Q1: Should the Australian Health Workforce Advisory Council (AHWAC) be reconstituted to provide independent reporting on the operation of the National Scheme?
Yes, I agree as the AHWAC was developed for this purpose therefore should be reconvened or an alternative independent council that ensures a national approach to reporting against agreed performance measures. It is important that there is transparency in this process that avoids local jurisdictional issues taking precedence.

Q2: Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?
This would seem reasonable if the AHWAC were reconstituted as an independent body as suggested in answer to the previous question. It is important that there is a separate to ensure that midwifery specific professional issues are appropriately addressed.

Q3: 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.
There are possibly differences in each profession, however, it is possible to establish this single Board. Midwifery could be included in this Board rather than under a Nursing Board

Q4: 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 per annum.
This is a sensible option, cost wise, whilst maintaining the separate identities of the professions

Q5: Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?
The savings achieved should be put back into the increasing workload of AHPRA staff, appropriate reimbursement for Board members and Panel members. Funding could also be then available to create a Midwifery Board.

Q6: 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.

Q7: Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?
Yes. The Australian College of Midwives should be the organisation to address prescribing and ordering test for midwives. The term ‘eligible’ midwives should be abandoned. Midwives could be
endorsed to prescribe once an accredited course has been completed. They do not need a title of ‘eligible’.

Q8: 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

Q9: What changes are required to improve the existing complaints and notifications system under the National Scheme?

Midwives have been disadvantaged by being under and Nursing and Midwifery Board, without adequate representation of midwives on the Board. This does vary between different jurisdictions. Complaints and notifications should be undertaken by the profession and also community members, some with recent experience as a consumer in that profession.

Q10: Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?

Not sure.

Q11: Should there be a single entry point for complaints and notifications in each State and Territory?

Yes

Q12: Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

There should be consistency.

Q13: 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?

There needs to be more transparency, particularly for notifiers. Often in relation to outcomes it is reported in the media and therefore often a biased account.

Q14: 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?

I am not sure, I would agree there needs to be some flexibility, however, consistency between jurisdiction also needs to occur and this may not happen in this case.

Q15: At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

This should be an individual decision. There are a number of variables, such as, if it is a criminal act or a health issue. It should not be disadvantaging to the practitioner once the matter is settled, however, there is the matter of public safety.
Q16: Are the legislative provisions on advertising working effectively or do they require change?

It is important that there are changes in relation to social media advertising. Any legislation changes need to be clear and well circulated to both the professions and the public.

Q17: How should the National Scheme respond to differences in States and Territories in protected practices?

There have been an issue is SA that the determination only covered labour and birthing and not antenatal and postnatal care. Also as this was SA Govt decision, it was not adopted by other states and the particular person has been able to continue her performance at births interstate, again, unprofessionally even though her registration was cancelled and with catastrophic outcomes.

Q18: 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?

Yes, particularly in relation to health practitioners who may have their registration suspended or lapsed and are practising as carers. It is an issue of public safety.

Q19: 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?

Not sure

Q20: 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?

When addressing midwifery, this is not occurring adequately. Midwifery is not always understood in relation to its scope of practice, and decision can be made that are not responsive to the workforce, particularly for midwives in private practice.

Q21: Should a reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?

yes

Q22: 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?
Q23: What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

ANMAC works closely with the NMBA to ensure that minimum requirements for entry to the professions are maintained. There are separate accreditation committees for nursing and midwifery that work well, recognising the need for members to be cognisant of contemporary practice, education and research.

Q24: How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

Not very effective, inconsistencies between jurisdictions. More communication required for overseas trained practitioners.

Q25: Should the appointment of Chairperson of a National Board be on the basis of merit?

Yes, definitely

Q26: 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 there is an effective division of role and function of the two.

Q27: Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?

Yes there is sufficient oversight.

Q28: The Review seeks comment on the proposed amendments to the National Law. Protected title changes

Midwife Practitioner is not used in midwifery, it is a tortology. Midwives do not have the same ‘advanced practice’ as nurse practitioners. A midwife does the same role on graduation regardless of the years post registration. There is a novice to expert aspect, however, the role is the same.

Current use is ‘eligible midwife’ – however, this is an aspect of contention, as in NZ all midwives can prescribe on graduation. We do need education programs for registered midwives to meet the criteria to prescribe and order test (so they are endorsed by regulation), however, the title of ‘eligible’ should be abandoned.