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By doctors for doctors

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Ms Sue Dawson
Independent Reviewer

By email: NRASComplexityReview@health.gov.au

Avant submission to the independent review of complexity in the National Registration and Accreditation Scheme

Thank you for the opportunity to provide a response to the independent review of complexity in the National Registration and Accreditation Scheme.

Our submission is attached.

Please contact us on the details below if you require any further information or clarification of the matters raised in the submission.

Yours sincerely

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Avant submission to the independent review of complexity in the National Registration and Accreditation Scheme

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Avant is a member-owned doctors' organisation and Australia's largest medical indemnity insurer, committed to supporting a sustainable health system that provides quality care to the Australian community. Avant provides professional indemnity insurance and legal advice and assistance to more than 90,000 healthcare practitioners and students around Australia (more than half of Australia's doctors). Our members are from all medical specialities and career stages and from every state and territory in Australia.

Avant provides assistance and advice to members involved with notifications to Ahpra and the Medical Board of Australia, and complaints to Health Complaints Entities (HCEs) and regulators in the co-regulatory jurisdictions. We have provided submissions to the various consultations on amendments to the National Law since the inception of the National Scheme.

Overall, we agree that the National Scheme needs to be efficient, fair and responsive for both health consumers and practitioners. We support the risk-based regulatory approach taken by Ahpra and the National Boards in their work to protect the public. It is important to get the balance right between the need to protect the public and ensuring that the process is proportionate and fair to practitioners. We advocate for clear and straightforward regulatory frameworks for medical practitioners that reduce administrative burden, promote fairness, and are easily understood and implemented.

We support the aims of the independent review to achieve simplification and harmonisation of the regulatory scheme where possible. There is inherent complexity with the existence of the two co-regulatory jurisdictions alongside the system in the other jurisdictions. In our view, this review is a missed opportunity to examine whether a truly national scheme is achievable in the interests of national consistency.

That said, any opportunity for national consistency should be explored and is welcomed in the interests of clarity and consistency for practitioners and the public. Ultimately, practitioners should be treated the same regardless of the jurisdiction in which they work.

Some additional points:

- Practitioners are concerned about increasing registration costs, and opportunities to improve efficiencies and obtain economics of scale are welcomed, but not at the expense

of quality and appropriate profession-specific representation and decision-making. The same applies to increasing community input and broader powers for health ministers under the National Law.

- In relation to complaints handling, we commend Ahpra and the National Boards for the work they have done to improve the management of lower risk matters. However, delays and inconsistencies still occur with serious matters and we support changes that will improve this.
- The impact of complaints and notifications on practitioners cannot be overstated. The complaints process can have a significant impact on health, wellbeing and livelihood of practitioners. This can have a flow-on effect on patients and the delivery of safe and high-quality health care. We commend Ahpra and the National Boards for the significant work they have done on ensuring this is recognised in the current processes. This initial progress should not be jeopardised as a result of any reforms.

We have provided answers to the consultation questions on Topics 2-4 and 6-9.

TOPIC 2: Governance and Stewardship – Strategic connection

Guiding Questions

1. **Do you think that a stronger strategic connection between workforce planning / strategy and health practitioner regulation is an important reform priority?**

   Regulatory reform needs to be an enabler not a barrier to workforce planning and strategy. There are benefits in having a more coordinated and proactive approach rather than individual changes being considered and implemented in isolation.

   A recent example where a stronger strategic connection would have been beneficial relates to workforce planning, the Kruk review and its implications for registration and accreditation standards for international medical graduates. The introduction of the Expedited Specialist pathway to address workforce shortages still presents some significant concerns. For example, there are ongoing concerns from professional bodies about the lack of information, timeliness and transparency about the determination of substantially equivalent qualification, supervision requirements and responsibility for patient care, as well as the content of the required orientation to the Australian healthcare system and cultural safety education. These concerns persist even as the staged introduction of the Expedited Specialist pathway is being rolled out.

   Similarly, a coordinated approach would be beneficial in relation to the Scope of Practice Review. This review arose out of the Strengthening Medicare Taskforce, and includes recommendations about the nature of work to be performed by various registered and unregistered health practitioners, which has implications for health practitioner regulation. The issues outlined in theme three in the independent would assist with this, but it is not clear whether this a deliberate and coordinated response or serendipitous.

   A stronger connection could assist to achieve a more strategic approach to workforce planning and health practitioner regulation and is an important reform priority.

2. **Do you have a perspective on how this could be achieved?**

   To achieve this, there needs to be genuine and effective coordination between all facets of strategic planning and regulatory reform. This should happen as a deliberate and clear part of setting reform agendas.

3. **Do you have a view on what success would look like if reforms to strengthen strategic connection occurred?**

   Success would be predicated on genuine coordination between regulators and other agencies and organisations. It would also need to have the support of the professions and strengthen their trust in the regulatory process.

   It would be beneficial for there to be an assessment of where connection has broken down or whether trust has been undermined to ensure these issues can be avoided in the future.

TOPIC 3: Governance and Stewardship - Regulatory Connection

Guiding Questions

1. **Do you think there is a need for the National Scheme to work more closely with other regulators and agencies?**

   We agree with the comment in the consultation paper on page 24 that there seems to be an insufficient focus on extracting regulatory intelligence and taking proactive steps to address emerging risks from within the National Scheme or to inform strategic priority setting. A proactive approach is preferable to a reactive response when issues emerge.

   We support an approach that aims for coordination and consistency between regulators and agencies that impact upon the work done by doctors. This helps to avoid duplication, ensure alignment of standards and reduce regulatory effort, as well as provide clarity for doctors about what is expected of them.

   There is also a need for regulators with compliance responsibilities to work together, in the interests of patient safety and for practitioners. A practitioner may be subject to multiple compliance activities arising from the one event given, for example, the remit of Ahpra, the Therapeutic Goods Administration (TGA) and state and territory medicines regulators.

   It would be beneficial to identify emerging issues earlier and develop an appropriate integrated regulatory response. At the moment, there can be a significant lag between identifying an issue (e.g. the example in the paper of medicinal cannabis) and developing appropriate responses to this.

2. **If so, which regulators or agencies do you think should be involved?**

   Coordination amongst Ahpra, National Boards and state-based complaints entities is an appropriate starting point.

Beyond that, the necessary regulators and agencies to be involved will depend on the specific area of regulation. Using cosmetic practice as an example, there would have been benefits from better coordination with the private health facilities licensing frameworks and regulation of practitioners at the time that guidance and/or legislation was being drafted. This would have helped clarify what was expected of practitioners, reduce inconsistency and potentially increase compliance.

In the area of advertising, practitioners have obligations under section 133 of the National Law, as well under the Therapeutic Goods Administration Act and the Australian Consumer Law. In our experience, there is often confusion about how these various obligations intersect and inconsistencies in information and guidance for health professionals and practices published by the different agencies. Greater coordination and cooperation between agencies when guidance is being drafted and finalised would benefit practitioners and patients.

Other examples where regulators could work more closely together are:

- In medicines and prescribing matters, there should be coordination between Ahpra and National Boards, state and territory medicines regulators and the TGA.
- In Medicare matters, it would be appropriate for there to be coordination between the Medicare compliance branch of the Department of Health and Aged Care, the Professional Services Review and Ahpra on emerging issues.

3. **Do you have a view about what structure or process should be used for this purpose?**

The most appropriate structure or process will depend on the specific issue and agencies/regulators involved.

We agree it would be beneficial to have a coordinating body or forum (such as the Health Workforce Strategy and Stewardship Forum (HWSSF) and/or Coordinator General Workforce Strategy & Workforce outlined in Concept 1) to undertake environment scanning and identify emerging issues, with the ability to engage with the regulators to devise and implement the appropriate response. Identifying emerging risks should be inherent in the environmental scanning process.

4. **Do you have a view on what success would look like if reforms to build connection across regulators were implemented?**

Success relies on a “whole-of-system” approach that considers regulation and regulatory reform within a broader strategic context. Better connection across regulators could involve:

- Early identification of emerging issues
- Consistent, coordinated, and proactive approaches to regulation. For example, joint statements or other guidance published by Ahpra, relevant National Boards and other appropriate organisations can help clarify the obligations and expectations of health practitioners.
- Better coordination in timing and implementation of any changes or new regulations. In our experience, there is sometimes a sense amongst doctors that changes are

brought into force without considering how those individual changes might intersect with other demands or expectations. This may also help counter the perception of knee-jerk, reactive responses to emerging issues.

- Clarity around the roles and responsibilities of different regulators and readily available information about how different regulators and agencies work together and what that looks like in practice.

TOPIC 4: Governance and Stewardship – Community Voice

Guiding Questions

1. **Do you see the need to strengthen the community input in setting strategic direction and priorities for the National Scheme.**

   No. We consider that current mechanisms for community input such as the Community Advisory Council, community representation on Boards and tribunals, and public consultation requirements, are sufficient.

2. **If yes, how do you think this could be done.**

   N/A.

TOPIC 6: Operational accountability and efficiency - Boards and Committees

Guiding Questions

1. **Do you see opportunities to reduce the number of Boards within the National Scheme. If so, can you provide detail.**

   While we understand the rationale for considering reducing the number of Boards, we consider that it is important that the Medical Board remains separate, to maintain the confidence of the profession.

2. **Do you see opportunities to reduce the number of Committees within the National Scheme. If so, can you provide detail.**

   There are opportunities to reduce the number of committees and a limited role for cross-profession committees where the nature of the issue is consistent across professions, where the issues are about ensuring compliance with clear existing standards (for example, registration standards) or where proposed regulatory or policy changes have impacts across professions or would benefit from cross-profession collaboration (for example, scope of practice and accreditation standards).

   For issues that affect all professions in essentially the same way, there is no need to incur additional and duplicated costs. This would also enable a coordinated approach to issues with representation from all professions instead of having one issue considered multiples times by individual committees (for example, English language standards).

There would need to be careful consideration of which areas are appropriate for cross-profession committees and representation from all professions to ensure any profession-specific factors are taken into account.

3. **Do you see any risks in any proposed adjustments to the number of National Boards and/or Committees, and if so, what are those risks?**

   Yes. There is a risk of profession-specific needs being lost in the effort to achieve consensus.

   There may also be a potential loss of confidence of the profession in the regulatory system.

   There may also be a risk of increased workload of the remaining committees if consolidated.

   One of the benefits of the current system of decision-making subcommittees is that more than one clinical view can be obtained. Given the range of opinions about the appropriateness of practice even within one specialty, this can enhance the quality of the decisions.

   It is important that any changes do not lead to a process whereby there is only one clinical voice contributing to decision-making, particularly where the clinical issue is beyond the scope of the reviewer.

4. **Do you think that the National Boards have too much operational focus?**

   N/A

5. **Do you think the National Boards have sufficient scope to focus on higher level policy issues and risks and to provide input to the Ahpra Board and ministers on these issues? If not, what changes would you suggest?**

   The National Boards have an important role to play in policy issues and providing strategic input to the Ahpra Board and ministers. Without knowing the detail of the relevant day to day operations, we cannot comment on whether National Boards currently have sufficient scope to do this.

   One of the important functions of the National Board is releasing guidance to practitioners about their professional obligations. In our experience, joint guidance from the relevant National Board(s) and Ahpra on policy issues assist greatly in educating practitioners about their professional obligations to encourage compliance and hopefully reduce regulatory activity/complaints. For example, the Joint statement on professional responsibilities for prescribing and dispensing medicines issued in June 2024. This should continue.

6. **Do you think cross profession decision making and collaboration in one or more functions across the National Scheme should be prioritised? If so, can you suggest where this might be most required and how this might be achieved?**

   While we agree there are benefits to cross profession decision-making and collaboration, we are concerned that profession-specific nuances may be lost in this process. Further

thought should be given to the circumstances in which it might be appropriate to have cross profession decision-making given the clinical nuances involved. See also our answer to question 2.

The quality of decision making might also be undermined if the effect of cross profession decision making is to reduce relevant professional input into decisions. This could also have an unintended consequence of reducing the confidence of professions in decision making.

7. **Do you think National Boards should be constituted with equal numbers of practitioner members and community members? If yes, why? If not, why not?**

   No. We recognise the important role that community input and community representation plays. However, we consider that the Medical Board should remain constituted by a majority of practitioners (current representation on the Medical Board is 8 medical practitioner members and 4 community members). Medical practitioners have trust and confidence that the majority of their Board's representatives are also medical practitioners with lived experience of working as a doctor. This representation allows regulatory issues need to be considered in the relevant context, which primarily is within medical practice.

8. **Do you think Health Ministers should have the flexibility to appoint a community member to the Chairperson role on a National Board? If yes, why? If no, why not?**

   No. We consider that it is important for the Chairperson to be a registered practitioner from the relevant Board, to be the credible voice for the profession, and to maintain trust and confidence.

   The Chairperson of a National Board is often called upon to make public statements about clinical and professional issues. Where the Chairperson is a registered practitioner from the relevant board, they bring advantages including their clinical background and knowledge of standard practices in the relevant profession. A Chairperson who is a practitioner from the relevant profession is able to make authoritative statements about clinical matters.

   In the medical context, the profession is more likely to have confidence in the National Board if the Chairperson is a member of the medical profession. A Chairperson from outside the profession could undermine the authority of the Board and confidence in the system.

9. **Do you have a view as to what top line KPIs and associated reporting would be most effective?**

   In general, top line KPIs should focus on timeliness and the quality of decision making.

   The KPIs should also incorporate measures to monitor and evaluate of the impact of changes arising from this review. This would involve gathering data about the effects following implementation to ensure those changes address the identified challenges, with plans in place for regular review embedded in this. After a number of years of reviews of the NRAS, it is important to be able to demonstrate appropriate action in response to any identified concerns.

TOPIC 7: Operational accountability and efficiency – Accreditation Functions

Guiding Questions

1. **Do you think that additional measures are required to make sure that accreditation functions support workforce strategy and planning priorities? If so, what measures do you suggest being considered?**

   Yes, particularly accreditation functions of specialist medical colleges and accreditation of medical training sites as it is unclear whether these are aligned.

   Workforce shortage should not necessarily mean requirements are altered as a way of increasing the available workforce. Increasing the workforce should not be given a higher priority than quality of care and it is important to balance workforce requirements with maintaining appropriate standards.

   The consultation paper (pages 46-47) sets out a detail list of reforms already in progress or completed. While most of these are led by Ahpra, some have other agencies or governments departments as the lead. We agree that this can create a challenge for coordinating reforms in one area with higher-level strategic priorities such as workforce planning. We are not convinced that this is necessarily solved by giving the Ministerial Council the power to issue a direction to bodies such as specialist medical colleges. We agree with the limitations to this approach outlined on page 48.

TOPIC 8: Coherent and Effective Complaints handling - Simplifying structures and processes.

Guiding questions

1. **Do you think it is necessary to simplify complaints handling?**

   Yes. We agree that consumers and practitioners often do not understand the National Scheme and are confused and frustrated about the way that healthcare complaints and notifications are managed. There is inherent complexity in the complaints handling system due to the state and territory differences and the co-regulatory system.

   There is also little general understanding that the National Scheme is a professional standards scheme rather than a complaints handling mechanism.

   One of the biggest challenges for members we have assisted is where they are not clear about the process or what is happening at various stages. We have acted for members who do not understand that they can still be referred to a health complaints entity (HCE) after there is a decision of no further action from Ahpra. This is compounded when there is a significant delay between the decision from Ahpra and initial correspondence from the HCE. This can create mistrust in the process.

2. **Do you support a single front door for lodging complaints within each State and Territory Health Complaints Entities?**

   Yes.

3. **If not, do you have other suggestions for simplifying the processes for lodging and assessing complaints?**

   N/A

4. **Do you have suggestions about what would be required to make this single front door model of complaints handling work?**

   For a single front door model to be effective, there needs to be:

   - Clearly delineated roles and responsibilities of Ahpra and the relevant HCE so that the scope and processes of each are clear, together with additional training and upskilling of staff where required.

   - An efficient and transparent triage process ideally involving clinical input and joint consideration between Ahpra and the HCE in each jurisdiction about the most appropriate entity to deal with the matter.

     While ideally there would be joint consideration in all cases, this may not be practical or necessary in every case, especially for minor or low-risk matters, or where it is clear that one or other is the most appropriate entity to deal with the matter. There should be a low threshold for joint consideration if there is any doubt.

   - Processes to ensure more serious matters are identified early so that they can be investigated expeditiously.

   - Education and information for practitioners and the public about the way complaints are handled to ensure expectations are set early. We would be happy to provide input into the content of this guidance at the appropriate time.

5. **Do you see risks in a single front door approach and if so, what are those risks?**

   Primarily, the risks will arise if the approach is implemented without the appropriate framework, supporting guidance documents and clarity of process.

   Also, without a robust process for joint consideration, there is a risk of duplication and delay if there are multiple issues in a notification handled by different entities. This should be avoided wherever possible by clear delineation of roles and responsibilities, and proper resourcing and training within the different entities. Ahpra and HCE processes should generally be mutually exclusive.

   From our experience in Queensland, where there is a single front door, there are still some instances of matters going back and forth between the different entities and of the different entities managing matters involving the same type of conduct, sometimes with inconsistent outcomes (see answers to Topic 9 for more information). This therefore remains a risk, and one that should be mitigated by clear roles and responsibilities and features outlined above in our answer question 4.

6. **Do you have a view on how joint decisions would be made between the health complaints entity and Ahpra about those complaints that should be referred to Ahpra as a Professional Standards breach?**

   In our experience the current system for joint decisions in the two co-regulatory jurisdictions works well. As outlined on page 54 of the consultation paper, this involves joint consultation and appropriate clinical input, when the complaint is first received to determine the appropriate entity to manage the complaint. Once that decision is made, there needs to be clearly articulated pathways about the next steps.

   We understand that in New South Wales, there are also regular quarterly meetings between the Health Care Complaints Commission (HCCC) and the Medical Council of NSW to address and resolve any specific issues. This enables the complaints handling process to be very responsive to emerging issues or concerns as these can be addressed promptly and efficiently. We support a similar model being introduced if a single front door approach to complaints handling is implemented.

   The decision-making process should also involve an escalation pathway for situations where agreement cannot be reached. This should be to a particular role or committee, so that there is consistency in how disagreements are resolved. Embedded in this should also be a process for tracking these resolutions and issuing guidance about the principles to apply to future similar decisions.

TOPIC 9: Coherent and Effective Complaints handling - high-risk notifications

Guiding questions

1. **What do you see as the problems if any, with the way high-risk notifications are currently managed? If you think there is a need for reform what should this look like?**

   Our experience is that serious investigations continue to take significant time. High risk notifications are inherently stressful for the practitioner, and the patient, and must be handled as expeditiously as possible managing all the relevant factors. In our experience, this is not always the case with delays at various stages in the process. Sometimes this is unavoidable if, for example, there are pending criminal matters that need to be resolved prior to proceeding with management of the notification. However where this is not the case, early identification of the issue and prompt management and resolution is required.

   We continue to be concerned about the way immediate action powers are exercised, particularly with recent examples where a tribunal has overturned the use of the Medical Board's immediate action powers. This is an emergency power and should only be used in exceptional circumstances, where immediate action is required to address the risk that a practitioner poses to the public. Recently case law highlights that the various public interest considerations are not being given sufficient weight, particularly those regarding proportionality and members of the health profession being able to practise.

   These issues could be addressed through the following types of reform:

- Clear guidance about the process for practitioners who are subject to a high-risk notification
- Articulation of timeframes and KPIs for timeliness
- Prompt and clear communication where there is/is likely to be a delay and the reasons for this
- Guidance for those managing notifications regarding the approach to exercising immediate action powers, incorporating learnings from tribunal decisions to guide that approach.

2. **Do you think the current division of responsibilities between National Boards and Ahpra in the management of high-risk complaints is working well. If yes, why? If no, why not? What changes would you suggest?**

   N/A

3. **Do you think that a stronger regulatory decision-making role for Ahpra would be beneficial and if so in what way?**

   This could be beneficial if it improves the quality and timeliness of regulatory decision-making.

4. **Do you think that a stronger regulatory decision-making role for Ahpra would be risky, and if so in way?**

   There is a perception among many in the medical profession that Ahpra has too much power and favours consumers. Moving decision-making away from the National Board to Ahpra could reinforce this perception and further reduce confidence in the system.

5. **Do you think the arrangements for providing clinical input to regulatory decision making are working well? If yes, why? If no, why not? What changes would you suggest?**

   In general yes.

   Ahpra has a number of internal clinical advisers who are able to provide input into notifications. Whilst this input is often invaluable, at times it can be limited by the fact it is an opinion provided by a single practitioner. To be confident in the quality of internal clinical reviews, we consider:

   - it is not appropriate for these roles to ever replace decisions being made by boards and committees with a majority of practitioner members
   - they should be subject to audits and peer reviews
   - practitioners providing these reviews should not provide opinions outside their own expertise, other than where they are either providing evidence (for example, college

guidelines or commonly used textbook material) or analysing independent peer opinions.

6. **Do you think the arrangements for hearing serious misconduct matters through state and territory tribunals are working well? If yes, why? If no, why not? What changes would you suggest?**

   It depends on the jurisdiction and the differences seem to be related to process and resources. Some examples of what works well are:

   - In Queensland, changes have been introduced over the last three years which cleared the previously existing backlog and has resulted in reduced waiting times for hearings and an improvement in timeframes. Several retired judges have been appointed to QCAT as judicial members to sit specifically in the practitioner list. The President manages the list with active case management. Directions and immediate actions are generally conducted on the papers.

   - In NSW, hearing dates are set at the first directions hearing and consent of the tribunal is required to amend the date. Like Queensland, retired judges sit as presiding members and the President actively manages matters.

   - In Western Australia, mediation and compulsory conferences are used, which can help to clarify the issues, reduce hearing times and improve timeliness.

   - Some tribunals (e.g. in South Australia) have the power to dismiss a matter if the Board agrees to withdraw it or if there is an application for a stay if the circumstances warrant it, for example due the practitioner's circumstances and where there is no utility in proceeding with a hearing.

7. **Have you observed significant inconsistency in the outcomes in tribunal decisions and if so, can you provide further detail and examples?**

   In our experience, there are inconsistencies in tribunal decisions, which can be broadly categorised as inconsistencies of outcome, approach or process.

   Inconsistencies of outcome

   In assisting our members we have seen the same type of conduct attract different sanctions and other outcomes depending on the jurisdiction. For example, a three-month suspension was given in Queensland for a practitioner who had a sexual relationship with a patient, whereas the same penalty was given in South Australia for a practitioner who hugged a patient and made an inappropriate remark.

   Inconsistencies of approach

   We have also seen examples of different approaches to the same type of high-risk matter depending on the source of the referral to the tribunal. This arises in Queensland where both the Office of the Health Ombudsman (OHO) and Ahpra/the Medical Board can refer matters to the tribunal, for example those involving alleged serious breaches regarding prescribing or boundary violations. The way these matters are managed differs between

the two entities, causing different experiences in terms of timeframes, case management and decisions.

Inconsistencies of process

In our experience, the processes followed in different jurisdictions may also be quite different. Sometimes this might be because of the benefits (discussed above) of the co-regulatory system in that jurisdiction, or on the other hand, because of limitations in the legislative tribunal powers in the relevant jurisdiction. It may also be contributed to by some jurisdictions not exercising certain powers where another jurisdiction with the same power does (for example, the power to dismiss proceedings).

It is important to recognise that each matter is different given the individual facts and circumstances and the system needs to be nuanced enough to allow for these variations and individual considerations to be properly weighed. However, that does not account for significant variation in sanctions particularly for the same type of conduct. It is unfair for practitioners to be treated differently based on their location.

8. **What do you think of the idea of a single national health practitioner tribunal to replace the current 8 separate state and territory tribunals?**

   In theory this could be a good concept and could improve consistency of decision making, however there appears to be no current legal mechanism by which this could occur.

9. **Do you believe that there is more that the National Scheme could do to strengthen performance on serious and high-risk complaints and if so, can you provide detail?**

   We understand this review is considering whether it would be appropriate to adopt the Director of Proceedings model similar to that which exists in NSW and Queensland. In our experience of assisting members in both jurisdictions (and in Queensland, comparing the management of Ahpra matters and OHO matters), the Director of Proceedings model works well. The Director of Proceedings provides an additional check on the strength of the case by working thought the evidence and ensuring there is enough evidence to effectively prosecute the case. In NSW, for example, the Director of Proceedings formulates the complaint for the tribunal. Having one person responsible for making decisions about proceeding to a hearing helps with consistency.

Avant Mutual
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