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Perspective

National registration scheme at 5 years: not what it promised

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Abstract. A national registration scheme for health professionals was introduced in Australia 5 years ago, replacing the long-standing state-based schemes. This review examines whether the scheme has delivered what it promised and makes recommendations for change. The available evidence indicates that the scheme's design and its implementation were rushed and that the legislation has serious flaws. Two parliamentary inquiries and the experience of registrants confirm that the system is more expensive, remote and bureaucratic than the previous state-based systems. The scheme has delivered benefits only in relation to portability of registration and a single national register. In addition, with two large jurisdictions participating in a 'co-regulated' mode, it is not truly a national scheme. To restore the confidence that health professionals need to have in the regulator, it is recommended that all jurisdictions seek to be 'co-regulated' and that the Australian Health Practitioners Registration Authority be pared back to providing a central database for national portable registration.

What is known about the topic? Although selected aspects of the national registration scheme have been the subject of comment, a global critique of the strengths and weaknesses of the national registration scheme has not been published previously.
What does this paper add? This critique identifies several legislative flaws in a scheme that has not met the aims set for it and that is not truly national.
What are the implications for practitioners? Recommended changes to the scheme have the potential to increase practitioner confidence in the scheme while reducing costs.

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Introduction

After 5 years experience of the national registration scheme, it is time to examine what the scheme has delivered. In 2009, it was suggested that the proposed scheme was a model fraught with problems and that it was being implemented too hastily.[1] The negative effect of that haste was documented in a 2011 Senate inquiry,[2] and further experience has confirmed problems with the scheme.[3] This review briefly recalls the premises on which the Productivity Commission recommended a national system, the aims declared by the Council of Australian Governments (COAG) and the intentions of the interim implementation authority. It also examines the Independent Review of the National Registration and Accreditation Scheme for Health Professions report,[4] commissioned by COAG, and COAG's response to the report,[5] both of which were recently made public. I then pose, and attempt to answer, several questions, with particular focus on the scheme's impact on the medical profession. My critique is not directed at members of the Medical Board of Australia (MBA), its state boards or staff of the Australian Health Practitioners Registration Authority (AHPRA), who strive to deliver services consistent with the National Law.

The Productivity Commission

The study conducted by the Productivity Commission was requested in March 2005. Its report, Australia's Health Workforce Research Report, was dated December 2005.[6] Given its breadth and potential importance, this was hasty. Its scope encompassed:

- factors affecting the supply of health workforce professionals
- the structure and distribution of the health workforce, and the consequences for its efficiency and effectiveness
- factors affecting demand for services provided by health workforce professionals
- the specific health workforce needs of rural, remote and outer metropolitan areas and issues of Indigenous health
- advice on the identification of, and planning for, Australian health care priorities and services
- advice on the issue of general practitioner (GP) services in or near hospitals on weekends and after hours.

The Productivity Commission recommended a single national accreditation agency and a separate single national registration board for all health professionals. Although a national approach was eventually agreed by COAG, these specific recommendations of the Productivity Commission were not acted upon.

The COAG agreement

In March 2008, COAG announced that the medical profession and eight other health professions would be included in a national accreditation and registration scheme as of 1 July 2010.[7] The objectives of the scheme, to be set out in new legislation, were to:

- provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
- facilitate workforce mobility across Australia and reduce red tape for practitioners
- facilitate the provision of high-quality education and training, as well as rigorous and responsive assessment of overseas-trained practitioners
- have regard to the public interest in promoting access to health services
- have regard to the need to enable the continuous development of a flexible, responsive and sustainable Australian health workforce, and enable innovation in education and service delivery.

In subsequent months, the Australian Health Workforce Ministerial Council announced additional elements of the scheme, including mandatory reporting, criminal checks, student registration and broadening the scope of health programs for doctors.[8] More recently the number of health professions included has risen to 14.

The implementation authority

In the October 2008 consultation paper[9] issued by the Australian Health Ministers' Advisory Council, one of the principles espoused was to 'build on the best aspects of the State and Territory schemes'. Early in its work, the National Registration and Accreditation Scheme implementation committee declared that it would aim to adhere to that principle.[9] It also declared that efficiencies gained through a national scheme would ensure that there would be no increase in the annual fee for renewal of registration.[3] Neither of these undertakings has been met.

Independent Review of the National Registration and Accreditation Scheme for Health Professions

The report of this review and COAG's response to its recommendations were made public in August 2015.[4,5] The report was wide ranging and made 33 recommendations, of which nine were accepted by COAG, 11 were accepted in principle, six were rejected and seven were deferred. Notably, COAG deferred a recommendation that the National Law be amended to reflect the Western Australia (WA) exemption to the mandatory reporting obligations of treating medical practitioners. COAG accepted a recommendation that, in effect, called for an overhaul of the way in which complaints and notifications are handled. The independent reviewer commented more than once on the need for the community and health professionals to have confidence in the notification system. Under the rubric of accountability, the reviewer emphasised the 'limited reporting to State and Territory jurisdictions' and 'a lack of performance measures as a whole'.[4]

Noting this background, especially the objectives laid down by COAG, several questions follow.

Do we truly have a national scheme?

The answer clearly is 'no'. New South Wales (NSW) agreed to participate in the registration process only. This was papered over as 'co-regulation'. In 2013, Queensland also became co-regulated. The National Law as passed in WA contained a significant change to the mandatory reporting provisions (see below). In addition, a 2012 Victorian Parliamentary inquiry recommended that Victoria also seek co-regulation.[3]

In passing, given what took place in the WA Parliament, it now seems probable that COAG chose the Queensland Parliament for the initial passage of the national law because it does not have an upper house. This meant that the chance of unacceptable change to the agreed legislation was greatly reduced. Nevertheless, the Queensland Premier at that time, Ms Anna Bligh, had what must have been an unusual experience of being lobbied by non-constituents from the other states for changes to the bill before her Parliament.

What identifiable benefits have come from the scheme?

AHPRA's annual reports (http://www.ahpra.gov.au/search.aspx?q=annual%20reports; verified 13 January 2016) contain little information to help answer this question. The reports focus instead on the scope of AHPRA's operations and the numbers of health professionals registered. However, one benefit is that health professionals may now move among jurisdictions readily and without additional registration costs; the numbers so benefitting were stated to be 11% of registrants in Victoria.[3] The unification of eight databases for each profession to create a single national register for each has also been a positive step that is likely to have enhanced the protection of the community. It is of note that this has created opportunities for national workforce and other research.[10] The independent review describes similar benefits.[4]

What are the drawbacks of the scheme?

The most obvious drawback was the sudden marked increase in the annual fee for renewal of registration (~50% for Victorian doctors in 2010). This was so widely condemned that political pressure was brought to bear on AHPRA and the boards to keep future increases within the consumer price index (CPI). This restriction may make it more difficult to fund desirable new initiatives.

Other drawbacks include the size of the new bureaucracy (creating problems of accountability and efficient access to information and advice), its remoteness from those it regulates (the members of each state medical board are now virtually invisible to the profession) and forcing of a single framework on all health professions. The single framework for some policy documents means that important guidelines are delayed by the need for every health professional board to be consulted and for agreement to be reached on wording. One example serves to show how impractical such a system is. The only health professionals at risk of blood-borne diseases are nurses, dentists, doctors and two or three other professions occasionally involved in invasive procedures; yet, all 14 boards must spend time considering new draft guidelines. As a result, in my state of Victoria, the guidelines of the previous Medical Practitioners Board for doctors on blood-borne diseases were withdrawn 5 years ago and we still await the national guidelines.

The remote bureaucracy, diminished visibility and flaws in the legislation (discussed below), as well as increased costs, may translate into loss of trust in the regulator. How much trust has been lost is difficult to gauge, but I encounter it commonly in my experience of counselling distressed doctors. That the independent reviewer was motivated to report that 'the national notification system has its merits. . .but must be improved if it is to gain the confidence of the public and practitioners' supports my anecdotal evidence.[4]

What are the flaws in the national law?

The most controversial flaw lies in Section 141, which covers mandatory reporting of several forms of alleged misconduct, along with alleged impairment of practitioners due to ill health where that impairment has placed the public at risk of substantial harm (Health Practitioner Regulation National Law Act 2009, http://www.ahpra.gov.au/About-AHPRA/What-We-Do/Legislation.aspx; verified 13 January 2016). There are two distinct problems. First, it is stigmatising to group the reporting of ill health with the reporting of allegations of sexual misconduct; ill health should have its own section in the national law. If this had been so from the outset, the unwise decision to make it mandatory for treating doctors to report an ill and possibly impaired doctor attending for care may have been avoided. Many commentators recognised that this was likely to deter or delay potentially impaired doctors from seeking help. The MBA was clearly uncomfortable with this aspect of the legislation and issued advice to treating doctors that this could be ignored if the treating doctor was confident that patients were not at risk. These problems could have been avoided if those drafting the national law had adopted legislation already working effectively in the larger states.

In WA, an amendment to the national law relieved treating doctors of the legal duty to report impaired doctors who posed a risk to the public, but did not excuse them from their ethical duty in this regard. The calls for this amendment to be made in Victoria[3] and in all jurisdictions[11] were picked up by the independent reviewer[4] but have been rejected by COAG 'pending further research'.[5]

Second, it will surprise most doctors that Section 178 of the legislation allows the MBA to issue a caution to a doctor (about the doctor's professional performance) without that doctor being interviewed by a Board member or even by an AHPRA staff member. Even more surprisingly, under Section 199, such a caution cannot be appealed. This is odd because all other Board decisions can be appealed. The potential effect of such a caution is significant because Section 206 of the legislation demands that any employer be informed of the caution, effectively making the caution public. Will the public be able to distinguish between a caution and a reprimand?

A third flaw in the national law was that it failed to define the term 'clinical practice'. A problem arose in that it was unclear whether doctors who had recently retired from clinical practice, and who had chosen non-practising registration, were permitted to undertake voluntary roles, such as teaching and mentoring. To address this, the MBA, in concert with the other boards, issued its own definition of 'clinical practice'. This definition was controversial in that it included an encyclopaedic list of non-clinical roles. In response to widespread criticism, the MBA had to re-interpret its definition.[12]

What has been lost through the national registration scheme?

The drawbacks of the national scheme vary among jurisdictions. The diminished visibility of the state medical boards has already been mentioned. No longer do all doctors receive regular communications from their local medical board. Visibility is linked to the sense of accessibility, which, when lacking, is likely to lead to lack of confidence and trust in the local board. Lack of visibility may reduce the quality of applicants willing to serve on the boards. The absence of local communication means that important regulatory information will be more difficult to circulate, as, for example, about legislation that is state based, such as laws pertaining to drugs and poisons.

As reported by the independent reviewer, in many jurisdictions neither patients nor doctors are happy with the notifications (complaints) processes.[4] For reasons that are not clear, the past practice of employing medically qualified staff to investigate complaints has been abandoned. This is likely to reduce the confidence that doctors under investigation need to have in the process and render investigations less efficient. When the investigation is about alleged impairment, the involvement of doctors is vital; in the UK, it has been suggested that lack of medical oversight in such investigations may be linked to unwell doctors committing suicide during the period of investigation and assessment.[13]

In Victoria, doctors had to live for several years with the threat that its well-funded doctors' health program, in place now for 15 years, may have to close. The delay in decision making by the MBA and AHPRA (finally addressed in April 2014[14]) in this matter was a sad reflection on the inefficiencies associated with this imposed centralised scheme. It was especially galling given that in 2009 COAG gave a very clear direction that the new scheme should 'broaden the scope of health programs that boards could support or provide to health practitioners to enable them to deliver services for education and prevention, early intervention, treatment and rehabilitation'.[8]

Another loss is that the previous eight state and territory medical boards learnt from each other and were, in effect, in competition to make improvements in medical regulation. This dynamic, which still exists in Canada, and which a past Chief Executive Officer of the UK General Medical Council noted in both Canada and Australia with a sense of envy, is now lost in Australia (Mr Finlay Scott, pers. comm.).

Under the previous system, it was very clear that the medical profession was regulated by the local medical board. Now, it is unclear whether doctors are regulated by AHPRA or by the MBA. Some announcements are made by AHPRA, others by the MBA and some are joint.[15] This confusion is inconsistent with the key function of AHPRA under Section 25 of the national law, which is 'to provide administrative assistance and support to the National Boards, and the Boards' committees, in exercising their functions'. Added to the regulator now being more distant from the profession, this confusion creates a serious risk that doctors will lose their sense of engagement in self-regulation

and the sense, important for maintaining professionalism, of this being a collegial endeavour.

Accreditation arm of the national scheme

As mentioned, the Productivity Commission recommended that a national accreditation agency be established that was separate from the registration agency. However, as enacted, the accreditation arm is part of, and subservient to, the registration board. Accreditation of medical schools to enable graduates to be registered by a medical board has a long history in Australia. Until the mid-1980s, this task was undertaken by the General Medical Council of the UK, but was assumed by the Australian Medical Council when established in 1985. In the 30 years since, the Australian Medical Council has become an icon of Australian medicine and is highly respected internationally and often copied. One of the least valuable and inappropriate outcomes of the national scheme is that the Australian Medical Council now has an insecure future, because it has to apply every few years to remain the chosen agency of the MBA. The COAG-commissioned independent review of the national scheme[4] made six recommendations about accreditation functions; these included an emphasis on reducing costs in line with those incurred in the UK. COAG accepted the recommendations in principle but has requested that AHMAC commission a comprehensive review of accreditation processes that also takes into consideration the earlier recommendations of the Productivity Commission.[5]

Conclusions and recommendations

The national scheme should be regarded as an expensive experiment that has partly failed. Initially, I felt that the absence of NSW from full involvement was unfortunate, because it meant that NSW stood aside from an important national debate. In hindsight, I recognise the wisdom of the reluctance of NSW to join. For those jurisdictions with a long experience of fully local and well-integrated health complaints commissioners, registration boards and independent disciplinary and appeal tribunals, the NSW model of co-regulation must now seem very attractive. To move in this direction would bring the benefits of more accountability of the core aspects of the scheme to the state health minister, a less remote bureaucracy and restoration of trust. The one aspect of the national scheme that is regarded as a success, namely a central database for national portable registration, should be maintained by a much pared-down AHPRA. The 'national law', which is in actuality a collection of state- and territory-based laws, hopefully will remain a worthwhile template in the longer term. Finally, the original Productivity Commission recommendation of an accreditation system that is separate from the medical regulatory system should be reactivated.

Competing interests

Currently none. However, in the past the author has served as President of the Medical Practitioners Board of Victoria and as President of the Australian Medical Council.

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References

1 Breen KJ. National registration legislative proposals need more work and more time. *Med J Aust* 2009; 191: 464–5.

2 Senate Finance and Public Administration References Committee. Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency. 2011. Available at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Completed%20inquiries/2010-13/healthpractitionerregistration/report/index [verified 10 October 2015].

3 Parliament of Victoria. Social and Legal Issues Committee inquiry into the performance of the Australian health practitioner regulation. 2014. Available at: http://www.parliament.vic.gov.au/images/stories/committees/SCLSI/Leg_ctee/AHPRA/Final_version_AHPRA_report_30314.pdf [verified 10 October 2015].

4 Council of Australian Governments. The independent review of the national registration and accreditation scheme for health professionals. 2015. Available at: http://www.coaghealthcouncil.gov.au/Publications/Reports/ArtMID/514/ArticleID/68/The-Independent-Review-of-the-National-Registration-and-Accreditation-Scheme-for-health-professionals [verified 10 October 2015].

5 Council of Australian Governments. Reissued communique: final report of the independent review on the national accreditation scheme for health professionals. 2015. Available at: http://www.coaghealthcouncil.gov.au/Announcements/ArtMID/527/ArticleID/71/Reissued-Communique-Final-Report-of-the-Independent-Review-on-the-National-Accreditation-Scheme-for-health-professionals [verified 10 October 2015].

6 Productivity Commission. Australia's health workforce, research report. Canberra; 2005. Available at: http://www.pc.gov.au/inquiries/completed/health-workforce/report [verified 10 October 2015].

7 Council of Australian Governments. Intergovernmental agreement for a national registration and accreditation scheme for the health profession. 2008. Available at: http://www.ahwo.gov.au/documents/National%20Registration%20and%20Accreditation/NATREG%20-%20Intergovernmental%20Agreement.pdf [verified 10 October 2015].

8 Australian Health Workforce Ministerial Council. Communique: Ministers consider submissions on legislation on national registration scheme. 2009. Available at: http://www.ahwo.gov.au/documents/National%20Registration%20and%20Accreditation/Communique%20-%20Ministers%20consider%20submissions%20on%20legislation%20on%20national%20registration%20scheme.pdf [verified 10 October 2015].

9 Practitioner Regulation Subcommittee, Health Workforce Principal Committee, Australian Health Ministers' Advisory Council. National Registration and Accreditation Scheme for the Health Professions. Consultation paper: proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. Canberra: AHMAC, Oct 2008. Available at: http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Call%20for%20submissions%20on%20proposed%20complaints%20arrangements.pdf [verified 13 January 2016].

10 Bismark MM, Fletcher M, Spittal MJ, Studdert DM. A step towards evidence-based regulation of health practitioners. *Aust Health Rev* 2015; 39: 483–5. doi:10.1071/AH14222

11 Goiran N, Kay M, Nash L, Haysom G. Mandatory reporting of health professionals: the case for a Western Australian style exemption for all Australian practitioners. *J Law Med* 2014; 22: 209–20.

12 Medical Board of Australia. FAQ: limited registration (public interest-occasional practice) 'who needs to be registered'. 2014. Available at: http://www.medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-Limited-registration-public-interest-occasional-practice.aspx [verified 10 October 2015].

13 Hawton K. Suicide in doctors while under fitness to practise investigation. *BMJ* 2015; 350: h813. doi:10.1136/bmj.h813

14 Medical Board of Australia. Health programs for medical practitioners and students. 2014. Available at: http://www.medicalboard.gov.au/News/Newsletters/April-2014.aspx#Programs [verified 10 October 2015].

15 Medical Board of Australia. AHPRA and Board respect Supreme Court decision. 2015. Available at: http://www.medicalboard.gov.au/News/2015-07-07-media-release.aspx [verified 10 October 2015].