Review of the National Registration & Accreditation Scheme for health professions

Submission by:
CRANApplus the professional body for remote and isolated health professionals

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INTRODUCTION

The National Registration and Accreditation Scheme (the National Scheme) for the health professions was implemented in 2010 and has created a more robust system with greater flexibility for the transient health workforce to provide services across the Australian context.

The National Scheme's key objectives are:

1. Protection of public safety
2. Facilitation of workforce mobility
3. Facilitation of high-quality education and training
4. Facilitation of assessment of overseas-trained health practitioners
5. Promotion of access to health services
6. Development of a flexible, responsive and sustainable workforce

CRANApplus

CRANApplus is the peak professional body for remote & isolated health professionals. We provide advice to Government, service providers, clinicians, and consumers on equitable access to safe high quality health services.

CRANApplus believes remoteness to be a complex subjective state, and the following factors should be considered:

• **Geography and terrain** limiting access & egress: mountainous terrains and islands can result in isolation from resources and limit access but still be within an area designated through the classification system as non remote e.g. Bruny Island (TAS).

• Being **socially & culturally isolated**: where living and working in a cultural different to your own / or where social networks are limited or different to your usual supports and networks.

• **Environmental & weather conditions** resulting in isolation: natural disasters such as flooding or inclement weather like snow and storms, result of other natural disasters.

• Isolation due to **vast distances** as per the remoteness classifications, distance and the time to access services can vary due to the mode of transport or the quality of the roads.

• **Setting for practice**: such as operating in the aeromedical environment where altitude is the isolation factor along with limited resources, or where security procedures is an isolating factor e.g. prisons.
• Being isolated from **professional peers and supports**, this includes health professionals working in non-health organisations e.g. detention centre’s, tourism, mining, industry.

• Isolation as a result of **infrastructure, communications, security** processes that limit access e.g. Defence forces, International development (AID workers). Unreliability of communication systems and referral pathways.

**CRANAplus believes** Remote health professionals are an integral part of the health care system in Australia and are specialist practitioners who provide and/or coordinate a range of health care services for a diversity of population groups. Remote health professionals are guided by ‘health’ as a whole-of-life concept, encompassing physical, spiritual and emotional well-being of individuals, family, community and the environment.

**CRANAplus stresses** that remoteness, in and of itself, is a social determinant of health.

**RESPONSES TO SPECIFIC QUESTIONS**

**Q1: Should the Australian Health Workforce Advisory Council (AHWAC) be reconstituted to provide independent reporting on the operation of the National Scheme?**

Yes - although caution should be applied regarding the composition and the governance of a new AHWAC to ensure it is not influenced by Federal or State political pressures, or any one powerful professional group.

**Q2: Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?**

Although this group may be one source of information and advice, **CRANAplus** fails to see how it would be adequately inclusive to ensure all professional disciplines, let alone specialist areas of interest, are reflected.

**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.**

No - In maintaining separate Boards there is a degree of assured understanding through appropriate expert representation, that have greater capacity in understanding the professional practice and thus public protection from a fully informed view.

In addition CRANAplus supports the creation of a Midwifery Board to separate the professions of Nursing & Midwifery).
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.

Yes - this appears to be a sensible approach to ensure the financial burden associated with regulation is minimized.

Q5: Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?

Assuming there is some logical consistency regarding the fees paid by each of the 9 disciplines, CRANApulse believes any savings should be re-invested in the broader objectives of AHPRA.

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?

CRANApulse does not have a strong view, however the economies of scale and the implementation of consistent standards across the entire health sector with one regulator (AHPRA) appears logical.

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?

CRANApulse supports option 1.

It is also imperative that the complaints processes are speedily investigated with the feedback to the complainant and the respondent greatly improved. It is imperative that an investigation includes not only professional peers of the same discipline but also peers within the same context of care.
For example: Remote Area Nurses practice in a specialist area with a complex scope of practice that is influenced by need, cultural pressures and clinical protocols. A panel of non-remote area nurses cannot appropriately review the performance of such a RANs practice. Thus it is important that the Regulator seeks appropriate professional, independent expertise, which can assess context of practice and scope of practice.

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

Due to the recent formation of this system, a more thorough assessment of the impact is required.

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?

Yes

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?

Transparency regarding process should not be public as this can have significant ramifications for the safety of practitioners working in small, isolated and culturally diverse communities. The outcomes of notifications should remain publically accessible through the AHPRA website.

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?

Yes – this will allow greater and quicker resolution of simpler issues that pose less of a threat to the general public, and will allow for greater involvement of the specialist areas of practice to be involved with professional regulation. This also will allow for greater investigation of the nature and motivation of the complaint, whilst still meeting the requirements of public safety and managing risk to patients.
Q15: At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

This should be determined at the time of the decision regarding the intervention, as it will be those investigators who can best assess the duration need.

Q16: Are the legislative provisions on advertising working effectively or do they require change?

Considering the ‘on-line’ and ‘connected’ world, CRANApplus believes that Option 3 should be further investigated and the bans removed altogether to promote a more health literate and engaged general public.

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

State and Territory based protected practices are contrary to the broader intent of the national scheme and should be openly and publicly discouraged, with preference to a national solution to challenges faced in specific areas of practice.

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?

No – however CRANApplus strongly supports the further development and implementation of a national code for unregistered health workers.

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?

Yes – Regardless of the outcome it should be nationally consistent. CRANApplus also supports flexibility for the treating clinician to make a choice (to which they are held accountable) regarding notification based on the assessment of risk to their client, and the risk posed by their client to the general public (following each episode of care).
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?

Unfortunately CRANAplus’ experience with the Rural & Remote Nursing Endorsement for Scheduled Medicines was problematic due to numerous delays and lack of capacity of the Nursing Board. This has and continues to place barriers in access to healthcare for the public living in remote and isolated areas of the country, as their most likely care provider is a nurse, who is unlikely to have access to obtain the endorsement (as educational preparation standards have not been implemented).

In addition the requirements for re-entry to the workforce for both Nurses and Midwives is restrictive, inflexible and not catering to the individual differences in circumstances. The process used for medical proceduralists takes into account each individual’s past career and experience.

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

Assuming that it is truly multi-disciplinary, reflective of the variety of contexts of practice and non-political, a new AHWAC could provide the advice as suggested. Health workforce planning and data gathering is a significant body of work and internal infrastructure similar to the previous HWA may need to be allocated.

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?

Although much work appears to have been undertaken (i.e. ANMAC reviews of accreditation standards), the gross inequities between professions and the level of financial supports provided prevent true integration and an uneasy imbalance. This requires concerted action to create fertile ground for improved multi-disciplinary education and improved models of care.
Q23: What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

Although they should remain independent from each other, they should fit like ‘hand in glove.’

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

CRANApplus is aware of issues with the implementation of the process for the overseas trained practitioner, and this should be resolved. However the standards need to remain high, especially considering many are encouraged to work in rural and remote areas where the burden of disease is higher, access to supervision is more difficult and a well functioning empowered multi-disciplinary team is paramount.

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

Yes – this also includes exposure and experience within the discipline, but also skills in governance and leadership.

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 – as mentioned earlier, CRANApplus supports the independence from each other of the Board and the accrediting authorities.

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

Yes

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

CRANApplus sees no issues’ with the amendments as described in the consultation paper.
SUMMARY

CRANAplus welcomes the opportunity to contribute to this review from the perspective of a ‘context of practice’ rather than from any one specific discipline. Regardless CRANAplus strongly encourages the reviewers to undertake close attention to the comments and views expressed by the discipline specific professional bodies, the engagement and acceptance of clinicians is essential to the development of good public policy.

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