1. Introduction

The Royal Australasian College of Physicians (RACP) is responsible for training, educating and representing over 21,000 specialist physicians and trainees in Australia and New Zealand.

The RACP welcomes the opportunity to provide input to the review of the National Registration and Accreditation Scheme for health professions (NRAS) being undertaken by Mr Kim Snowball on behalf of the Australian Health Ministers’ Advisory Council (AHMAC).

Our submission to this review will address the questions raised in the consultation paper prepared by Mr Snowball in August 2014, and published on the AHMAC website. There are a number of questions where the RACP feels it is not in a position to provide comment, and we have omitted these from our submission.

2. Responses to questions raised in the consultation paper

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

The discussion paper suggests three possible functions for a reconstituted Australian Health Workforce Advisory Council (AHWAC):

- assessment of all regulators,
- provision of independent advice regarding proposed changes in the standards and
- reporting on actions within the National Scheme.

The last of these functions includes the responsibility for informing regulators about health workforce reform priorities.

We consider that, because of the disparate nature of the tasks proposed, it would not be appropriate for a reconstituted AHWAC to take on the role of the first function; that of undertaking the assessment of all regulators. This role raises important questions about the overall complexity of the scheme and the possible need for an additional set of standards for the conduct of the regulatory bodies.

We feel it would be possible however for a reconstituted AHWAC to be in a position to provide relevant advice on matters where reform programs would lead to changes in standards.

There is considerable need for a process to deliver on the third function - that of reporting on actions within the National Scheme - and this is something that we feel a new AHWAC could take on. It would be important that this role is recognised as being central to providing an effective mechanism through which there can be proper consideration of innovation and reform.

One of the main areas where innovation and new ways of thinking is most required is in ensuring we are not being restricted by the traditional boundaries of health professions. These boundaries are currently enshrined and reinforced by the current structure, particularly because of the need to deal with complaints and notifications.

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

A reconstituted AHWAC may well be a suitable forum for resolution of such issues.
3. Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? Estimated cost saving $11m per annum?

Given that this proposal does not involve modifying the framework for specialist medical practitioner education and training, the RACP does not consider it has sufficient understanding of the operations of the nine National Boards to be able to provide an informed response to questions 3, 4 and 5. We fully support operational efficiencies where possible, however it is vital that the search for efficiency and savings does not adversely affect the effective working of the organisations, and that changes are implemented in a considered manner.

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

The RACP recognises that the NSW co-regulatory system in medicine appears to have functioned well since the introduction of the NRAS in 2010, and notes the decision by the Queensland Government in 2012 to abandon the original structure and to move to a similar structure for all health professions.

However we consider that, although potentially attractive, the Queensland model has not yet had sufficient time to demonstrate its effectiveness.

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?

The RACP strongly supports the revision of mandatory notification provisions to ensure there is a nationally consistent approach and appropriate protection provided to health practitioners under active treatment.

This issue also highlights the vital need for regulators to engage with professional bodies, such as the specialist medical colleges, to develop appropriate processes for providing timely advice from AHPRA and the Board about formal decisions arising from tribunals or other hearings.

This is particularly important where a practitioner’s registration has been suspended or removed. However, it also extends to allowing the colleges to undertake support and remediation roles in collaboration with the regulators where such interventions have been determined as relevant.

It is perhaps ironic to note that remediation and performance monitoring processes are mandated for colleges by the accreditation standards of the AMC, but that the appropriate delivery of these is inhibited greatly by the fact that the colleges are not generally notified of relevant determinations. This must be resolved.

20. 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?

Overall, the current NRAS largely delivers on its regulatory functions however its structure inhibits its ability to address issues of innovation and reform. We would argue that a much more forward looking approach to recognising specialty groups within broad categories would
be a considerable benefit to stimulating innovative thinking on a range of education, health workforce and service delivery issues.

Similarly, the overall segregation of the health professions has the inadvertent effect of reinforcing professional boundaries rather than encouraging flexibility.

The effect of the Specialist Register as a barrier to reform within the area of specialist medical services is addressed further in our response to Question 22, however it should be noted that we fully recognise the difference between the intent of the Specialist Register and the current reality of its flawed interpretation outside the immediate regulatory environment.

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

The RACP is concerned that the thinking underpinning this question suggests that the innovation and reform needed in the health workforce can be implemented through a regulatory approach. Successful reform is far more likely to emerge from the profession when encouraged and enabled by the context of an accommodating or adaptable regulatory framework.

On the other hand, it is certainly true that a reconstituted AHWAC could provide important leadership regarding gaps in accessing health services, provided the recommendations were underpinned by solid modelling and data on the supply and distribution of health professionals.

The group may well be able to contribute an important perspective on how the nation's health workforce might be structured and distributed in order to best meet the needs of the community. However, we note that there does not appear to be any evidence that the current structure has encouraged or brought about genuine reform.

22. 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?

From the perspective of the education, training and ongoing clinical practice of medical specialists, the current arrangements can actually inhibit changes to the training structures and trialing and development of new health professional roles which might better address health needs and current issues. This is especially the case with the Specialist Register, but also applies to other matters outside the scope of the NRAS (eg Medicare).

For example, the current Specialist Register has a fixed range of "protected" titles which does not appropriately cater for existing and future disciplines within recognised broad groups such as 'Specialist Physician'. All current or future graduates of the specialist training program need to fit into an existing registration category. This is required for the purposes of credentialing within a health service, for eligibility for Medicare recognition and for a range of other issues. However many of these other purposes were not foreseen in the original development of the register, or have emerged from interpretations of the register's function which differ from the original intent of having these protected titles.

Perhaps the most egregious example of this is the removal of a number of highly experienced and competent specialist physicians from consultant General Medicine rosters by administrators in a range of hospitals, on the grounds that they do not hold registration as Specialist Physicians in General Medicine. This is despite the fact that the physicians affected had served on these rosters in these hospitals for many years.
Whilst the intent of the register was never to inhibit the ongoing activity of skilled physicians, it has had the unfortunate impact of doing exactly that in a range of settings.

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

In the area of medicine, training for entry to the profession, pre-vocational training and vocational programs are all quality assured through mandated accreditation processes. The key to the success of the model is the use of well-defined standards which articulate appropriately between the various stages, focus on outcomes rather than program structure and requirements, and support a continuous quality improvement approach to program development.

An additional benefit of the peer review process is that there is a strong educational element for those undertaking the accreditation reviews. This works to promote understanding of the process and its intentions, and to spread more widely a good understanding of innovations and reform achieved elsewhere. Although the process at the level of specialty training is demanding, in terms of direct and indirect costs to organisations undergoing the accreditation process, the benefits are significant and we would not support any major change to the process.

The College suggests that there would be benefit to other regulated health profession regulators giving this model careful consideration; especially its focus on outcomes rather than structure or process.

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

The specialist medical colleges undertake assessment of specialist international medical graduates on behalf of AHPRA and the MBA under the conditions of a formal assignment of this function to each college. The current processes for assessment of specialist medical practitioners are appropriate in the broad sense, but clearer guidance from AHPRA and the MBA on implementation would assist greatly in achieving more consistency and flexibility.

In particular, there is not a sufficiently clear articulation of the way in which the objective of the NRAS regarding flexibility should be implemented.

Furthermore, the structure of the Specialist Register works against flexibility in the assessment of practitioners from international settings. Again, there are other influences outside NRAS (such as Medicare) which can also inhibit flexibility in the process; although Medicare also has the capacity to make independent determinations regarding access to specific rebate categories which can lead to increased flexibility in some cases.

25. Should the appointment of Chairperson of a National Board be on the basis of merit?

The selection of National Board Chairs should be done through a formal and transparent selection process, and be decided on the basis of relevant skills and demonstrated experience, including leadership of groups or organisations, and specific expertise relevant to the role of the Chair.

26. Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?
Accrediting authorities need sufficient independence from regulatory bodies to ensure protection of standards from issues of expediency, especially where potentially simple solutions to complex problems such as workforce numbers and distribution might be attractive. We acknowledge also that there are effective international models such as the UK’s General Medical Council where a single agency retains both regulatory and accreditation functions. In these cases, the effective separation of the core functions has been managed effectively within the organisations.

Given that there are a range of arrangements around the assignment of the accreditation functions of the respective Boards, our comments relate only to the arrangement between the Medical Board of Australia and the Australian Medical Council.

The RACP welcomes the extended period of assignment of the accreditation function to the AMC. The process for accreditation of programs of training for specialist medical practitioners is prolonged in all cases and the periods of accreditation for successful colleges are considerably longer than the period for which the accreditation function has been assigned. This introduces an element of uncertainty into the accreditation process which is largely unhelpful.

The successful administration of the accreditation process is heavily dependent on the scrupulous independence of the accrediting agency, and the self-review, continuous quality improvement approach with assessment by peers which underpins the AMC process is highly regarded locally and internationally.

The legislation itself provides for final approval of the accreditation decision by the regulator. In that the circumstances under which an AMC recommendation on accreditation might be altered by the MBA have yet to be discovered, this element of residual doubt leaves some concern about the true level of the AMC’s independence. It is clear however that, in the current circumstances, the arrangement functions well, issues around funding of the AMC’s accreditation functions notwithstanding.

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

The RACP considers that there is very effective oversight of the accreditation decisions made by the AMC and its accreditation groups. We do not have a view on process undertaken in the other regulated health professions.
3. Conclusion

Much has been achieved since the establishment in 2010 of the National Registration and Accreditation Scheme. The RACP unreservedly supports its objectives to protect the safety of the public, facilitate workforce mobility across Australia, and enable the development of the health workforce required to meet Australia’s future health needs.

One of the cornerstones to the NRAS’s success is its cross-jurisdictional, collaborative and consultative organisational model. This is vital to appropriately managing the federated system in which health practitioners work in Australia and supporting their movements across States and Territories borders.

The NRAS is a regulatory system based on individuals and individual health professions. Its main focus must remain on ensuring that professional standards are maintained in the public interest. The regulatory system should not be overly restrictive; but be able to accommodate flexibility and innovation coming from other areas of the health system.

However it needs to be recognised that there are practical limitations as to how much innovation and reform can be instigated and driven by a regulatory system. Much of the reform and new approaches to future health practitioner roles and building effective multidisciplinary health teams centred on patients’ needs has to come from health policy, employment arrangements and the workplace culture that underpins delivery of health services themselves. Such reforms can also be supported through the new National Safety and Quality Health Service Standards and accreditation processes.

The RACP applauds the commitment by the AHMAC to implementing regular reviews of the scheme and seeking feedback from organisations who are both affected by it and who contribute to its success. We would be happy to provide further clarification on our comments or to participate in additional consultations.