



Victorian Legislative Council Inquiry into the Performance of the Australian Health Practitioner Regulation Agency (AHPRA)

“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 2.2.2011¹, former Productivity Commissioner

1. **The Australian Doctors' Fund (ADF) welcomes the Victorian Parliamentary Inquiry** into the performance of the Australian Health Practitioner Regulation Agency (AHPRA). This submission is specific to the Australian Medical Profession but may have application to other professional groups.

Recommendation Summary

2. The ADF recommends that the Victorian Parliament (and all state and territory parliaments) **move to reclaim direct responsibility for the registration and regulation of all medical practitioners in Victoria**, i.e. to install a Victorian Medical Board as the only intermediary between a registered medical practitioner practising in Victoria and the Victorian Minister for Health. (See recommendations below.) i.e. the Australian Doctors' Fund is recommending that the Australian medical profession be no longer under the management/control/partnership of AHPRA.
3. The ADF maintains that **medical practice in Australia and Victoria achieved high standards long before the establishment of AHPRA**. Administrative harmonisation does not require the creation of authoritarian structures and 'bureaucratic managers'. There was no compelling evidence that Victorians were any less protected under the previous model of medical regulation or that they are any more protected now under AHPRA.

AHPRA surplus to requirements

4. The **ADF's criticism of AHPRA as an unnecessary entity, in this submission in no way relates to any particular individual or public servant** or groups of public servants employed by AHPRA or appointed to its Boards. Rather, the ADF's analysis reveals flaws in the structure of the AHPRA model as the monopoly regulator of "more than 560,000 health professionals."² In the case of the medical profession, AHPRA is not only surplus to requirements, it is adding unnecessarily to cost and causing greater complexity.
5. On its website, AHPRA states that it is "partnering with National Boards" to protect the public and set standards and policies that all registered health practitioners must meet. The reality however is that **the COAG/National Registration model hands AHPRA effective control over the decision making processes of all Boards**. There are no nationally independent professional Boards under the AHPRA model. In the case of the medical profession, the major difference is that where previous State and Territory Boards were directly accountable to the Legislature through their respective Ministers for Health, this is no longer the case (see points 18 & 19 below).

¹ Catallaxy files, The AHPRA : yet another Federal cock-up, ,<http://catallaxyfiles.com/2011/02/02>

² AHPRA website, <<http://www.ahpra.gov.au/>>



This therefore raises the question as to whether the public has more or less protection than under the old model.

6. **A monopolist regulator with broad 'protecting the public' objectives, captured customers (registrants), and a committee of nine stakeholders as its Manager (Ministerial advisory committee), will inevitably grow from within. There will be broader missions, increasing costs and growing complexity (all "nominally" in the "public interest").** The reality is that almost any activity, project or program can be justified in terms of 'protecting the public'. Furthermore, **the costs of these activities can be passed onto the compulsory customers in the form of higher registration fees.**
7. **Much has been made about AHPRA's ability to deliver a national registration database for the medical profession** and the creation of a national board (Medical Board of Australia). These claimed achievements conveniently ignore the fact that for 10 years prior to AHPRA the State medical boards had developed a national database in the form of The National Compendium of Medical Registries. Whilst there was a clear imperative to upgrade this national database, this software upgrade did not require the creation of AHPRA. To suggest otherwise, is to deny the fact that each year hundreds of thousands of Australians register online with their sporting teams and professional organisations without the need or oversight of hundreds of public servants.
8. **Long before AHPRA and the Medical Board of Australia, the Presidents of State and Territory Medical Boards met as a National Committee** within the **Australian Medical Council (AMC)** without the help/cost of AHPRA. Through the AMC the Australian medical profession has always sought to coordinate at a national level. In cases of national emergencies, doctors have always been able to respond to interstate requests without bureaucratic interference.
9. Whilst the issue of **inter-jurisdictional registration did involve a small minority of doctors completing 2 registration forms** (the cost of which has now been grossly exceeded by AHPRA's fees) the fact that interstate doctors had to re-present to a registration process close to where they wish to practise **provided additional opportunities to assess/validate the reasons for a medical practitioner's change in practice location** (effective risk management). Simultaneous jurisdictional registration has removed this filter from the system.
10. **The test as to the need of any structure, function or process is to contemplate what would happen if it was removed.** In the case of AHPRA, **the ADF maintains that neither the medical profession nor the public would be adversely affected if the profession was removed from AHPRA's administrative control** (i.e. a return to the State and Territory Board model). (See recommendations below). Given that **each state and territory has its own harmonised legislation and has continued to undertake most of the tasks associated with its prime functions of licensing and disciplinary tribunals**, the ADF maintains that AHPRA's absence would produce no loss of effectiveness. A National Medical Board consisting of the Presidents of State and Territory Boards would maintain a national cooperative approach without unnecessary bureaucratic interference and cost.
11. Furthermore, the costs of national registration should decline as the medical profession's substantial contribution to **AHPRA's 570 staff and 100 contractors** is reduced. There are **no reports that the ADF has seen where the delivery of healthcare has seen any significant improvement since AHPRA's formation.** A computer registration



program does not require a bureaucratic structure to operate effectively. It requires parameters, maintenance and a clear set of regulations for its use by State and Territory Boards. (see recommendations below)

One size fits all healthcare

12. Clearly **the creation of AHPRA was not for the purposes of establishing a national register or in the case of the medical profession, a national board** since both were already operational. The ADF has always maintained, based on the evidence, that **AHPRA's raison d'etre was/is principally ideological** (albeit masquerading as administrative reform). **The goal was to create a centrally administered and controlled "one size fits all" health workforce** as outlined by Prof Stephen Duckett (recently of Alberta, Canada), a major contributor to the 2005 state government sponsored, Productivity Commission Report into Health Workforce³. (A close reading of this report reveals a series of disclaimers to its recommendations and an admission on its final page that it was unable to measure the productivity of the health sector)⁴. In his June 2005 paper, Interventions to facilitate health workforce restructure, Prof Duckett states as follows, ***"The changes to facilitate flexibility outlined above can be undertaken unilaterally by states changing registration board legislation or by the Commonwealth changing the MBS arrangements"***⁵.
13. The ADF maintains that **the community is best protected when regulation recognises real and significant differences** defining the roles, culture, skills and knowledge base of the various health professions and occupations. This diversity should not be subject to mindless attempts to impose top-down uniformity. To do so, will impoverish medical practice not strengthen it.

Perverse incentives

14. **Under the AHPRA model, there is no incentive for the Agency, or the Boards to concentrate activity** on core tasks as set in the legislation, and **every incentive to meddle in every aspect of medical practice** with increasing volumes of guidelines, policies and codes of conduct hence **confusing important distinctions between the law and ethics**⁶. Furthermore, much of this activity is already being duplicated by Medical Colleges and multiple safety and quality agencies/programs, to the extent that medical practitioners are flooded with material "guiding their clinical behaviour." The latest proposal being considered by AHPRA/MBA is for all medical practitioners to be relicensed. Should this policy be adopted by all AHPRA controlled Boards, we are likely to see 560,000 AHPRA controlled registrants sitting additional exams, paying additional costs and fees with little if any evidence that the process does anything substantial to "protect the public".

³ Productivity Commission Australia's Health Workforce, Productivity Commission Research Report, 22 Dec 2005, pXV

⁴ Ibid, p.387, "Overall currently available information does not support the full assessment of health sector productivity and hence the efficiency of health provision

⁵ Stephen J Duckett, Interventions to facilitate health workforce restructure, Australian & New Zealand Health Policy, 2005, 2:14,p4

⁶ As Professor Paul Komesaroff has so eloquently pointed out, "The fine details of the conduct of clinical relationships cannot be represented in a set of injunctions relating to styles or outcomes of behaviour, no matter how elaborate. Although clinical practice may refer indirectly to universal principles, in its details it is singular and specific, responding to individual circumstances and needs. Like other kinds of professional and moral behaviour, it thrives on diversity, discontinuity and difference. This is especially true in the multicultural and pluralistic setting of Australian society." The Australian Medical Council draft code of professional conduct: good practice or creeping authoritarianism?", Paul A Komesaroff and Ian H Kerridge, MJA, Volume 190 Number 4, 16 February 2009.



Has AHPRA Improved the Productivity of Australia's Health Professionals?

15. The ADF has always maintained⁷ that **AHPRA model created by COAG contributes nothing to improved productivity of Australian health professionals**. To the contrary, it has added unnecessary complexity, cost, inefficiency and rigidity. Centralisation is not always synonymous with simplification. The ADF notes recent comments from the former Premier of Victoria, the Hon. Jeff Kennett in relation to COAG. **“He said yesterday that it [COAG] had introduced new layers of bureaucracy affecting the public and the business community and limited politicians' ability to make quick, common sense decisions”**⁸. The ADF maintains the same can be said for the AHPRA model of healthcare regulation.

Who does AHPRA Answer to?

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

Has AHPRA Simplified the Registration of Medical Practitioners?

17. The answer is no. Under the management of AHPRA, the new national registration computer program which has made it possible to register online achieved such dysfunction that it resulted in a Senate Inquiry. Setting aside so-called teething problems with a new computer system that requires a virtual government department to administer it, continual problems arise when medical practitioners wish to change arrangements or have arrangements clarified. Rather than speaking to a specialised state or territory medical board secretary's office the registrant is dealing with a massive centralised bureaucracy where their needs are one of 560,000 registrants. The registrant has become a very small fish in a very large pond.

Added to this, there are now multiple layers **between a doctor registering and the 9 health ministers** who have collective public accountability for licensing of medical practitioners in all states or territories. Whereas previously there was one agency between a registering doctor and the health minister, **there are now six potential jamming points**, all of which come with a price tag. Medical registration fees which are ultimately passed onto patients have rocketed and the potential for bureaucratic hazards has increased substantially. The ADF asserts the AHPRA model adds additional layers of complexity and ignores the basic principles of risk management, **“A complex system contrary to what people believe does not require complicated systems and regulations and intricate policies. The simpler the better. Complications lead to multiplicative chains of unanticipated effects”**⁹ (Nassim Taleb, Distinguished Professor of Risk Engineering at New York University). The creation of AHPRA has added

⁷ http://www.adf.com.au/archive.php?doc_id=182

⁸ Kill COAG before it kills us, says Jeff Kennett”, Joe Kelly, The Australian, 14 Dec 2012.

⁹ Nassim Taleb, Antifragile, Random House 2012, p.11



nothing beneficial to a patient's healthcare, or strengthened the doctor/patient relationship. To the contrary, it has driven up cost and imposed additional demands on hard-working doctors.

18. The line of communication for the old model was:
1 health minister → State Medical Board → medical practitioner
19. The line of communication for the new AHPRA model is:
1 health minister → 8 health ministers → COAG → AHMAC → AHPRA → National Medical Board → State Medical Committees → medical practitioner
20. In summary, the ADF maintains that in implementing the AHPRA model, **we have moved from the simple to the complex and ignored the dictum of sound administration, namely "less is more and usually more effective."**¹⁰

Recommendations

1. Legislate to re-establish the Victorian Medical Board as the sole regulator of medical practice in the State of Victoria.
2. Release the Victorian medical profession from any obligation to, or control by AHPRA and return all funding to the Medical Board of Victoria.
3. Allow the Medical Board of Victoria to provide a registration service capable of being used by any medical practitioner which will simultaneously register a doctor in all state/territory jurisdictions. Should this recommendation be taken up by other states/territories, it will set up a competitive registration service and hence drive innovation and improvement in service delivery via competition.
4. Allow the re-established Medical Board of Victoria to introduce or modify categories of medical registration which will provide for the contribution of Victoria's senior doctors in a way that facilitates their ongoing participation and contribution to quality medical practice.
5. Legislate to allow for the President of the re-established Medical Board of Victoria to represent the Board on a reconstituted Joint Medical Boards Advisory Committee as the National Board for the Australian medical profession.
6. The Australian Doctors' Fund is available to speak to this Inquiry concerning this submission.

Stephen Milgate
Executive Director

For and on behalf of the Directors and Management Committee of the Australian Doctors' Fund Ltd
29 January 2013

¹⁰ Nassim Taleb, *Antifragile*, Random House, 2012, p 11