Review of the National Registration and Accreditation Scheme for health professions

Submission from the Australian Chiropractors’ Association of Australia
Main Recommendation

The option of a single Health Professions Australia Board to carry regulatory responsibility for the nine low regulatory workload professions is not supported by the Chiropractors’ Association of Australia (CAA).

CAA believes it is essential for each registered profession to have its own Board for standard and policy development, approval of accreditation standards and to maintain opportunities for innovation and changes to workforce reform and practices (included cross-profession matters). The CAA would strongly resist any move to form a single Board with regulatory responsibility for more than one profession that also included chiropractors.

Chiropractic Association of Australia

The Chiropractors’ Association of Australia (CAA) is the peak body representing the interests of Australian chiropractors and their patients. The CAA is a national organization with state and territory branches. The CAA corporate structure is one of a company limited by guarantee. The organization has over 3,000 members. The CAA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

Contact CAA

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1. Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?

Position of the CAA: NEUTRAL

The CAA has adopted a neutral position on this proposal. Nevertheless, CAA is not confident a reconstituted AHWAC will strengthen the accountability of the National Scheme either on a national level or to individual State and Territory Health Ministers. The Independent Reviewer has noted “a view that the National Scheme is not adequately accountable to State and Territory Health Ministers and that there is a need for the National Scheme’s operation to be assessed and held accountable as a whole.” However, we are not told who holds this view or why. Furthermore, in the public Consultation Paper the Independent Reviewer does not spell out how greater accountability will be achieved by reconstituting the AHWAC. In the absence of reasoning to support his proposal CAA believes it is likely to add further complexity and provide additional unwarranted bureaucratic layering to the National Scheme.

We believe this view is supported by reference to the numerous agencies or processes either contained in the National Law (or other laws impacting on agencies established under the National Law) as set out in the public Consultation Paper including:

- annual reporting and audited financial statements
- Ministerial Council policy directions and approvals with respect to registration standards and endorsements for specialties, scheduled medicines, areas of practice and acupuncture
- review of National Board registration and disciplinary decisions by State and Territory tribunals
- freedom of information protections
- privacy protections
- review of administrative decisions by the National Health Practitioner Ombudsman
- judicial review of decisions
- human rights charter legislation and anti-corruption legislation
- Council of Australian Governments (COAG) best practice regulation requirements.

Finally, as AHWAC is no longer active, reconstituting it would in practice represent an increase in regulation under current arrangements.

2. Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross professional issues are addressed?
Position of the CAA: NOT SUPPORTED

The CAA does not support this proposal. Specifically CAA believes a reconstituted AHWAC would encounter significant difficulty exercising any authority to arbitrate or mediate in cross-professional disputes. The legitimacy of its authority would be subject to robust questioning and challenge by the professions or parts thereof. More generally, the CAA has reservations about a reconstituted AHWAC as spelt in question one above.

3. Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? Estimated cost saving $11m per annum.

Position of the CAA: NOT SUPPORTED

The option of a single Health Professions Australia Board to carry regulatory responsibility for the nine low regulatory workload professions is not supported. CAA believes it is essential that each profession has its own Board for standard and policy development, approval of accreditation standards and maintaining opportunities for innovation and changes to workforce reform and practices (included cross-profession matters). The CAA would strongly resist any move to form a single Board with regulatory responsibility for more than one profession that also included chiropractors.

CAA also questions the estimated cost saving for this proposal of $11 million per annum. Primarily because the “respective professions would remain with protected title and have direct input into matters affecting the regulation of the profession through dedicated subcommittees of the Board” and because, with respect to accreditation, “professional input into specific elements of the courses of study, and other discipline specific areas would be preserved”.

It may be the case that one or more health practitioner groups entered the NRAS too early in which case there may have been advantages in waiting for sufficient practitioner numbers to be established. Alternatively, one or more health practitioner groups may not pose a significant risk to community safety or, there may be more cost effective means of regulating these professions available. Nevertheless, even if this were the case, we do not believe it would justify a single Health Professions Australia Board to carry regulatory responsibility for all nine low regulatory workload professions.

In July this year AHPRA cited a key achievement of the National Scheme over the past four years has been the development of a comprehensive set of regulatory policies and standards, across and within professions, to ensure appropriate protection of the public. Establishing a single Health Professions Australia Board to
manage the regulatory functions that oversee the nine low regulatory workload professions would put this at risk.

4. Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? Estimated cost saving $7.4m pa.

Position of the CAA: SUPPORTED

This proposal would most likely meet the needs of the nine low regulatory workload professions while also addressing any concerns about community safety. Although we question the estimated cost saving of $7.4 million per annum, it is probable that some savings could be made under the proposed model while also maintaining the ability for each Board to develop appropriate standards and policies, approve accreditation standards and maintain opportunities for innovation and changes to workforce reform and practices.

5. Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?

Position of the CAA: SUPPORTED

6. Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?

Position of the CAA: SUPPORTED

Any future proposals for professions to be included in the National Scheme should continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis. This was agreed by the COAG and set out in the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for The Health Professions* (IGA) in March 2008.

The IGA establishes six criteria in the form of questions for assessing the need for statutory regulation of unregulated health occupations:

1. It is appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?
2. Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

3. Do existing regulatory or other mechanisms fail to address health and safety issues?

4. Is regulation possible to implement for the occupation in question?

5. Is regulation practical to implement for the occupation in question?

6. Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

The IGA establishes that an unregistered occupation must meet all six criteria to be considered for registration. In addition, restrictions on the practice of a profession should only occur where the benefits of the restriction to the community as a whole outweigh the costs.

These requirements continue to be appropriate today and are strongly supported by the CAA.

7. Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?

Position of the CAA: NOT SUPPORTED

As the public Consultation Paper makes clear, inclusion in the National Scheme, and the additional regulation that it imposes, must only occur where community safety is at significant risk and no alternative, more cost-effective means of regulating the profession is available.

The CAA notes that a National Code of Conduct for healthcare workers is currently being developed on behalf of state, territory and commonwealth health ministers under the auspices of the AHMAC. Earlier this year a draft National Code was prepared for discussion and public consultation, based on codes already applying in New South Wales and South Australia. If enacted in each state and territory, this National Code will set minimum enforceable standards of practice for any person who provides a health services which is not regulated under the Health Practitioner Regulation National Law.

Adoption of the proposed national Code of Conduct for health care workers by each state and territory should provide adequate protection of the public while negating the need to recognise these professions in the National Law unless they specifically meet the necessary criteria to be considered for registration as noted in question six above.
8. Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?

Position of the CAA: NOT SUPPORTED

AHWMC is already able to draw on sufficient expert advice to guide it on threshold measures for entry to the National Scheme. This includes the Principle Committees of the AHC, in particular the Health Workforce Principal Committee, State and Territory jurisdictions, AHPRA and the National Boards. Existing public consultation processes would also feed into this processes.

9. What changes are required to improve the existing complaints and notifications system under the National Scheme?

Position of the CAA: SUPPORT OPTION ONE

CAA would support changes outlined in option one i.e. retain the existing configuration of notifications handling but improve the process via a range of administrative and legislative changes. Importantly, this option retains the majority of the roles and functions currently managed by the National Boards and Health Complaints Entities while making adjustments to the existing framework to address and remedy problems that have been identified.

10. Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?

Position of the CAA: NOT SUPPORTED

Queensland only moved to a co-regulatory model in July 2014 so it too early to determine whether all other States and Territories should adopt the same or a similar model.

Nevertheless, there is merit in ensuring, as far as practicably possibly, that a common approach to co-regulatory arrangements is maintained in jurisdictions where this applies to ensure equitable outcomes with respect to complaints and notifications across all jurisdictions consistent with the application of the National Law.

11. Should there be a single entry point for complaints and notifications in each State and Territory?
Position of the CAA: NEUTRAL

There may be merit in a single entry point for complaints and notifications in each State and Territory to alleviate the perception that current arrangements under the National Law are difficult for consumers (and even health practitioners) to navigate. However this may be difficult to achieve in the current climate as individual state and territory jurisdictions increasingly seek to determine the most appropriate model for receiving and triaging complaints and notifications.

12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

Position of the CAA: SUPPORTED

As far as practically possible performance measures and prescribed timeframes for dealing with complaints and notifications should be adopted nationally to strengthen both consumer and practitioner confidence in the regulatory system.

13. Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?

Position of the CAA: INCREASE TRANSPARENCY

A notifier might be provided with additional insight into the process that has occurred in their case and further explanation when a finding of “No Further Action” is made (i.e. the health practitioners conduct, performance or health did not fall below accepted levels). This would require a discussion on the balance, interplay and limitations of what is available on the register, what is needed to drive the administrative processes and what is told to a notifier.

14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

Position of the CAA: SUPPORTED

15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

CAA supports the current provisions in the National Law that give National Boards a discretion, in circumstances where the practitioner has an impairment, to decide not
to include, or to remove information on the register about a condition imposed, or undertaking accepted, if it is deemed necessary to protect the practitioner's privacy and there is no overriding public interest argument for this information to be published.

In other situations, where an adverse finding has been recorded against a practitioner and a condition imposed, or undertaking accepted, this information should be removed from the register at the expiration of the intervention unless there is a strong and continuing public interest argument for this information to remain on the register.

16. Are the legislative provisions on advertising working effectively or do they require change?

Position of the CAA: SUPPORT OPTION THREE

The legislative provisions on advertising are not working effectively and require change. CAA favours option three outlined in the Public Consultation paper; removing the ban on testimonials all together.

17. How should the National Scheme respond to differences in States and Territories in protected practices?

Inconsistencies in protected practices across Australia should be eliminated or at least minimised as far as possible.

18. In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

Position of the CAA: NOT SUPPORTED

No. CAA believes current provisions in the National Law are sufficient to effectively protect the public from harm.

19. Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

Position of the CAA: SUPPORTED
CAA would support revision of the mandatory notification provisions to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment. In circumstances where this would not pose a risk to the public.

20. To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?

With respect to facilitating access to services, developing a flexible, responsive and sustainable health workforce, and innovation in education and service delivery, National Boards and Accrediting Authorities play a minor, though not insignificant role. The primary role of the Boards is setting minimum standards and Accrediting Authorities review programmes against these standards.

21. Should the proposed reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?

Position of the CAA: NOT SUPPORTED

This can already occur through via the AHWMC (utilising the expertise of Principle Committees of the AHMAC, in particular the Health Workforce Principal Committee), State and Territory jurisdictions, AHPRA and existing public consultation processes.

22. To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?

The focus of Accrediting Authorities is almost exclusively discipline specific which makes it difficult at present to accommodate multidisciplinary education and training or to coordinate multidisciplinary accreditation processes to any great extent.

Accrediting Authorities are more effective when considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs, especially in collaboration with universities and other accredited educational institutions and the professions. Nevertheless, many of these issues are better addressed post-professionally through continuing professional development programmes.
23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

The trend towards higher levels of qualification in several professions and at some educational institutions probably relates more to economies of scale and cost savings that can be achieved in undergraduate education as well as a desire to foster multidisciplinary training at this level. Although this does increase cost to students, as far as standards are concerned there appears to be little or no negative impact (indeed these registrants exceed the minimum qualifications).

24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

CAA believes the current processes for assessing and supervising overseas trained practitioners are adequate to maintain the standards for entry into the profession.

25. Should the appointment of Chairperson of a National Board be on the basis of merit?

Position of the CAA: SUPPORTED

26. Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?

With respect to chiropractic profession CAA believes there is at present an effective division of roles and functions between the Chiropractic Board of Australia and the Council on Chiropractic Education Australasia, the accreditation authority responsible for accrediting education providers and programs of study for the chiropractic profession.

27. Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?

CAA believes there is sufficient oversight for decisions made by the Council on Chiropractic Education Australasia.