Review of the National Registration and Accreditation Scheme for health practitioners

Thank you for providing an opportunity for the Pharmacy Council of New Zealand (Council) to comment on the Review of the National Registration and Accreditation Scheme for Australia health practitioners.

The Council is a statutory body established with the primary purpose of protecting the health and safety of the public. It has the following key functions:

- Determining scopes of practice for pharmacists
- Prescribing qualifications required for scopes of practice within the profession
- Registering pharmacists
- Setting standards and guidelines
- Reviewing practising pharmacists when concerns are raised about competence, professional conduct or health
- Promotion of education and training in the profession.

Council will respond to those questions in the consultation document that draw parallels with the New Zealand health practitioner registration and accreditation processes and environment.

Q3 – Should a single Health Professions Advisory Board be established to manage the regulatory functions that oversee nine low regulatory workload professions? (Estimated cost saving $11m per annum).

Q4 - Alternatively should the nine National Boards overseeing low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? (Estimated cost savings $7.4m pa).

Council considers the second option allows National Boards to retain independent professional functions at the same time providing for a degree of cooperation and sharing of regulatory functions that may eventuate in cost savings spread across the nine Boards involved.

It is desirable that health professions are not over regulated and it is clear from the data presented that the most efficient use of the regulatory resource is directed towards the area of greatest volume and risk. It therefore follows that some degree of consolidation of the nine smaller professional regulators might achieve this. A competency based Board to oversee the nine professions may work, however much of the profession-specific knowledge required to govern the regulatory work (ie notification committees, health etc.) is still required, so there is a need to carefully consider whether savings would eventuate. Additionally, this body would still require roles such as professional standards, oversight of scopes of practices, meeting scopes of practices, accreditation etc.

Council would also suggest that on the face of it, until the structure is set out and evaluated the projected cost savings cannot be accurately predicted, resulting in estimates that are simplistic.
Q5 – Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?
Registrants should receive some benefit from efficiency savings but AHPRA may also wish to see some financial return on this shared regulation. Investment in policy development across the nine professions could be beneficial given many may not be in a position to do this individually i.e. part of the savings should be reinvested in policy and strategy work to ensure effective and efficient regulation.

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 associated cost benefit analysis?
Council would anticipate that new professions applying for regulation would need to meet a threshold based on key criteria. The criteria would include that the health services provided involve a risk of harm to the public, or that the nature, frequency, severity and likelihood of risk of harm, or of other factors justifies regulation.

Q7 – Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?
The primary purpose of the National Law is protection of public wellbeing. ‘Other regulatory means’ is likely to include employers who have a degree of conflict of interest; therefore Council believes any amendments should be given careful consideration.

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?
This appears to be a logical step; however it should be done in consultation with all affected organisations.

Q9 – What changes are required to improve the existing complaints and notifications system under the National Scheme?
Q10 - Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?
Q11 - Should there be a single entry point for complaints and notifications in each State and Territory?
Council believes that the National Law and relevant State and Territory legislation should be nationally consistent, and should be amended to provide a single entry point for health consumer complaints against a health practitioner. There needs to be careful and deliberate alignment of state process to ensure effective and efficient articulation that prevent unnecessary delays. An independent commissioner could also provide an advocacy service for ‘low-level’ complaints (as measured against agreed criteria) where a dispute resolution process involving the complainant can be undertaken.

Notifications relating to health or professional conduct issues, and not involving a health consumer could be made directly to the relevant National Board, provided all Boards have a consistent and agreed approach to managing them which is seamless and people-centric. Council believes is also essential that there is sharing of notifications to Federal bodies to ensure all responsible bodies are aware of them.

Q12 – Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?
The review document outlines AHPRA’s Key Performance Indicators (KPIs) for the management of notifications and complaints. It would be logical for these to be adopted nationally and promoted to the public so all involved are aware of the expectations.

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?
Rather than National Boards having alternative dispute resolution processes, an independent commissioner could make available an advocacy service. This may include information and advice on self-advocacy using a nation-wide group of independent advocates. If National Boards had more power, there is the potential to undermine confidence in the scheme if the process is not transparent to the objective observer or becomes a play-ground for lawyers getting health professionals an easy opt-out.

Q15 – At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?
Council recommends consideration is given to similar provisions as those under the New Zealand “Clean Slate” Act. Under that Act, a criminal record is hidden from the public if the person meets certain eligibility criteria which include:

- no convictions within the last 7 years;
- never been sentenced to a custodial sentence;
- never been ordered to be detained in a hospital due to a mental condition, instead of being sentenced;
- not been convicted of a “specified offence” (e.g. sexual offending against children).

Eligibility under the scheme also includes completing a rehabilitation period, but the ‘clean slate’ component must be balanced with the possibility of re-offending where public safety may continue to be a risk. Whatever eligibility criteria are considered, there should be provision to protect vulnerable children and consideration should be given to not removing acts of gross financial and fraudulent activity.

Whatever the final decision, Council believes there needs to be a clear differentiation between conviction and committal under a mental health act, but one that ensures the same net effect as far as a clean slate outcome is concerned.

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?
The Council believes that notification where there is evidence of misconduct not associated with a health condition should be mandatory. In cases of impairment, where the practitioner is receiving treatment and there is no risk to public safety notification should not be mandatory but health practitioners should be strongly advised to assess whether notification is in the best interests of the affected health practitioner (Practitioner B). The notifier (Practitioner A) must also have reason to believe that Practitioner B poses a risk of harm or a risk of serious harm.

Q21 – Should the proposed reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?
The Council believes it would be logical to expect a reconstituted Australian Health Workforce Advisory Council to take responsibility for the planning and development of the health workforce including access gaps. It should also ensure staffing issues are aligned with planning on delivery of services and that the healthcare workforce is fit for purpose.

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?
The Council’s involvement with the Australian Pharmacy Council, which is contracted to accredit undergraduate programmes on our behalf, indicates that the opportunities for multidisciplinary education and training is a consideration given high priority to all accreditation applications.

Q23 – What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualifications for entry to professions remains available?
Council suggests that discussion between regulators, educational institutions and health workforce planners, at least on an annual basis, would be beneficial to ensure accreditation arrangements are satisfactory, the workforce is sufficient, and is supplied with highly qualified practitioners.

Q24 – How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?
The Pharmacy Council of New Zealand and the Pharmacy Board of Australia utilise similar processes for overseas trained practitioner registration. The process is sufficiently robust and endeavours to minimise barriers to registration, at the same time ensuring public safety is protected.

Q25 – Should the appointment of Chairperson of a National Board be on the basis of merit?
The Council supports consideration being given to the appointment of National Board Chairs based on merit. Health practitioners have relevant professional skills to contribute to the Board but may not have the necessary governance or HR experience, for example. As with all appointments, Council believes the appointment should be the right person with the right skill set, be they a practitioner or a lay person.

Q26 – Is there sufficient oversight for decisions made by accrediting authorities? If not what changes are required?
Council believes that there may not be sufficient oversight of the Accreditation Council’s although it is difficult to see how this can be improved without imposing further layers of bureaucracy and therefore financial burden.

The Council acknowledges that the analysis of the Australian Accreditation Councils’ functions has not yet been completed; therefore the Pharmacy Council will respond further when that document becomes available.

Yours sincerely

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