Fair Complaints, Clinical Independence and Regulatory Integrity Policy 2026

A national reform plan for AHPRA and the National Boards

This policy protects patients and practitioners by replacing open-ended, low-threshold regulatory processes with fast triage, enforceable deadlines, procedural fairness, independent oversight and strong safeguards against pharmaceutical or other commercial influence.

Public safety remains paramount. Administrative punishment, commercial bias and needless delay do not.

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1. Executive Decision

Australian Health Ministers should agree to a nationally consistent amendment of the Health Practitioner Regulation National Law and direct AHPRA and the National Boards to implement the reforms within twelve months. The model amendment legislation should then be applied or adopted across participating jurisdictions.

The decision required of Ministers is to adopt the following operating rules as minimum national standards.

- Screen weak, trivial, misconceived, collateral-purpose and vexatious notifications before a practitioner is required to respond.

- Complete preliminary screening within 14 days and preliminary assessment within the existing 60-day statutory period.
- Finish ordinary matters within six months and complex matters within twelve months unless the independent reviewer approves a limited extension.
- Give practitioners the allegations, material, reasons, realistic timeframes and regular progress updates.
- Prohibit pressure to apologise, admit wrongdoing or perform contrition as the price of procedural mercy.
- Protect lawful, evidence-informed clinical judgement, including lawful off-label use and the use of off-patent medicines.
- Expose and manage pharmaceutical, device, insurer, consultancy and other commercial interests through public registers, recusals, audits and penalties.
- Create an independent National Scheme Complaints and Regulatory Integrity Reviewer with binding procedural powers.
- Publish performance, delay, vexatious-notification, consultant-spending and conflict-of-interest data each year.

2. The Problem

The supplied article and practitioner discussion describe a system in which complaints can be used as leverage in family-law, employment, refund and prescribing disputes; practitioners can spend months preparing formal responses to matters that ultimately require no action; and the process itself can damage health, relationships, income, careers and patient care. These accounts are firsthand claims and commentary, not findings in every individual case. They nevertheless identify recurring system risks that legislation should test, measure and control.

AHPRA's 2024–25 reporting confirms scale and delay are real management issues. It recorded 22,658 notifications about 16,209 practitioners nationally, 5,627 open notifications at year end, and 20 per cent of open notifications aged twelve months or more. It also reported that only 1.4 per cent of notifications closed during the year resulted in loss of registration or disqualification. These figures do not prove that the remaining complaints were improper, but they reinforce the need for disciplined triage, proportionality and timely resolution.

The current National Law already permits a National Board to take no further action where a notification is frivolous, vexatious, misconceived or lacking in substance. The weakness is that the power is discretionary and sits inside a process that can still impose substantial cost and distress before it is used. The reform must move the filter to the front door and make dismissal mandatory when the statutory threshold is not met.

3. Regulatory Capture and Pharmaceutical Influence

The concern that AHPRA or a National Board has been captured by pharmaceutical interests must be capable of being proved or disproved through records, not buried under assurances. Regulatory capture can occur through direct financial interests, repeated reliance on the same funded experts, undisclosed research or advisory relationships, industry-sponsored education, revolving-door appointments, selective evidence standards, informal communications or institutional dependence on commercially aligned bodies.

The reform therefore applies equally whether the suspected influence comes from a pharmaceutical manufacturer, medical-device company, insurer, private hospital group, consultancy, professional association, litigation funder or any other entity with a financial stake in a regulatory outcome.

Ivermectin is included as an example of an off-patent medicine that can attract political and commercial controversy. The legal rule should be neutral: patent status, profitability, public controversy or absence of manufacturer sponsorship must never be treated as evidence that a practitioner is unsafe. A prescribing decision must instead be assessed on its legality, the evidence reasonably available at the relevant time, the practitioner's scope and competence, informed consent, dose, monitoring, contraindications, documentation and the individual patient's circumstances.

4. Policy Objectives

1. Protect the public from unsafe, impaired or unethical practice through rapid attention to credible risk.
2. Protect practitioners from unnecessary harm caused by weak, weaponised, commercially influenced or badly managed processes.
3. Preserve honest reporting by patients, families, employers and practitioners acting in good faith.
4. Preserve clinical independence while maintaining evidence, consent, safety and professional standards.
5. Make conflicts, expert selection, industry contact, consultant spending and decision delays visible and auditable.
6. Restore confidence that regulatory decisions are made for patient safety rather than institutional, political or commercial convenience.

5. Reform Pillar One — Front-End Screening

Requirement	Rule
14-day intake decision	A trained decision-maker must determine jurisdiction, factual sufficiency, public-risk relevance, duplication, collateral purpose and urgency before requiring a practitioner response.
Mandatory threshold	A matter proceeds only where stated facts, if accepted, are capable of establishing a ground for notification and further regulatory action would be proportionate.
No-response pathway	A practitioner is not contacted or required to answer where the matter can be dismissed or resolved from existing objective information.
Anonymous notifications	Identity may remain confidential, but a fully anonymous notification proceeds only where objective material corroborates it or the alleged risk is serious and immediate.
Collateral disputes	Family-law, employment, commercial, refund, insurance and litigation contexts must be identified and assessed for motive, duplication and independent corroboration.
Good-faith reporting	An unsubstantiated complaint is not automatically vexatious. Sanctions apply only to knowingly false, fabricated, malicious or recklessly misleading notifications.

6. Reform Pillar Two — Enforceable Timeframes

- Acknowledge receipt within two business days.
- Complete intake screening within 14 calendar days.
- Complete preliminary assessment within 60 days.
- Finalise ordinary matters within six months of receipt.
- Finalise complex matters within twelve months of receipt.
- Require independent approval for any extension, limited to 90 days at a time and supported by published, case-specific reasons.
- Give monthly written updates stating work completed, work outstanding, responsibility for delay and the expected decision date.
- Prioritise matters involving immediate action, loss of income, serious health vulnerability or material restrictions on practice.

Failure to meet a deadline does not automatically terminate a genuine public-safety case. It triggers independent review, a recovery plan, senior accountability and consideration of reimbursement for avoidable professional costs caused by unreasonable administrative delay.

7. Reform Pillar Three — Procedural Fairness

- Provide a clear statement of each allegation, the statutory ground, the material relied upon and the possible outcomes.
- Disclose relevant exculpatory, contextual and contradictory material, subject only to necessary protections for safety, privacy and active investigations.
- Allow a reasonable response period and proportionate extensions.
- Prohibit adverse inference merely because a practitioner denies an allegation, requests evidence, obtains legal advice or declines to apologise.
- Separate intake, investigation and final decision-making functions in serious or contested matters.
- Require written reasons that address the practitioner's central evidence and explain why the selected action is necessary and proportionate.
- Remove unsubstantiated allegations from operational risk profiles once a matter is finally closed, while retaining a sealed audit record for lawful review.

8. Reform Pillar Four — Practitioner Wellbeing

Regulatory kindness is not softness. A calm, competent process improves evidence, participation and public-safety decisions. Every notice must identify a trained contact officer, independent support options and the expected next step. At-risk practitioners must receive regular contact, and health information must be limited to what is relevant and necessary for the regulatory decision.

- Mandatory suicide and self-harm risk training for notification staff and decision-makers.
- A wellbeing screen at first contact and after major escalation points.
- Independent navigation support that does not report confidential therapeutic content to the regulator.

- Use of a treating practitioner's information before ordering duplicative independent assessments where appropriate.
- Immediate incident review after a suicide, attempted suicide or serious self-harm linked in time to a regulatory process, with de-identified public findings.

9. Reform Pillar Five — Clinical Independence

The National Law must state that lawful clinical practice is not misconduct merely because a medicine is generic, off-patent, inexpensive, used off-label, unsupported by a commercial sponsor or inconsistent with a non-binding policy. The TGA states that off-label use is generally a clinical decision for the prescriber and ordinarily does not require TGA approval. That discretion carries responsibility and must be assessed through transparent clinical criteria.

- No adverse finding based solely on patent status, price, profitability, sponsor preference, media controversy or off-label status.
- No secret evidence standard. The Board must identify the evidence, guidance and date-specific professional standard relied upon.
- Consider all materially relevant evidence, including negative, null, observational, mechanistic and real-world evidence, according to its quality and relevance.
- Require expert reviewers to answer the actual patient-specific question and disclose contrary evidence and uncertainty.
- Protect good-faith scientific disagreement and public policy speech unless it creates a demonstrable connection to unsafe practice or breaches a valid professional obligation.
- Preserve all applicable medicines, poisons, therapeutic goods, informed-consent, advertising and professional-standard laws.

10. Reform Pillar Six — Anti-Capture Safeguards

Safeguard	Minimum Standard
Public interest register	Five-year disclosure of employment, consultancies, research funding, speaking fees, travel, gifts, shares, patents, litigation roles and advisory positions for decision-makers and experts.
Automatic recusal	No participation where a reasonable person could apprehend that a pharmaceutical or other commercial interest could influence the matter.
Independent expert pool	Competitive appointment, published selection criteria, diversity of clinical opinion and a prohibition on repeat dependence on one institution or funded network.
Industry contact log	Publication of meetings, communications and submissions concerning standards, guidelines, enforcement priorities or individual classes of medicine.
Gifts and benefits ban	No gifts, sponsored travel, hospitality or benefits from regulated commercial interests, subject only to tightly defined nominal exceptions.
Revolving-door rule	Two-year restriction on senior regulators and principal advisers moving into paid roles with entities materially affected by their recent decisions, with disclosed exemptions.

Safeguard	Minimum Standard
Evidence audit	Independent audit of whether comparable evidence standards are applied to patented, generic, off-patent and non-commercial therapies.
Consultancy transparency	Publish consultant contracts, purpose, value, deliverables, conflicts and whether recommendations were accepted or rejected.
Protected disclosures	Protection for staff, practitioners and experts who disclose suspected capture, improper influence, evidence suppression or unlawful expenditure.

11. Reform Pillar Seven — Independent Oversight

A National Scheme Complaints and Regulatory Integrity Reviewer should be appointed by the Health Ministers Meeting for a fixed term after public merit selection. The Reviewer must be institutionally separate from AHPRA and the National Boards and must not have held a senior pharmaceutical, device, insurer or AHPRA role during the previous five years.

- Review delay, denial of procedural fairness, undisclosed conflicts, expert selection and alleged collateral-purpose notifications.
- Direct disclosure, recusal, reassignment, a timetable, reconsideration or correction of a defective process.
- Audit systemic patterns across medicines, practitioners, complainants, experts and decision-makers.
- Refer suspected corruption, criminal conduct, serious maladministration or misuse of public funds to the proper authority.
- Publish de-identified findings, compliance rates and unresolved recommendations.
- Avoid substituting clinical merits where the National Law gives that function to a Board, panel or tribunal, except to require lawful reconsideration.

12. Implementation

Period	Action
First 90 days	Health Ministers agree reform principles; establish drafting and implementation taskforce; preserve relevant records; begin external conflict and delay audit.
Months 3–6	Model National Law amendment Bill is introduced; AHPRA publishes interim interest and industry-contact registers; staff training begins.
Months 6–12	Legislation commences; Reviewer appointed; intake screening, deadlines, notices and expert-panel rules operational.
Months 12–18	Participating jurisdictions complete application or adoption; first thematic audit of prescribing cases involving generic, off-patent and off-label medicines.
At 24 months	Independent statutory review reports to every participating Parliament and the Commonwealth Parliament.

13. Performance Measures

- Percentage screened within 14 days and assessed within 60 days.
- Median and 90th-percentile duration by profession, allegation and outcome.
- Number dismissed without practitioner response and number determined frivolous, vexatious, misconceived or lacking substance.
- Number involving collateral proceedings and the outcome of those matters.
- Number of extensions, identity of approving authority and reasons.
- Practitioner and notifier experience scores, reported separately.
- Self-harm and suicide incident reviews and implementation of recommendations.
- Declared conflicts, recusals, industry contacts and breaches.
- Outcomes in matters involving off-label, generic and off-patent medicines.
- Consultancy and external legal spending, deliverables and realised savings.
- Registration-fee movements attributable to notification administration.

14. Safeguards Against Unintended Consequences

Nothing in this policy prevents immediate action where there is a serious risk to the public, protects dishonest or reckless prescribing, limits mandatory notification duties, blocks a genuine patient complaint, or treats commercial unpopularity as proof that a treatment works. The reform requires the regulator to prove its reasoning, disclose its interests, act proportionately and finish the job on time.

15. Sources and References

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