National Alliance of Self-Regulating Health Professions

Submission to the National Registration and Accreditation Scheme Review

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Submitted via email to: nras.review@health.vic.gov.au
Executive summary

Since its implementation the National Regulation and Accreditation Scheme (NRAS) has made significant steps in establishing a nationally consistent framework to protect the health and safety of those who access health services. Through these achievements the NRAS, commencing under National Law in July 2010, has raised the community expectation that all Australian healthcare delivery meets a governed standard, with established public protection processes in place.

Notably this expectation is currently only met for a quarter of recognised health professions through NRAS. The remainder of Australian health practitioners operate outside of a formalised framework, with public protection offered only through a mix of practitioner voluntary membership of a self-regulating professional association, employer workplace arrangements and individual state legislation.

The primary concern of a robust health regulatory system is public safety through the assurance of quality service provision. Unfortunately self-regulation in its current form is not sufficiently far-reaching because it cannot mandate standards beyond entry level, nor ensure that all practitioners submit to a code of ethics/conduct and a complaints management system.

Existing self-regulatory arrangements only regulate members or those who seek voluntary accreditation. Most self-regulated professions have examples of serious public complaints where the practitioner was either not a member or chose to resign membership, providing no avenue to pursue the complaint and ensure public safety. This highlights the gaps in the current health practitioner regulatory system where there is a high level of regulation for the professions partnering with AHPRA in NRAS, but no enforceable public protection for the other three-quarters of Australia’s health professions.

These current arrangements run contrary to public expectation that a formal regulation structure exists which provides recognition of qualifications, minimum entry standards, assurance of practice standards, a code of conduct and ethics, and a single avenue for complaints.

The National Alliance of Self Regulating Health Professions (NASRHP), operating under the Auspice of the Allied Health Professions Australia (AHPA), is composed of nine allied health professions which are not described under the NRAS, and is representative of the broader collective of self-regulating health professions in Australia. The core objectives of NASRHP are to:

- seek clarity regarding regulation for their respective professions
- benchmark their self-regulatory environment
- advocate on behalf of the public for an improved health regulatory environment
- address the challenges and consequences for the professions and health agencies of the current fragmentation in health practitioner regulation.

In 2012, the NASRHP developed a detailed cost effective model for the inclusion of self-regulating health profession under the NRAS. This, Harnessing self-regulation to support safety and quality in healthcare delivery: A comprehensive model for regulating all health practitioners1 (the Submission) is included at attachment 1.

The NASRHP contends that to protect the interests and safety of the public a single national authority such as the Australian Health Practitioner Regulation Agency (AHPRA) should be responsible for managing the regulation of all health practitioners. This requires an integrated framework covering the

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registered professions, authorised self-regulating professions and negative licensing of those practitioners who do not otherwise fit within the regulation processes, as described in the Submission.

**Recommendation**

The national law be amended to include a description of self-regulating health professions for inclusion under the NRAS.

Authorised self-regulation, with reserved/protected title legislation, will require practitioners utilising the protected title to meet standards for practice set by the professional association. All regulation will be managed by AHPRA and the framework will be fluid, such that on AHPRA’s recommendation a profession may move out of or into the NRAS should its demonstrated risk profile change.

**Unintended consequences as a result of a confined application of the NRAS**

Examples:

1. Health Workforce Australia’s decision to only include registered professions in the Health Professionals Prescribing Project\(^2\). It is understandable that when considering a policy to extend prescribing of pharmaceutical products, governments needs to ensure there are appropriate standards and adequate complaints system in place for protecting the public. However, this decision meant that self-regulated professions like Dietetics, speech pathology and social workers, who have a clear role in formal extension of prescribing rights (with some already engaged in such practices in Queensland) were not included in this project. This is a curious and awkward consequence and is contrary both to the intent of the project and the NRAS to the detriment of the effective delivery of healthcare.

2. Changes to Victorian legislation in August 2014 to improve safety and security measures for emergency workers in Victorian has been applied for the 14 AHPRA registered health practitioner groups (the letter from the Honourable David Davis MP, Victorian Minister for Health, is at Attachment 2).

3. AHPRA registration as a mandatory criteria for health professionals applying for Doctoral Scholarships offered by the Windermere Foundation\(^3\) to support the professional development of Victorian health practitioners who will become future leaders in their profession.

4. The online publication ‘Australian Doctor’ states ‘the contents of this site are available to Australian Registered Health Practitioners only’. This gives the continual message, particularly to doctors, that everyone else is less worthy and should be excluded\(^4\).

The above four examples are indicative of the types of unintended consequences that have resulted from the establishment of a two tier regulatory system which has developed as a result of a confined application of the NRAS. More examples can be provided on request.

The establishment of the NRAS has raised the expectations of the community, health professionals and broader stakeholders that all health professions in the continuum of Australian healthcare delivery meets a governed standard, with established public protection processes and regulation in place.


The NASRHP, and individual self-regulating health professionals, do raise these issues as they are identified, however often (as with legislation that has just been amended) there is limited opportunity effect timely change to the systems and opportunities that are established only recognising AHPRA registered professions.

Amending the national law to include a description of self-regulating health and establishment of an integrated framework for authorised self-regulation as described in the submission not only responds to the national regulation expectations of people accessing health services, it would also addressed many of the unintended consequences of the two tier regulatory system currently in place.

**Responses to questions from the consultation paper**

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?*

The NASRHP strongly supports this.

The Submission outlines how practitioners in the self-regulated professions can be captured in a sensible regulatory framework. It provides for a more cost effective option for increased regulation, rather than extending the current NRAS model to each individual profession, and argues that the public risk, whilst deemed medium to low, can be further minimised and managed through authorised self-regulation.

The proposed model addresses the public need for safety, and minimises risk with the least administrative impact. Through this model’s protection of title for self-regulating health professions the public can be assured that their treating practitioner has the appropriate qualifications, competency, and meets other credentialing requirements.

Further to this, the proposed model is proactive and seeks to identify and prevent risk through the promotion of quality standards. Other models, such as legislated codes of conduct, are reactive models, reliant on an adverse event, its reporting, and the subsequent discipline procedure outcome.

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

NASRHP strongly supports this.

Establishment of a legislatorial definition of self–regulating health professions under the NRAS is required to achieve national consistency of the regulatory functions that assure the health and safety of those who access health services.

The NASRHP argues that other regulatory means in place for self-regulating health professions (such as through workplaces or voluntary membership to professional bodies) do not provide adequate public protection. The NASRHP member professional associations vary from covering 98% to 50% of their profession. The public risk posed by so many practitioners working outside of a regulatory environment is unacceptable.

The primary advantage of the proposed model is that it embraces a right-touch nationally consistent regulatory methodology focused on patient and consumer safety and quality healthcare which fills the gaps in the current regulatory environment that is silent on the quality and safety of healthcare provided by 75% of health professions.
11. Should there be a single entry point for complaints and notifications in each State and Territory?

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

The NASRHP supports both of these on the provision that, more importantly, there is a single nationally consistent single entry point for complaints and notifications for all health professions.

A key component of the proposed model for regulation ensures that all practitioners, whether a NRAS described profession or authorised self-regulating profession, are held accountable against enforceable profession specific standards of practice supported by a transparent complaints and notification handling process.

A significant advantage of the proposed model is that it embraces a right-touch regulatory methodology focused on patient and consumer safety and quality healthcare. It fills the gap in the current regulatory environment that is silent on the quality and safety of healthcare provided by 75% of health professions.

This model addresses the public need for safety, and minimises risk with the least administrative impact. Through protection of title the public can be assured that their treating practitioner has the appropriate qualifications, competency, and meets other credentialing requirements.

The proposed framework and model of authorised self-regulation outlined builds on current knowledge and structures, satisfies community expectations of healthcare quality and safety and supports the growth of health professions in Australia.