SUBMISSION TO THE REVIEW OF THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR HEALTH PROFESSIONS

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Introduction

I welcome the opportunity to comment on the Review of the National Registration and Accreditation Scheme (NRAS) for health professions.

Although I am not a health professional registered under the National Law I have an in-depth understanding of regulatory and accreditation principles as well as many years researching the health regulatory landscape in Australia and internationally. This has been done in my capacity as the Principal Policy Advisor to Paramedics Australasia in the development of their proposals for independent registration\(^1\) of paramedics in both Australia and New Zealand. That work has encompassed all aspects of best practice health regulation and its implementation under the National Law.

Equally important is my abiding interest in regulation as a health service consumer and many years experience associated with the National Association of Testing Authorities (NATA)\(^2\) as an operator of laboratories, accreditation assessor (lead and panel) and Executive Board member. I was also a member for several years of the Executive Steering Committee of the Hong Kong Laboratory Accreditation Scheme (HOKLAS).\(^3\)

My background includes several years’ service as a member of the Education Committee for Engineers Australia and as both lead assessor and panel member for the assessment of Certificate, Diploma, Degree and postgraduate university programs.

Finally I have a continuing interest in health care delivery, quality and equity standards at a national level through my invited (co-opted) membership of the Executive Committee of the Australian Health Care Reform Alliance.\(^4\)

My views therefore are shaped by personal interests and experience, detailed research on relevant issues, broad regulatory experience and the input provided by my close relationship with individual health practitioners and their professional societies.

My experience with Paramedics Australasia is particularly germane as paramedics are currently unregistered and belong to one of several groups of unregistered health workers seeking registration under the National Scheme. Considerable material in this response is taken from my research work associated with that body (not cited).

Establishing regulatory benchmarks

Regulation and labour mobility

Internationally, the impact of regulatory activities on the health professions has become part of the public policy and mutual recognition agenda. Furthermore, the realisation has grown that the underlying principles and practices of regulation are founded on common principles that should accordingly govern the decision to regulate any health profession.

\(^1\) https://www.paramedics.org/advocacy/registration/
\(^3\) http://www.itc.gov.hk/en/quality/hkas/hoklas/about.htm
\(^4\) http://www.healthreform.org.au/
In most jurisdictions, professional associations play a prominent role in the regulation of the profession because of their close links with practitioners and their capacity to mobilise relevant expertise and practice competencies. Internationally, many regulatory arrangements are executed by a profession or industry group through a self-regulatory regime with or without the ultimate protection of legislation.

Regardless of the mechanisms, a continuing theme in discussions about the regulation of professions is the portability of skills and mobility of practitioners. In that respect, the registration of health professionals and the creation of a national register that records an individual practitioner’s skill and knowledge level are important elements in achieving reciprocity of recognition across jurisdictional boundaries and in fostering workforce mobility. Such mobility is crucial for the health professions to ensure safety and equity in healthcare. It assists workforce sustainability that benefits the community through better access to quality care and ultimately protects the public.

Entry qualifications and education programs form only part of an effective regulatory regime. The ethical standards, complaint mechanisms, competencies framework and the maintenance of professional competence are other key factors, and while educational accreditation is a crucial element, it is only one piece of the jigsaw comprising the fabric of regulation. These aspects are covered in various sections of the consultation document.5

Why regulate at any level?

The market-based rationale for regulation suggests that when faced with a choice of service providers, many consumers may be unable to make a rational choice. Expert professional services are taken at face value, with the consumer generally having to rely on the expertise of the practitioner and not well placed to assess the nature and quality of the service. Moreover, in real life there are often significant constraints on the services market with only a single provider being available, so that consumers/patients are unable to make a free choice between competing services.

Regulation of a profession therefore may be justified if it can provide protection for the consumer through guaranteeing the quality of service by virtue of the regulatory body having more information and expertise at its disposal than the average consumer - and using that knowledge to license or register the practitioner. Regulatory controls may also mandate adequate information disclosure with respect to maintaining professional standards and quality of service.

If the service activity at a practitioner level is provided in conjunction with an agency function such as a hospital, clinic, diagnostic service or paramedic services provider (aka ambulance service), then the public interest becomes multi-dimensional.

Healthcare, with its multiple participants, specialised and expensive interventions and layers of interaction between different practitioners and providers, is subject to greater than normal public interest and consumer protection considerations. Not only are consumers commonly unable to judge the expertise of the individual professional but they are frequently faced with no choice of provider. In rural and remote areas, these constraints become even more marked.

While the case for regulation of health practitioners should not be controversial, it remains unclear which form the regulation should take. A graded response may be appropriate

5 Review of the National Registration and Accreditation Scheme for health professions
based on the overall perceived risk and public interest (see later). Once the basic quality of service is assured (the necessity criterion), measure that generate confidence and trust in the profession appears paramount and regulation should aim at enhancing that trust relationship (value added criterion). Two basic models have evolved in the Australian context which are: registration under the National Law/AHPRA model; and the adoption of a National Code of Conduct for unregistered health workers.⁶ ⁷

Some professions stress the need for self-regulation, on the basis that only a rigorous system of peer review is satisfactory to limit the risk of poor quality service. The impact of these risks is conspicuous in the health sector where the consequences of maltreatment may go well beyond the immediate patient outcomes. Public expectations and perceptions play a significant role and any suspicions of inadequacy generate serious public concerns and loss of public confidence. An example of the sensitivity of public perceptions is provided by the current responses to the distressing outbreaks of the Ebola virus disease.⁸

The tendency of self-regulating professions to protect their scope of practice as a means of benefiting their members has been consistently noted in studies of professional regulation inside and outside of health care.⁹ The self-regulatory model thus suffers from perceptions of self-interest, conflict of interest, lack of accountability and lack of community (citizen) engagement.

In theory, selective professional regulation and licensing may restrict supply, increase the perceived value and incomes and promote exclusivity and status without contributing materially to public health or safety. It can also mask poor governance, restrictive practices, internal divisions and professional rivalries and disputes.

The community might expect government to protect it from such influences but self-seeking behaviour is difficult to identify and separate from other sound public interest arguments for regulation. Auditing professional bodies for compliance, using benchmark measures and forcing the functional separation of professional, service and complaint/disciplinary matters internally are other mechanisms to potentially limit the likelihood of self-serving practices.

These activities are at best additional control mechanisms and responses to ensure the integrity of the basic regulatory processes and they are therefore likely to remain as governmental functions and introduce additional costs beyond the primary regulatory load.

Thus, while strongly supporting the case for substantial involvement of front-line practitioners and professional bodies in the regulatory process, I note that devolution of regulatory responsibility does not remove the ultimate cost to the consumer despite potentially reducing the visible financial impact on government. In the words of the Rt Hon. John Hutton, former UK Secretary of State for Business, Enterprise and Regulatory Reform: “there is no such thing as free regulation. “

The community benefits to be gained from government intervention in economic terms through consolidation, scale, and independence therefore should not be underestimated in any benefit cost analysis, especially when allied with perceptions of the public interest.

Applying best practice regulatory principles to health regulation

Any work undertaken by, or on behalf of, Ministerial Councils is subject to the requirements of the COAG best practice regulation guide. This is to ensure that where regulatory change is being contemplated there are effective arrangements to maximise the efficiency of new and amended regulation, and avoid unnecessary compliance costs and restrictions on competition. The dilemma lies in assessing adequacy, effectiveness and efficiency and the identification of costs and their location within the system.

For example, the trouble with empowering industry associations with regulatory functions, is that they are subject to rent-seeking, limited vision, moral risk and tempted to seek progress in their own interests, thus rendering their competency suspect in the public interest.10

Recent times have demonstrated how corporate social responsibility demonstrably lags behind immediate stakeholder and management interests, and the ethos of government responsibility and ethical accountability for the public interest has consistently been shown to be unmatched by other mechanisms.

The real challenge therefore is to integrate the protection of the public with the level of primary risks associated with professional practice and match these factors with the necessary and available regulatory mechanisms.

Considerable work has been done in the UK on the regulation of health care and health professionals as a result of highly public Inquiries which forced a reappraisal of the handling of complaints, the role of the General Medical Council and the revalidation of doctors.11 In addition, general principles of good regulation have been developed by the UK Better Regulation Task Force (BRTF) under the Better Regulation Executive (BRE).12 The BRE guidelines say that regulation should be:

- **proportionate**: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised.
- **accountable**: regulators must be able to justify decisions, and be subject to public scrutiny.
- **consistent**: Government rules and standards must be joined up and implemented fairly.
- **transparent**: regulators should be open, and keep regulations simple and user friendly.
- **targeted**: regulators should be focused on the problem, and minimise side effects.

When dealing with healthcare, these views are further supported by the statement articulated by the UK Ministry of Health13 of the key principles that should underpin statutory professional regulation, viz:

“First, its overriding interest should be the safety and quality of the care that patients receive from health professionals.

Second, professional regulation needs to sustain the confidence of both the public and the professions through demonstrable impartiality. Regulators need to be independent of Government, the professionals themselves, employers, educators and all the other interest groups involved in healthcare.”

12 http://www.cabinetoffice.gov.uk/regulation/about_us/index.asp
Third, professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professionals as it is about identifying and addressing poor practice or bad behaviour.

Fourth, professional regulation should not create unnecessary burdens, but be proportionate to the risk it addresses and the benefit it brings.

Finally, we need a system that ensures the strength and integrity of health professionals within the United Kingdom, but is sufficiently flexible to work effectively for the different health needs and healthcare approaches within and out with the NHS in England, Scotland, Wales and Northern Ireland and to adapt to future changes.”

I suggest in addition that the principles for regulation must incorporate:

- **Effectiveness** – the regulatory system should be effective in protecting the public from harm and fostering the provision of high quality health care;

- **Accountability** – registration processes should provide accountability to the community for their decisions and operations;

- **Transparency** – the decision making processes should be open, clear and understandable both to consumers and to practitioners;

- **Fairness** – regulatory/registration boards should maintain an acceptable balance between protection of patients/consumers rights and interests, and those of the regulated health professions;

- **Efficiency** – the resources expended and the administrative burden imposed by the regulatory system should be commensurate with the level of risk regardless of where in the system these costs are incurred;

- **Consistency** - there should be consistency across different jurisdictions in the regulatory arrangements for the health professions (for example, between closely related sovereign states like New Zealand and Australia and their internal legal structures); and

- **Flexibility** – the regulatory system should be able to respond to emerging issues in a timely manner as the health care system evolves and the roles and functions of health professionals change (for example, emerging health professions).

While these principles provide guidance on the objectives and outcomes of regulation, they leave the detailed mechanisms unstated. In Australia the regulation of 14 health professions through the NRAS is established under the Health Practitioner Regulation National Law Act (the National Law) as in force in each state and territory. An Intergovernmental Agreement (IGA) signed by Council of Australian Governments (COAG) members in March 2008 underpins the National Scheme and identifies its objectives as:

- protection of public safety;

- facilitation of workforce mobility and high quality education and training;

- promotion of access to health services; and

- development of a flexible, responsive and sustainable workforce.

The objectives and guiding principles are set out in the IGA and Section 3 of the National Law and my considered assessment is that the operations of AHPRA and the various regulatory Boards under the NRAS fulfil the primary functions of appropriate regulation. I also agree with the Independent Reviewer\(^\text{14}\) that there may be scope for improvements (p 6).

Identifying regulatory competence

It is in the interests of all stakeholders to have regulatory mechanisms that hold public confidence. As noted earlier, regulatory systems vary substantially across industries and countries. Even so, the characteristics of good regulatory governance are increasingly being recognised as: clarity, predictability, autonomy, accountability, participation, and open access to information. Each of these factors aids in making a regulatory system transparent in the eyes of stakeholders, and enhancing the outcomes.

Worldwide regulatory practices already espouse the transparency principle. Almost all regulators now maintain open Web sites and publish annual reports with information about the regulator, the regulated persons or entities, and the regulatory decisions made in each year.

In his landmark review of legal services Sir David Clementi formed the view that for effective regulation and public confidence it was desirable for some regulatory functions to be carried out by bodies that are wholly separate from the professional associations or service providers. The chief of these externalised functions are client complaints, disciplinary matters and the setting of practice rules. I agree with these views.

In this respect, when considering the management of complaints, there is a consistent opinion that they should be handled independently of a profession to properly command public support. To serve the public interest, the complaints body also needs to have a substantial non-professional membership.

Furthermore, it was Clementi’s view that clients should have access to a single point of contact (one-stop-shop approach) and not be expected to navigate a complex series of complaint processes, thus simplifying the process and making it easier for the user/patient. This principle has been a key factor in establishing the Queensland Health Ombudsman.

Articulation of these principles shows the improbability of providing comparable provisions that ensure rigour and independence within any regulatory system that is primarily composed of either employers or practitioners. If the same or equivalent regulatory functions are to be performed then the costs will be comparable but the benefits of scale and consolidation will be lost.

Regulatory systems and complaint mechanisms are needed that meet community expectations of engagement and user-focus, rather than systems that are primarily profession or service-focused. The public interest in the fairness and transparency of the regulatory process also demands that there be meaningful lay representation.

The determination of statutory regulation in this context is not simply a matter of cost but one also of consequences. To be acceptable, the needs of consumers and the public interest must be at the heart of any regulatory system - as exemplified by AHPRA.

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15 Lorenzo Bertolini, *How to improve regulatory transparency, Emerging lessons from an international assessment*, GRIDLINES, Note No. 11 – JUNE 2006

16 Review of the Regulatory Framework for Legal Services in England and Wales Final Report
  Sir David Clementi, December 2004

17 The Future of Legal Services: Putting Consumers First, Response of the Legal Aid Practitioners Group, January 2006 (response to White Paper on reform of the legal services sector October 2005)
  [http://www.lapg.co.uk/docs/LAPG%20response.pdf](http://www.lapg.co.uk/docs/LAPG%20response.pdf)

Identifying the public interest

One of the key issues to be resolved in regulation is the identification and assessment of the public interest. In an insightful study carried out for the Health Professions Regulatory Advisory Council (HPRAC),\textsuperscript{19} the “public interest” was explored in depth, with the outcome being the view that it is best promoted by adherence to the six fundamental objectives that underpin the Regulated Health Professions Act (RHPA).\textsuperscript{20} These objectives and their associated criteria identified by the study are paraphrased below:

<table>
<thead>
<tr>
<th>Criterion #1 - Protection from harm</th>
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<td>The RHPA embodies the protection from harm principle through a number of key provisions and mechanisms such as the harm clause (section 30), the scope of practice regime (including the scope of practice statements for each profession, the controlled acts, the authorised acts and title protection) and the various regulations made under the RHPA.</td>
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<tr>
<th>Criterion #2 - Quality care</th>
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<td>The RHPA attempts to ensure that the care provided by individual regulated health care professions is of high quality and that the standard of care provided by each regulated health professional is maintained or improved. This can be seen in numerous provisions such as: entry to practice requirements, competency reviews, patient relations programs and Quality Assurance Committees in the governing regulatory Colleges.</td>
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In addition, Colleges have the authority to make Codes of Ethics for their members, to make regulations about standards of practice and to define “professional misconduct”.

No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious harm may result from the treatment or advice or from an omission from them.

<table>
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<th>Criterion #3 - Accountability</th>
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<td>Under the RHPA, regulated health professionals are accountable to their patients/clients, Colleges and the public. This accountability is promoted through various provisions such as: the complaints and discipline process, the public’s access to information on the register, patient relations programs and the public/professional composition of College Councils.</td>
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<th>Criterion #4 - Accessibility</th>
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<td>Another public interest objective of the RHPA is that individuals have access to services provided by the health professions of their choice. Further, the notion of accessibility includes not only access to health professions, but also to the regulatory system as a whole.</td>
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<th>Criterion #5 - Equity</th>
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<td>The principle of equity embraces the concept of procedural fairness as well as equalisation of benefits or outcomes. The intent of the RHPA was to ensure that all individuals are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board. The notion of procedural fairness can be seen in the RHPA by the provisions for the right to notice and submissions before Committees as well as all procedural and evidential rights under the Health Professions Procedural Code and the</td>
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\textsuperscript{20} \url{http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm}
Statutory Powers Procedure Act.

**Criterion #6 - Equality**

Equality of regulatory obligations among health care professions is considered to be in the public interest. The legislative objective of equality is achieved through the application of a common regulatory framework to all health professions, despite their differences in scope of practice or their overlapping scopes of practice. The RHPA treats all regulated health professions the same and obliges all governing Colleges to adhere to the same corporate structure, purposes and procedures.

The general tenor of these findings provides suitable guidance and a framework for determining the rigour and underlying principles of regulation that is in the public interest and which is universally applicable. They provide a framework for responding to many of the Questions in the consultation paper.

These principles are replicated in various ways through the National Law, albeit independent legislation applies in each jurisdiction. From the context of the above discussion and the observations of the independent reviewer in the consultation paper it is clear that I strongly support the introduction of the National Scheme as fulfilling the primary goals of regulation in enhancing the safety and wellbeing of the public. I also acknowledge that improvements may always be feasible.

**Detailed Responses to the Consultation Paper**

The questions posed by the Independent Reviewer are addressed in greater or lesser detail in the following sections. Citations and cross-references are limited for brevity.

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

2. **Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?**

   An on-going national assessment of the efficacy of the NRAS and the operations of AHPRA is supported. This may be provided by a body such as the The Australian Health Workforce Advisory Council (AHWAC) as suggested by the Reviewer.

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.**

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.**

   The regulatory structures should reflect the level of risk and the potential consequences of harm. The various functions of regulation embody fundamental activities that must not be compromised. These include such matters as the mechanisms to achieve transparency and procedures to ensure investigative integrity, due process and natural justice.

   These functions are not something to be dismissed on the basis of numbers and unit cost but must be retained for every discrete professional calling. While individual case costs...
may vary widely depending on the particular circumstances, to achieve equivalent levels of investigative rigour and decision-making will require essentially the same levels of cost regardless of the profession.

The low regulatory load professions do not stand alone. All professions would benefit from measures that ensured optimum regulatory performance. What will help to reduce costs is the aggregation of cases and precedents and sharing of data so different Boards may benefit from related cases – in a legal and practice sense.

On that basis and from other considerations, a single Board for the nine professions is not supported in part because it does not recognise the unique features of individual professional practice. Whatever options are adopted to minimise individual costs, particular care must be taken to preserve the capacity of all professions to provide meaningful input to the regulatory processes.

As another option I support the exploration of potential 'blended' Boards through aggregation of a number of the more closely aligned professional groups into two or more cohesive units. This would be a considered decision based on affinity of interest rather than regulatory load.

As a corollary I strongly support the sharing of other regulatory functions across all boards as feasible. Examples of this might be various forensic activities, legal functions and financial operations. Regardless of the ‘front-end’ operations of all Boards, AHPRA should explore combining back-office operations and cost sharing across all Boards.

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

Savings achieved through various operational economies should be returned to registrants through lower fees once appropriate sinking funds have been established to allow for contingent liabilities. Long term, the operation of the NRAS should be self-supporting and not profit-making, and the fee structures should reflect that principle.

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?**

Yes – with the caveat that the threshold may be a complex weighted assessment and all costs and benefits must be considered including the marginal costs taking into account existing embedded regulatory costs.

In 1992 Australian Health Ministers agreed that mutual recognition was an important step towards agreed national standards for health occupations. In concert with mutual recognition principles, Health Ministers agreed in 1993 that no further action would be taken to regulate any additional health occupations unless the need for doing so had been agreed by the Australian Health Ministers Conference (via the Australian Health Ministers Advisory Council (AHMAC)).

Among the implications of the 1992 Mutual Recognition Agreement and the subsequent enabling legislation, is that by default, the minimum standard of education set by one jurisdiction for registration automatically becomes the standard for registration in all other jurisdictions.
In April 1993, AHMAC established a Working Group to provide advice on the procedures for the assessment of statutory regulation of (then) partially regulated and unregulated health occupations. The outcome of that process\(^{21}\) was the formulation of six criteria for regulatory assessment. These constitute the so-called 1995 AHMAC criteria for assessing the regulatory requirements of unregulated health occupations.

These criteria still hold, and it is notable that in approaching the issue of registering a new profession, the New Zealand Ministry of Health decided to adopt similar principles\(^{22, 23}\) as the United Kingdom, Ontario and Australia in considering applications from professions seeking regulation. The Ministry expressed the view that there was a need to be ‘explicit about the criteria that will be used to advise the Minister as to whether regulation is justified’.

A key trigger for regulatory intervention is the potential for significant harm to the consumer which compounded by the interrelationship between the public interest and the perceptions of risk to public health and safety. The harm criterion also contains elements of a ‘chicken and egg’ conundrum in that the risk of harm may be a consequence of a lack of regulation.

Numerous research studies have shown how perceptions of risk may be skewed and vary with circumstances - with some difficulty being experienced in developing acceptable and objective measures of risk. What this means is that while this criterion is appropriate in principle, it must be interpreted in context.

Nearly all occupations have the capacity to cause some harm, but given the costs of compliance, intervention may be reasonably limited to cases where the harm has the potential to be significant. The New Zealand Policy Framework for Occupational Regulation\(^{24}\) provides useful guidance in this respect.

Significant harm is defined as significant harm to one person or moderate harm to a large number. Moderate harm to a large number might arise from one event or from the aggregated actions of different providers of a service. Significant harm that is irreversible (such as permanent disability) is more likely to justify intervention than reversible harm.

The case for involvement in regulating an occupation is thus subject to a degree of interpretation by public policy makers. Concepts such as “significant harm” cannot be defined with precision and may mean different things under different circumstances.

For this reason the determination of significant risk need to be applied in the light of the particular circumstances relating to an occupation. Harm takes many forms and may involve less obvious mental harm as well as physical harm. Because of the interplay between harm and the public interest, the AHMAC Criteria must be applied sensitively.

The interplay between risk and harm in determining the likelihood of regulatory intervention is also shown graphically below (taken from the Policy Framework for Occupational Regulation).

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**Risk Assessment Model to Determine Regulatory Intervention**

By way of example, the clinical activities of currently unregistered paramedics are aimed at preserving life, preventing illness or injury and promoting patient recovery. Like in many medical practices, the work varies from low to high risk where the interventions, based on clinical indications, clearly pose a serious risk of harm to the health and safety of the patient.

Paramedics must make time critical decisions about the immediate administration of restricted, powerful and potentially dangerous drugs. The responsibility for the administration of these drugs in an emergency situation may well rest solely with the paramedic.

Paramedic practice also comprises a range of physically invasive procedures that involve varying degrees of risk to the patient. The highest risk procedures such as sedation, paralysis, endotracheal intubation and artificial ventilation are known to have potentially fatal consequences if the paramedic’s clinical judgment is in error or through poor execution of the procedure. However, like medical practitioners, there is a great deal of patient care involving lower levels of risk.

Paramedic practice thus has a combination of many lower or moderate risk activities and a substantial number of high risk activities. The important factor is that these cumulatively give rise to what must be assessed objectively as representing ‘significant risk’ to the public.

When determining the threshold of risk for entry to the NRAS similar (relevant) risk assessments should be applied for all professions seeking regulation. Moreover, while the risks may be clear-cut for some like medical practitioners, nurses and paramedics, other areas involving (say) preventive health and mental health may have less obvious but equally valid ramifications and will need careful and sensitive treatment. Physical harm is not the only risk to be considered.
7. Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?

The intent of the National Law is to regulate those professions where the threshold of public risk is met and there are demonstrated advantages in having statutory regulation. That may exclude many professions where lower levels of risks are present.

Various proposals have been advanced for their regulation and the regulation of unregistered health workers is currently the subject of other developments involving a National Code of Conduct. This might call on other mechanisms such as self-regulation to perform some of the regulatory functions outlined by Clementi and others. This approach would be consistent with the intent of AHCAC Criterion No 2.

One of the difficulties is the assessment of regulatory rigour and independence in defining the adequacy of public protection. There is a need to approach the issue not just as an alternative mode but from the perspective of mechanisms that: ‘appropriately address regulation in a transparent and comprehensive manner’.

In this regard, the regulatory proposals articulated by Sir David Clementi are instructive and he outlined the primary functions of regulation as:

- setting minimum entry standards and training;
- formulating professional roles to which individuals are expected to adhere;
- monitoring the individuals providing services;
- enforcing professional roles where necessary;
- implementing a complaints procedure; and
- implementing a disciplinary procedure for individuals who are negligent or breach the professional roles of practice.

To be acceptable, other means of regulation must be able to demonstrate that the profession or the alternative mechanism can fulfil all these functional roles through the combination of suitable educational pathways, continuing education, and other professional activities.

In some professions statutory regulation and self-regulation mechanisms may not be present and the determination of need is clear cut.

In other cases, however, processes of self audit and clinical review may be present but not robust, or may focus on aspects of performance that are primarily designed for the purposes of clinical reporting at the macro level, rather than key performance indicators based on the execution by the practitioner of the professional practice itself.

In other circumstances (especially for employed professionals) the focus may be inappropriate and create tensions between the exercise of clinical judgement and restrictive controls driven by an ‘employer bias’. The financial implications to the employer arising from regulatory issues may create an environment of moral risk leading to tensions between the clinical indications and operational demands. Employer regulatory controls in such circumstances again would not be desirable.

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Employer-driven regulation for example, tends to create a situation of restricted practitioner mobility and economic thraldom which is effectively a restriction of trade and not in the public interest. Again using paramedics as an example in Australia there is currently no national registration framework for a paramedic. Thus, if a practitioner chooses to leave their employment with a statutory emergency service provider, they effectively lose the right to practice their chosen profession regardless of their fitness-to-practice. This is not in the public interest nor does it facilitate mobility.

Employer-based regulation thus carries a heady mix of moral risk, conflict of interest, and raises concerns with the principles of due process and natural justice, making it inappropriate for an employing body to serve also as the professional regulatory authority body that can determine an individual's right to clinical practice (if otherwise competent).

Another option that might arise is for cross regulation by other groups of registered practitioners to supervise the activities of a profession. Similar issues apply as for employer groups. Short of being present and holding the hands of a practitioner, and providing direct guidance in decision-making, such a model holds no discernible advantage. It will still be the knowledge and skill of the practitioner that determines the outcome of any intervention or procedure. A better solution might be the use of a 'blended' regulatory Board or authority catering for more than one profession to optimise the use of scarce human and financial resources, but not the concept of ‘in loco parentis’ when dealing with professional regulation.

Thus it is not enough to demonstrate the existence of an alternative regulatory mechanism but that these mechanisms show their suitability for the purpose consistent with the level of risk exposure. Suitable sharing of regulatory responsibility between educationalists, practicing professionals and employers, and public engagement through lay participation with potentially an independent lay Chairperson are among the measures that would be necessary to meet the criterion of an appropriate alternative regulatory mode.

Regardless of the particular professional field, if these conditions of multipartite engagement and objectivity are not met, then the alternative regulatory mechanisms fail to meet the test of appropriate independence and no recognition should be provided under the national Law. A hierarchy of justification should apply and health professionals whose procedures or interventions hold particularly significant risks should be automatically subject to statutory and proactive regulation. Maintaining responsibility for professional standards and regulation of higher risk professionals via the NRAS therefore remains the preferred mode of regulation to protect the public.

8. Should 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

No response is offered in the absence of further details on the form of such a Council and its (revised) powers. Suffice to say that the body providing advice should be structured to ensure innovative approaches that take account of changing workforce practices and technology across both existing and emerging disciplines.

For example one should reject the proposition that a profession must satisfy a number of invasive procedures or clinical interventions with the potential for harm. There is risk in making autonomous decisions or exercising judgement which can substantially impact on patient health or welfare that may amply meet the threshold level of risk.
Discussions about healthcare are often bedevilled by a clinical and interventionist philosophy without due recognition of the holistic nature of healthcare. Many procedures and professional endeavours in health may be diagnostic and preventive in their application with equal or greater impact on long term patient health without involving invasive procedures or direct clinical interventions.

Risk is also relative and situational. For example, intubation of a trauma victim by a paramedic operating under emergency conditions in the field with adverse weather and lighting conditions is demonstrably higher risk than a similar procedure carried out by a registered medical practitioner under controlled clinical conditions in a hospital. Both procedures are clinically significant and qualify as risky interventions, but one carries substantially higher risk and requires a high order of judgement in its application.

Given that regulation applies to the practitioner and not to the procedure, it is suggested that the hierarchy of justification should be based principally on the need to exercise judgement in a clinical context. As a corollary, the extent to which the practice of the profession involves riskier activities may well be used to determine the urgency for regulatory action or raise the level of significant response.

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

The consultation paper indicates that the current complaints and notification provisions may lead to confusion. Some professions have also been vocal in their criticism about the procedures, but to what extent that is a tactic to blunt the operation of the National Scheme, a hangover from the past systems or represents real deficiencies in the processes is not known to the author.

My personal experience in law enforcement and corruption investigations in Australia and Hong Kong has shown that many people are unaware of the rigour required for investigating cases that meet no more than the ‘balance of probability’ test much less higher order criminal investigations.

It is also feasible that during the formative years of AHPRA some of these investigative standards were not well known or applied. The registration of over 600,000 health practitioners across 14 professions in multiple jurisdictions and in the space of a few years is a massive achievement and it is to the credit of AHPRA that it has been accomplished so well. Most critics of AHPRA may never have had to mobilise the resources and systems needed to achieve that performance ab initio.

A national scheme of regulation should provide clear pathways for consumers and practitioners to bring matters of concern to the attention of the appropriate authorities. An effective complaints and notifications process will be simple to navigate, transparent, consistent and facilitate timely resolutions.

The practical difficulties in achieving these goals are shown by the need for integrity bodies like the NSW Independent Commission Against Corruption and Queensland Crime and Corruption Commission to issue comprehensive guidelines on complaints management and investigative procedures.26

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Matters such as the distinction between a ‘complaint’ and a ‘notification’ are not well understood by the public. They are generally ignorant of the different pathways to resolution for complaints and notifications, the relevant bodies that handle these cases and the rights and obligations of complainants and notifiers.

The current lack of consistency across jurisdictions adds confusion, with Co-regulatory bodies operating in some states (New South Wales, Queensland), and exemptions offered in other states in certain circumstances (Western Australia and Queensland provide exemptions to the requirement for mandatory notifications if the subject is receiving treatment). This differential treatment is undesirable and detracts from the consistency that should apply under a National Scheme.

As a basic principle the National Scheme should embody consistent provisions with regard to the complaints and notifications process in every jurisdiction. In addition AHPRA should prepare and disseminate suitable guidelines for the management of complaints and notifications under the National Law.

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

Some of the claimed benefits of a co-regulatory and single entry approach are provided by the Queensland Health Ombudsman27 and in the following webcast: http://webcast.achsm.org.au/Mediasite/Play/bb756483192c40cc806707ffcc4203c041d

One of the benefits of a national regulatory scheme is to ensure consistency and minimum standards of fitness to practice. It is equally important that the response to complaints and notifications be undertaken in a consistent manner across jurisdictions for each profession.

To the extent possible, common problems should result in comparable outcomes across jurisdictions. A co-regulatory approach in only some jurisdictions could distort the outcomes and thus common approaches are supported across all jurisdictions.

| 11. Should there be a single entry point for complaints and notifications in each State and Territory? |

A single entry point for complaints and notifications is strongly supported, as it would provide a clear procedure that is user-friendly and remove the onus placed on consumers to know where and how to lodge a complaint or notification. That approach is also consistent with the Clementi findings and from my practical experience in the best ways of handling corruption, fraud and misconduct complaints and cross-jurisdictional handling of major crime involving multiple law enforcement agencies.

A single entry point would facilitate the lodgement process, minimise stress on the complainant, provide initial assessment of the issues and streamline the process by determining the most appropriate pathway for handling a complaint or notification.

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

Timeliness is a vital feature of any well-functioning complaints system. Delays in the resolution of cases raises registrant and public concerns and diminishes trust in the regulatory system. Unreasonable delay has been advanced as one reason for the Queensland co-regulatory arrangements. Measure to resolve matters in a timely fashion would improve the real and perceived performance of the National Scheme.

AHPRA is currently investigating the reasons for National Boards failing to meet key performance indicators and one expects it will identify and implement remedial measures to improve performance.

The adoption of prescribed timeframes along with performance pledges has been found useful in developing responsive and efficient organisations in other complaint management environments and there is no reason to think that a similar disciplined approach would not work in this case.

However, the performance targets must be practical and reasonable as (from direct experience) the investigation and resolution of issues can be very time consuming. Effective consultation with National Boards therefore should be undertaken on the setting of realistic and achievable targets.

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?

As outlined under the earlier regulatory principles section, transparency is essential for good regulation. The lack of transparency in investigative terms and in reporting outcomes is among the factors that I have found gravely detracts from the integrity of regulation of the currently unregistered paramedic workforce. Lack of transparency also is among the well-accepted facilitators of fraud and corruption, nepotism, bullying and harassment.

Regulators everywhere face the challenge of building the demand, awareness, and capacity of professionals, consumers and other stakeholders to participate effectively in the regulatory process. One benefit of statutory registration is the aggregation of resources together with public perceptions and acceptance of the regulatory role of government through accessible websites and other communication channels.

Clear procedures, established processes and good documentation supported by effective hard copy and on-line communications provide some of the key elements to achieving transparency. Process flowcharts, clearly written plain English notices and forms and performance pledges all contribute to the information mix that will achieve transparency by providing sufficient information to understand the steps in the process and set the expectations of all parties.

To achieve the required level of transparency, an operational review might suffice to assess the internal and external communications systems and identify potential areas of improvement. This might consider various patient and practitioner relations programs.
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?

Alternative Dispute Resolution or ADR normally refers to the non-judicial resolution of issues where an impartial person assists those in a dispute to resolve the issues between them. It may take various forms and can be used to resolve issues of considerable complexity and indeterminate value. ADR involves a facilitative process in engaging the parties to a dispute and clarifying the issues in the expectation that the parties can reach an agreement in settlement. The potential benefits of ADR include the avoidance of an adversarial legal case, speedy resolution and lower costs.

Among the various modes of ADR are Arbitration, Mediation, Conciliation and Advisory Services, each of which has particular attributes and advantages in resolving a dispute and advising the parties about the range of possible outcomes.

Provided the practices conformed to recognised procedural principles such as those I am familiar with from the Hong Kong International Arbitration Centre28 or The Institute of Arbitrators & Mediators Australia29 the resolution should be fair regardless of the complexity of the case. Among these principles is agreement by all parties to proceed to ADR in good faith.

ADR is a recognised mechanism for the resolution of issues and its use is supported as an appropriate means of (potentially) speedy resolution of many issues.

Since there is currently no comprehensive or uniform legislative framework for ADR in Australia it would be necessary for AHPRA to establish which of several potential models of ADR would govern its operation and under what circumstances it might be employed.

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

It may be appropriate for an adverse finding and the associated intervention(s) recorded against a practitioner to remain on record indefinitely. The presence of an adverse finding is unlikely to have any long term damage provided it is clear that the issue had been appropriately addressed.

The benefit of this policy would be to demonstrate that the practitioner had been the subject of remedial intervention(s) and thereby obviate any potential for blackmail or prevent any denigration of the practitioner through rumour and innuendo.

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

Controls on advertising by health professionals may be justified on the grounds of protecting the public from false and misleading information. These controls may cover not only internet websites but also various Social Media channels.

28 http://www.hkiac.org/en/
Social Media poses particular problems because of its immediacy and interactive nature and the degree to which users express personal views in public. This has led to claims of inappropriate use including the issue of testimonials.

It is unreasonable for a health practitioner to monitor and respond (or not) to the myriad of messages posted on Social Media platforms such as Facebook and Twitter alone, much less the other channels.

It is ironic that Social Media is one of the burgeoning means of engaging people and providing transparency yet also poses risks for practitioners across several areas including confidentiality and potentially unprofessional conduct.

No particular advice is provided other than to continue to explore the available options that might enable fair comment without being classified as being testimonials.

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

Consistency across all States and Territories is a key feature of an effective National Scheme and independent approaches to matters such as protected practices are detrimental to achieving the objectives underpinning the National Scheme.

Every effort should be made to avoid such anomalies through advance notice of concerns and effective consultation between all affected stakeholders.

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 introduction of a National Code of Conduct for unregistered health workers is supported. On the basis of available information it should suffice for lower risk and lower acuity purposes by specifying minimum professional standards and enforcement measures. These measures should achieve national consistency in interim prohibition orders, preferably with a single national register, common grounds for issuing prohibition orders and comparable penalties for breach of a prohibition order.

No observations are made in relation to the impact of the National Code on the application of the National Law other than the desirability of holding regular joint meetings or seminars and the exchange of appropriate data between the two systems to share experiences and discuss developing regulatory issues.

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

It is in the public interest for a National Scheme to provide as much consistency across jurisdictions as possible. However under the federal system of government the different jurisdictions have the power to make different laws. This has often proved an impediment to change and carries economic costs.
Treating practitioners in Western Australia and Queensland differently through the provision of exemptions not available elsewhere is considered contrary to best practice and is not supported. The mandatory notification provisions are supported.

Given the conflict between these two positions it is recommended that other options be explored with a view to having some mandatory reporting provisions of suitable strength in all jurisdictions.

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?

No specific comment is offered, as the evidence base held is inadequate and the time scale too short to establish long term trends.

As outlined in this submission (p 6) the objectives and guiding principles set out in the IGA and Section 3 of the National Law and my considered assessment is that the operations of AHPRA and the various regulatory Boards under the NRAS well fulfil the primary functions of appropriate regulation.

The issues raised go beyond regulation and into the realms of workforce innovation and reform in the health and wellness sector. That having been raised, considerable concern is held that the demise of Health Workforce Australia\(^ {30}\) will have an adverse impact on health workforce innovation across all these areas.

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

Yes.

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?

No specific comment is offered, as the evidence base held is inadequate.

23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

A strong relationship between regulators and educational institutions would be beneficial in maintaining currency with contemporary practice, technological advances and evidence-based research.

\(^ {30}\) https://www.hwa.gov.au/
Other aspects include a need to maintain a close understanding of supply and demand through industry and academic links as well as association with health workforce bodies or units.

Independent accreditation of educational programs is important and should continue with the accrediting body independent of employer and professional groupings.

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

No specific comment is offered, as the evidence base held is inadequate. The provision of a National Scheme for registration is supported however, as the best way to provide a one stop shop for the assessment of overseas trained professionals.

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**Glossary**

The following abbreviations are used in this submission.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADR</td>
<td>Alternative Dispute resolution</td>
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<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
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<tr>
<td>AHMAC</td>
<td>Australian Health Ministers Advisory Council</td>
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<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>HPCAA</td>
<td>Health Professions Competency Assurance Act 2003 (NZ)</td>
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<tr>
<td>IGA</td>
<td>Intergovernmental Agreement</td>
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<tr>
<td>NRAS</td>
<td>National Registration and Accreditation Scheme</td>
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<tr>
<td>RHPA</td>
<td>Regulated Health Professions Act (Ontario)</td>
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<td>UK</td>
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