think tank, but it could act as an arms-length body to work through concerns with accreditation processes. The AMC has strategic capabilities as well as operational ones, and participating directly in a stronger, independent body can support improvement to accreditation processes.

We are aware processes have been established to ensure health ministers are not surprised by college decisions to remove accreditation through the policy direction mentioned on page 44. We would support this as the most appropriate way to ensure health ministers are not caught by surprise and, more importantly, are made aware of issues earlier so they can prioritise work to address the issues.

Fees

The consultation paper does not adequately discuss the Australian Health Practitioner Regulation Authority (Ahpra) registration fees and transparency of funding.

At Senate Estimates on 26 October 2023, Senator David Pocock asked Mr Martin Fletcher, Ahpra CEO, about what had contributed to the 16 per cent fee increase for medical practitioners. Mr Fletcher's response demonstrated that doctors' fees were covering the costs of reforms to the health system, which should have been paid for by health ministers. From the Hansard:

> "...the increase, as you say, was closer to 16 per cent — $860 to $995 — for registration this year. That does reflect a range of things. As I indicated, there is the work in notifications. I would particularly also highlight the work in cosmetic surgery, where we've made a substantial investment in a cosmetic surgery enforcement unit, which has a huge focus on medicine. We've had a much stronger focus on things such as sexual boundary violations. We've had, as I say, a general increase in the number of notifications. We're also investing in a every (sic) significant digital transformation program. The system we're working with at the moment was the one we got back in 2010. That's 13 years old. I would say in the IT world that is more like 100 years, when you think of what has happened over the last 10 to 13 years. We're having to invest in that. We've also made a substantial investment in improving timeliness and responses in relation to internationally qualified medical applicants seeking registration in Australia. All of those things have added to the increased cost for medicine. That is reflected in that fee increase."

The AMA was supportive of the cosmetic surgery reforms, however, the issues with this sector were well known for decades. The 130,000 medical practitioners should not have had to cover the cost of past regulatory inaction. Likewise, it was the Australian public who benefited from the improvements to IMG processing, not the doctors already within the scheme.

To be clear, we do not oppose these reforms — we oppose health ministers using Ahpra registration fees to fund them.

The AMA is legitimately concerned if the health ministers turn the National Scheme into a health workforce body, the fees of the registrants will be funding this endeavour.

We would like to see clearer reporting on how Ahpra fees are used. As highlighted earlier in the submission, there is insufficient accountability of the health ministers within the National Scheme, and this is one of the major aspects that must be improved.

Governance and stewardship — strategic connection

Workforce

The National Scheme is not an avenue for health ministers to drive workforce reform. The executive summary of the consultation paper states the purpose of the National Scheme is "protecting public health and safety, by ensuring that our health practitioners are appropriately skilled and trained, and

meet expected standards of performance and conduct". The AMA agrees and supports this. The National Scheme enables a health workforce and it should contribute to the development of workforce policy, development and reform through the provision of data and guidance. It is not a workforce scheme.

We sympathise with the desires of health ministers to address our current workforce shortages. The solution is not to change the fundamental purpose of the National Scheme which is to ensure patients are cared for by practitioners who are trained to the highest possible standards.

Point 3 on page 32 of the consultation paper reads:

> "Apart from the references to public protection being the 'primary purpose' and the 'paramount objective' (which is not what the National Law says), there is no detail in the regulatory principles about how the National Boards and Ahpra weigh potentially competing National Law objectives in regulatory decision-making. This would be necessary and expected, noting that at times there may be tensions (for example, between ensuring public protection and at the same time facilitating access to services) that are likely to impact decision-making."

This is an incorrect interpretation of the National Law. There is no tension or conflict because the purpose is to ensure health professionals meet essential standards to provide care to the public.

The suggestion that we amend accreditation or regulation within the National Scheme to enable public access to a health professional who does not meet high standards undermines the second guiding principle of the National Law: "public confidence in the safety of services provided by registered health practitioners and students."

There are improvements that can be made at different parts of the National Scheme to support the workforce. We have seen this recently with the improvements Ahpra has implemented in response to the Kruk Review. This led to a 27 per cent increase in the number of international medical graduates (IMGs) approved to work in Australia, while the time to process applications decreased 26 per cent.

The AMA would also like to see improvements to the process for moving from non-practising registration back to practising, as this is a complicated process which could be simplified without compromising safety.

There is a significant cohort of IMGs living in Australia at various stages of the registration process who are "stuck" between different parts of the National Scheme or are unable to meet certain requirements like recency of practice due to personal circumstances. The AMA would be happy to connect the review team with some of these individuals to help them understand some of the genuine complexities impacting people ready to join the workforce.

There are many tweaks and improvements in various parts of the National Scheme that could support and grow our workforce without compromising standards.

The National Scheme has a role in guiding workforce policies, but these policies need to be developed outside the scheme with independent, evidence-based input. Independence is crucial because

political priorities often emphasise access over maintaining standards. Currently, Australia faces the problematic situation where a health profession's scope of practice is largely determined by election campaign promises rather than professional standards.

The AMA has been clear health workforce policy and reform must be developed and managed outside the National Scheme since the NRAS Review in 2017 (the Wood review).[i] Health Workforce Australia (HWA) was established for this purpose and had, over time, put in place structures and processes to ensure key stakeholders were able to provide meaningful input into this advice. With the demise of HWA, consideration of expanded scopes of practice has largely been left to state and territory governments. The individual health practitioner boards and these entities do not appear to work collaboratively and constructively on the issue.

As such, the National Scheme has failed to provide the appropriate mechanism to support the workforce reform agenda by providing a robust forum for scrutinising the need and evidence for, and public debate of, changes to the roles and responsibilities of health professionals.

This review could recommend the establishment of an independent health workforce agency to provide the appropriate advice to health ministers on health workforce reform to ensure Australia develops the health workforce it will need. It is not reasonable to ask the regulator to provide this policy advice.

The best solution to address Australia's current and future health workforce demands is an appropriately funded, Independent Health Workforce Planning and Analysis Agency (IHWPAA).

Analysing the healthcare workforce must be independent from the National Scheme. Robust workforce data and analysis must drive health workforce policy, planning, and decision making. The AMA advocates for a separate agency that is data driven to advise the health ministers on how the National Scheme can support a growing workforce.

Health workforce planning in Australia has stagnated since the abolition of HWA in 2014, with minimal modelling or planning reports produced since 2017. The consequences of this neglect are increasingly evident. An IHPWAA would ensure Australia has a health workforce with the right skills, in the right locations, to meet future community needs and demand. We need evidence-based policy that will minimise wasted expenditure while enabling us to adapt proactively and efficiently to changing healthcare demands, ensuring all Australians have access to high-quality healthcare.

The AMA advocates for the establishment of a national IHWPAA to progress the targeted and sustainable development of the health workforce. Without this coordinating body, Australia's health workforce will continue to fall short of meeting community needs and expectations.

Governance and stewardship — regulatory connection

The AMA is supportive of stronger regulatory connections between bodies of the National Scheme and other regulators. For example, the AMA has been supportive of Ahpra and some of the National Boards working with the Therapeutic Goods Administration and other regulators on concerning

developments in closed-loop prescribing models, largely focused on cannabis. The concern we have is how these tasks are funded. As detailed above, where bodies of the National Scheme are tasked with other duties, appropriate funding must be provided.

Governance and stewardship — community voice

Queensland as the sole state which passes National Law amendments

Page 23 stipulates Queensland is the jurisdiction responsible for passing amendments to the National Law. However, all other National Scheme responsibilities are shared. The centralisation of responsibility for passing amendments to the National Law in Queensland presents several challenges. They hinder the effectiveness of the National Scheme and its ability to adapt to the diverse needs of the healthcare system across Australia. These challenges include:

1. **Lack of flexibility**: Other jurisdictions may have unique needs or concerns not adequately addressed by Queensland's legislative approach. This can lead to gaps in regulation that may not reflect the specific contexts of different regions.
2. **Bureaucratic delays**: Centralising amendments in one jurisdiction can create bottlenecks, slowing down the process of updating laws in response to evolving healthcare needs or issues.
3. **Potential for misalignment**: The priorities and perspectives of Queensland may not always align with those of other states and territories, leading to potential conflicts or dissatisfaction among stakeholders.
4. **Imbalance of influence**: There is a risk that Queensland's interests may overshadow those of other jurisdictions, impacting the collaborative nature of the National Scheme.

The Queensland parliament has one chamber. This limits scrutiny of amendments to the National Law and results in draft amendments being passed without change. The AMA and other bodies do provide feedback during the review stage, however, this often results in only minor changes. This is convenient for health ministers, but a problem for health professionals. We would strongly encourage the review team to review the appearances of health professionals at the public hearing on the 2022 amendment to the National Law, along with the written submissions, to understand this concern.

One way to truly address the complexity within the National Scheme would be to pass amendments to the National Law in another jurisdiction to allow bodies representing the nearly one million registered health professionals in Australia, to challenge the amendments and drive improvements.

Operational accountability and efficiency — scheme wide objectives and priorities

The National Law objectives have been taken out of context, particularly parts B and F, which allude to workforce. The National Scheme was established to create one national register to enable healthcare practitioners to move between states as required. This scheme is about regulation and standards, not workforce. Workforce issues must be considered and addressed outside the National Scheme.

The consultation paper has missed an opportunity to explore how the regulatory side of the scheme functions, specifically how much of the approach of Ahpra and the National Boards is based on

discipline as opposed to support and uplifting professions. The AMA believes there is too great a focus on discipline, which has undermined support for the National Scheme among registrants.

The AMA works closely with the Medical Board and we understand the commitment of the board to protecting the profession and improving standards, but there is a disconnect from the broader profession. The telehealth guidelines are a positive example of working with the profession to develop positive standards, seeking to encourage best practice provision of care. However, the recent consultation on the introduction of mandatory health checks for doctors over the age of 70 demonstrates the other side of this. The great challenge with this process was the focus on adding requirements for a cohort of doctors to remain working in the profession rather than support for this cohort and their colleagues to help retain them or discuss retirement when it is appropriate.

We would strongly encourage the review team to focus on the aspects of the National Scheme that could be updated to facilitate National Boards playing a more supportive role for their professions while continuing to meet goals around professional standards.

Operational accountability and efficiency — boards and committees

The AMA does not support amalgamating the Medical Board with another board. We see no reason why other boards should be amalgamated but will defer to our colleagues in other professions to comment. Having a profession-led board is important as it ensures connection between the profession and the regulator. The AMA would like to see a focus on improving this connection as one of the objectives and outcomes of this review.

Doctors in Australia are among the best trained in the world, regulated by a profession led medical board. This is a proven model, with a strong understanding of the complexity of medical training and education and the need to maintain high standards of care for patients.

Among medical practitioners, there is already a clear distrust of Ahpra and the Medical Board. The AMA has increased engagement with the Medical Board in recent years and we have tried to include members in this. Changing this, or appointing a non-doctor as chair, risks further diminishing the profession's already limited confidence in the Board.

Community members play an important role in the operation of the National Scheme. The reality is that from a medical perspective, the chair of the Medical Board must be a medical practitioner – bringing with them the unique and extensive knowledge of the practice of medicine that is necessary for this critical leadership role. It is imperative they remain profession specific. National Boards must have control over their decision whether to appoint a community member to the chairperson role on a National Board.

This discussion on page 57 stems from a recommendation from the 2014 Snowball review, which was accepted by health ministers, but not implemented. This review is about complexity within the National Scheme, but appointing a community member to the chairperson role does not reduce complexity. It may in fact add to complexity.

The paper has failed to acknowledge the sentiments of the medical profession to Ahpra and the National Boards. The reviewers need to focus on improving this. There is no evidence presented pertaining to the benefit of a community member chairperson. Such a change will further damage the National Boards' relationships with medical professionals and de-value the medical profession.

The Australian Institute of Company Directors (AICD) stipulates the chair acts an important link in communicating information between the board, the members, and the public. They must have a strong understanding of the function and operations of the industry.[ii] Doctors who are chairs of the Medical Board must be well versed in their various legal, ethical, and professional obligations as doctors, employees, and board members. The participation of doctors on the Medical Board is an asset because of their deep knowledge of clinical problems, best practices, quality indicators, and other issues related to the safety and quality of care within medicine.[iii]

Operational accountability and efficiency — accreditation functions

The AMA does not support accreditation functions being altered to support workforce strategy and planning priorities. Any proposal to integrate accreditation with workforce strategy carries a significant risk of lowering standards and creating issues related to the scope of practice.

The AMA endorses the Ahpra Board's independent Accreditation Committee in providing expertise in accreditation systems to ensure the professions registered under the National Scheme are done so to the highest standards. It is essential accreditation remains independent of political interference. The Accreditation Committee must work better with bodies like the AMC. They must be connected in their endeavours and goals.

Coherent and effective complaints handling — simplifying structures and processes

Single front door entry for complaints

The AMA agrees that having a single front door for consumer complaints and having clear guidance and information for consumers and practitioners can address some of the complexity faced. For the wellbeing of practitioners, it is important that lower-level complaints are identified early and addressed promptly. For higher-risk cases, careful consideration must be given so they are handled appropriately. A single health complaints entity requires commitment by health ministers nationally working towards uniformity. Transition into this comes at a cost and health ministers must be prepared to fund any new entity proposed. Further consultation must be conducted with key stakeholders to ensure funding, infrastructure and processes remain fully transparent.

If changes to the "business process" are made as discussed on page 56, Ahpra's primary objective must continue to be public safety, and any investigation should prioritise upholding this goal. Communication is important and the AMA absolutely agrees there are improvements to be made to the process of communicating notification outcomes, but these changes must all occur within a framework that does not undermine the objectives of Ahpra regulation. If the regulatory framework is

built around customer satisfaction, it could compromise safety, further penalise registrants, and ultimately lead to higher costs for registrants.

Practitioner distress (page 56)

The AMA is extremely disappointed at the failure of the consultation to properly explore the impact of the Ahpra notification process on practitioners. This receives about half a page in a 109-page document. This is particularly disappointing noting the findings of the '*Expert Advisory Group to explore practitioner distress while involved with the regulator'* are still fresh in the memories of all health professionals.

The AMA has consistently raised the impact the regulatory process has on doctors' health and wellbeing. The study conducted from January 2018 to December 2021 identified 16 deaths and four instances of attempted suicide or self-harm among practitioners who were subject to regulatory notifications. Fifteen recommendations were made in response to the expert advisory group and study into practitioner distress.

The AMA participated in a symposium hosted by Ahpra in the aftermath of the report, and we acknowledge the improvements to processes implemented in recent years. The issue is Ahpra and the National Boards operate within the terms of the National Scheme.

The AMA has written to health ministers, first in November 2022 and again in April 2023 after not receiving a response, calling for health ministers to:

- mandate, either through a ministerial directive or changes to the National Law, that Ahpra has a duty of care to the registrant, and a duty to minimise the mental health impacts and financial effects on the health practitioner who may be subject to a notification
- require Ahpra and the Medical Board to offer confidential support by an independent mental health professional to any health practitioner under investigation
- require all investigations to be completed promptly — with an average target of six months except in exceptional circumstances
- ensure a practitioner has the right to be personally present and to be legally represented during all stages of the investigative process, with the practitioner or their legal representative having the full and unfettered right to support their case.

The AMA calls for the review team to place practitioner distress experienced as a result of the National Scheme at a higher priority. We urge this matter to be given the highest level of attention throughout further consultations and discussions with the health ministers. There are many reasons for practitioner distress, including the complexity within the system and the difficulty practitioners face during the notifications and complaints process. Practitioner distress and complexity of the National Scheme go hand-in-hand, and therefore must be considered in parallel.

Co-regulation of the National Scheme

The presence of independent state and commonwealth regulatory bodies has created a co-regulatory environment with differing jurisdictional responsibilities. For medical practitioners who work across multiple states, it creates a great deal of confusion. The AMA receives feedback from doctors about their notification experiences and the impact the process has on financial freedom, emotional wellbeing, confidence to reattempt re-registration, and eventual closure of notification.

While we accept this is outside the terms of reference of the review, we object to this exclusion as it is one of the great sources of complexity within the National Scheme.

Scope and expansion of the National Scheme

There are some interesting ideas in this section that the AMA is open to support. The reviewers should engage with accreditation bodies and education and training providers to understand the impacts they would have on current and future training programs and health service resources.

Possible reform concepts

Concept 1

Implementing a stewardship model is very difficult to achieve. It is almost a cultural shift whereby stakeholders are asked to embrace stewardship. The existing regulatory culture is largely reactive rather than proactive, which is because much of it is led by health ministers. There are no pathways for professions to genuinely lead reform. The most significant recent example of this is the regulation of cosmetic surgery. The AMA and other medical bodies have been calling for reforms to the sector dating back to before the establishment of the National Scheme. These calls did not receive a genuine response until a series of current affair programs exposed the issues to a broader audience. In response, the health ministers called for a program of reform with unrealistic deadlines, funded by Ahpra registrant fees. While the AMA is supportive of the final model, there are outstanding issues to be addressed. More importantly, it is a poor model for a reform process.

As a result, this aspect may hinder any successful adoption of concept 1.

There is a risk the stewardship model could lead to regulatory decisions being influenced by workforce demands rather than being based on principles of public safety and practitioner competence. This is particularly evident because concept 1 places workforce highly in the flow chart and very close to health ministers. If the balance is not carefully managed, it could compromise the quality and safety standards of healthcare regulation by prioritising workforce supply over maintaining rigorous standards.

Concept 2

The AMA strongly disagrees with concept 2.

While concept 2 theoretically aims to centralise some decision-making and governance structures to streamline processes, there is a risk that the unique needs and nuances of individual health professions could be overlooked. The current structure's profession-specific boards ensure regulatory decisions are informed by clinical expertise from each field. Centralising or resetting accountabilities may dilute this specialised input, potentially compromising the quality of regulatory decisions. Thus, finding the right balance between central oversight and maintaining profession-specific knowledge in decision-making processes is crucial. There is a concern that reducing the number of decision-making bodies or delegating more responsibilities to Ahpra could undermine the role of profession-specific boards.

There is a significant amount of complexity in implementing the proposed changes. The risk with such reform will involve restructuring across multiple entities within the National Scheme. Given there are currently 119 regulatory decision-making bodies, any reform effort to reset accountabilities would require careful planning, coordination, and possibly legislative changes. This could be a lengthy, costly and complex process and lead to service delivery disruptions or create uncertainty for practitioners and stakeholders.

Delegating more responsibilities to Ahpra while resetting the division of roles with the National Boards could lead to Ahpra taking on a larger operational workload, potentially overburdening it if adequate resources and support are not provided. Increased delegation to Ahpra without corresponding increases in resources or structural adjustments could result in slower response times or inefficiencies, which would be counterproductive to the intended reforms. It could also undermine the positive work Ahpra has done to date in reducing the notification process time among others.

If the reforms are perceived as reducing the profession-specific input or not adequately addressing transparency and fairness, there could be further fracturing of trust in the regulatory system. The public and practitioners may worry that their interests are not sufficiently represented or that regulatory decisions are being made by individuals who lack clinical expertise in specific areas, i.e. the health ministers.

The consultation paper notes the need for better integration and coordination with other health regulators and related agencies. However, achieving this through concept 2 may not fully resolve the issue of fragmented oversight across various health regulatory bodies. Broader coordination with external regulators (such as state and territory health complaints entities or other health-related agencies) remains a complex task that extends beyond the scope of this proposal.

Concluding remarks

The solutions to Australia's workforce shortages will require investment in the capacity of our health system including the training, recruitment and retention of practitioners and the expansion of collaborative models of care where doctors and other health professionals work together in delivering care for patients. This is achievable but requires investment and long-term planning which is best achieved through independent bodies not reliant upon political cycles. Watering down accreditation standards will not solve current workforce shortages while creating risks to patient safety.

We understand the review team has asked for alternatives to the proposals put forward in consultation paper 1. We have endeavoured to provide these, but in some instances the changes will require deeper engagement. Specifically, changes to accreditation will require robust engagement with the medical colleges. As noted earlier, the AMA is happy to facilitate this.

Contact

president@ama.com.au

[i] Australian Medical Association. (2017). AMA Submission on the Independent Review of Accreditation within the National Registration and Accreditation (NRAS) Scheme Draft Report.

[ii] Australian Institute of Company Directors. (2024). https://www.aicd.com.au/board-of-directors/roles/chairman/roles-and-responsibilities-of-the-chair.html

[iii] Mason, D. J., Keepnews, D., Holmberg, J., & Murray, E. (2013). The representation of health professionals on governing boards of health care organizations in New York City. *Journal of urban health: bulletin of the New York Academy of Medicine*, *90*(5), 888–901.