

STICKING UP FOR VICTORIA? — VICTORIA'S LEGISLATIVE COUNCIL INQUIRES INTO THE PERFORMANCE OF THE AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY

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This article analyses the report of the Victorian Legislative Council's Legal and Social Issues Legislation Committee ('Committee') from its Inquiry into the Performance of the Australian Health Practitioner Regulation Agency (AHPRA). AHPRA is a national body that provides administrative support for the National Registration and Accreditation Scheme (NRAS), under which practitioners in 14 health professions across Australia are regulated. The article considers the Committee's findings and recommendations in light of the impetuses for the creation of the NRAS, as well as the structure and implementation of the NRAS and AHPRA. It is argued that the value of the Committee's report is confined to its identification of important issues concerning the NRAS and AHPRA that, in the near future, will require a more critical and comprehensive investigation than the Committee undertook.

I INTRODUCTION

Two scandals in the first years of the 21st century eroded Australians' confidence in their system of regulating health practitioners. Dr Graeme Reeves and Dr Jayant Patel were charged with committing heinous crimes against patients while they were employed in hospitals and registered as medical practitioners by the Medical Boards of New South Wales and Queensland respectively. The only charges ultimately sustained against Patel related to his fraudulent representations to his registration body. Nevertheless, public outrage and government alarm in response to the original charges against Patel and to the events surrounding Reeves led to several inquiries into the cracks in the health system through which these practitioners had fallen.

These probes and the expression of concerns about the structure of Australia's health regulation system generally led to the formation of the National Registration and Accreditation Scheme (NRAS) on 1 July 2010. The NRAS brings together 14 health professions that were previously regulated individually and by different authorities in each state and territory. They are now regulated under the one scheme

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by National Health Practitioner Boards ('Boards'), which receive administrative assistance from the Australian Health Practitioner Regulation Agency (AHPRA), a national body. The NRAS was hailed as a panacea to perceived problems with long-standing arrangements for regulating health professionals, but since it commenced operating, the NRAS, the Boards and AHPRA have been the subject of adverse media attention and official reviews.

The most recent parliamentary assessment of the NRAS and AHPRA is a report of the Victorian Legislative Council's Legal and Social Issues Legislation Committee ('Committee') from its Inquiry into the Performance of AHPRA ('Inquiry'), tabled on 12 March 2014. In calling for the Inquiry, the Hon David Davis, Victorian Minister for Health, sought an investigation that would 'stick up for Victoria' by reviewing AHPRA's performance and the NRAS 'from Victoria's viewpoint' and assessing the capacity of the national scheme to protect Victorians.¹

This article argues that the Inquiry was misconceived and unnecessary. Given the NRAS is a national scheme and AHPRA operates nationally, it is inappropriate to explore their operation and impact in only one state in isolation from the national context. Further, before the NRAS commenced, an independent review of the national scheme was scheduled to take place at its three-year anniversary ('three-year review').² The three-year review — which commenced in July 2014 — will be able to conduct a more thorough examination of the scheme than the Committee and yield more useful recommendations. The Committee recognised this: its minority reports query the wisdom of the Inquiry's reference for this reason,³ and many recommendations in the majority report suggest areas for investigation by the three-year review. The value of the Committee's report is largely confined to its identification of these issues rather than its analyses of them, which are often superficial and in some instances prioritise Victorians' interests over the needs of others in the national scheme.

This article details the impetuses for the creation of the NRAS, including the administrative failures that enabled Reeves and Patel to continue practising medicine relatively unscrutinised by medical registration authorities after extremely serious allegations had been made about their professional conduct. It traces these origins and also explains the structure and implementation of the NRAS in order to evaluate the Committee's findings and recommendations, and determine whether its report 'stick[s] up' for Victorians and indeed all Australians.

1 Victoria, *Parliamentary Debates*, Legislative Council, 23 October 2012, 4693 (David Davis, Minister for Health).

2 Council of Australian Governments, *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* (2008) cl 14.1 ('Intergovernmental Agreement').

3 Jenny Mikakos and Nazih Elasmr, Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency — Minority Report* (2014) 153; Colleen Hartland, Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency — Minority Report* (2014) 159.

II BACKGROUND TO THE CREATION OF THE NRAS

A Two Scandals

Significant defects in the medical profession's regulation system enabled Dr Graeme Reeves, the so-called 'Butcher of Bega', to commit crimes against patients and Dr Jayant Patel, dubbed 'Dr Death', to practise medicine for years after deceiving his registration body about his background and becoming the subject of shocking complaints.

Reeves was the subject of 35 complaints from nursing and medical staff during his 15-year appointment as a Visiting Medical Officer (VMO) in obstetrics and gynaecology with the North Sydney Area Health Service.⁴ It was only in 1996 after Reeves had been employed for 10 years, however, that the health service first informed the New South Wales Medical Board of allegations made about his aggressive manner, failure to provide adequate anaesthesia to patients during procedures (such as an attempt to remove a placenta) and poor clinical management of patients' labour and aftermath.⁵

The following year, the Board constituted a Professional Standards Committee (PSC) in response to complaints about Reeves' management of nine obstetric patients.⁶ The PSC found Reeves had engaged in 'unsatisfactory professional conduct', and suffered from 'personality and relationship problems, and depression that detrimentally [affected] ... his mental capacity to practise medicine'.⁷ The PSC identified critical deficiencies in Reeves' practise of obstetrics: his treatment of one patient resulted in her death, another patient's life was endangered, and in another case a baby died.⁸ Reeves was reprimanded, but permitted to continue practising medicine, albeit with some restrictions: he was barred from clinical practice of obstetrics and required to comply with conditions regarding supervision of his medical practice and monitoring of his health.⁹

Nevertheless, in 2002, after Reeves disclosed only the conditions on his practice, but not his prohibition from practising obstetrics, the Southern Area Health Service appointed him as a VMO with clinical privileges in obstetrics and gynaecology at Bega and Pambula District Hospitals.¹⁰ When the health service and the Board discovered this appointment breached the prohibition, the health

4 Deirdre O'Connor, 'Review of the Appointment, Management and Termination of Dr Graeme Reeves as a Visiting Medical Officer in the NSW Public Health System' (Report, New South Wales Health, 2 May 2008) 3.

5 Ibid 5; Peter Garling, New South Wales Department of Justice, *First Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (2008) 7.

6 Garling, above n 5, iii.

7 Ibid 10 [2.28]–[2.29]; *Re Reeves* [Nos 40006/03; 40008/03; 40003/04] (New South Wales Medical Tribunal, 23 July 2004) 6 (McGuire J, Dr Atkinson, Dr Vamos and Dr Gleeson) ('*Re Reeves*').

8 *Re Reeves* (New South Wales Medical Tribunal, 23 July 2004) 7.

9 Ibid; Garling, above n 5, iii, 10 [2.37]. The Board included Reeves in its 'Impaired Registrants Program'.

10 Ibid; O'Connor, above n 4, 11; Arjun Ramachandran, 'Medical Board Defends Action on "Mutilation Doctor"', *The Age* (online), 27 February 2008 <<http://www.theage.com.au/articles/2008/02/27/1203788409524.html>>.

service continued Reeves' employment in exchange for an undertaking from him to cease obstetric practice, which he subsequently contravened.¹¹

On 23 July 2004, the New South Wales Medical Tribunal ordered the removal of Reeves' name from the register of medical practitioners due to his breaches of his registration and deception of the health service and the Board.¹² By this time, however, Reeves had seriously harmed at least three more patients; he was found to have indecently assaulted two patients while conducting internal pelvic examinations and maliciously inflicted grievous bodily harm on another by removing her clitoris in an operation to excise a lesion on her labia.¹³

Mr Peter Garling SC, appointed by the Governor of New South Wales to inquire into matters concerning the delivery of acute care services in New South Wales Public Hospitals, found the order banning Reeves from practising obstetrics was not available on the Internet nor clearly identified in the Board's computer record, so the health service would not have been told of the prohibition even if it had inquired.¹⁴ In addition, former Judge, the Hon Deirdre O'Connor, engaged by the New South Wales Health Department to conduct a review of matters arising out of Reeves' case, reported that the exchange of information between the Board and the health service was unsatisfactory: the Board did not provide a full copy of the PSC decision, including its findings that led to the orders and conditions, and the Board relegated to the health service the task of determining how to implement the requirement that Reeves practise only gynaecology.¹⁵

In the case of Patel, had the Queensland Medical Board checked his credentials, it would never have granted him unconditional registration.¹⁶ In his application for registration, Patel fraudulently declared that his registration as a medical practitioner in a foreign country had been unrestricted.¹⁷ He provided only part of a certificate of the Oregon Board of Medical Examiners, which omitted the restraint imposed on him in 2000 from performing surgeries involving the pancreas, liver resections, and ileoanal reconstructions.¹⁸ Patel also failed to disclose that the New York State Board had disciplined him in 1984 and, following further disciplinary action in 2001, he surrendered his licence to practice.¹⁹ If

11 Garling, above n 5, iv [17].

12 *Re Reeves* (New South Wales Medical Tribunal, 23 July 2004) 30–2.

13 *Reeves v The Queen* (2013) 227 A Crim R 444; Paul Bibby, 'Victim Livid at Bega Doctor's Sentence', *Sydney Morning Herald* (online), 1 July 2011 <<http://www.smh.com.au/nsw/victim-livid-at-bega-doctors-sentence-20110701-1gttl.html>>; Margaret Scheikowski, 'Former Doctor Guilty of Removing Carolyn DeWaegeneire's Genitals without Consent', *The Daily Telegraph* (online), 10 March 2011 <<http://www.dailytelegraph.com.au/story-e6freuy9-1226019237310?nk=454f5dafba2e4a38454057b60b5d5a72>>; Ramachandran, above n 10: almost 800 women subsequently made complaints about Reeves to the 'Medical Error Action Group'.

14 Garling, above n 5, vi–vii.

15 O'Connor, above n 4, 9.

16 Queensland, Queensland Public Hospitals Commission of Inquiry, *Report* (2005) 2 [1.8]–[1.9] ('*Queensland Public Hospitals Commission of Inquiry — Report*').

17 Queensland, Bundaberg Hospital Commission of Inquiry, *Interim Report* (2005) 6–7 ('*Bundaberg Hospital Commission of Inquiry — Interim Report*').

18 *Ibid* 6.

19 *Ibid* 7.

the Board had contacted Patel's previous employers or registration authorities, it would have discovered this history.²⁰

Before and after granting Patel registration in 2003, the Board never assessed Patel's qualifications, experience, knowledge or skills.²¹ Patel was registered under the 'area of need' scheme; due to workforce shortages, the Board permitted overseas trained doctors (OTDs) who were ineligible for the category of general registration open to Australian medical graduates to work in a region deemed to lack sufficient medical practitioners to meet residents' needs.²²

Further, the Board failed to monitor Bundaberg Base Hospital's (BBH) employment of Patel and oversight of his work. It did not inquire whether BBH had received any complaints about Patel and never required any supervision of Patel's practice or peer assessment of his work, which BBH did not arrange.²³ Although the Board initially granted Patel registration to work as a Senior Medical Officer, BBH quickly promoted him to the position of Director of the Department of Surgery.²⁴ The Board renewed Patel's registration for this role even though the Royal Australasian College of Surgeons had not reviewed Patel's surgical expertise and he was therefore ineligible for specialist registration.²⁵

It was neither the Board nor BBH, but Ms Toni Hoffman, Nurse Unit Manager of the Intensive Care Unit at BBH, Mr Rob Messenger, a Member of Parliament whom Hoffman contacted, and journalist Mr Hedley Thomas who exposed the serious allegations that had been made about Patel.²⁶ Between 2003 and 2005, BBH's administration never communicated to the Board and took no action in relation to over 20 complaints made by staff and patients about Patel, most notably that a high proportion of Patel's patients experienced significant complications or died, and Patel's behaviour had been inappropriate.²⁷

Ultimately, the only convictions sustained against Patel concerned his fraud. Prior to that, however, and following a government appointed inquiry, he had been sentenced by the Supreme Court of Queensland to imprisonment for seven years for allegedly committing egregious crimes against patients. The Hon Geoffrey Davies AO, appointed to conduct the Queensland Public Hospitals Commission of Inquiry in 2005, considered that Patel had 'performed surgical procedures ... that were beyond his competence, skill and expertise, beyond the capacity of the

20 *Queensland Public Hospitals Commission of Inquiry — Report*, above n 16, 2, 6, 34, 376.

21 *Ibid* 34; Bob Birrell and Andrew Schwartz, 'The Aftermath of Dr Death: Has Anything Changed?' (2005) 13(3) *People and Place* 54, 56.

22 Birrell and Schwartz, above n 21, 54; *Queensland Public Hospitals Commission of Inquiry — Report*, above n 16, 28.

23 *Queensland Public Hospitals Commission of Inquiry — Report*, above n 16, 2, 4, 140.

24 *Ibid* 2, 136; Birrell and Schwartz, above n 21, 56.

25 Birrell and Schwartz, above n 21, 56; *Queensland Public Hospitals Commission of Inquiry — Report*, above n 16, 139.

26 *Queensland Public Hospitals Commission of Inquiry — Report*, above n 16, 1, 160–1, 171.

27 *Ibid* 4, 143; Jayne Hewitt, 'Is Whistleblowing Now Mandatory? The Impact of Mandatory Reporting Law on Trust Relationships in Health Care' (2013) 21 *Journal of Law and Medicine* 82, 93; The Medical Board of Queensland first discovered complaints had been made about Patel when it met with the Queensland Nurses Union on 15 February 2005.

Hospital ... to provide adequate post-operative care, and unnecessary'. Moreover, he found that, 'as a result of negligence on the part of Dr Patel ... 13 patients at [BBH] died and many others suffered adverse outcomes'.²⁸ In 2010, a jury in the Supreme Court of Queensland convicted Patel of manslaughter of three patients and unlawfully doing grievous bodily harm to another patient during surgery.²⁹

Nevertheless, after Patel had served two and a half years of his prison sentence, on appeal the High Court of Australia quashed the convictions and ordered a new trial (on the basis that a miscarriage of justice occurred when the prosecution changed its case during the trial, rendering irrelevant evidence that had already been admitted).³⁰ In an initial retrial in relation to a charge of Patel's manslaughter of one of his patients, a Supreme Court jury found him not guilty, following which the Queensland Director of Public Prosecutions decided not to proceed with further retrials regarding the other charges originally laid against Patel.³¹ At a sentencing hearing in the District Court in Brisbane, Patel pleaded guilty to fraudulently obtaining registration as a medical practitioner in Queensland for which he was sentenced to imprisonment for two years, wholly suspended.³²

B Concerns about Australia's Health Regulation System

Before the final outcome in Patel's case, the exposure of allegations about his and Reeves' conduct — especially in the media — had sparked calls for reform to the regulation of the medical profession.³³ Some changes were implemented immediately. The New South Wales Medical Board ensured information about practitioners' performance and conduct was accessible by health services, and legislative amendments introduced mandatory requirements for medical

28 *Queensland Public Hospitals Commission of Inquiry — Report*, above n 16, 190.

29 *R v Patel* [2010] QSC 199 (4 June 2010).

30 *Patel v The Queen* (2012) 247 CLR 531; Marissa Calligeros, 'Jayant Patel Finally Leaves Queensland', *Brisbane Times* (online), 22 November 2013 <<http://www.brisbanetimes.com.au/queensland/jayant-patel-finally-leaves-queensland-20131122-2y0aq.html>>; Jared Owens, 'Jayant Patel Walks Free After High Court Quashes Manslaughter Convictions', *The Australian* (online), 24 August 2012 <<http://www.theaustralian.com.au/news/patel/story-e6frg6n6-1226457333848>>. The prosecution initially alleged that Patel had performed operations incompetently and negligently, but then changed its case to argue Patel's decisions to undertake surgery were inappropriate.

31 Sarah Elks, 'Call to Drop Remaining Charges as Patel Acquitted of Manslaughter', *The Australian* (online), 14 March 2013 <<http://www.theaustralian.com.au/news/nation/call-to-drop-remaining-charges-as-patel-acquitted-of-manslaughter/story-e6frg6nf-1226596742260>>; Calligeros, 'Jayant Patel Finally Leaves Queensland', above n 30.

32 *R v Patel* (Unreported, District Court of Queensland, Judge Martin, 21 November 2013); Marissa Calligeros, 'Jayant Patel Walks Free from Court', *Brisbane Times* (online), 21 November 2013 <<http://www.brisbanetimes.com.au/queensland/jayant-patel-walks-free-from-court-20131121-2xwzv.html>>.

33 Other cases involving poorly performing doctors, such as Dr Abdalla Khalafalla, had similarly caused alarm and led to calls for reform. It was ultimately found that deficiencies in Dr Khalafalla's training, qualifications and competence had seriously compromised his handling of surgical complications. Yet, due to inadequate communication between the Medical Board of Queensland, the Royal Australasian College of Surgeons and Mackay Base Hospital, and delays in dealing with concerns raised about his clinical competence and performance, Dr Khalafalla had been permitted to practise as an 'Area of Need Deemed Specialist' performing surgery until a whistleblower eventually exposed the matter: see Health Quality Complaints Commission, 'An Investigation Into Concerns Raised by Mrs De-Anne Kelly About the Quality of Health Services at Mackay Base Hospital' (Report, August 2008) 15–16, 19–20.

practitioners to report colleagues' unprofessional conduct.³⁴ In Queensland and elsewhere, medical boards tightened checks on OTDs' credentials and more rigorously assessed whether they had appropriate qualifications and experience to practise medicine in 'areas of need'.³⁵

Notwithstanding these initiatives, scrutiny of Australia's health professions that were then self-regulated (albeit pursuant to legislation) had already begun. On 25 June 2004, the Council of Australian Governments (COAG) requested the Productivity Commission ('Commission') to 'undertake a research study to examine issues impacting on the health workforce ... and propose solutions to ensure the continued delivery of quality health care'.³⁶ Many may not have used the word 'continued' in that sentence by 19 January 2006, when the Commission delivered its report. In addition to scandal, drivers for reform identified by the Commission in their report entitled 'Australia's Health Workforce' were shortages of health workers and 'health workforce arrangements' that were perceived to be 'extraordinarily complex'.³⁷

According to the Commission, problems stemmed from the independence of different health professions and their state-based regulatory authorities. At that time, health practitioners who were regulated were subject to the direction of their particular profession in the state or territory in which they practised. There were eight health regulatory systems, at least 85 health practitioner registration boards, more than 20 bodies accrediting health practitioners' education and training, and various professional bodies administering codes of conduct.³⁸ The boards set registration standards and criteria for admission to their professions, maintained registers of practitioners, enforced compliance with professional standards and administered disciplinary procedures, while accreditation agencies set education and training standards.³⁹ From 1992, 'mutual recognition' legislation enabled practitioners registered in one Australian jurisdiction to obtain registration in another by paying relevant fees, but not undergoing further assessment of their qualifications or experience.⁴⁰

The Commission found that profession-based assessment of health practitioners' education and training courses hindered 'workplace innovation' and led to 'inconsistent requirements across professions', assessments of varied quality, and high costs for education and training institutions.⁴¹ In addition, the Commission

34 O'Connor, above n 4, 2; Hewitt, above n 27, 92.

35 *Bundaberg Hospital Commission of Inquiry — Interim Report*, above n 17, 10; *Queensland Public Hospitals Commission of Inquiry — Report*, above n 16, 378; Birrell and Schwartz, above n 21, 59.

36 Productivity Commission, 'Australia's Health Workforce' (Research Report, Productivity Commission, 22 December 2005) iv.

37 *Ibid* xiv, xix.

38 *Ibid* xix, 134; Australian Health Practitioner Regulation Agency, '2010–11 Annual Report: AHPRA and the National Boards' (30 September 2011) 12 ('*AHPRA Annual Report 2010–11*'); the Productivity Commission found more than 90 health profession boards pre-dated the NRAS, whereas AHPRA identified 85 pre-existing boards.

39 Productivity Commission, above n 36, 134, 361.

40 *Ibid* 135.

41 *Ibid* xxxiv, 111.

concluded that, owing to registration boards' considerable discretion, registration standards, conditions imposed on registrants and administrative processes differed markedly between professions and jurisdictions.⁴² Consequently, notwithstanding mutual recognition arrangements, health workers seeking to practise in more than one jurisdiction or regulated health profession frequently encountered obstacles, administrative duplication and increased costs.⁴³ Further, registration boards needed to ensure that they informed one another when they imposed conditions on or suspended or cancelled the registration of practitioners in case they sought unrestricted registration in another state or territory.⁴⁴

Before the Commission released its report, Victoria introduced some consistency to the regulation of health professions within that State. Following a 2002 review by the Victorian Department of Human Services into the regulatory framework governing registered health professionals, the *Health Professions Registration Act 2005* (Vic) (*HPR Act*) was passed to apply the same legislative requirements to 12 health professions.⁴⁵ Nevertheless, uniform regulation of health professions in one jurisdiction in addition to some medical boards' changes did not assuage the Commission's concerns that the health regulation system that was in place in Australia was not adequately serving health practitioners or the public.⁴⁶

C The Conception of the NRAS

Possible reforms included wresting responsibility for regulation of health practitioners from the professions altogether or at least introducing greater oversight of those regulators' activities.⁴⁷ The solution the governments ultimately endorsed — the NRAS — represents a balance between such alternatives. The NRAS was the brainchild of the Commission, conceived when allegations about Reeves and Patel, and expressions of concerns about the structure of Australia's health regulation system, were at their height. The Commission's solution was to overhaul the states' and territories' existing health practitioner registration and accreditation systems and substitute them with a unique scheme.

The Commission recommended creating a 'national accreditation board, responsible for accreditation across the health workforce', as well as a 'single national registration board for all health workers'⁴⁸ and 'profession-specific panels'.⁴⁹ The registration board would develop and administer nationally

42 Ibid xxv, 112, 135.

43 Ibid xxxiv, 136, 140.

44 Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency — Final Report* (2014) 10.

45 Ibid 8.

46 Hewitt, above n 27, 88. Since 1990 at least three other commissions of inquiry into healthcare in Australia had raised similar concerns to the Garling and Davies reports about the health professions' capacity to deal appropriately with practitioners who were performing poorly.

47 Ibid 88–9.

48 Productivity Commission, above n 36, xxiv, xxv.

49 Council of Australian Governments (Communiqué, 14 July 2006) 4 <http://archive.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/coag140706.pdf>.

uniform standards for registration and disciplinary matters, and base registration standards on an independent accreditation board's recommendations.⁵⁰ The Commission forecast that these changes would lead to a more efficient, effective and 'responsive' health workforce that could move across jurisdictions unimpeded, reducing administrative costs.⁵¹

COAG embraced the Commission's recommendations, though with some amendments, and prepared the groundwork for the birth of the NRAS. At its meeting on 14 July 2006, COAG agreed to establish the NRAS with nine health professions.⁵² COAG considered a national registration scheme (including a national process for assessing OTDs) would 'facilitate workforce mobility, improve safety and quality, and reduce red tape', and a national accreditation scheme for health education and training would 'simplify and improve the consistency of current arrangements'.⁵³ Subsequently, however, COAG agreed to establish a single national agency for both registration and accreditation functions and 'national profession-specific boards'.⁵⁴ In the transitional phase, existing accreditation bodies would continue to perform accreditation functions with the registration boards reviewing these arrangements within three years.⁵⁵

On 26 August 2008, the Commonwealth and all the states and territories entered into the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* ('*Intergovernmental Agreement*'). This agreement provided that the NRAS would commence on 1 July 2010. The governments would contribute \$19.8 million over the following four years to establish it and thereafter the NRAS would be funded exclusively through registrants' fees.⁵⁶

Pursuant to the *Intergovernmental Agreement*, the NRAS was implemented through a national 'applied laws' model.⁵⁷ Queensland hosted the substantive legislation to establish the NRAS: the *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (Qld),⁵⁸ and the *Health Practitioner Regulation National Law Act 2009* (Qld), which sets out the 'Health Practitioner Regulation National Law' ('*National Law*') in its schedule.⁵⁹ Between November 2009 and August 2010, most other states and the territories adopted

50 Productivity Commission, above n 36, xxv, xxxiv, 141.

51 Ibid xiv, xxxiv, 141.

52 Council of Australian Governments, above n 49, 4.

53 Ibid.

54 *Intergovernmental Agreement*, above n 2, cl 2.5.

55 Ibid attachment A cls 1.34, 1.36.

56 Ibid cl 12.1; Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 6; Council of Australian Governments, above n 49, 4.

57 *AHPRA Annual Report 2010–11*, above n 38, 7.

58 Section 10 of the *Health Practitioner Regulation National Law Act 2009* (Qld) repealed this statute.

59 Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 6–7; *Intergovernmental Agreement*, above n 2, cl 6.3.

and applied the *National Law* as a law of their jurisdictions.⁶⁰ The exceptions were Western Australia and the Australian Capital Territory, which passed corresponding legislation that was identical in many respects to the *National Law*, but made some modifications to it, and New South Wales.⁶¹ With its *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW), New South Wales created a co-regulatory jurisdiction whereby health professionals are regulated under both the *National Law* and other state legislation, and health profession boards share regulatory responsibility with health complaints bodies.⁶² New South Wales modified pt 8 of the *National Law*, which sets out processes for dealing with issues related to practitioners' health, performance and conduct, and retained its previous complaints handling arrangements, but it agreed to participate in the national scheme for registration and accreditation purposes.⁶³

When the NRAS commenced on 1 July 2010, it applied to 10 health professions that had already been regulated in most or all Australian jurisdictions: podiatry (which was added to the scheme after COAG's July 2006 meeting); chiropractic; dental; medicine; nursing and midwifery; optometry; osteopathy; pharmacy; physiotherapy; and psychology.⁶⁴ From 1 July 2012, four further professions, which previously had been unregulated or only regulated in a few jurisdictions, joined the scheme: Aboriginal and Torres Strait Islander health practice; Chinese medicine; medical radiation practice; and occupational therapy.⁶⁵

III THE NRAS

A The Structure of the NRAS

A number of entities, including AHPRA, share responsibility for achieving the goals of the NRAS and complying with its principles. The primary objective of the NRAS, outlined in the *Intergovernmental Agreement* and the *National Law*, is 'to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered'.⁶⁶ Other stated aims include: providing high

60 *AHPRA Annual Report 2010–11*, above n 38, 2, 7, 10; Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 3–4; *Intergovernmental Agreement*, above n 2, cls 6.4, 6.5: the states and territories were required to repeal 65 pieces of health practitioner registration legislation.

61 *Intergovernmental Agreement*, above n 2, cl 6.4; *Health Practitioner Regulation National Law (WA) Act 2010* (WA) s 4(7); *Health Practitioner Regulation National Law (ACT) Act 2010* (ACT) sch 1. Western Australia's legislation created an exemption to the mandatory reporting requirements for practitioners in the *National Law*, while the Australian Capital Territory's legislation involved the Health Services Commissioner integrally in the National Boards' decision-making.

62 *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) s 6.

63 *AHPRA Annual Report 2010–11*, above n 38, 8.

64 *Ibid* 7; Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 3.

65 Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 3.

66 *Ibid* 1; *Intergovernmental Agreement*, above n 2, cl 5.3(a); *Health Practitioner Regulation National Law Act 2009* (Qld) sch s 3(2)(a) ('*National Law*'); Queensland, *Parliamentary Debates*, Legislative Assembly, 6 October 2009, 2513 (Paul Lucas).

quality health practitioner education and training, and rigorous assessment of overseas trained health practitioners; reducing red tape; improving administrative efficiency and consistency; facilitating workforce mobility; and developing ‘a flexible, responsive and sustainable Australian health workforce’.⁶⁷ One of the key guiding principles of the NRAS is that it ‘operate in a transparent, accountable, efficient, effective and fair way’.⁶⁸

Although removed from the practical tasks (including decision-making about individual health practitioners) undertaken to fulfil the NRAS’ goals, the governments play a significant guiding role by overseeing the NRAS and making high-level decisions concerning its operation.⁶⁹ The Australian Health Workforce Ministerial Council (‘Ministerial Council’), comprising the health ministers of the Commonwealth and states and territories, provides policy direction to other entities in the scheme, proposes legislative amendments, appoints members of the National Boards, and approves registration and accreditation standards.⁷⁰ The Australian Health Workforce Advisory Council (‘Advisory Council’) assists the Ministerial Council to exercise these responsibilities by providing independent advice to it about matters related to the NRAS.⁷¹

The 14 Boards for each of the health professions determine how practitioners will be regulated. Their functions include: developing and approving standards, codes and guidelines for their professions; approving accreditation standards developed by accreditation authorities; establishing requirements for registration and registering suitably qualified and competent persons in the profession; and overseeing the receipt, assessment and investigation of notifications about practitioners’ health, conduct and performance.⁷² The Boards are able to establish committees in each jurisdiction — State and Territory Boards — to which they can delegate their functions, and the National and State and Territory Boards can also appoint internal committees.⁷³

Importantly, the Boards can and do delegate functions to AHPRA and its staff.⁷⁴ AHPRA — the National Agency — works with National and State and Territory Boards by providing them with administrative assistance and operational support to fulfil their functions.⁷⁵ AHPRA and the Boards have joint statutory responsibility in relation to various matters. The Boards and AHPRA are required

67 *National Law* sch ss 3(2)(b)–(f); Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 1–2.

68 *National Law* sch s 3(3)(a).

69 *Intergovernmental Agreement*, above n 2, cls 7.5, 7.8; Australian Health Practitioner Regulation Agency, ‘2012/13 Annual Report: AHPRA and National Boards’ (13 January 2014) 19 (*AHPRA Annual Report 2012–13*’).

70 *Intergovernmental Agreement*, above n 2, cl 7.5; *National Law* sch ss 11–12; *AHPRA Annual Report 2010–11*, above n 38, 8.

71 *Intergovernmental Agreement*, above n 2, attachment A cls 1.1–1.2, 1.8; *National Law* sch s 19.

72 *Intergovernmental Agreement*, above n 2, attachment A cls 1.4, 1.25; *National Law* sch ss 35, 38–9.

73 *Intergovernmental Agreement*, above n 2, attachment A cls 1.5, 1.25; *National Law* sch s 36; *AHPRA Annual Report 2010–11*, above n 38, 9; Legislative Council Legal and Social Issues Legislation Committee, above n 44, 21.

74 *National Law* sch s 37(1); *AHPRA Annual Report 2010–11*, above n 38, 9.

75 *National Law* sch s 25; *AHPRA Annual Report 2012–13*, above n 69, 21–2.

to keep up-to-date national registers of practitioners and students registered in the health professions.⁷⁶ AHPRA, in consultation with the Boards, must develop and administer procedures to ensure the Boards operate efficiently and effectively.⁷⁷ Further, the Boards and AHPRA are required to enter into 'health profession agreement[s]' that outline the services that AHPRA will provide to the Boards.⁷⁸

AHPRA also has functions for which it is solely responsible. It is required to establish procedures for: developing accreditation and registration standards, codes and guidelines to be approved by the Boards; receiving and dealing with applications for registration and other registration related matters; and receiving and dealing with notifications about health practitioners and students.⁷⁹ In addition, AHPRA is required to administer the procedures surrounding registration of health practitioners, keep an up-to-date list of approved programs of study for the health professions, and advise the Ministerial Council about the administration of the NRAS.⁸⁰

In practice, AHPRA, on behalf of the Boards, manages the registration and renewal processes for health practitioners and, except in New South Wales and Queensland, manages investigations into practitioners' health, conduct and performance, and monitors impaired practitioners and practitioners' compliance with conditions on their registration.⁸¹ To perform this work, as the *National Law* requires, AHPRA established local offices in each state and territory, and a national office based in Melbourne that supports the NRAS' operations.⁸² AHPRA is governed by the AHPRA Agency Management Committee, which decides its policies and ensures that it functions properly, effectively and efficiently in working with the Boards.⁸³

Other bodies external to the Boards, AHPRA, and their overseers also play roles in the NRAS. Accreditation authorities develop accreditation standards for the Boards, assess education providers, study programs and overseas qualifications, and examine overseas trained practitioners.⁸⁴ The Boards are able to exercise their functions in cooperation with or with the assistance of health complaints entities, including the Victorian Office of the Health Services Commissioner (OHSC), which conciliate and help resolve complaints made about health service providers.⁸⁵ The Boards and health complaints entities discuss with each other notifications or complaints they have received about health practitioners and how they will deal with them. In addition, the Boards establish health panels and performance and professional standards panels, which comprise non-Board

76 *National Law* sch ss 25(f), (g).

77 *Ibid* sch s 25(b).

78 *Ibid* sch s 26.

79 *Ibid* sch ss 25(c), (e), (i).

80 *Ibid* sch ss 25(e), (h), (j).

81 *AHPRA Annual Report 2012–13*, above n 69, 22; *AHPRA Annual Report 2010–11*, above n 38, 26; *Health Ombudsman Act 2013* (Qld) s 25 ('*Health Ombudsman Act*').

82 *National Law* sch s 28; *Intergovernmental Agreement*, above n 2, attachment A cl 1.6.

83 *National Law* sch s 30; *Intergovernmental Agreement*, above n 2, attachment A cl 1.16; *AHPRA Annual Report 2010–11*, above n 38, 9.

84 *National Law* sch s 43; *AHPRA Annual Report 2010–11*, above n 38, 9.

85 *National Law* sch s 32(3)(d).

members and make decisions about practitioners' performance, conduct and health. The Boards are also required to refer matters to tribunals for adjudication if they believe a practitioner has engaged in professional misconduct or their registration was obtained improperly, or if a panel requires them to do so.⁸⁶

B The Implementation of the NRAS

By 1 July 2010, legislation creating the NRAS had been passed in all jurisdictions except Western Australia, 10 Boards and their members had been appointed, and AHPRA had been formed (over 400 staff transferred from pre-existing registration authorities) and its national and local offices set up.⁸⁷ Four days later, online national registers of practitioners in 10 health professions were made available on an AHPRA website.⁸⁸ Producing the new information technology system had involved migrating 1.5 million records concerning over 500,000 health practitioners (which had been inconsistently maintained in 37 databases).⁸⁹

Notwithstanding these significant developments, vital processes for the day-to-day running of the NRAS had not been fully formulated the moment it began. Consequently, the Boards' and AHPRA's efficacy and efficiency were thwarted from the outset. It is reasonable to ask whether the architects of the NRAS underestimated the magnitude of the undertaking. The Productivity Commission predicted 'some disruption and other transitional costs as existing arrangements are changed', but considered 'these can be minimised through intelligent design of the new arrangements'.⁹⁰ While attention may have been paid to the overall structure of the NRAS in advance of its commencement, those planning for its implementation did not adequately prepare the practical components necessary

86 Ibid sch s 193.

87 *AHPRA Annual Report 2010–11*, above n 38, 1–2; Department of Health, Submission No 50 to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, 17 April 2013, 5 ('Department of Health — Submission No 50'). The *Health Practitioner Regulation National Law (WA) Act 2010* (WA) was passed in August 2010 and most of its provisions commenced in October 2010: Government of Western Australia, Department of Premier and Cabinet, *Assent, Commencement and Ceasing Information for Acts* <[http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/LIDocument:56P/\\$FILE/Table9.pdf?OpenElement](http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/LIDocument:56P/$FILE/Table9.pdf?OpenElement)>.

88 Australian Health Workforce Ministerial Council, Submission No 70 to Senate Finance and Public Administration References Committee, Parliament of Australia, *Inquiry into the Administration of Health Practitioner Registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, April 2011, 8.

89 *AHPRA Annual Report 2010–11*, above n 38, 1; *Department of Health — Submission No 50*, above n 87, 5–7.

90 Productivity Commission, above n 36, 142.

for its operation; they devoted insufficient resources to the establishment of the NRAS and held unrealistic expectations of the time required to set it up.⁹¹

The scheme brought together different health professions that had historically dealt with practitioners in varied ways, as well as staff and members of health profession boards who had refined unique work processes. The systems under which they had operated were abolished, but crucial structures for administering this unprecedented scheme were not in place on 1 July 2010 and participants had limited training in the new framework.⁹² Significantly, customer service teams only began operating in AHPRA's local offices in February 2011.⁹³ In spite of these deficiencies, important work had to begin immediately because processes in relation to many practitioners were incomplete on the commencement of the scheme and needed to be managed under transitional provisions in the *National Law*. Pre-existing registration authorities had not yet made decisions about certain applications for registration, and had either started, or started but not finished, dealing with notifications made to them about practitioners.

In AHPRA's first annual report, Mr Peter Allen, Chair of the AHPRA Agency Management Committee, acknowledged, '[t]his past year has seen AHPRA established at breakneck speed as a new national organisation with responsibility for implementing a complex range of regulatory functions'.⁹⁴ The costs of this rush would not go unnoticed and the NRAS was criticised soon after it commenced. In the first year of its operation, AHPRA's registration processes were the focus of much of this criticism, specifically delays in renewing practitioners' registration. In one widely publicised case, Dr Sandra Gaffney, a general practitioner in Dubbo, could not treat a terminally ill patient and was unable to complete her scheduled shift at a hospital emergency department because she had inadvertently been deregistered.⁹⁵

Responding to the outcry, on 23 March 2011, the Senate referred to its Finance and Public Administration References Committee an Inquiry into the Administration of Health Practitioner Registration by AHPRA.⁹⁶ In its report of June 2011, the Senate Committee recognised that the introduction of the NRAS was a complex and enormous project, but considered 'the implementation was far from well managed'.⁹⁷ This Senate Committee found that the public had difficulty

91 Senate Finance and Public Administration References Committee, Parliament of Australia, *Inquiry into the Administration of Health Practitioner Registration by the Australian Health Practitioner Regulation Agency (AHPRA)* (2011) 111–12 ('*Inquiry into the Administration of Health Practitioner Registration*'); Medical Board of Australia, Submission No 42 to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, 18 January 2013, 3 ('*Medical Board of Australia — Submission No 42*').

92 *Medical Board of Australia — Submission No 42*, above n 91, 3; *Department of Health — Submission No 50*, above n 87, 5.

93 *AHPRA Annual Report 2010–11*, above n 38, 1.

94 *Ibid* 3.

95 Mark O'Brien, 'AHPRA Faces Senate Inquiry', *Medical Observer* (online), 29 March 2011 <<http://www.medicalobserver.com.au/news/ahpra-faces-senate-inquiry>>.

96 *Inquiry into the Administration of Health Practitioner Registration*, above n 91, 1.

97 *Ibid* 111.

contacting AHPRA staff; that untrained staff provided inaccurate and inconsistent information; and that AHPRA had been poorly managing the registration process, failing to advise practitioners they needed to renew their registration and tardily processing applications for registration.⁹⁸ As a consequence of AHPRA's shortcomings, the Senate Committee concluded, practitioners lost income and employment, employers of health practitioners had to find alternative staff, patients' care was compromised when they could not access practitioners, and patients were unable to claim for Medicare rebates and private health insurance in relation to services provided by unregistered practitioners.⁹⁹

While the Senate Committee blamed AHPRA for these problems, it found fundamental deficiencies in the construction of the scheme led to AHPRA's failures. It lamented the poor accountability measures for AHPRA and concluded, '[f]or AHPRA itself to be responsible for a breakdown of the entire system of registration of health practitioners in Australia is a dismal example of policy implementation and public administration'.¹⁰⁰

The following year, it was one of the State Boards' responses to notifications that came under the spotlight. In 2012, the Queensland Crime and Misconduct Commission appointed retired Supreme Court Judge, the Hon Richard Chesterman QC, to assess a public interest disclosure that had been made to the Parliamentary Crime and Misconduct Committee regarding the regulation of medical practitioners in that State.¹⁰¹ The Hon Lawrence Springborg, Queensland Minister for Health, followed Mr Chesterman's recommendations. He appointed a panel, led by Dr Kim Forrester, to review whether the previous Medical Board of Queensland (MBQ) and the Queensland Board of the Medical Board of Australia (QBMA) had responded in a timely and appropriate way to notifications about medical practitioners' conduct.¹⁰² The Minister also appointed Mr Jeffrey Hunter SC to review the MBQ, QBMA and AHPRA's files in all cases in the previous five years in which a disciplinary sanction had been imposed on a medical practitioner where a patient had died or suffered serious bodily harm, to determine if criminal charges should be laid.¹⁰³

Minister Springborg acted immediately in response to reports he received. The *Forrester Report* of 5 April 2013 concluded that processes followed by AHPRA and the QBMA to reach decisions about notifications did not protect the public adequately and that, of the 596 cases it reviewed, 363 had been poorly handled.¹⁰⁴

98 Ibid 112.

99 Ibid 112–13.

100 Ibid 114, 116.

101 Queensland, *Final Report: Chesterman Report Recommendation 2 — Review Panel*, Parl Paper No 2375 (2013) i, 1 ('*Forrester Report*'). The public interest disclosure was made by Ms Jo-Anna Barber, a former investigator of the Medical Board of Australia, to Mr Rob Messenger, Member of Parliament.

102 Ibid i, 1, 5–6.

103 Lawrence Springborg, 'Police Asked to Investigate Six Queensland Doctors' (Media Release, 31 March 2013) <<http://statements.qld.gov.au/Statement/2013/3/31/police-asked-to-investigate-six-queensland-doctors>>; Kim Forrester, 'A New Beginning for Health Complaints in Queensland: The Health Ombudsman Act 2013 (Qld)' (2013) 21 *Journal of Law and Medicine* 273, 273.

104 *Forrester Report*, above n 101, xix.

The panel found that notifications were not dealt with consistently or promptly, including serious notifications that required an urgent response.¹⁰⁵ Moreover, the QBMBA had decided to take no further action in response to concerning notifications and had not sanctioned practitioners who demonstrated a poor standard of professional conduct or competence.¹⁰⁶ After Minister Springborg issued a formal notice to the QBMBA's members to show cause why they should retain their positions, most resigned and the remaining members were removed.¹⁰⁷ Pursuing Mr Hunter SC's recommendations, six Queensland doctors were referred to police to investigate whether they had committed criminal offences.¹⁰⁸

Findings regarding the management of notifications about health practitioners under the NRAS led the Queensland Parliament to pass the *Health Ombudsman Act* in order to amend how the *National Law* applies in Queensland and render that State a co-regulatory jurisdiction.¹⁰⁹ Pursuant to this legislation, since 1 July 2014, registration matters have continued to be dealt with under the NRAS, but the Health Ombudsman now receives all complaints about health practitioners practising in Queensland.¹¹⁰ The Health Ombudsman deals with serious disciplinary matters, refers minor notifications to AHPRA and the Boards, and monitors their performance.¹¹¹

IV THE VICTORIAN INQUIRY

A *The Inquiry's Terms of Reference*

The implementation of the NRAS was deemed sufficiently controversial in Victoria to warrant an investigation in that State, too. The terms of reference for the Inquiry into the Performance of AHPRA to be undertaken by the Legislative Council's Legal and Social Issues Legislation Committee were 'to inquire into, consider and report on the performance of [AHPRA] including the cost effectiveness, the regulatory efficacy of and the ability of the national scheme

105 Ibid xix–xx.

106 Ibid xxiii.

107 Janelle Miles, 'Queensland Medical Board Members Resign following Health Minister's Show-Cause Notice', *The Courier Mail* (online), 27 April 2013 <<http://www.couriermail.com.au/news/queensland/queensland-medical-board-members-resign-following-health-ministers-show-cause-notice/story-e6f9e0of-1226630205520>>; *AHPRA Annual Report 2012–13*, above n 69, 43.

108 Springborg, above n 103.

109 Explanatory Notes, Health Ombudsman Bill 2013 (Qld) 1, 3; Forrester, 'A New Beginning for Health Complaints in Queensland', above n 103, 273.

110 Explanatory Notes, Health Ombudsman Bill 2013 (Qld) 3; *Health Ombudsman Act* s 11; Forrester, 'A New Beginning for Health Complaints in Queensland', above n 103, 274.

111 *Health Ombudsman Act* ss 14(6), 25, 91; Explanatory Notes, Health Ombudsman Bill 2013 (Qld) 3; Forrester, 'A New Beginning for Health Complaints in Queensland', above n 103, 276.

to protect the Victorian public'.¹¹² The Committee was thus required to examine AHPRA's performance and the NRAS generally. Nevertheless, this article argues that the Committee's analyses of AHPRA and the NRAS were constrained because the Committee was also directed to focus on their operation and impact specifically in Victoria and the Committee's investigation took place largely in Victoria.

Victorian individuals and entities were responsible for around half of the 55 written submissions made to the Committee and the evidence provided to its public hearings.¹¹³ With the exception of a day of hearings in Brisbane (to consider imminent changes to Queensland's health complaints process), the Committee conducted its Inquiry in Victoria.¹¹⁴ Moreover, Minister Davis explicitly requested a review of the health regulation system 'from Victoria's viewpoint', to ensure it was meeting the 'interests of ... Victorian health practitioners and the Victorian community'.¹¹⁵ He maintained this Committee would thereby 'stick up for Victoria' in relation to a 'significant issue for the Victorian economy' and 'Victoria's reputation'.¹¹⁶ The Committee understood its task was to assess the effects of the NRAS on Victorian health practitioners and consumers, and the extent to which the scheme was 'protecting the Victorian public'.¹¹⁷

Arguably, the parochial focus of the Victorian Inquiry deprived the Committee of the capacity to examine a national entity and scheme in their national context, because the Committee was not required to consider their operation in all jurisdictions. This will be the project appropriately undertaken by the independent three-year review of the scheme that, pursuant to the *Intergovernmental Agreement*, the Ministerial Council initiated in July 2014.¹¹⁸ Minister Davis justified the conduct of a Victorian Inquiry so soon before the commencement of the three-year review on the basis that in 'national forums' there is the potential for concerns to be 'watered down ... and on some occasions brought down to the lowest common denominator'.¹¹⁹

112 Victoria, *Parliamentary Debates*, Legislative Council, 23 October 2012, 4687 (David Davis, Minister for Health). The Legislative Council's Legal and Social Issues Legislation Committee was initially required to present its final report by 29 November 2013, but the final reporting date was extended to 13 March 2014; Victoria, *Parliamentary Debates*, Legislative Council, 17 October 2013, 3206 (David Davis, Minister for Health).

113 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 4, 135–40.

114 *Ibid* 4–5.

115 Victoria, *Parliamentary Debates*, Legislative Council, 23 October 2012, 4693 (David Davis, Minister for Health).

116 *Ibid*; Victoria, *Parliamentary Debates*, Legislative Council, 23 March 2011, 579 (David Davis, Minister for Health).

117 Legislative Council Legal and Social Issues Legislation Committee, above n 44, v, 2.

118 *Intergovernmental Agreement*, above n 2, cls 7.5(j), 14.1; Standing Council on Health, (Communiqué, 11 April 2014) 3 <[http://www.health.gov.au/internet/main/publishing.nsf/Content/4A5AFC36B5238FDECA257CB7001C1B90/\\$File/DEPT002.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/4A5AFC36B5238FDECA257CB7001C1B90/$File/DEPT002.pdf)>: the Ministerial Council has determined that the NRAS review will be undertaken by an independent reviewer and has appointed Mr Kim Snowball to undertake that role.

119 Victoria, *Parliamentary Debates*, Legislative Council, 23 October 2012, 4693 (David Davis, Minister for Health).

Ironically, however, issues regarding AHPRA and the NRAS that deserve expansive and forensic investigation were diluted in the Committee's report due to its narrow orientation and also its failure to undertake a comprehensive and critical analysis of the scheme. The Committee relied on views expressed by individuals and organisations that made submissions to it (submitters) to shape the scope of its Inquiry.¹²⁰ In its report, the Committee mostly recited submitters' opinions and adopted one or more of them without thoroughly evaluating arguments for and against particular propositions. As a consequence of its preoccupation with state-based concerns and superficial examination of the national scheme, at times the Committee inappropriately prioritised Victorian rather than national interests.

It is this writer's view that the value of the Committee's report lies mainly in its identification of matters for future exploration. These issues include: the utility of the NRAS' structure and its various entities' accountabilities, functioning and relationships with one another; AHPRA's response to the Senate Inquiry's recommendations and its current performance; the transparency of AHPRA's public financial reporting and the cost effectiveness of AHPRA and the NRAS compared with pre-existing registration authorities; health programs for practitioners; practitioners' understanding of their mandatory reporting obligations in different jurisdictions; the causes, effects and extent of delays in the Boards' and AHPRA's management of notifications about practitioners; and the adequacy of AHPRA's communication with external stakeholders. It appears the Committee appreciated that it was hampered by its Victorian focus and the three-year review could better investigate these issues. Many of the Committee's suggestions begin with the words, '[t]hat the Victorian Minister for Health recommend to [the Ministerial Council] that the three-year review of [the NRAS] include consideration of the following'.¹²¹

B The Committee's Findings and Recommendations

1 The Structure and Governance of the NRAS

The first subject that the Committee discussed in its report deserves close consideration. This article maintains that a thorough assessment of the structure and governance of the NRAS would entail examining how well the entities of the NRAS are fulfilling their functions and how the relationships between these entities are progressing. The Committee, however, focused only on submitters' specific concerns, which did not provide sufficient evidence to justify the Committee's conclusion that the NRAS is a 'large and complex bureaucracy with potential confusion over lines of responsibility and accountability'.¹²² This is exemplified by the Committee's concession that, while it found that the Advisory

120 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 4.

121 See, eg, *ibid* 36. The Committee also emphasised that the Productivity Commission is reviewing its 2005 report and will soon be making proposals for healthcare over the next 10 years: at 2.

122 *Ibid* 26.

Council ‘adds another layer to a large bureaucracy’, it was ‘not in a position to discuss [its] value’.¹²³

As the NRAS comprises many entities, its structure may seem complex. Nevertheless, in its submission to the Committee, AHPRA explained, ‘on a daily basis the National Scheme is delivered by AHPRA in partnership with the National Boards, with the Ministerial Council providing high level oversight, and accreditation authorities exercising accreditation functions for the professions’.¹²⁴ The Committee did not make substantial recommendations for simplifying these arrangements or demonstrate in any meaningful way that they are unnecessarily complicated.

One aspect of the NRAS’ structure and governance that the Committee deemed problematic is the apparent diminution of the Victorian Health Minister’s power over regulation of health practitioners since the NRAS commenced. According to its report, the main reason for the Committee’s complaint was that it was attempting to ‘stick up for Victoria’ or at least for its Health Minister. Yet the Committee did not provide any evidence that the Victorian Health Minister’s role as a member of the Ministerial Council limited his capacity to represent Victorians’ interests. Further, the Committee did not explain why, in a national scheme, all of the governments should not share responsibility for scrutiny of its operation and why AHPRA should be more accountable to individual state and territory parliaments.

The Committee reported some submitters’ contentions that, without one individual responsible for health practitioner regulation in Victoria, it is difficult for decisions to be reached and for the scheme to be changed in Victorians’ interests.¹²⁵ Under the NRAS, however, state and territory health ministers do have significant responsibilities, including appointing members of State and Territory Boards and receiving information about local matters, and, as members of the Ministerial Council, they have equal opportunity to raise issues relevant to their jurisdictions and equal input into decisions made at the national level.¹²⁶ The Ministerial Council undoubtedly has a busy agenda filled with matters deriving from all jurisdictions, and it needs to reach a consensus to make decisions. Nevertheless, the scheme strives for national consistency in health regulation and there are few issues that affect one jurisdiction only. While a query about a matter related to registration of practitioners, for instance, could derive from one state or territory, a decision made about it will need to be applied uniformly across Australia. It therefore seems only appropriate that the respective ministers for health share responsibility for those decisions.

123 Ibid 24.

124 Australian Health Practitioner Regulation Agency, Submission No 40 to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, 1 March 2013, 10 (‘AHPRA — Submission No 40’).

125 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 27–9.

126 Evidence to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, Melbourne, 11 December 2013, 281 (M Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency).

The Committee found that '[t]he tabling of an annual report by AHPRA in each state and territory Parliament does not constitute sufficient accountability and scrutiny measures'.¹²⁷ It did not, however, explain why the Ministerial Council's oversight of AHPRA's performance constitutes an inadequate measure of scrutiny over AHPRA's operations necessitating individual parliaments' increased involvement.¹²⁸ Further, the Committee did not refer to AHPRA's note in its *2012/13 Annual Report* that, since February 2011, it 'has provided regular updates on key operational activities and emerging issues' to the Ministerial Council at the Standing Council on Health meetings and '[t]his contact complements the bilateral discussions that AHPRA has, as needed, with individual Health Ministers on matters that are of particular interest to that state or territory'.¹²⁹

The Committee conveyed some submitters' concerns about other entities in the national scheme without considering relevant issues adequately. For example, the Committee found that the 'composition of National and State Boards is too heavily weighted towards practitioners' and suggested the three-year review 'consider the merits of increased non-practitioner membership and flexibility to appoint non-practitioner chairs to National Boards'.¹³⁰ Yet the Committee did not go so far as to recommend amendments to the *National Law*, which requires that at least half, but not more than two-thirds of National Board members must be practitioners and that the Chairperson must be a practitioner.¹³¹ The Committee acknowledged that the legislation does not stipulate requirements for the composition of State and Territory Boards, but it did not suggest increased community membership of those committees.¹³² The Committee also did not discuss the extent to which the Boards, in fulfilling their functions, depend on members who are experts in the relevant health professions.¹³³

The Committee observed that the Productivity Commission's recommendation of a single national accreditation authority has not yet been implemented; there are currently 11 separate accreditation authorities.¹³⁴ The *Intergovernmental Agreement* and the *National Law* allow for this circumstance,¹³⁵ however, and the Committee did not advocate the benefits of cross-profession accreditation or explore some submitters' concerns about AHPRA's involvement in accreditation

127 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 31. The Senate shared this concern: *Inquiry into the Administration of Health Practitioner Regulation*, above n 91, 114–15.

128 *AHPRA — Submission No 40*, above n 124, 11.

129 *AHPRA Annual Report 2012–13*, above n 69, 19.

130 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 21, 37.

131 *National Law* sch s 33.

132 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 35.

133 Written Correspondence from the Australian Health Practitioner Regulation Agency to Richard Willis, Secretary, Legal and Social Issues Committee, 26 November 2013, 2 <http://www.parliament.vic.gov.au/images/stories/committees/SCLSI/AHPRA_letter_to_Victorian_Parliamentary_Inquiry.pdf>. AHPRA informed the Committee that 'there is no international consensus about the right balance of professional and community involvement in decision making'.

134 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 31. The Committee did not note that COAG's vision of a single national agency for registration and accreditation has also not been realised.

135 *Intergovernmental Agreement*, above n 2, attachment A cls 1.35–1.37; *National Law* sch ss 43, 253, 301.

matters.¹³⁶ The Committee also did not explain why it found a ‘need to streamline the functions of the separate accreditation authorities’ or how it proposed this should be done.¹³⁷

2 AHPRA’s Performance

Although the Committee undertook to evaluate the ‘overall performance’ of AHPRA,¹³⁸ it did not conduct a comprehensive assessment of AHPRA’s response to the Senate Inquiry’s suggestions and any residual implementation issues. Indeed, the Committee recommended that the three-year review perform that task.¹³⁹ The Committee confined its discussion of this subject to reciting some submitters’ perceptions of AHPRA (as well as their attitudes to the NRAS that were unrelated to AHPRA’s performance).¹⁴⁰ Based merely on the Committee’s finding that there was a sense AHPRA had addressed many of the implementation problems and its registration processes had improved, the Committee recommended that ‘Victoria should remain part of the National Scheme with respect to [its] registration and accreditation [components]’.¹⁴¹ The Committee reached this conclusion without closely examining AHPRA’s current registration system and in spite of also finding that AHPRA’s early difficulties had eroded public confidence in its administration of registration matters.

In addition, the Committee did not investigate shortcomings in AHPRA’s performance that, according to some submitters, remain unresolved. Consequently, the value of its report in this respect is confined to a suggestion that the Victorian Health Minister bring those issues to the Ministerial Council’s attention.¹⁴² Particularly deserving further consideration are certain practitioners’ and health services’ experiences that AHPRA has been unresponsive to their concerns; that staff communicated inadequately with them; and that AHPRA’s internal processes are not transparent.¹⁴³ It is the view of this writer that the three-year review should also address possible ‘inconsistent decision-making’ within AHPRA, about which some submitters expressed concern.¹⁴⁴ Notwithstanding AHPRA’s attempts to introduce common policies, procedures and processes within its organisation, there are many opportunities for staff in its local offices to make inconsistent decisions in relation to the regulation of health practitioners. Countless administrative decisions, varying in size, are made on a daily basis, the health professions still differ from one another in their cultures and expectations

136 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 32–3.

137 Ibid 36.

138 Ibid 39.

139 Ibid 47.

140 Ibid ch 3.

141 Ibid v, viii, 43, 46–7, 57.

142 Ibid 57.

143 Ibid 51–3.

144 See, eg, Australian College of Nurse Practitioners, Submission No 13 to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, 1 February 2013, 2–3.

of practitioners, and each notification is unique, requiring to some extent a response that lacks a clear precedent.¹⁴⁵

3 Cost Effectiveness and Registration Fees

Another topic that the Committee appropriately identified as meriting consideration, but on which it neglected to make any substantial findings, is the cost effectiveness of AHPRA and the NRAS.¹⁴⁶ The Committee blamed AHPRA for its apparent inability to evaluate its cost effectiveness, maintaining that AHPRA's public financial reporting has been deficient.¹⁴⁷ It was useful for the Committee to highlight AHPRA's transparency regarding its financial position as an issue for future consideration, and the Committee's recommendations for additional information AHPRA might include in its annual reports are of some benefit.¹⁴⁸ Nevertheless, this article argues that the Committee could have undertaken deeper analyses of the financial information to which it did have access, such as details AHPRA provided of its expenditure as well as its initiatives to improve its cost effectiveness, and the health profession agreements published on AHPRA's website that include AHPRA's financial statements for each Board.¹⁴⁹ In addition, the Committee appeared to place little weight on information AHPRA gave it. For instance, the Committee refers in its report to 'some concerns ... that the larger professions may be cross-subsidising smaller professions in the Scheme', though AHPRA explicitly denied this was the case.¹⁵⁰

The Committee's neglect of certain evidence in reaching its conclusions is also reflected in its recommendation that health practitioner registration fee increases be statutorily capped at no greater than Consumer Price Index (CPI) rises.¹⁵¹ In making this suggestion, the Committee did not take into account unanticipated expenses that led the Boards to increase registration fees since the NRAS commenced, or contingencies that may necessitate increases to registrants' fees beyond CPI inflation in the future.¹⁵² The Committee was responding to

145 See Australian Health Practitioner Regulation Authority, '2011/12 Annual Report: AHPRA and National Boards' (1 November 2012) 57–8 (*AHPRA Annual Report 2011–12*). See also *AHPRA Annual Report 2012–13*, above n 69, 19 regarding attempts to achieve consistency between Boards' work. But see Australian Doctors' Fund, Submission No 2 to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, 29 January 2013, 3 (*Australian Doctors' Fund — Submission No 2*); Hewitt, above n 27, 86, which identify significant differences between the health professions.

146 The Hon David Davis, Victorian Minister for Health, directed the Committee to investigate this subject, maintaining, '[o]ne of the claims about the national system was that it would be more efficient. In fact the system has been more costly, practitioners have to pay more for their registration fees and those costs are ultimately paid by consumers': Victoria, *Parliamentary Debates*, Legislative Council, 18 April 2013, 1106 (David Davis, Minister for Health).

147 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 77.

148 Ibid 74, 77.

149 Ibid 63–4, 74; *AHPRA — Submission No 40*, above n 124, 39.

150 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 64, 77; *AHPRA — Submission No 40*, above n 124, 38; Evidence to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, Melbourne, 17 April 2013, 37.

151 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 77.

152 See, eg, *Medical Board of Australia — Submission No 42*, above n 91, 4.

some submitters' contentions that, while registration fees had increased since the NRAS began, levels of services provided to registrants had not improved.¹⁵³ Nevertheless, AHPRA, the Medical Board of Australia (MBA) and the Victorian Department of Health explained to the Committee the unexpected costs involved in establishing the scheme and delivering its beneficial new functions, which had resulted in initial increases in registrants' fees.¹⁵⁴

Further, the Committee's recommendation suggests it paid insufficient regard to constraints embedded in the scheme that would prevent registration fees from becoming exorbitant. A rise in registrants' fees will not be dictated by the whim of one or a few individuals; the health profession agreements entered into by AHPRA and the Boards must specify fees payable by practitioners and, if those entities cannot agree on the amount, the Ministerial Council can direct them about how to resolve their dispute.¹⁵⁵ In addition, a key principle of the NRAS enshrined in the *National Law* is that 'fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme'.¹⁵⁶ While the Committee was concerned that 'reasonable' is not defined in the legislation,¹⁵⁷ common sense and rules of statutory interpretation would ensure those fees were not excessive. Indeed, the Committee found that the fees have been reasonable so far. Practitioners who register in two or more jurisdictions pay less in registration fees under the NRAS than they did before it existed and recent fee increases have correlated with CPI rises.¹⁵⁸

4 Health Programs for Doctors, Nurses and Midwives

Although the Committee was anxious to curtail increases to registrants' fees, it endorsed the continuation of health programs that, in incurring further costs for the NRAS, could have the opposite effect. Nevertheless, the Committee did not recommend any alternative source of funding for Victorian health programs for doctors, nurses and midwives that might support its suggestion that AHPRA be required to subsidise their continued operation without increasing registrants' fees.¹⁵⁹ While the Committee's report usefully underscores the importance of health programs for practitioners, its recommendations also inappropriately favour Victoria's needs over the interests of other parties in the national scheme.

The Committee did not justify its argument that the Victorian Doctors Health Program (VDHP) and Nursing and Midwifery Health Program (NMHP) should continue in their current form within a scheme designed to serve a range of other health professions in other jurisdictions as well. The VDHP and NMHP

153 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 71–2.

154 Ibid 66–8, 72–3.

155 *National Law* sch ss 26(1)(a), (2).

156 Ibid sch s 3(3)(b).

157 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 64.

158 Ibid 65, 70, 77.

159 Ibid 71, 83, 86, 88. Some evidence was nonetheless presented to the Committee, suggesting that the creation of national health programs for doctors, nurses and midwives might not necessitate increases to registration fees: at 83, 86.

were established in Victoria in 2000 and 2006 respectively to support doctors, nurses, midwives and students who were experiencing health problems.¹⁶⁰ Under the *National Law*, the Boards have discretion as to whether they will 'provide financial or other support for health programs for registered health practitioners and students'.¹⁶¹ Since the NRAS commenced, the MBA and Nursing and Midwifery Board of Australia (NMBA) have continued to fund the VDHP and NMHP, but only provisionally and the future of both programs is uncertain.¹⁶²

The Committee recognised that these health programs have been critical to the protection of the public, but it did not explain why, in a national scheme, fees paid by registrants in 14 health professions in all jurisdictions should be applied to fund programs accessible by practitioners in only two professions in one state.¹⁶³ The Committee noted that the MBA and NMBA are exploring the possibility of introducing national health programs for medical practitioners, and nurses and midwives.¹⁶⁴ It would, however, have been useful for the Committee to consider how current health programs could be adapted or replicated to accommodate the needs of practitioners in all health professions and in all jurisdictions.

5 The Health Practitioner Complaints Process

Despite condoning inconsistency in health programs for practitioners in different health professions and jurisdictions, the Committee expressed concern about inconsistency in health complaints processes across Australia.¹⁶⁵ Nevertheless, further variation in those processes could arise if, as the Committee recommends, Victoria was to become a co-regulatory jurisdiction for health, conduct and performance matters.¹⁶⁶ The Committee did not explain why it assumed that wresting responsibility from AHPRA and the Boards for management of notifications about health practitioners would address problems the submitters

160 Ibid 79 (quoting Victorian Doctors Health Program, *How We Help* <<http://www.vdhp.org.au/website/services.html>>), 84, 88.

161 *National Law* sch s 35(1)(n).

162 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 80–1 (quoting Australian Medical Association, Submission No 18 to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, 1 February 2013, 3), 87–8 (quoting Nursing and Midwifery Board of Australia, 'National Board to Fund Nursing and Midwifery Health Program for Two More Years' (Media Release, 4 September 2013) 1).

163 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 81, 88. The MBA indicated to the Committee that it does not consider it appropriate that, in a national scheme, it uses fees paid by health professionals in all jurisdictions to fund services for medical practitioners in one state only: at 81, quoting Medical Board of Australia, Submission No 42 to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, 28 February 2013, 7.

164 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 83 (quoting Medical Board of Australia, 'Medical Board to Fund Health Program/s for Doctors' (Media Release, 6 March 2013) 1), 86–7 (quoting NMBA, 'Explanatory Notes: Management of Nurses, Midwives and Students with Impairment' (Media Release, 16 November 2012) 3). Those programs would probably be managed independently of the Boards and AHPRA.

165 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 132–3.

166 Ibid 134.

found with the notifications process in Victoria. Indeed, the Committee did not explore these issues in depth or consider other ways of tackling them. Consequently, the value of the Committee's discussion of this subject, like its examination of many other topics, is limited to its illumination of matters that require further investigation.

The Committee did not justify its recommendation that Victoria should follow the New South Wales and Queensland models and become a co-regulatory jurisdiction, or suggest how a substitute for AHPRA and the Boards should manage notifications about health practitioners.¹⁶⁷ The Committee maintained that notifications are 'best managed at a local level',¹⁶⁸ but AHPRA's Victorian office does precisely that.

The efficacy of Queensland's new Health Ombudsman role is as yet largely untested. While the Committee endorsed Queensland's then imminent 'single entry point for all health practitioner complaints' and '[i]ndependent arbiter', it did not evaluate the merits of investing all that decision-making in one individual.¹⁶⁹ Indeed, the Health Ombudsman's role is extremely broad, as it subsumes functions previously performed by the Health Quality and Complaints Commission, AHPRA and the National Boards.¹⁷⁰ The Health Ombudsman receives and deals with all complaints about 'health service[s]' provided by registered and unregistered health practitioners and health service organisations.¹⁷¹ The Health Ombudsman can refer matters regarding registered health practitioners to AHPRA, unless a practitioner may have engaged in professional misconduct or another ground exists for suspension or cancellation of a practitioner's registration. In the latter circumstances, the matter can be referred to the director of proceedings, an employee of the Office of the Health Ombudsman, who in turn can take proceedings before the Queensland Civil and Administrative Tribunal.¹⁷²

In contrast to Queensland, New South Wales's complaints handling system — partly established in 1994 — has had years to refine many of its processes and involves a number of entities. The Committee gave no reason why the NRAS could not in time develop processes of the same quality. In New South Wales, the government funded, independent Health Care Complaints Commission (HCCC) receives and assesses complaints about health services provided by registered and unregistered health practitioners and health service organisations.¹⁷³ Since 1 July 2010, complaints about registered health practitioners can also be made to the New South Wales-based health professional councils for each of the 14 health professions regulated under the *National Law*.¹⁷⁴ These councils receive

167 Ibid.

168 Ibid 133.

169 Ibid 131.

170 Explanatory Notes, Health Ombudsman Bill 2013 (Qld) 2.

171 *Health Ombudsman Act* ss 7–8, 25(a).

172 Ibid ss 12, 91.

173 *Health Care Complaints Act 1993* (NSW) s 3(1)(a); *AHPRA Annual Report 2012–13*, above n 69, 22; *AHPRA Annual Report 2010–11*, above n 38, 26.

174 *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) sch 1 item 15 s 144C.

administrative support from the Health Professional Councils Authority, rather than AHPRA.¹⁷⁵ The HCCC must notify the councils of complaints it receives that involve practitioners who are or were registered, and the councils and the HCCC must consult one another before taking action on complaints and refer appropriate matters to each other. Both can also refer complaints to the councils' Professional Standards Committees and are obliged to refer more serious complaints to the New South Wales Civil and Administrative Tribunal.¹⁷⁶ The Committee expressed concern about differences in approaches to, and apparent consequent public confusion about, mandatory reporting requirements for health practitioners in Australia.¹⁷⁷ Nevertheless, the Committee did not explain why Victoria's conversion to a co-regulatory jurisdiction would cure, or indeed not exacerbate, these issues. It is this writer's view that investigating how best to educate practitioners about their reporting obligations — which can vary depending on the jurisdiction in which they are practising — would be a more productive exercise than pursuing the Committee's suggestion of considering how to increase national consistency in mandatory notification requirements.¹⁷⁸

To increase public protection, the *National Law* introduced mandatory reporting obligations for registered health practitioners, their employers and education providers. They must notify AHPRA if they form a reasonable belief that a health practitioner has behaved in a way that constitutes 'notifiable conduct' or a student has an impairment that may place the public at risk.¹⁷⁹ Although the operation of pt 8 of the *National Law* is modified in New South Wales, practitioners in that State share these duties.¹⁸⁰ In Western Australia, however, practitioners are not required to notify AHPRA if they form that 'reasonable belief in the course of providing health services' to a practitioner or student.¹⁸¹ The *Health Ombudsman Act* similarly exempts treating practitioners in Queensland from making a mandatory notification, but only if they believe their patient has not engaged

175 Health Professional Councils Authority, *Home* (4 February 2015) <<http://www.hpca.nsw.gov.au>>. The councils can, inter alia, refer practitioners for health or performance assessments or to an Impaired Registrants Panel: *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) sch 1 item 15 ss 145B(1)(f)(i)–(iii).

176 *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) sch 1 item 15 ss 145A–145D.

177 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 89–90.

178 Ibid 105; *AHPRA Annual Report 2012–13*, above n 69, 136. The National Boards have already published guidelines on mandatory notifications, which are available on their websites.

179 *National Law* sch ss 140–3. 'Notifiable conduct' includes practising the practitioner's profession while intoxicated, sexual misconduct and placing the public at risk of harm due to the practitioner's impairment or departure from professional standards: at ss 140(a)–(d). For discussion of the reasons for introducing these provisions and their potential implications, see Kim Forrester, 'Notifications and Mandatory Reporting — Two Years On' (2012) 20 *Journal of Law and Medicine* 273; Hewitt, above n 27; Ian Freckelton, 'Regulation of Health Practitioners: National Reform in Australia' (2010) 18 *Journal of Law and Medicine* 207, 219–20.

180 Health Care Complaints Commission, *Mandatory Reporting Requirements for Registered Health Practitioners, Employers and Education Providers* (28 August 2014) <<http://www.hccc.nsw.gov.au/Information/Information-For-Health-Providers/Mandatory-reporting---What-Practitioners-need-to-know->>>.

181 *Health Practitioner Regulation National Law (WA) Act 2010* (WA) s 4(7), sch s 141(4)(da).

in ‘professional misconduct’ or their impairment will ‘not place the public at substantial risk of harm’.¹⁸²

The Committee did not evaluate which of these mandatory reporting obligations are most likely to protect the public. Its report similarly neglects to assess the potential risk to public safety caused by delays in managing notifications. The Committee’s recommendation that the Victorian Minister for Health alert the Ministerial Council to evidence of such delays has value,¹⁸³ but the Committee’s analysis of this possible problem was otherwise superficial. Indeed, the Committee did not substantiate its assumption that New South Wales’s complaints handling processes and the notifications management system in Queensland will be more efficient than equivalent Victorian processes under the NRAS.

As the Committee emphasised, New South Wales and Queensland’s systems are bound by statutory timelines for handling notifications. Yet the *National Law* also stipulates that the Boards complete preliminary assessments of notifications within 60 days, and requires that other aspects of the notifications process be undertaken ‘as soon’ or ‘quickly’ as ‘practicable’.¹⁸⁴ Further, AHPRA advised the Committee that it has introduced key performance indicators (KPIs) for all stages of its notification process.¹⁸⁵ The Committee maintained that those KPIs were insufficient compared with New South Wales and Queensland’s statutory timelines, but the Committee did not comprehensively analyse whether the latter were realistic, took into account idiosyncrasies of different notifications and, in New South Wales, had generally been met.¹⁸⁶ The Committee also placed little weight on AHPRA’s references to causes of delays over which it has little or no control (such as difficulties in obtaining swift access to relevant information) and its commitment to managing notifications in a more timely way, or evidence that delays in managing notifications had already diminished since the early days of the NRAS.¹⁸⁷ Indeed, it would have been useful for the Committee to question the extent to which delays in the recent past might still have been attributable to the inadequate preparation for the commencement of the scheme.

182 *Health Ombudsman Act* pt 23 s 326 item 25; Explanatory Notes, Health Ombudsman Bill 2013 (Qld) 4.

183 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 57, 90.

184 *National Law* sch ss 149(1), 152(1), 161(1), 162. The Boards must provide a practitioner/student with notice of a notification ‘as soon as practicable after receiving’ it and of a decision to investigate a notification ‘as soon as practicable’ after making this decision, and ensure that investigators conduct investigations ‘as quickly as practicable, having regard to the nature of the matter to be investigated’: at ss 152(1), 161(1), 162.

185 Evidence to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, Melbourne, 11 December 2013, 282 (Australian Health Practitioner Regulation Agency), cited in Legislative Council Legal and Social Issues Legislation Committee, above n 44, 110.

186 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 111, 126–7. The Committee only noted that the HCCC assessed complaints within the 60-day timeframe that is similarly required by the *National Law*.

187 *Ibid* 105–6 (citing Australian Health Practitioner Regulation Agency, ‘Do You Have a Concern About a Health Practitioner? A Guide for People Raising a Concern (Making a Notification or Complaint)’ (Guide, 18 June 2013) 15), 121; Health Services Commissioner, Submission No 5 to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, 30 January 2013, 2.

While the Committee appropriately highlighted concerns about the adequacy of AHPRA's communication with external parties, particularly during investigations of notifications, it did not explore the extent of this problem or improvements that could be instituted.¹⁸⁸ In its report, the Committee underscored the importance of AHPRA's regular communication with notifiers, practitioners and health services by repeating submitters' evidence of stresses they experienced when notifications were made.¹⁸⁹ The Committee did not, however, assess whether the Boards were meeting their statutory obligation to provide written notice of the progress of investigations to practitioners and notifiers at not less than three-monthly intervals.¹⁹⁰ The Committee's report also does not refer to statutory restrictions imposed on the Boards with respect to information they are permitted to provide to notifiers about their decisions.¹⁹¹ This writer maintains that it would have been useful for the Committee to examine whether the Boards are complying with their statutory obligations and whether those requirements are appropriate. AHPRA informed the Committee of its recent efforts to improve communication — including publishing information about the notification process on its website and establishing a Community Reference Group — but the Committee did not comment on whether such initiatives might be sufficient to address this issue.¹⁹²

A possible problem the Committee identified that could, in this writer's view, be alleviated through improved communication is public confusion over the roles of AHPRA, the Boards and the OHSC.¹⁹³ Nevertheless, the Committee merely maintained that lack of clarity for consumers regarding which entity to approach causes delays in the notification process (when notifications are not sent to the appropriate body or are sent to more than one entity) and reduces public confidence in the system, without recommending ways to rectify this matter.¹⁹⁴ Evidence received by the Committee suggested some consumers did not understand the distinction between the OHSC's role to resolve complaints about practitioners through conciliation, and the Boards' function to protect the public by restricting the practice of health professionals who may be placing the public at risk as a result of their health, conduct or performance.¹⁹⁵

In fact, the Committee itself did not take into account the Boards' regulatory role when it expressed concern about notifiers' 'inadequate rights' under the NRAS.¹⁹⁶ The Committee was uncomfortable that the *National Law* removed the option

188 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 90, 111.

189 Ibid 106–9 (citations omitted).

190 *National Law* sch s 161(3).

191 Ibid ss 151(4), 180(2), 191, 192(4). A Board must give a notifier a notice stating the reason it has decided to take no further action in relation to a notification, but if the Board decides after investigating the matter either to take action or not to do so, or a panel makes a decision about a practitioner in response to a notification, the Board must provide a notice to the notifier that includes only information about the decision that is available on the Board's register.

192 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 110.

193 Ibid 90, 134.

194 Ibid xii–iii, 117–18, 124.

195 Ibid 117–18 (citations omitted); *AHPRA Annual Report 2012–13*, above n 69, 137; *AHPRA — Submission No 40*, above n 124, 41.

196 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 90, 134.

available to notifiers under the *HPR Act* to seek review of a Board's decisions 'not to conduct an investigation', 'take no further action after an investigation' or 'refer the matter to a professional standards panel'.¹⁹⁷ Yet the Committee did not consider whether this change is appropriate given that the Boards have no power to resolve complaints about practitioners. The statutory title of 'notifier' is deliberate: the *National Law* restricts their role to putting Boards on notice of a possible risk to the public and they are not seen as 'complainants' to whom the Boards can offer some redress.¹⁹⁸ Further, the Committee appeared to place little weight on AHPRA's comment to it that notifiers' previous entitlements were not required as a check on Boards' disciplinary processes because most Board decisions were upheld on appeal¹⁹⁹ (even though the Committee noted that in New South Wales, where complainants can seek a review of the HCCC's assessment decisions in limited circumstances, most initial decisions have similarly been confirmed).²⁰⁰

V CONCLUSION

It is not surprising that a few submitters to the Inquiry favoured abandoning the NRAS and returning to local regulation of individual health professions in Australia.²⁰¹ The project is an extremely ambitious and wholly untested experiment. To outsiders, the scheme can appear unwieldy and unduly complicated. Yet its potential benefits, acknowledged by submitters and the Committee, are significant: the increased mobility and flexibility of health practitioners (including flying doctors, and those working in regions that cross state and territory borders or in emergency situations outside their principal jurisdiction of practice) who need only register once to practise anywhere in Australia; a national database of up-to-date data about registered health practitioners that is accessible by the public and assists in workforce planning; and enhanced collaboration and learning between health professions.²⁰² The most important question, however, is: does the NRAS offer superior protection to the public than the state-based system of regulating health practitioners?

197 Ibid 112; *HPR Act* s 60.

198 *AHPRA Annual Report 2011–12*, above n 145, 80. Notifiers are nonetheless free to take civil action against health practitioners.

199 Letter from Australian Health Practitioner Regulation Agency to Legislative Council Legal and Social Issues Legislation Committee, 26 November 2013, app 1 19, cited in Legislative Council Legal and Social Issues Legislation Committee, above n 44, 113.

200 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 127.

201 Ibid 53–4; *Australian Doctors' Fund — Submission No 2*, above n 145, 1; Australian Society of Ophthalmologists, Submission No 39 to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, 3; Australian Society of Orthopaedic Surgeons, Submission No 23 to Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, 12 February 2013, 1.

202 Legislative Council Legal and Social Issues Legislation Committee, above n 44, 48–9, 54–6 (citations omitted).

The Victorian Inquiry did not yield any substantial response to this question and, consequently, failed to 'stick up' for Victorians, let alone all Australians. The Committee did not consider, for instance, the impact of important initiatives that were introduced by the *National Law* specifically to strengthen public protection, such as identity and criminal history checking of applicants for registration.²⁰³ Indeed, the Committee did not explain how its most substantial recommendation — to modify the operation of the NRAS in Victoria by returning to state-based handling of notifications about practitioners — could increase public safety. As it is not founded on a comprehensive evaluation of relevant issues, the Committee's suggestion that Victoria become a co-regulatory jurisdiction seems premature. Moreover, it is possible that such a change could prove detrimental to Victoria and undermine the scheme.²⁰⁴

It may in fact take some years to ascertain whether the NRAS can offer Australians greater public protection than the pre-existing health regulation system. Nevertheless, the three-year review will be an essential vehicle for beginning a thorough assessment of the national scheme.²⁰⁵ This review can tackle the crucial issues neglected by the Victorian Inquiry, such as: would a prospective employer or patient obtain more accurate information about a health professional under the new scheme than might previously have been available to them? Is the risk of another scandal on the scale of Reeves, for instance, diminished as a consequence of the implementation of the NRAS? The three-year review can also consider adjustments that may need to be made to the scheme and whether legislative amendment, and/or variation of administrative processes, is required to institute such changes.

203 Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 5, 11–12; *National Law* sch ss 77–9.

204 Letter from Australian Health Practitioner Regulation Agency to Legislative Council Legal and Social Issues Legislation Committee, 26 November 2013, 2.

205 *Ibid.*