Dear Mr Snowball,

The following paper contains a response from the office of the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC) to the consultation paper 'Review of the National Registration and Accreditation Scheme for Health Professions'.

As there is currently no ombudsman officially appointed to the role of NHPOPC, this response has been prepared by the Manager of the NHPOPC Office, with input from senior staff, based on the experiences of the office in dealing with complaints about AHPRA and the national boards over the past year.

The response addresses some of the issues raised in the paper in detail and provides responses to some of the specific questions raised.

In particular, I would like to draw your attention to the issues raised on page 13 of the consultation paper in relation to 'co-regulatory arrangements for complaints handling'.

In a co-regulatory jurisdiction, the NHPOPC would not have jurisdiction over 'notifications' (complaints), to the extent that such complaints are handled by HCEs and not by AHPRA or the National Boards. Therefore, under the current legislation, the NHPOPC would likely only have jurisdiction over registration matters and privacy issues in those states with co-regulatory arrangements.

If a co-regulatory model is adopted nationally, then a communication tool (flow chart) that outlines the different processes for notifications/complainants (HCE’s) as opposed to registration issues (AHPRA) and identifies the relevant appeal processes for each pathway should be made publicly available.

Thank you for considering our submission. Please contact this office if you have any questions about the matters raised.

Regards

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**NHPOPC office response to review of the National Scheme**

**Complaints and notifications**

**Communication with notifiers**

When a person makes a notification to AHPRA about a practitioner, they instigate a process. However, once the process has commenced, the notifier becomes almost irrelevant from that point on. Consequently, they have little to no opportunity to contribute to the process they started in any meaningful or constructive way. The result is that the notifier is usually very dissatisfied, feels sidelined by the process, and believes practitioners are given more weight, access, and opportunity to participate in the process.

As noted in the consultation paper, AHPRA does not consider a notifier to be a part of the notification process. This is putting notifiers offside, and in some instances is resulting in suboptimal outcomes. As a result, notifiers often move to the next step, which is finding another organisation (such as the NHPOPC) to complain to. Notifiers have reported to the NHPOPC that, after initially being asked to provide documentation relevant to the complaint, they are not contacted again by AHPRA until the complaint has been finalised. In some circumstances, the notifier is in possession of additional information that is highly relevant to the case. However, AHPRA has not contacted them again to ask for additional information. This has resulted in ‘no further action’ being taken in some cases due to ‘insufficient’ information or evidence being provided. However, notifiers have advised that additional information or evidence was available – they were simply not asked for it.

In addition, AHPRA does not discuss likely outcomes or reasonable expectations based on a particular complaint. Rather, a standard letter is sent to all notifiers, regardless of the nature of the complaint. This results in notifiers having very little idea as to what outcomes can be expected, further resulting in extreme dissatisfaction with the notifications process.

**Joint consideration process**

The consultation paper notes that Health Complaints Entities (HCEs) deal with issues relating to health systems (such as hospitals or community health centres) and fees and charges. While this is true, the statement is misleading as it implies that this is all HCEs deal with. In fact, HCEs also deal with complaints about individual practitioners, including unregistered health practitioners (for example, naturopaths or massage therapists). They may conciliate or mediate complaints against unregistered practitioners, and in some states (NSW, Queensland and SA) they may issue prohibition orders. In this way, individuals who complain about unregistered health practitioners are treated differently than those who complain about registered health practitioners, and in many cases may achieve a more satisfactory outcome.

In the absence of clear criteria surrounding the joint consideration process between AHPRA and HCEs, it may be possible that complainants are being encouraged to notify AHPRA about individual practitioners (which would obviate the need for conciliation), rather than lodge complaints about health systems, which may require more resources (e.g. for conciliation or mediation). Notifiers/Complainants may be forced down the AHPRA path whereby they are not party to the complaint process in a consultative way and this results in notifiers feeling that they have not been heard. If the current system is to continue, there should be agreed criteria for determining
which complaints are dealt with by HCEs, and which complaints are dealt with by AHPRA. This criteria should be public so that complainants understand what will happen to their complaint. A flow chart for complainants would be helpful to assist them to understand how they will be involved in either process and enable them to make an informed decision about which pathway to take.

In cases where the complaint is heard by AHPRA and it is determined that ‘no further action’ will be taken, criteria should be developed to determine the circumstances under which the complainant can return to the HCE to pursue the issues for conciliation. Often the complainant wants the matter heard with them as a party to the resolution (seeking an apology, compensation, explanation from the health professional etc.) and under the current legislation, the NHPOPC office is unable to facilitate this (since the NHPOPC office only looks at the administrative actions of AHPRA).

As the consultation paper notes, there is a ‘risk threshold’ used by National Boards to determine whether a practitioner’s conduct represents a risk to public health and safety. However, this ‘risk threshold’ is not clearly defined. ‘Risk threshold’ criteria should be developed for each health profession. It is certainly not clear to consumers that such a threshold exists, and that any complaint about a practitioner’s conduct which does not meet this threshold is likely to result in ‘no further action’. Again, a mechanism needs to be developed so that the matter may be returned to the HCE for conciliation if the threshold is not met and where conciliation is desired by the complainant.

Where complaints about registered practitioners are assessed by HCEs in the first instance, then complaints which are considered serious in nature and potentially reach the agreed ‘risk threshold’ should be referred to AHPRA, and the reasons for this explained to the complainant. For complaints not referred to AHPRA, complainants should then have an opportunity to participate in conciliation or mediation (if appropriate) through the HCE. Feedback should be sought from consumers as to the outcome they are seeking, and information provided at an early stage.

For complaints referred to AHPRA, there should also be increased communication between AHPRA and the notifier particularly in relation to the outcome, and the decision(s) taken by the National Board. Sections 151 & 180(2) of the National Law should be amended to allow the Board to provide information to the notifier/complainant in greater detail than just what is on the public register.

As discussed in the paper on page 17, the current arrangements in Victoria whereby the Health Services Commissioner will not deal with matters that have already been considered by a National Board is often problematic for complainants. Again, generally complainants are seeking some form of recognition of their complaint and conciliation with the health professional (i.e. seeking an apology, compensation, explanation from the health professional, acknowledgement of a mistake etc.) This is not within the remit of the NHPOPC office and complainants to this office are often disappointed as the NHPOPC office cannot provide them with a desired resolution.
Timeliness in response to notifications

Section 149 (1) states that:

(1) A National Board must, within 60 days after receipt of a notification, conduct a preliminary assessment of the notification and decide –
   (a) Whether or not the notification relates to a person who is a health practitioner or a student registered by the Boards; and
   (b) Whether or not the notification relates to a matter that is grounds for a notification; and
   (c) If the notification is a notification referred to in paragraphs (a) and (b), whether or not it is a notification that could also be made to a health complaints entity.

In practice, AHPRA has chosen to interpret this section to mean that all preliminary enquiries must be made within 60 days of receiving a notification. This often prevents them from obtaining all necessary information and documentation before making a ‘preliminary assessment’ to the Board, which may result in insufficient information being provided to a Board in order to inform their decision. The NHPOPC office has investigated matters where AHPRA has sought a response from a health practitioner (where a notification has been made against them) and the health practitioner has either:

- not responded at all,
- not provided the information or documentation requested by AHPRA,
- not responded to all matters raised in the notification.

When the NHPOPC office has queried AHPRA as to why the health practitioner was not followed up to provide an appropriate response, AHPRA has explained that their interpretation of section 149 (All inquiries must be completed in 60 days) prevents them from doing so.

The NHPOPC is of the view that an alternative interpretation of section 149 (1) should be considered. That is, that the ‘preliminary assessment’ should ONLY consider whether the notification fits the criteria outlined in subsections (a) – (c). This would give AHPRA additional time (if required) to obtain all necessary information to ensure that a National Board is able to make a fully informed decision with regards to a notification. The NHPOPC is of the view that this has not always happened in the past, and that redefining what constitutes ‘preliminary assessment’ consistent with the alternative interpretation of the National Law (subject to legal advice) would reduce the risk of insufficient information being provided to National Boards in the future. Notifiers would need to be informed as to the length of time it may take.

Co-regulatory arrangements

If there is a nationally consistent move to co-regulatory jurisdictions, the NHPOPC would no longer have jurisdiction over ‘notifications’, since these will now be dealt with by the relevant HCE and not by AHPRA and the National Boards. Therefore the NHPOPC would only have jurisdiction over registration matters and privacy issues.

This would need to be communicated to the public, so that dissatisfied complainants are made aware that the NHOPC office is not able to deal with complaints related to notifications/complaints to HCEs.

Co-regulatory arrangements would be more equitable in the way that complaints about both registered and unregistered health practitioners are dealt with. Members of the
public are generally not aware that all health practitioners – in particular allied health practitioners – are not subject to the same level of regulatory oversight. Therefore a patient who had a complaint about a nurse and a dietician at a public hospital would not be aware that the nurse was 'registered' and the dietician was not. In most jurisdictions, the complaint about each practitioner would be dealt with differently – one through AHPRA, where the patient would not be a party to the complaint, and the other through an HCE, where alternative dispute resolution would be possible. This unequal treatment of practitioners is problematic for both the practitioners themselves and for complainants.

As moves are currently underway to introduce a national code of conduct for unregistered health practitioners and increased powers for HCEs to enforce the Code, it makes sense to ensure that complaints handling processes against registered and unregistered health practitioners are brought into line and to ensure that the outcomes of complaints are substantially equivalent. This is essentially what has happened in Queensland with the introduction of the Health Ombudsman Act 2013.

Co-regulatory arrangements have the potential to increase the timeliness of complaints handling, as consideration of complaints would not be dependent on the agenda of a Board sitting once a month. National Boards would therefore be free to focus on the core business of registration, accreditation, implementing and enforcing decisions taken by the HCE and monitoring any conditions placed on registration.

The existence of co-regulatory arrangements in two jurisdictions already raises issues of equality across the National Scheme. If registrants and members of the public are treated differently in different jurisdictions, as is already the case, then the objectives and guiding principles of the National Scheme are compromised. The issue of who pays for the complaints handling/notifications functions in co-regulatory jurisdictions has already caused inequities within the system, with NSW registrants paying less than their interstate counterparts. For the National Scheme to function effectively, there needs to be a consistent system of complaints/notifications handling Australia-wide. Consideration should be given to the best method to achieve this.

Education taught and assessed in English

The office of the NHPOPC has received a number of complaints from practitioners who believe that the current English Language standard used by the National Boards, and in particular by the Nursing and Midwifery Board of Australia, is discriminatory.

Under the existing provision, National Boards may grant an exemption from the requirements where the applicant provides evidence that they completed a specified period of secondary and/or tertiary education (generally five years) in one of the following countries: Australia, Canada, New Zealand, Republic of Ireland, South Africa, United Kingdom or United States of America. This potentially discriminates against applicants who have completed secondary and/or tertiary education in English in a country not listed in the standard. For example, a nurse who has completed five years of secondary studies in English in Singapore and then completed tertiary training in nursing in Australia, would not be eligible for an exemption.

There is no clear rationale for recognising secondary and/or tertiary education that is taught and assessed in English only in the seven countries listed in the standard. Consideration should be given to including any country where secondary and/or tertiary education is taught and assessed in English.
English language tests

The office of the NHPOPC has received a number of complaints from individuals who have been unable to achieve the requisite score of 7 in all components of the IELTS test in a single sitting, despite having achieved a score of 7 or greater in all the components over a series of tests. Complainants have pointed out that the testing organisations are private businesses and as such have an incentive to design the test so that some applicants will have to sit the test on multiple occasions. The current cost to sit an IELTS examination is $330, making the cost of multiple tests prohibitive for many applicants.

The office has also been advised that applicants are strongly encouraged by the testing organisations to enroll in workshops costing between $300 and $400 to prepare them for sitting the test.

The office of the NHPOPC is also concerned that IELTS test is not ‘fit for purpose’ as it is a generic test which covers material on complex topics (for example, agricultural productivity, military operations) which is clearly unrelated to the health professions. There is no evidence that every registered or enrolled nurses who was NOT required to sit an IELTS test would be able to achieve the minimum score required by the standard. However, based on complaints brought to the NHPOPC, there is considerable evidence of applicants for whom English is a first language, who were educated and have been registered in (for example) the UK not being able to achieve the required score of seven across all test components. This strongly suggests that the IELTS test is not ‘fit for purpose’ and that an alternative test should be specifically developed or commissioned by AHPRA.

In April 2014, the office of the NHPOPC made a submission to the 2013/14 Nursing and Midwifery Board of Australia (NMBA) discussion paper on the English language standard. This submission included a number of case studies which show that the standard is often applied in a way that fails to recognise English language proficiency sufficient for the safe practice of the relevant profession.

Proposed removal of discretionary exemptions

The 2013 NMBA discussion paper on amendments to the English Language standard proposed the removal of the provision enabling the application of discretion to the standard. This increases the rigidity of the standard and further reduces its ability to take individual circumstances to be taken into account. It is preferable that the provision enabling discretion be retained and a suitable framework developed to guide the regulators in its application.
Governance of the National Scheme

As noted on page 14, issues have been highlighted regarding the effectiveness of the NHPOPC. The NHPOPC is an important component of the governance and hence the accountability of the National Scheme. However, since its inception the office has encountered significant difficulty in fulfilling its designated role due to limited resources - budget and staff. Since the commencement of the National Scheme, there has been either no Ombudsman, or an Ombudsman who was only appointed on a very part-time basis. Only for six months of the last four years (Jan-June 2014) was an Ombudsman able to make some inroads into establishing the effective operation of the NHPOPC office (increased budget and employment of staff to process complaints). As a result, there has been no real accountability on the part of AHPRA and the National Boards with regards to registration and notification decisions, since the National Scheme commenced in July 2010. It is therefore difficult to establish a baseline for the performance of AHPRA and the National Boards in this area or to provide comprehensive feedback to this Review.

There has also been no accountability on the part of the host jurisdiction to report to the AHWMC on the operation of the office of the NHPOPC. This has resulted in undue delays and resourcing difficulties which have exacerbated the problems identified above.

The NHPOPC agree with the statement on P 41 ‘As the National Scheme was intended to be administered on a cost recovery basis, the same principle should apply to the resourcing of the NHPOPC.’ Recently AHMAC agreed that registration funds collected by AHPRA will fund the NHPOPC office. The NHPOPC considers that there should be no cost to complainants who use the services of the office of the NHPOPC.

In addition, the background paper states that the NHPOPC ‘helps people who feel they have been treated unfairly by the administrative processes of the National Scheme.’ This statement is inaccurate as it implies as the NHPOPC acts as an advocate for complainants, i.e. that the office ‘helps people’. While the NHPOPC can investigate the administrative processes of AHPRA and the National Boards, it does not ‘help’ or advocate on behalf of any individual. It is more accurate to say that the office of the NHPOPC assesses and investigates complaints relating to administrative actions or decisions taken by AHPRA and any of the 14 national health practitioner boards (National Boards).

National Boards and Accreditation Authorities

The AHMAC

The Australian Health Workforce Advisory Council (AHMAC) is one of the four agencies (along with AHPRA, the National Boards and the Agency Management Committee) whose administrative actions and decisions may be investigated by the NHPOPC in response to a complaint. However, it is unclear from the consultation paper when or how the AHMAC was constituted, and why it is no longer active. This information is necessary in order to properly address Question 1: Should the AHMAC be reconstituted to provide independent reporting on the operation of the National Scheme? What were the initial terms of reference and how would these be amended to reflect the current goals and objectives of the National Scheme? As an independent body it would be an appropriate mechanism for the AHMAC to provide independent reporting to health ministers.
Establishment of a Health Professions Australia Board

Although the establishment of a single board to carry regulatory responsibility for nine professional groups under the National Scheme is supported in principle, it is unclear where the estimated $11 million in cost savings would be found. While it is acknowledged that the Board and Committee fees associated with running nine national boards would be significantly reduced, other functions delegated by the nine national boards still have to be undertaken by AHPRA. As AHPRA already consolidates registration functions across professions, it is difficult to see how such large cost savings could be achieved without significant staff cuts. The analysis assumes that the functions being carried out by AHPRA are currently being undertaken with a great deal of inefficiency. Similarly, it is unclear how cost savings of $7.4 million could be achieved by ‘consolidating’ functions into a single national service to the nine boards, when, to a large extent, these services are already consolidated by AHPRA. A reduced cost of $7.4 million, if achieved without altering the current Board structure, equates to around 100 staff (using an average full time board support salary of $74,000). More detail is needed on where these staffing cuts might come from and what the real associated savings would actually be.

The data provided in the analysis needs more clarification. It appears that the assumptions being made are not borne out by the actual data provided by AHPRA. For example, the data from which the projected savings are generated predicts a ‘Boards expected cost’ of $22.5m for medicine, when the actual figures provided by AHPRA indicate a total spending for the MBA of $63.8m.

Additionally, the calculations seem to be based on the stated premise that the “unit cost analysis suggests that the size of the board has some role in explaining the relative expense of regulation, with larger boards appearing less costly”. However, outside of the ‘outliers’ in terms of size (nursing and midwifery and ATSIHP) used as examples, there appears to be quite a low correlation between board size and per unit cost. Obviously the complexity of regulating a given profession (for example, medicine and dentistry, both of which have a high per until cost yet are large professions) must be factored into any calculations but it is unclear what weighting, if any, has been used to calculate the estimated $11M savings. At face value, it would appear that more savings could be gained from improving the efficiency with which the more complex professions are regulated, rather than amalgamating the functions of the low-cost professions.

More information is also needed on the registration process for each profession. A state by state flow chart for each Board including all their committees and sub-committees would be helpful to show the committee structure (for example during the registration or notifications process) for each profession, the steps that an application for registration goes through and the steps for a complaint for each Board.

Page 57 refers to a review of the purpose and effectiveness of the 62 committees of the National Boards and the 101 committees of the State/Territory Boards. It would be of value to have a list of each committee’s function(s) and a flow chart of how they fit in to the Board’s decision making process when dealing with either a registration issues or a notification/complaint.
Specific questions raised by the consultation document

Public protection - Advertising

It is unclear how testimonials encourage consumers to believe they require unnecessary treatment. Examples of where this might occur are needed.

Removing the ban on testimonials may make it more difficult to monitor or prevent vexatious or defamatory testimonials.

Mandatory notifications

In WA and Qld, it is unclear who determines whether a practitioner poses a risk to the public. If the practitioner has integrity then they should not fear seeking treatment for an impairment and not be concerned about the mandatory report to AHPRA. As health practitioners have to put their patients’ care and wellbeing first. Similarly, AHPRA has an obligation to put the safety of the public first. It is unlikely that the exemptions would reduce the risk to the public. For example, patients of neurosurgeon Dr Suresh Nair (cocaine addiction) had a right to know that he was impaired before undergoing treatment by him. If mandatory reporting exists under the National Law then all health practitioners should be required to report notifiable conduct. This reduces the risk to patients. If there are exemptions, it is too difficult to assess and monitor risks to patients.

Workforce reform and access

The NHPOPC office has received a number of complaints from practitioners who are required to upgrade qualifications after a period out of the workforce (for example, five years). The options for upgrading their qualifications are often extremely limited, infrequently offered, expensive and confined to certain geographic locations. In some cases the advice provided has not been appropriate for the requirements of the applicant (for example, in cases where supervised practice is required rather than upgraded qualifications). There also seems to be a great deal of inconsistency across professions.

The consultation paper states that the National Scheme facilitates access, but does not describe how this is achieved. While it is acknowledged that the National Scheme facilitates workforce mobility and reform, it is difficult to see how it facilitates access.

Current standards are too stringent and this may result in health professionals not being able to work in certain health care settings. The question of whether health professionals becoming overqualified in relation to minimum standards for registration needs to be considered, along with the related question of whether the qualification bar is being set too high for the actual role the Health profession will play in the health sector.

Assessment of overseas practitioners (relates to Question 24)

There are currently gaps in the processes with respect to the assessment and supervision of overseas trained practitioners, particularly in communication with practitioners when applying for registration and guiding them into bridging courses when they do not meet the standards.

For example, AHPRA’s lack of communication with the Australian Nursing and Midwifery Accreditation Council about the changes to the registration standard for nursing and the upgrade from a diploma level to a Bachelor degree level has caused great confusion for nurses immigrating from OS (particularly England) about their prospects of being registered in Australia and has resulted in numerous complaints.
Answers to specific questions in the consultation paper

Question 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?

- It would be helpful if AHPRA & the Boards could provide the notifiers with reasons for their decisions in addition to what is publicly available on the register, and for section 151 and 180 (2) of the National Law be amended to that effect.

Question 14 - Should there be more flexible powers for the National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and notifier?

- Yes this should definitely occur or it should then automatically be passed onto another party to undertake the resolution process.

Question as to whether the Boards are equipped to deal with Notifications.

- AHPRA and the registration boards’ core business is the registration of health practitioners. It may be better for notifications and complaints to go to a HCE or Tribunal that has the expertise in dealing with complaints (mediation, conciliation, negotiation with complainant) and they in turn make a recommendation to the Board re any disciplinary actions to be implemented against the health practitioner.

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

- This would depend on the findings, the seriousness of them, the risk to the public safety (based on criteria about the risk threshold) and whether this will affect their ability to practice in the future. Need to give examples of when the findings would be removed.

Questions 20 & 22 - 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? 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?

- Only the Boards and accreditation authorities can provide an accurate response to the question of how they are meeting the statutory objectives and guiding principles of the National Law.

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

- A reconstituted AHWAC could inform regulators etc. only if they are independent to the Boards and accreditation authorities.

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

- A close relationship between regulators and educational institutions is required to ensure that the health professions are being trained to the relevant standards to
ensure a robust workforce to meet health service demands now and into the future.

**Question 25 - Should the appointment of Chairperson of a National Board be on the basis of merit?**

- Chairs should be appointed on merit. You would assume that each Board would have the relevant health professionals as sitting members to inform on clinical issues relevant to that health profession.

**Question 27 - Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?**

- There does not appear to be sufficient oversight of accreditation authorities. Could AHWAC undertake this role as they would be able to provide independent advice?

**Proposed amendments to the National Law and Regulations**

- Section 149 – it would be preferable if all complaints went to the HCE first, which then decides, in consultation with the AHPRA, whether it is a matter for the National Board (i.e. meets the ‘risk threshold’ – which needs to be defined for each board.).
- Section 226 – information on the register. Under what circumstances would you need to protect the privacy of the practitioner about their conditions or undertakings? Under what circumstances might a third party be affected? Give examples.
- Div 13 part 8 - Appealable decisions – change to 30 days, this will keep it consistent with other sections under the national law.

**General comments**

- It would be helpful to include the relevant sections of the National Law to which you are referring to in the consultation paper, for example, section 151 and 180 (2) regarding information that can be revealed to notifiers.
- P 83 - Notification flowchart – Under what circumstances are matters referred to a tribunal? Which tribunal is used?
- P 87 - QLD Health Ombudsman – under what circumstances are matters referred back to AHPRA?