1. Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?
Yes; this would aid in the creation of a consistent and uniform national scheme. However, it is essential that any engagement relating to the National Scheme, particularly health reform, also encourage and incorporate continued input from the health professional bodies.

2. Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?
Yes; currently, cross-professional issues fall outside the standard guidelines for handling conflict. This would allow for unbiased and fair mediation between professions, though we must ensure that this is not used as a forum for large professions to bully or impose limitations upon smaller, or emerging, professions. Again, AHWAC should commit to continued discussion with health professional bodies on any and all issues which arise within their professions.

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.
No; such a merger undermines the ability of professions to work with their respective board toward improvements in safety, quality and service development. The proposal at this time fails to identify how the integrity of individual profession will be protected. A significant concern exists in relation to a similar model in the UK under the HCPC where the ability of small professions to gain attention in the system has been severely impacted.

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.
Yes; this would allow continued autonomy of the professions, while still reducing unnecessary work duplication and spending.

5. Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?
Yes. The scheme began with a principle of being self-funded with no cost shifting between professions. If the scheme achieves reduced costs through efficiencies, these must be passed on to registrants.

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?
No; while admission to the National Scheme should be carefully monitored and limited, the exclusion of professions who pose no potential risk through their practice has indeed unintentionally disadvantaged these ‘non-registered’ health practitioners. Should a case be made for membership, based on credible practice, a strong and developing professional body and evidence of outcomes, then a profession should not be automatically excluded simply because they lack a risk element in their work.
7. Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?
Yes. The national scheme has been used for convenience by governments and companies to identify health professionals. This has created unintended consequences and should be addressed by recognising an appropriate self-regulation model such as the one proposed by the National Alliance of Self Regulating Health Professions.

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?
Yes; this would help to limit the creation and operation of multiple different governance and advisory committees to oversee a single area, as so often occurs.

9. What changes are required to improve the existing complaints and notifications system under the National Scheme?
Option 2 presented in this paper outlines a good approach to changes required to improve the current system. The complaints and notifications system has improved due to work done by AHPRA over the last couple of years and that ongoing work to provide clarity and efficiency must continue. The system should allow for State Ministers to have local authority under the national scheme where systematic or significant issues are reported in the jurisdictions health system or in the interest of public safety within their jurisdiction.

10. Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?
No; this system is confusing for patients and practitioners and practitioners often note that it results in increased or extra fees. Our profession now pays a higher fee in NSW as a result of co-regulation and we are concerned that further co-regulation will introduce confusion, complexity, unnecessary regulation and ultimately higher costs for podiatrists. The existing national scheme should be amended to meet the needs of state ministers to respond locally and in a timely manner rather than through co-regulation.

11. Should there be a single entry point for complaints and notifications in each State and Territory?
Yes; people who have had a negative experience with a practitioner should be able to access their options for filing a complaint easily, and multiple points of entry are confusing and unnecessarily complicated. The single entry point in each state should nationally consistent but be able to cooperate and coordinate with state based health complaints systems.

12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?
Yes; again, there should be consistency in the approach of states.

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?
No; complainants need to have the process of a complaints progression through the system explained clearly, including how long this is expected to take and at what points they should expect to be contacted. If a complaint does not result in disciplinary action, perhaps due to
lack of merit, the complainant should have the reasoning for this decision explained to them subject to balancing privacy for all parties.

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?
Yes; resolution should be sought through the least confronting and costly process available, providing consent is received from all parties. This should be a legitimate option.

15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?
Adverse findings must all be recorded and should not at any time be removed from the registrants file. There should be the opportunity for a registrant to apply to the Board to have the adverse finding removed from the publicly available information from the register which should be granted once the Board is satisfied that there is no longer a risk to the public. In some cases, the board should be able to determine a time for the automatic removal from the publically available information. Cases which resulted in no disciplinary action should not be recorded.

16. Are the legislative provisions on advertising working effectively or do they require change?
The provision legislating against testimonials should be removed; given how widespread social media and feedback websites have become, it is unrealistic to expect that a practitioner should be accountable for what is said about their practice on any one of these forums.

17. How should the National Scheme respond to differences in States and Territories in protected practices?
The National Scheme should be enabling legislation based on the broadest safe practice available at any time. By way of example, a podiatrist who has undertaken appropriate training is able to apply for endorsement of their registration regardless of limits imposed by state legislation. This allows the practitioner to prescribe in those states where the legislation permits and will enable them to practice immediately when other states amend their legislation without requiring amendments to the national scheme.

We urge the Standing Council on Health to continue to work toward nationally consistent law in areas governing protected practice. This impacts greatly on practitioners that are transient such as those travelling regularly with sporting teams (amateur and professional), specialised practitioners who regularly consult in multiple states, educators who provide practical workshops in multiple jurisdictions, conferences held in different jurisdictions, practitioners providing telehealth consultations (eg. A prescription written resulting from a telehealth consultation may be illegal if the provider is in NSW where this is not restricted and the patient is in Canberra where it is), providers in border areas (particularly where providing home visits).
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?
The National Code of Conduct for unregistered health practitioners, the National Registration and Accreditation Scheme and recognition of a self-regulation scheme should sufficiently protect the public from demonstrated 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?
Yes; these provisions protect practitioner’s rights as patients.

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?
The registration system for health practitioners has improved significantly with the introduction of national registration. There has been improvements in transparency, online access to registers, online renewals and increasing consistency between professions in areas like advertising without undermining individual professions. The entry of overseas trained professionals has been appropriate in podiatry and accreditation of undergraduate courses has been managed appropriately. The scheme ought to continue to fine tune some areas to improve the timeframes for investigations and to address perceived challenges for state ministers (and avoid co-regulation) over the coming three years.

21. Should a reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?
Yes; this would help to limit the creation and operation of multiple different governance and advisory committees to oversee a single area, as so often occurs. Again, health professional bodies must remain an integral and included part of any consultation or process to protect the professional integrity of professions.

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?
More could be done to allow greater flexibility in the education of practitioners, particularly in areas such as supervision levels for prescribing endorsements where simulation and group supervision may shorten the time required to achieve competence.

23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?
An open and established relationship should allow for educational institutions to continue to update and improve their education programs to ensure their graduates are prepared to enter the workforce. This will improve the quality of new-graduate practitioners and also ease their transition into the workforce as a fully trained, capable and aware practitioner.
24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?
Given the recent review of the guidelines, these processes are sufficiently effective.

25. Should the appointment of Chairperson of a National Board be on the basis of merit?
The Chairperson should be appointed on merit however the current requirement for the chair to also be a member of the profession should be maintained.

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?
Yes.

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