Submission to the Independent Review of the National Registration and Accreditation Scheme for Health Professionals

October 2014
Guiding Principles

The Consumers Health Forum of Australia (CHF) supports the continuation of the National registration and Accreditation Scheme for health professionals in its current form, as a decentralised entity across jurisdictions. However, it is concerned that the current direction of the Scheme could put at risk the focus on national consistency – which was the point of establishing the Scheme in the first place. After four years of operation, it is undeniable that there are deficiencies with the Scheme’s ability to deliver on its guiding principle to promote public confidence in the health system.

CHF believes that the deficiencies in the Scheme stem from its overall lack of transparency. The Scheme is complicated, difficult to audit and assess, is at risk of becoming inconsistent across jurisdictions. It lacks meaningful engagement with, and accountability to, consumers and practitioners who lodge complaints and notifications about inappropriate or unsafe health care.

The National Law was well intentioned in its design to consolidate an even more complicated and fractured regulatory system into something more consistent and accessible. It was also meant to afford the practitioner with due process in order to ensure a thorough review of a complaint. However, this process has left consumers with little to no information after the complaint or notification has been lodged. With three-in-five notifications ending in no action taken, there is the perception that the Scheme exists primarily to protect health practitioners rather than consumer or public safety.

Another key deficiency in the Scheme is in how the component entities resolve notifications that also involve systemic health system issues. Under the Scheme’s design, these are supposed to be passed over to Health Complaints Entities (HCEs) for resolution, but it is unclear how well the interaction between AHPRA, the National Boards, HCEs, and other co-regulatory entities are working together in this regard.

With this in mind, our comments focuses on three overarching principles:

- Elevate the public safety to the overarching objective of the Scheme;
- Promote practices that will ensure the Scheme’s transparency and accountability; and
- Ensure that those who make complaints about inappropriate care, be they consumers or registered health practitioners, are not at a disadvantage when making a notification.

CHF supports the development of a single point of entry in each State and Territory for consumers, practitioners, and others who believe they have witnessed or received inappropriate or inadequate care.

There should be “no wrong door” to this point of entry, with every potential site of care having readily available and accessible information on how a person could make a complaint or notification. This point of entry should be able to communicate clearly with those who come to it on what a complaint or notification entails, the standards against which it will be evaluated, and how they will be kept informed throughout the process. To ensure these occur, CHF supports legislative timeframes for the managing of notifications.
Behind the point of entry, there should be very clear mechanisms by which complaints and notifications are managed between the Scheme’s component entities. Complainants and notifiers ought to be kept well informed of the resolution process, and be afforded every opportunity to participate. Where there are cross-professional or systemic issues, it should be the role of a single entity to facilitate the resolution process in consultation with stakeholders involved.

At the top of the Scheme, there ought to be very clear objectives with very clear measures of success. To enforce these objectives, there must be a single, national entity that has the authority, independence, and capability to report to Ministers on the Scheme’s success.

As much as practicable, and in consultation with the States and Territories, CHF supports the development, implementation, and enforcement of consistent standards for the adjudication and resolution of complaints and notifications.

Our submission has been developed through consultation with our members, feedback received from a consumer forum held on 3 September 2014, responses received to a consumer survey run by CHF and its members until 1 October (see attached), and attendance at the Review’s consultation forums held in each State and Territory in the last weeks of September. We have also drawn on evidence to the Victorian parliamentary inquiry, recent publications in the *Medical Journal of Australia*, and work undertaken independently by our members, in particular the Health Issues Centre and its consumer-centric project with AHPRA, and various consumer representatives.

**Response to Questions in the Consultation Paper**

Based on this input, we have chosen the most relevant questions from the Consultation Paper to answer that support the primary principles of our submission.

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

Based on the limited information it has, CHF supports the concept behind this proposal. If the Scheme is to be more closely measured against specific performance goals going forward, then there ought to be independent performance monitoring and public reporting. This information would be vital for ministers, stakeholders, and the public to be able to assess the success of the Scheme.

The consultation paper did not provide sufficient information about the proposed composition of the reconstituted Council to comment on this proposal in detail, however we would recommend further stakeholder consultation should this proposal go forward. In particular, it is unclear how the Council membership would selected, how broad it would be, and how it would be supported to undertaken its responsibilities. Regardless of the model chosen, CHF would strongly recommend that any re-constituted AHWAC include a consumer advisory panel in order to ensure it has access to consumer perspectives on the matters under its consideration.

CHF would support giving the reconstituted board auditing responsibility over all of the Scheme’s components to ensure the validity of the information it receives from the component entities.
CHF recommends the establishment in National Law of regular three-year reviews of the Scheme, such as the kind undertaken for this consultation, under the auspices of the reconstituted AHWAC, to allow for continuous evaluation and consultation of the Scheme with its stakeholders.

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

CHF would only support this proposal, if it did not detract from the Council’s responsibilities in relation to monitoring and reporting on the Scheme.

3. **Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions?**

CHF supports this proposal, but shares the concerns expressed by the nine professions that such a single Board could result in the limitation of expert, professional advice in resolving notifications. As such, the new National Board ought to be required to have profession-specific advisory panels.

We are also concerned that if any of the professions under this new Board saw a growth in workload, they would not easily be able to reconstitute themselves under an independent National Board. In keeping with our recommendation to Question 1 for legislated, regular three-year reviews, the Scheme should constantly evaluate the workload of the individual professions under the single board to ensure that their consolidation continues to be appropriate.

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?**

CHF supports the continued application of the criteria specified in the original COAG Intergovernmental Agreement, as the threshold which should be applied to new professions to enter the Scheme. The safety of consumers and the public should be given primacy.

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

CHF supports further exploration of this issue, particularly in those instances where public safety may be protected through other regulatory means, but where there may not be sufficiently robust and transparent complaints handling and disciplinary processes in place to maintain consumer and public confidence in the certainty of that protection.

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?**

CHF would only support this proposal on the basis that the Council establishes a separate expert assessment group to apply the COAG endorsed criteria to any proposal for new entrants into the Scheme. Given the small size of the previously constituted Council, there is no guarantee a reconstituted group would have the time or expertise to be able to thoroughly and appropriately assess new Scheme entrants, so specialist expertise should be applied to this task.
9. **What changes are required to improve the existing complaints and notifications system under the National Scheme?**

There are several changes that are required to improve the management of complaints and notifications. There needs to be very clear communication with consumers about the difference between a complaint and notification, and the pathways each will take. This information should be available, as practicable, at any point of contact a consumer may have with the health system. Our survey found that most consumers, when they make a complaint or notification, do so at the level of their health provider as opposed to other Scheme entities.

There also needs to be better management of complaints and notifications that “cross over,” either by professions or by jurisdiction (i.e., to be managed by a Health Complaints Entity or a National Board and AHPRA). The Scheme currently silos the handling of complaints and notifications, and does not provide easy facilitation of cross-over issues.

Natural justice should be a fundamental tenet of the way in which complaints and notifications are handled in the Scheme.

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

It is too early to determine the success of the Queensland co-regulatory model to say for certain whether it ought to be adopted across all States and Territories. In general, we do support the idea of an independent entity having the ability to assess and resolve complaints in a timely manner, and we support legislated timeframes for managing complaints and notifications and regular communicating with those who made them. CHF believes this would be facilitated most appropriately by a single point of entry model.

CHF supports in principle the establishment of a national entity that can oversee the performance of the National Boards and AHPRA while being able to report on performance by jurisdiction. However, if the co-regulatory approach were adopted across all States and Territories, then they should have consistent criteria for assessing and reporting on the performance of the Scheme so that Ministers, stakeholders, and the public can transparently evaluate the performance of the States and Territories.

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

CHF strongly supports this proposal. However, as discussed earlier in our submission, these single points of entry in each jurisdiction should not simply be another bureaucratic arm. They must serve the critical function of informing people about the process their complaint or notification will undergo, the criteria for its evaluation, and what resolutions the person might expect at the end of the process. This work would be greatly aided by the legislating of specific timeframes for key milestones, e.g., the decision of a body to accept a complaint, the assessment of the complaint, the initiation of an investigation, and periodic communications with the person throughout the investigation process up to and including its conclusion.
The single point of entry should be comprehensive, to allow for complaints about practitioners, services, facilities, insurers, departments and others, and then allow the appropriate regulatory authority to manage the complaint behind the scenes. Consumers should not have to become experts in legislation and regulations to figure out where to go to make a complaint or which agency has the power to address their concerns.

Information about the single point of entry should also be available at each potential site of health care, as much as practicable, and there should be very clear instructions promulgated throughout the health system on how to direct a person who wishes to make a complaint or notification on how to access the point of entry.

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

CHF supports this proposal as a concept, but would need more information on the specified timeframes. In general, CHF believes the shortest timeframes ought to concern decisions on accepting and assessing complaints and notifications, communicating back with the person raising the issue, and initiating the investigation. It is vital for promoting public confidence in the health system that complaints be resolved transparently, and open lines of communication with those who make complaints and notifications are essential in this task.

Open communication is critical in managing expectations with those who make complaints, otherwise they might feel like the system ignored their desired outcome. CHF believes that prescribed timeframes for managing complaints and notifications, in conjunction with prescribed timeframes for communications with notifiers and complainants, would go a long way to improving public confidence in the system and outcomes for complaints and notifications.

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?

There is currently insufficient transparency to both notifiers and the community about the outcomes of disciplinary processes. There are many reasons for this, but the key issue is that there is no consistent, national requirement for National Boards, AHPRA, or other entities to keep consumers and notifiers informed about the disciplinary process. Moreover, there is not readily accessible data on the outcomes of disciplinary actions; and much of the work done to date to quantify these outcomes has had to come at the result of dedicated parliamentary inquiries or academic-supported reviews. These are labour intensive, subject to variable criteria, and inconsistent across jurisdictions.

It is not in keeping with the overall mission to protect public safety to have a system that is difficult to understand, access, and audit.

The Scheme’s success ought to be measured against very clear desired outcomes. The Consultation Paper and consultation forums drew significant attention to the key performance indicators for health regulation used by the United Kingdom’s Professional Standards Authority; and while not all of their indicators are applicable to the disciplinary process, the general principle of “right touch” regulation can be applied. It is not burdensome to require entities under the Scheme to mandatorily communicate with notifiers at key milestones – and their performance against these timelines can be measured and reported.
Furthermore, consumers and practitioners should be informed of the route their complaint or notification will take at the outset. This can be accomplished by establishing a single point of entry to the system. If it should be later determined that the notification or complaint ought to be transferred to another entity, then that should also be communicated back to the initial notifier.

On the disciplinary processes itself, notifiers should be regularly updated on the progress of their notification – even if the investigation and deliberations are still pending – and be properly informed of the reasons behind any decisions or delays.

Finally, there ought to be an entity with broad oversight, reporting, and auditing authority for the Scheme. As discussed in our response to Question 1, we would support giving a reconstituted AHWAC auditing authority to ensure there is transparency and accountability across the Scheme.

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?**

CHF supports flexibility where possible, but these powers should not compromise the purpose of the Scheme to promote public safety. If a notification presents a serious risk to the public, then that ought to be fully pursued, and the sanctions appropriate. However, if the notification could be resolved through the complaints resolution process, then National Boards should either be able to facilitate that resolution, or have more authority to work in connection with Health Complaints Entities, or similar dispute resolution entities, and the stakeholders to resolve the complaint.

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

CHF believes that these matters should be considered on the basis of the severity of the adverse finding. CHF would not support a blanket cut-off date for the removal of an adverse finding for a health practitioner. Instead, CHF supports AHPRA working with the National Boards to determine, to the extent practicable, what ought to be consistent penalties for the most common adverse findings, and then set duration based on severity. This would ensure consistency between jurisdictions and National Boards regarding adverse sanctions, and promote transparency for what consumers and practitioners can expect should a National Board make an adverse finding.

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?**

CHF is deeply concerned that the National Code of Conduct for unregistered health practitioners will not go far enough to protect the public health and interests, but we recognise the limitation of the National Law and the Scheme in being able to mitigate the risk of unregistered health practitioners. Remedy under the Scheme might be found in amending and expanding advertising prohibitions to include any person who, under the guise of promoting a health care service, makes “false, misleading or deceptive or is likely to be misleading or deceptive” claims about the efficacy of their treatment; and AHPRA could collect and maintain information about unregistered health practitioners who receive complaints under this section. Alternately, or in tandem, should a
jurisdictional Health Complaints Entity (or similar) issue a prohibition order against an unregistered health practitioner, the prohibition order could be posted by AHPRA under an unregistered health practitioner section to ensure public awareness. This would be done in conjunction with the States and Territories mutually recognising each other’s prohibition orders.

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?

CHF supports the principle of exempting mandatory notification of registered health practitioners who are undergoing treatment, which means that health practitioners are able to continue performing their work safely and with minimal risk to the public.

Due to a lack of public data about how routinely health practitioners avoid seeking care for fear of triggering a mandatory notification – although we have heard anecdotal evidence to this point – we cannot form an opinion based on the scale of the problem that warrants a blanket exemption. CHF encourages the Independent Review to explore the potential for a middle ground between the options it presented, whereby health practitioners might be afforded a probationary period of treatment where, lacking evidence of imminent risk to public safety, they can receive care without triggering a notification. If the care becomes ongoing, the practitioner demonstrates a risk to public health, or unilaterally terminates treatment before resolving the underlying health issue and risk to their practice, then a mandatory report ought to be triggered.

Furthermore, we believe that a large issue in practitioner reluctance to seek care when required has to do with a fear over vexatious reporting if they are discovered. There are insufficient penalties for practitioners who are found to have made vexatious reports against their colleagues or across professions. Currently, National Boards are only required to take “no further action” against such notifications. CHF therefore recommends that Section 151 of the National Law be amended to contain clear penalties for practitioners who are found to have made unsubstantiated or vexatious reports against those seeking care.

Whatever the course chosen, CHF is concerned that the Independent Review may have looked too narrowly at the costs associated with mandatory notifications – in terms of regulatory burden – rather than the potential impact on public health and safety.

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

CHF would be concerned that this potentially significant body of work would dilute the focus of the AHWAC from its responsibilities in relation to monitoring and reporting on the Scheme. We do, however, believe that this is an important body of work, which needs thorough and regular consideration, particularly given the abolition of Health Workforce Australia as a driver of workforce reform priorities and addressing forecasted health service access gaps. This type of consideration is particularly important for those professions which have not neatly fallen within the Commonwealth or State/Territory spheres of planning responsibility in the past, such as allied health.
25. Should the appointment of Chairperson of a National Board be on the basis of merit?

CHF strongly supports this proposal and applauds the intent of this proposal to allow persons such as consumer and community representatives of National Boards to become chairpersons. Consumer representatives on National Boards are critical to ensuring that notifiers are not being ignored in the review process, or that the general public is not being put at risk by allowing an unsafe practitioner to continue practicing. It is important that the Review has recognised the importance of this role consumer and community representatives have to play.

However, we believe that professions’ ultimate accountability ought to be with their colleagues. It is also important in giving registered health practitioners the confidence that notifications made against them are being reviewed by persons with experience in the details of their profession.

If the Independent Review wants to make recommendations for improving the ability for consumers and community representatives to have on the notifications review process, then CHF would encourage the Review to examine proposals to create consumer juries or advisory panels under the National Boards that can review notifications from the consumer perspective and make recommendations on outcomes and sanctions.

Moreover, the reconstituted AHWAC should be structured to include consumer representation in order to ensure that the body’s reports to Ministers includes evidence about how the Scheme’s performance against its objectives is impacting consumer confidence in the Scheme as a whole.

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

We note that the majority of these amendments are very technical in nature, and we do not have specific comments for the majority of them. CHF reserves detailed comment on these amendments until such a time as they become open to public consultation in greater detail. We would like to make brief comments of principle on a few of the proposed amendments under consideration.

**Mandatory communications by National Boards to notifiers**

CHF strongly supports the amendments proposed to require National Boards to inform notifiers of key milestones regarding the notification, and to provide detailed explanations when a National Board determines that no further action will be taken on a notification.

**Actions following suspension**

CHF holds that practitioners who are suspended from practising ought to be required to re-apply for re-instatement and registration. Unless a National Board has good reason to believe that the suspension was made on erroneous or misleading information, practitioners who were suspended should be required to demonstrate through re-application that they are able to practice safely. This might be where the proposed review period comes into play, whereby a National Board could review the evidence that was made to support a decision to suspend, and whether that evidence was valid.

**Notice of a decision to take action**

CHF supports a broad definition to notify all places of practice about actions taken against a registered health practitioner.
Results and Analysis from the
Consumer Survey on the National
Registration and Accreditation Scheme
for Health Professionals

October 2014
Introduction

The Consumers Health Forum of Australia, in consultation with its members and consumers, developed this survey to help inform consumer submissions to the Independent Review of the National Registration and Accreditation Scheme (the Scheme). There were 168 responses to the survey, with 86.3% (145) completing the survey and 5.4% (9) partially completing the survey. Our analysis is drawn from the 154 completed or partially completed responses.

We framed the survey to ask consumers about their confidence in the complaints resolution process broadly, even though we are aware that the technical term for complaints made about health practitioners is “notification” under the National Scheme. Consumers, by and large, are unaware and uninterested in the technical terminology when it comes to reporting their issues, and the layperson definition used is “complaint.” So in order to keep the survey consumer-accessible, this survey used the layperson definition rather than the technical.

Survey Takers’ Demographics

The survey takers were diverse across age groups, with 66% aged between 30 and 59 (Table 1). All Australian States were represented in the group of respondents. The respondents’ geographic distribution generally followed that of the Australian population at large, although Victoria was significantly over-represented, while Western Australia was significantly under-represented (Table 2). New South Wales and Queensland were also under-represented.

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<th>Age Range</th>
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There were not enough respondents in each State and Territory to undertake a jurisdictional analysis.

Nine per cent of respondents spoke a language other than English at home, and no respondents indicated Aboriginal or Torres Strait Islander heritage. As such, we were unable to undertake a comparative analysis about the experience of culturally and linguistically diverse groups.
An overwhelming majority of respondents (69.8%) indicated that they had visited a health provider within the last month, and many (44.4%) said that they saw a health provider nine or more times per year (Tables 3 and 4). Chart C reflects the distribution of respondents’ frequency of visiting a health provider against their date of last visit. This suggests that respondents to the survey were predominantly high-end users of the health system.

### Familiarity with the Scheme

The survey asked respondents to rate their familiarity with key terms and entities associated with the National Registration and Accreditation Scheme (NRAS). These entities were the Scheme itself, the Australian Health Practitioner Regulation Authority (AHPRA); National Boards; the National Health Practitioner Ombudsman and Privacy Commissioner; Health Complaints Entities (HCE), and; Accreditation Authorities. The question used a Likert Scale – 1 (low familiarity) to 5 (high familiarity) – and rotated the names of the entities.
AHPRA was the most familiar entity to respondents (3.24), and HCEs the least (2.35). The expectation would be that AHPRA, which operates at the top of the Scheme and has less direct interaction with consumers would have lower levels of familiarity. This result is concerning given the high proportion of frequent health care users, and the fact that Health Care Entities are typically perceived as the go-to for health consumers who encounter an issue with the health system. It is possible that consumers who took the survey are familiar with the specific name of the HCE in their jurisdiction without knowing that it is an HCE (eg, the Health Care Complaints Commission in New South Wales).

If there is to be reform in the way complaints are managed locally – given that consumers who have a complaint or notification appear to be starting the process at their point of care – then Health Care Entities ought to have a larger role to play and, thus, should be more familiar to the consumer.

**Consumer positions on key questions of the review**

Although the consultation paper for the review of NRAS presents 27 questions, this survey considered key questions for consumers in the operation and effect of the Scheme. Respondents were asked their support for statements concerning the consistency of criteria for resolving complaints and notifications; mandatory reporting; centralised responsibility for accreditation and complaints resolution, and; consumer access to information about health practitioners’ registration status and complaints made about them. The question used a Likert Scale – 1 (low support) to 5 (high support) – and rotated the position statements.

Across all respondents, support for positions favouring consumer access to information, mandatory reporting, and consistency of complaints resolution criteria were very high (above 4.50 average, Table 6). The least supported position statement was for the establishment of a national entity to resolve consumer complaints, although it was still high (4.34 average).

Another set of position statements asked respondents to rate the effectiveness of the current scheme in meeting its key objectives for patient safety and workforce flexibility. Across all position
statements, support in the Scheme was moderate to low (between 2 and 3 on the Likert Scale), with confidence least in the Scheme’s ability to ensure that complaints are resolved fairly and transparently (2.27 average, Table 7).

**Complaints and notifications resolution**

Almost two-thirds of survey respondents (66.4%) indicated that they had, at some point, felt the need to report a practitioner due to their health or impairment, conduct, qualifications, or performance. Of those, however, less than one-third (31.1%) went through with making a notification.

Of the respondents who made a notification, 45.2% did so at the practitioner’s site of employment. This is concerning because, while under the Scheme, practitioners or their employers are required to report notifiable conduct which comes to their attention, it is possible that practitioners and employers might either incorrectly or inappropriately apply the standards for notifiable conduct and make no such report, or attempt to resolve the notification “in house.” It also places the notifier in the position of being identifiable by the health practitioner and employer about whom they are alerting, which can be intimidating.

Indeed, of the 70.1% of survey respondents who said they did not go through with making a notification, almost 21% indicated a concern about their privacy or fear of retaliation as a reason for not making a notification (Table 8). The most cited reason for failing to make a notification, however, was a lack of awareness or support on making a notification (46.8%).

Consumers were given the opportunity through the survey to describe their experiences:

*Respondent A*: “At the time, I [had] no way of complaining to a higher authority except management. I kept taking the issue to them. In the end I asked if he had to kill someone before something would be done. They investigated what was happening, [and] he was fired and deregistered so that he couldn't practice again”
Respondent B: “I wasn’t able to find out how to lodge a complaint, as the only person I was able to contact was the one I wanted to complain about (this was part of the original problem too). I could not seem to get any more info on line and there seemed to be no way of lodging a complaint or giving any feedback at the hospital.”

Respondent C: “The process, when this happens is usually tumultuous and exhausting and often the time following such incidents just leaves you unable to do any more than the immediate caring that is often required. Fighting any battles is very difficult and drags on. It is also debilitating and exhausting and saps any little bitty of energy you may have left after the medical interventions where the incident occurred. It has happened to me more than once and I just couldn’t face it. It is really difficult dealing with the people involved at the time and when it's over you just need to get out and try to reassemble your life and that of any others involved.”

Not surprisingly, more than half (54.8%) of the survey respondents who had made a notification said that the process was “Not at all transparent”, and 64.5% said that their complaint had either not been resolved to their satisfaction or that they had simply never received information about whether their notification was resolved.

The negative experiences of those survey respondents who had made a formal notification against a health practitioner is reflected in the lack of confidence other survey respondents had in their expectations of the complaints resolution process. Respondents indicated low confidence in their perceived ability to make a notification if they felt obligated (2.82 average, 40% “1” or “2”) or that their notifications would be resolved fairly or transparently (2.50 average, 44% “1” or “2”).

Other issues

The survey concluded with an open-ended question for respondents to raise additional issues. 28 respondents provided answers that were relevant to the Scheme in some way. There were a variety of themes raised in these responses, but the most common one was promoting better communication about how the complaints process works (eg, how to make a complaint or notification), needing to improve outcomes for consumers, and providing for and greater transparency in the resolution process.

“I have assisted a friend in making a complaint . . . and the process and outcome was terrible. It took a year to conduct multiple interviews with her and with her doctor and other colleagues . . . and then the only response she got was two lines. Completely added insult to injury when all she was trying to do was make sure the doctor followed up on future patients . . . [She] wasn't after money or anything from him except the knowledge he would do better for future patients.”

“I think knowing how and where to complain is very empowering as it's something that can be used if/when needed. I think this information needs to be disseminated to the general community not only those that ‘feel stronger to advocate for themselves’. There are also those that do not speak/or speak limited English, or vulnerable groups. Everyone needs to be aware of these services.”
There were also several comments about protecting the privacy of both those who make complaints and notifications, and the practitioners under investigation, as well as how much information should be available about the notifications and outcomes made for practitioners.

**Conclusion and discussion**

Consumers’ unfamiliarity with the National Registration and Accreditation Scheme, the process for making a notification, and broad dissatisfaction with the outcomes – real or expected – present serious issues to be taken into account when reforming the Scheme. Other research indicates that consumers expect to have their issues with the health care system, including specific practitioners, resolved quickly and transparently. Any reforms to the Scheme must take this into account. From the consumer perspective, these are the most urgent reforms needed to the Scheme.

The component entities of the Scheme that would have the most direct interaction with consumers also need to be more visible in their presence and function. Given that consumers are beginning the complaints and notifications process at the site they received the inappropriate care, it is essential that these sites have the information consumers need to begin the notification process. In general, there needs to be more support provided to consumers on how to make a complaint or notification.

The survey demonstrates that improved communication with consumers about how to make a notification is vital. There is also a strong expectation that the criteria for resolving their notifications be consistent across jurisdictions, although if not necessarily under the same model.
## Table 1
**Age Distribution of Survey Respondents**

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## Table 2
**State and Territory Distribution of Survey Respondents by Respondents’ Self-Reported Post Code**

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<th>State</th>
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</tr>
<tr>
<td>NSW</td>
<td>26.2%</td>
<td>32.1%</td>
<td>-5.9</td>
</tr>
<tr>
<td>QLD</td>
<td>14.9%</td>
<td>20.1%</td>
<td>-5.2</td>
</tr>
<tr>
<td>SA</td>
<td>7.7%</td>
<td>7.3%</td>
<td>+0.4</td>
</tr>
<tr>
<td>ACT</td>
<td>5.4%</td>
<td>1.7%</td>
<td>+3.7</td>
</tr>
<tr>
<td>WA</td>
<td>3.6%</td>
<td>10.8%</td>
<td>-7.2</td>
</tr>
<tr>
<td>TAS</td>
<td>1.8%</td>
<td>2.2%</td>
<td>-0.4</td>
</tr>
<tr>
<td>NT</td>
<td>0.6%</td>
<td>1.0%</td>
<td>-0.4</td>
</tr>
</tbody>
</table>

## Table 3
**Survey Respondents’ Reported Last Visit to a Health Care Service Provider**

<table>
<thead>
<tr>
<th>Date of Last Visit</th>
<th>Per Cent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one week ago</td>
<td>37.0</td>
</tr>
<tr>
<td>Less than one month ago</td>
<td>32.7</td>
</tr>
<tr>
<td>1 to 3 months ago</td>
<td>19.8</td>
</tr>
<tr>
<td>3 to 6 months ago</td>
<td>4.3</td>
</tr>
<tr>
<td>6 to 12 months ago</td>
<td>3.1</td>
</tr>
<tr>
<td>1 year or more</td>
<td>1.2</td>
</tr>
<tr>
<td>Don’t know / Don’t Remember</td>
<td>1.9</td>
</tr>
</tbody>
</table>

## Table 4
**Survey Respondents’ Reported Annual Frequency For Visiting a Health Care Service Provider**

<table>
<thead>
<tr>
<th>Date of Last Visit</th>
<th>Per Cent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than once per month</td>
<td>21.6</td>
</tr>
<tr>
<td>9 to 12 times per year</td>
<td>22.8</td>
</tr>
<tr>
<td>5 to 8 times per year</td>
<td>27.8</td>
</tr>
<tr>
<td>2 to 4 times per year</td>
<td>20.4</td>
</tr>
<tr>
<td>Less than twice per year</td>
<td>7.4</td>
</tr>
</tbody>
</table>
Table 5
Just before you took this survey, how familiar were you with the following terms and organisations? (5 = Very familiar, 1 = Not at all familiar)

<table>
<thead>
<tr>
<th>Term</th>
<th>Average</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Health Practitioner Regulation Authority (AHPRA)</td>
<td>3.24</td>
<td>34.0%</td>
<td>16.7%</td>
<td>10.3%</td>
<td>10.3%</td>
<td>25.6%</td>
<td>3.2%</td>
</tr>
<tr>
<td>National Boards</td>
<td>3.01</td>
<td>23.7%</td>
<td>18.6%</td>
<td>14.7%</td>
<td>12.2%</td>
<td>26.3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Accreditation Authorities</td>
<td>3.00</td>
<td>18.6%</td>
<td>24.4%</td>
<td>15.4%</td>
<td>12.8%</td>
<td>24.4%</td>
<td>4.5%</td>
</tr>
<tr>
<td>National Health Practitioner Ombudsman &amp; Privacy Commissioner</td>
<td>2.68</td>
<td>14.6%</td>
<td>19.7%</td>
<td>14.6%</td>
<td>14.0%</td>
<td>33.1%</td>
<td>3.8%</td>
</tr>
<tr>
<td>National Registration and Accreditation Scheme (NRAS)</td>
<td>2.60</td>
<td>15.4%</td>
<td>16.7%</td>
<td>12.8%</td>
<td>12.8%</td>
<td>35.9%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Health Complaints Entities (HCE)</td>
<td>2.35</td>
<td>13.5%</td>
<td>12.8%</td>
<td>10.9%</td>
<td>16.7%</td>
<td>42.9%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Table 6
How strongly do you agree or disagree with the following statements? (5 = Strongly agree, 1 = Strongly disagree)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Average</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>The criteria and processes for managing complaints made about health practitioners should be consistent across all States and Territories.</td>
<td>4.81</td>
<td>83.4%</td>
<td>9.9%</td>
<td>3.3%</td>
<td>2.6%</td>
<td>1.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Health practitioners should be required to report their colleagues if they reasonably believe them to have provided unsafe or inappropriate care.</td>
<td>4.59</td>
<td>72.8%</td>
<td>16.6%</td>
<td>5.3%</td>
<td>2.6%</td>
<td>1.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Consumers should have easy access to a comprehensive, up-to-date directory of health care providers, to include their registration status and complaints made about their practice.</td>
<td>4.57</td>
<td>70.4%</td>
<td>18.4%</td>
<td>7.2%</td>
<td>0.7%</td>
<td>2.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>There should be a single, national entity responsible for the development of accreditation standards for the education and training of health professionals.</td>
<td>4.40</td>
<td>61.8%</td>
<td>22.4%</td>
<td>10.5%</td>
<td>2.6%</td>
<td>2.0%</td>
<td>0.7%</td>
</tr>
<tr>
<td>There should be a single, national entity responsible for resolving complaints made about unsafe or inappropriate care.</td>
<td>4.34</td>
<td>55.6%</td>
<td>27.2%</td>
<td>9.3%</td>
<td>2.6%</td>
<td>2.6%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>
Table 7
How confident are you in the following aspects of the Scheme?
(5 = Very confident, 1 = Not at all confident)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Average</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>...That health practitioners in Australia are being properly educated, trained, and accredited to provide their services?</td>
<td>3.05</td>
<td>7.4%</td>
<td>26.2%</td>
<td>38.3%</td>
<td>16.8%</td>
<td>9.4%</td>
<td>2.0%</td>
</tr>
<tr>
<td>...That the current system provides for a health workforce that is flexible and innovative in responding to Australians’ health care needs?</td>
<td>2.72</td>
<td>2.7%</td>
<td>17.4%</td>
<td>39.6%</td>
<td>23.5%</td>
<td>13.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td>...That the existing system is able to protect consumers against health practitioners who provide inappropriate or unsafe services?</td>
<td>2.28</td>
<td>3.3%</td>
<td>11.9%</td>
<td>21.9%</td>
<td>21.9%</td>
<td>30.5%</td>
<td>10.6%</td>
</tr>
<tr>
<td>...That the existing system is able to transparently and fairly resolve consumers’ complaints about health practitioners who provide inappropriate or unsafe care?</td>
<td>2.27</td>
<td>2.0%</td>
<td>9.9%</td>
<td>25.8%</td>
<td>23.8%</td>
<td>27.8%</td>
<td>10.6%</td>
</tr>
</tbody>
</table>

Table 8
Most Common, Inferred Reasons Survey Respondents Did Not Make a Notification
(Answers could include multiple reasons)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Per Cent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of knowledge about how to make a notification, or lack of support in making one.</td>
<td>46.8</td>
</tr>
<tr>
<td>Lack of confidence in the process’ ability to provide a satisfactory outcome.</td>
<td>37.1</td>
</tr>
<tr>
<td>Fear of retaliation or lack of confidentiality in the process.</td>
<td>21.0</td>
</tr>
<tr>
<td>Perception that the process would be too resource or energy intensive for the desired outcome.</td>
<td>17.7</td>
</tr>
</tbody>
</table>
Appendix – Consumer Survey

Before we begin the survey, we would like to know a little bit more about you. These questions are optional, but your answers will help us better understand the views and experiences of consumers like you.

Q1. What is your age range?
   □ Under 18
   □ 18-24
   □ 25-29
   □ 30-39
   □ 40-49
   □ 50-59
   □ 60-69
   □ 70-74
   □ Older than 74

Q2. What best describes your gender?
   □ Male
   □ Female
   □ Intersex / Indeterminate / Unspecified

Q3. Are you of Aboriginal or Torres Strait Islander origin?
   □ Yes
   □ No

Q4. Do you speak a language other than English at home?
   □ Yes
   □ No
Q5. What is your four-digit postcode? 

The National Registration and Accreditation Scheme covers many kinds of health care service providers, beyond general practice, to include chiropractic, dental, nursing and midwifery, pharmacy, and psychology services. We would like to ask you about your experience in seeking health care services from these and any other health care provider.

Q6. How frequently do you visit a health care service provider
- □ Less than twice per year
- □ 2 to 4 times per year
- □ 5 to 8 times per year
- □ 9 to 12 times per year
- □ More than once per month

Q7: When was your last visit to a medical practitioner?
- □ Less than one week ago
- □ Less than one month ago
- □ 1-3 months ago
- □ 3-6 months ago
- □ 6-12 months ago
- □ 1 year or more
- □ Don’t know / Don’t remember

We would like to get a sense of your general awareness of the National Registration and Accreditation Scheme and the entities involved. Don’t worry about answering “correctly.” You will not be disqualified from the survey based on your answers to this question.

Q8: Just before you took this survey, how familiar were you with the following terms and organisations? (5 = Very familiar, 1 = Not at all familiar)

<table>
<thead>
<tr>
<th>Term/ Organisation</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Registration and Accreditation Scheme (NRAS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian Health Practitioner Regulation Authority (AHPRA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Boards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Health Practitioner Ombudsman &amp; Privacy Commissioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Complaints Entities (HCE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accreditation Authorities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q9: How strongly do you agree or disagree with the following statements? (5 = Strongly agree, 1 = Strongly disagree)

<table>
<thead>
<tr>
<th>Statement</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health practitioners should be required to report their colleagues if they reasonably believe them to have provided unsafe or inappropriate care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There should be a single, national entity responsible for resolving complaints made about unsafe or inappropriate care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There should be a single, national entity responsible for the development of accreditation standards for the education and training of health professionals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The criteria and processes for managing complaints made about health practitioners should be consistent across all States and Territories.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumers should have easy access to a comprehensive, up-to-date directory of health care providers, to include their registration status and complaints made about their practice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The National Registration and Accreditation Scheme has several guiding principles, described in law. Among them are that the Scheme is to operate in a transparent, accountable, efficient, effective and fair way. The Scheme also allows for restrictions on the practice of a health professional if it is necessary to ensure health services are safe and appropriate.

Q10: How confident are you that the existing system is able to protect consumers against health practitioners who provide inappropriate or unsafe services?
- □ 5 – Very confident
- □ 4
- □ 3
- □ 2
- □ 1 – Not at all confident
- □ Don’t know / Not sure

Q11: How confident are you that the existing system is able to transparently and fairly resolve consumers’ complaints about health practitioners who provide inappropriate or unsafe care?
- □ 5 – Very confident
- □ 4
- □ 3
- □ 2
- □ 1 – Not at all confident
- □ Don’t know / Not sure
The National Registration and Accreditation Scheme has several objectives, described in law. Among them are that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered to do so. The Scheme was also designed to enable the continuous development of a flexible, responsive and sustainable Australian health workforce.

Q12: How confident are you that health practitioners in Australia are being properly educated, trained, and accredited to provide their services?

- □ 5 – Very confident
- □ 4
- □ 3
- □ 2
- □ 1 – Not at all confident
- □ Don’t know / Not sure

Q13: How confident are you that the current system provides for a health workforce that is flexible and innovative in responding to Australians’ health care needs?

- □ 5 – Very confident
- □ 4
- □ 3
- □ 2
- □ 1 – Not at all confident
- □ Don’t know / Not sure

The greatest driving principle and objective of the National Registration and Accreditation Scheme is protecting patient safety. To promote this objective, the Scheme put in place a complaints process for consumers to raise issues about the safety and quality of the health care they received.

Q14: Have you ever felt the need to complain about a health care practitioner due to their health or impairment, conduct, qualifications, or performance?

- □ Yes
- □ No (Go to Question 20 - Do not answer Questions 15-19)

Q15: Did you file a formal complaint?

- □ Yes
- □ No (Go to Question 19 – Do not answer Questions 16-18)

Q16: Where or with whom did you register your complaint?

- □ At the practitioner’s workplace
- □ To the State or Territory’s Department of Health or Ombudsman
- □ To the State or Territory’s Health Complaints Entity
- □ To the practitioner’s National Board
- □ To the National Health Practitioner Ombudsman & Privacy Commissioner
- □ To the Australian Health Practitioners Regulation Agency
- □ None of the above
Q17: How would you rate the transparency of the complaints resolution process?
- □ 5 – Very transparent
- □ 4
- □ 3
- □ 2
- □ 1 – Not at all transparent
- □ Don’t know / Not sure

Q18: Was your complaint resolved to your satisfaction?
- □ Yes
- □ No
- □ The resolution process is ongoing
- □ I received no further information about my complaint
- □ Other (please specify below)

Go to Question 22 – Do not answer Questions 19-21

Q19: Could you describe why you did not file a formal complaint? Please do not specify the health practitioner or entity in your response

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Q20: If you ever did feel the need to complain about a health practitioner in the future, how confident do you feel that you could lodge a complaint?
- □ 5 – Very confident
- □ 4
- □ 3
- □ 2
- □ 1 – Not at all confident
- □ Don’t know / Not sure

Q21: If you ever did feel the need to complain about a health practitioner in the future, how confident are you that your complaint would be handled transparently and fairly?
- □ 5 – Very confident
- □ 4
- □ 3
- □ 2
- □ 1 – Not at all confident
- □ Don’t know / Not sure

Q22: Is there anything more you would like to say about the topics raised in or related to this survey?

________________________________________________________________________________
________________________________________________________________________________