RACGP Submission to the Australian Health Ministers Advisory Council (AHMAC)

Review of the National Registration and Accreditation Scheme for health professions

9 October 2014

The Royal Australian College of General Practitioners
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Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Australian Health Ministers Advisory Council (AHMAC) for the opportunity to contribute to the Review of the National Registration and Accreditation Scheme for health professions (Review).

About the RACGP

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting and maintaining the curriculum and standards for education, training, quality general practice, and for supporting GPs in their pursuit of clinical excellence and community service.

RACGP submission to AHMAC

In 2009 the RACGP supported the development of the National Registration and Accreditation System (NRAS) that would:

- protect public safety
- facilitate workforce mobility
- facilitate high-quality education and training
- facilitate assessment of overseas-trained health practitioners
- promote access to health services, and
- develop a flexible, responsive and sustainable workforce.

This was on the proviso that the NRAS:

- did not impinge on the medical profession’s autonomy
- did not limit the profession’s role in setting and maintaining medical practitioner registration standards, and training program accreditation standards
- did not allow political and economic imperatives to drive health workforce reform
- operated in a transparent, accountable, efficient and fair manner
- fees payed by regulated health practitioners remained reasonable.

The RACGP acknowledges the Australian Health Practitioner Regulation Agency’s (AHPRA) efforts to address the problems associated with the NRAS implementation during the start-up phase. However the submissions received during the 2014 Victorian Legislative Council inquiry into the performance of the AHPRA indicate there are still a number of operational issues that require rectification.\(^1\)\(^2\)

These relate to the NRAS’:

- governance
- accountability – to health practitioners
- complaints and notification processes
- requirement for mandatory reporting by treating practitioners
- transparency, accountability, efficiency and fairness of all processes
- fees payed by regulated health practitioners.

The RACGP is concerned the Review is not focusing on addressing the problems that still exist with AHPRA’s implementation of the NRAS in these areas. Resolving the issues associated with the implementation of NRAS should be a priority before any discussion and further action is taken to use the NRAS as mechanism for health workforce reform.
With regard to the information provided by AHPRA, there is no need to re-constitute the Australian Health Workforce Advisory Council (AHWAC) to report on the extent to which the NRAS is meeting the objectives set out in the National Law. The RACGP contends that this function is already being performed by AHPRA and the National Boards through their annual and quarterly reporting.

These data can be exported to the Department of Health, which has absorbed the functions of Health Workforce Australia, for further analysis, in combination with data from other sources to identify opportunities to improve service accessibility through workforce innovation.

Further, better governance and accountability to all stakeholders – including registered health practitioners – can be achieved through improved systems, processes, and communication.

The RACGP also does not support the creation of a single national board for health professions considered to be of ‘low risk to the public and have low workloads.’ Their regulation should remain as high as that of the health professions considered to pose a ‘high risk / have a high workload given unprecedented rate at which all health professions are expanding their scope of practice. This includes independent assessment, diagnosis and treatment of conditions traditionally treated by the medical profession – which is considered the highest risk / workload profession.

The design of the NRAS allows for the use of practitioner registration and training program accreditation for workforce reform purposes. This is being pursued by health professions through revision of their registration and accreditation standards, codes and guidelines. We have observed clear alignment of expanding scopes of practice with government workforce reform objectives. The RACGP continues to assert that it is inappropriate to use health practitioner registration standards and training program accreditation standards for workforce reform purposes.

The standards for health practitioner education, training and registration must be primarily informed by evidence of best practice – as determined by each health profession with the most extensive expertise in the relevant discipline. This should occur in consultation with other health professions, with full consideration of the broader impacts on health service provision and the quality and safety of patient care.

This issue and the risks it poses were extensively discussed during development of the NRAS design phase. It is disappointing and counterproductive to see that the Review is considering further use of the NRAS for workforce reform purposes again.

In relation to complaints and notifications, the RACGP supports efforts to streamline and simplify the complaints and notifications process. In particular, flexible arrangements that allow the National Boards to resolve a complaint via an alternative dispute resolution (for example settling matters by consent between the practitioner and patient) is supported.

Lastly, as stated multiple times since 2007, the RACGP firmly believes treating practitioners must be exempt from mandatory reporting. The inclusion of mandatory reporting for treating practitioners is self-defeating, as health practitioners who need treatment are deterred from seeking treatment. If health practitioners are not receiving the care they need, their health is compromised and the risk to the public increases. Exempting treating practitioners from mandatory reporting will ensure that health practitioners are afforded the same rights as the general public, in that they can seek health care without fear of being reported to a regulatory authority.
1. Governance

Overall, the governance of health practitioner registration and training program accreditation has increasingly come under the direct or indirect control of the Australian Health Workforce Ministerial Council (AHWMC) through the:

- AHPRA Agency Management Committee
- National Boards
- Accreditation committees established by each National Board
- State / Territory Boards – appointed by jurisdictional Health Ministers, and
- National Health Practitioner Ombudsman and Privacy Commissioner.

This reflects the extent to which health workforce planning, development and regulation can now be determined by political and economic imperatives. This has the potential to:

- create a bureaucratic and draconian system of health workforce training and deployment
- detract from the quality and safety of patient care
- increase the burden of disease, and
- inflate costs.

Past Ministerial and Productivity Commission inquiries into the health practitioner workforce have revealed that the bureaucratisation of public hospitals is an example of what occurs when health practitioners feel disenfranchised from their hospital administration and unable to participate in corporate and clinical governance systems and processes. Staff morale, productivity, innovation and the ultimately quality and safety of patient care was compromised.\(^3\)\(^4\)

To prevent this from occurring at a national level the health practitioners regulated under the NRAS, must be involved in the governance of their profession by the agencies that administer the NRAS (e.g. AHPRA and National Boards).

Clinical leaders with sound knowledge of their respective disciplines, and how they interface with other health professions, to optimise patient care, must continue to play a central role in:

- setting practitioner registration and training program accreditation standards for future generations
- assessing applicants against those standards
- investigating breaches of their standards and codes of practice
- evaluating data captured about the performance of the NRAS, and
- using this for health workforce planning and development purposes.

2. Accountability

The RACGP supports improved accountability to all stakeholders – that is the Australian public, government and the regulated health practitioners.

2.1. NRAS accountability to Government

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

The Review focuses on NRAS accountability to government (national, state / territory level) citing that ‘currently there is no mechanism to measure the National Scheme’s performance in relation to its delivery of the key objectives set out in the National Law’.
To address this problem, the consultation paper proposes that AHWAC be reconstituted to provide independent reporting on the performance of the National Scheme (based on pre-defined performance measures) at a national, state / territory level.

The RACGP asserts that such mechanisms already exist. That is, AHPRA and the National Boards already collect and report on the extent to which the NRAS is achieving the objectives set out in the National Law. For example, in 2012, the Medical Board of Australia (MBA) began publishing quarterly data profiling Australia’s medical workforce, including a number of statistical breakdowns about registrants.

This can be used to evaluate NRAS’ performance, in relation to its delivery of the key objectives set out in the National Law, in the following ways:

- **Protect public safety** – the National Boards already report on the registration status of all regulated health practitioners and the rates and types of:
  - notifications received
  - assessments conducted
  - referrals made to other agencies, such as jurisdictional health services complaints commissioners
  - investigations conducted by AHPRA / National Boards, and
  - determinations / outcomes achieved.

- **Facilitate workforce mobility** – the National Boards already report on health practitioners’ mobility in terms of their distribution across:
  - states / territories
  - places of practice
  - specialties / endorsement type by location
  - age groups by registration type, and
  - gender groups by registration type / location.

- **Facilitate high-quality education and training** – the National Boards already report on approved (independently accredited) programs of study.

- **Facilitate assessment of overseas-trained health practitioners** – the National Boards already collect and variably report on certain overseas-trained practitioner data.

This information could be exported to the Australian Government Department of Health and used, in combination with data from other sources, to:

- evaluate access to services
- identify health service gaps, and
- identify health workforce innovation that may help address service limitations.

2.2. NRAS accountability to health practitioners

**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?

The RACGP notes that the consultation paper’s emphasis is on accountability to the public and in particular notifiers.

The regulated health practitioners are also central to the disciplinary processes and the concept of accountability – as they are individuals and groups that can affect, or are affected by the NRAS administrative agencies’ (AHPRA and the National Boards’) policies and/or actions.
The RACGP has received numerous complaints about:

- the difficulties general practitioners experience with AHPRA / MBA’s disciplinary and other processes, and
- their disquiet about the way the NRAS is being used for workforce reform purposes.

NRAS needs to improve its accountability to the regulated health professions. That is, the NRAS’s administrative agencies (e.g. AHPRA and the National Boards) need to improve the way they respond to, and balance the needs of all health practitioners, in their decision-making processes and activities. This can (in part) be achieved by the administrative agencies:

- becoming more transparent and operationally consistent – across all jurisdictions
- facilitating greater health practitioner participation in their processes
- being subject to health practitioner evaluation, and
- including efficient and effective complaint and response mechanisms (see section 4 of this submission for further information).

This will increase the NRAS credibility and legitimacy with health practitioners as stakeholders – leading to stronger governance structures and increased organisational learning and active participation in health workforce innovation.

2.3. Accountability of accrediting authorities

The RACGP notes the consultation paper re-visits the question of ‘whether the NRAS course accreditation function is to be exercised by an external accreditation entity or a committee established by the national Boards’ (under Governance and accountability of accreditation agencies - page 41), as was foreshadowed during the Scheme’s establishment phase.

The Review discussion paper further highlights (under International comparison - page 42) that ‘in the United Kingdom and New Zealand, regulators have a central role in the development of standards and the accreditation of education and training of health professionals.’

The RACGP, along with the entire medical profession (2008) originally opposed the idea of combining national registration (of medical practitioners) and accreditation (of medical school and college training programs) under the one scheme as it was seen to pose a high a risk of:

- diminishing the medical schools’ and colleges’ role and ability to implement training programs based on evidence of best practice, and
- increasing government control of accreditation standards, leading to training program content deviating from best practices for workforce reform purposes, based on political and economic imperatives.

As was articulated by the co-signatories to joint submission on the proposed arrangements for accreditation under the NRAS in 2008:

*Every part of accreditation of medical education and training should be independent of any political process.*

*The public’s confidence in the accreditation process to deliver the highest standards of medical education and training, and consequently patient safety and quality care, must be protected.*
This requires a process that legally obliges Ministers to accept advice from an independent accrediting agency via the national medical board.

To achieve this, we believe that the independent accrediting body should have formal delegated authority in respect of developing and approving accreditation standards as well as for decisions to accredit individual courses.

Further, in order for the accreditation function to be independent of government, the legislation will need to guarantee that there is also no interference from the National Agency in respect of accreditation standards. The legislation should contain explicit provisions that preclude the National Agency from making decisions that impact either on the content, or administration, of accreditation standards.

If the independence of the accrediting body for medical education and training is not retained, there is a real risk that standards for accreditation of medical education and training could be eroded and manipulated. This is because Ministers will be able to influence (via policy directions) professional and accreditation standards to address workforce issues or achieve cost savings.

For example, a direction could be issued encouraging accreditation agencies to accredit shortened training courses. Through policy directions from Ministers on accreditation standards and/or the influence of the National Agency on the accrediting body, inappropriately short courses could then be accredited in future as a means of introducing a rapid process for bringing people into the health workforce.

There is nothing in the consultation paper that serves to allay these concerns.

As the independent national Accreditation Authority for medical education and training programs (as endorsed by the Medical Board of Australia) the Australian Medical Council (AMC) has performed its accreditation role in an exemplary fashion.

Hence the RACGP strongly argues for the AMC’s retention as an independent Accrediting Authority for medical school and medical college training programs.

**Question 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?

This question appears to suggest that the National Boards and Accrediting Authorities should play an active role in health workforce reform.

The RACGP does not believe the National Boards and Accrediting Authorities should play an active role in health workforce reform.

National Boards and Accrediting Authorities can fulfil their respective roles by remaining informed of each health profession’s education, training and registration requirements, set by their educational institutions.

Health workforce reform needs to be promoted from the ground up. Patients, health practitioners, and the education, training and research institutions need to lead health workforce reform. Their ideas and consensus agreement (within and between professions) about how best to prevent and reduce the burden of disease should be a key driver of innovation.

**Question 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?
General practice is a medical specialty that is delivered as part of a co-located, multi-disciplinary team, with growing links to additional health services, in both the community and acute care sector. It is reliant on seamless health practitioner cooperation and collaboration for optimal patient care.

This service model reflects nation-wide delivery the RACGP’s unique Fellowship Training and Continuing Professional Development (CPD) Programs.

The Australian Medical Council accredits the RACGP’s continually evolving Fellowship Training and CPD Programs, which are designed to meet the changing needs of general practitioners patient populations.

Among other things, the AMC’s accreditation accommodates:

- clinical leadership requirements
- changes in models of care including – multi-disciplinary and collaborative team based care
- population health training requirements
- advances in the quality and safety
- changes in clinical technologies
- use of e-health, and
- changes in training program capacity.

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

No, it is not necessary for a direct relationship to exist between regulators and educational institutions. Ultimately the successful assessment of the minimum qualifications for entry to professions requires a peer-based approach.

Independent peer review processes have the ability to assess the quality of training (that non-peers do not have) according to pre-determined training standards, that meet international best practice.

Current medical specialist training programs in Australia — including CPD programs — are required to meet AMC’s Guidelines for Specialist Medical Colleges as part of their accreditation function, in accordance with the Health Practitioner Regulation National Law 2009 and Medical Board of Australia standards.

The independence of this peer process is necessary to ensure that the best quality of training remains available for the health and safety of the Australian community.

**Question 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?

Yes, there is effective division of roles and functions.

The National Boards should concentrate on protecting the public by maintaining nationally consistent, high registration standards.

The independent Accrediting Authority (the AMC for the medical profession) should concentrate on protecting the public by maintaining nationally consistent, high training program accreditation standards that reflect evidence of best practice.

Education and training program accreditation standards should not be dictated by the objectives underpinning the National Law. There are many broad factors that determine how well education and training program content meets the Australian community’s health care needs.
Medical schools and specialist medical colleges are closely connected with and highly responsive to patient population needs through their constant engagement with their members, students and trainees. Hence, they are best placed to inform development of education and training curricula and accreditation standards – with input from many other stakeholder with valuable insight.

**Question 27: Is there sufficient oversight for decisions made by Accrediting Authorities? If not, what changes are required?**

Yes there is sufficient oversight for decisions made by Accrediting Authorities. The National Boards have the power to ultimately approve or reject accredited training programs and impose range of conditions that reflect policy decisions taken by the Australian Health Ministers Advisory Council.

### 3. The future for regulation of health practitioners

#### 3.1 Maintain 14 National Boards

The RACGP supports maintenance of 14 distinct National Boards for two reasons.

First, the unprecedented rate of each health professions’ evolution (in terms of the rate at which new knowledge, skills and experience is being made part of their routine clinical practice) necessitates close regulatory control, to ensure that the quality and safety of their patient care does not become a new and crippling issue for the healthcare system. The consolidation of two or more National Boards would result in those professions losing the ability to intimately understand the particular professions nuances and thus needs, including by way of future workforce requirements.

Secondly, the quality and safety standards that have been attained, by generations of long standing professions, must be protected and preserved – not diluted by trying to find the lowest common denominators among co-regulated health professions. Adopting the lowest common denominator across professions would only lower the current high quality standards. These standards, and compliance with those standards, should be monitored and maintained by boards/committees with extensive experience in each profession – with input from other health professions / stakeholders who may be affected by changes to their profession.

Issues of cross-professional innovation should be facilitated through formal channels of communication between the 14 National Boards and better systems and processes for changing scope of practice – with the support of other health professions.

#### 3.2 Establish a Health Professions Australia Board

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

The RACGP does not support the creation of a single National Board for the nine health professions considered to be of ‘low risk to the public and have low workloads’ – based on the presumption that they can be co-regulated and require a less stringent regulatory framework.

The RACGP believes their regulation should remain separate, and as high as that of the health professions considered to pose a ‘high risk’. This is due to the unprecedented rate at which all health professions are individually evolving and expanding their scope of practice. This includes independent assessment, diagnosis and treatment of conditions traditionally treated by the medical profession.
Without equivalent education, training and clinical experience, health professions classified ‘low risk’ and with a ‘low workload’ (by this consultation paper) will increase the risk of misdiagnosis and/or late diagnosis and treatment of conditions that require medical attention.

Hence, lowering the level of stringency and amalgamating the regulatory framework governing some health profession’s has the potential to compromise the quality and safety of patient care.

3.2.2 For high risk professions

The RACGP opposes any future introduction of a single Board for the five health professions seen to be of higher clinical risk and workload – including the medical and nursing professions. The reasons are similar to those for maintaining the 14 distinct national boards, as provided under Section 3.1 of this submission.

3.2.3 Use of common regulatory mechanism

**Question 4.** Alternatively, should the nine national Boards overseeing the low regulatory workload professions be required to share regulatory functions for notifications and registration through a single service?

Each of the 14 National Boards should be able to separately apply the same type of regulatory systems and processes to achieve consistency and efficiency gains, without amalgamating their operations.

4. Complaints and notifications

4.1 National coordination of complaints and notifications

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

As stated during the original consultation regarding national registration and accreditation in 2008, the RACGP supports national coordination of complaints and notifications, combined with mechanisms to ensure that local state and territory issues can be appropriately considered (e.g. via state/territory committees).

However, the RACGP believes that the “entry point” of notifications is primarily an administrative issue, and is unrelated to how notifications are managed by the relevant National Board. The “patient/notifier experience” can be effectively managed by ensuring that there is a single entry point, which then communicates in a timely and efficient manner with the appropriate National Board. The outcomes of the process, whether it is a complaints resolution (please see below) or a notification into the conduct of the health practitioner, can also be coordinated by the “entry point”.

4.2 Performance measures and timeframes for complaints handling

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

Whilst the RACGP is overall supportive of the current complaints process, improvements can be made to increase efficiency and meet the needs of both the community and the profession.
Unfortunately, the College continues to receive adverse feedback from general practitioner members regarding the AHPRA complaints process, including:

- unnecessarily lengthy complaint processes
- poor/delayed communication of investigation and hearing outcomes, including the outcomes of panel and tribunal hearings
- issues of procedural fairness, and
- inconsistency of outcomes.

Feedback from RACGP members indicates it is not uncommon for investigations into the professional conduct of general practitioner to exceed 6 months, even when there is little substance to the allegations.

Investigations into the professional conduct of a health practitioner is a stressful period for the health practitioner involved, and has a significant impact on their mental health and wellbeing.

It is therefore important all investigations and outcomes of hearings are completed in a swift and timely manner. This will aid in reducing stress and uncertainty for those health practitioners involved. Timely resolution of notifications will also reduce the likelihood that the investigation itself, rather than any alleged notified behaviour, adversely impacts safety due to the increased stress on the health practitioner involved.

As described below in 4.3, flexible powers for the National Boards to resolve complaints will also significantly improve current arrangements.

4.3 Flexible powers and delineation between complaints and notifications

**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 practitioners and the notifier?

The RACGP is supportive of a flexible approach for dispute resolution, facilitated by the relevant National Board, in agreement between the practitioner and the notifier.

A flexible approach will:

- enable the resolution of “complaints” (as opposed to notifications) with efficiency
- reduce the likelihood of unrealistic expectations regarding outcomes for minor complaints/concerns
- improve patient/notifier experience through swift resolution
- reduce stress for the involved health practitioner
- reduce the administrative burden for the relevant National Board.

4.4 Office of the Health Ombudsman (Queensland model)

**Question 10:** Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner be adopted across all states and territories?

The College believes there is no need for a national Office of the Health Ombudsman (or similar organisation) if the National Boards are supported through a single point of entry, have flexible powers for complaint resolution (aimed at delineating between a complaint and a notification), and adhere to national timeframes and performance measures for notifications.
4.5 Privacy and procedural fairness for health practitioners

The RACGP notes that the consultation paper provides an overview of the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC).

The College supports, in principle, a process that would support health practitioners’:

- right to privacy
- right of reply
- right to procedural fairness
- opportunity for independent investigation, and
- right of appeal.

However, given the current cost of the scheme (particularly for medical practitioners), the RACGP would not support the introduction of increased registration to fund the NHPOPC. Funds required to support the operation of NHPOPC, or similar organisation, should either be absorbed within current funding arrangements, or be funded by the government to support the scheme’s accountability to the public and the health professions.

5. Mandatory notifications

5.1 Protect public safety – exempt treating practitioners

**Question 19:** Should mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

The RACGP has opposed mandatory reporting by treating practitioners since its introduction under the National Law. As GPs have advised the RACGP, mandatory reporting for treating practitioners increases the risk that health practitioners will not seek independent medical assessment, advice and treatment when:

- suffering with a physical or psychological medical condition, or
- exposed to the risk of infection in their personal or professional lives.

It is important to note that mandatory reporting was designed to protect public safety. However, extending mandatory reporting to treating practitioners is self-defeating, as health practitioners who need treatment are deterred from seeking treatment. If health practitioners are not receiving the care they need, their health is compromised and the risk to the public increases.

Given that the vast majority of mandatory notifications come from peers, not treating practitioners, it is reasonable to conclude that health practitioners are avoiding and/or hiding health issues from treating practitioners – as predicted by the medical profession since the concept was first raised. Health practitioners hiding health issues does not support public safety.

Exempting treating practitioners will support the original intent of mandatory reporting – which is to protect public safety – by supporting health practitioners to seek the treatment they need.

The RACGP recommends the adoption of the Western Australian model of mandatory reporting, whereby treating practitioners are exempt.

This model retains mandatory reporting of peers, but affords health practitioners the same rights as all other patients in Australia. That is, health practitioners would be able to seek treatment and advice without fear of being reported to a regulatory authority.
5.2 Doctors’ health programs

The RACGP would like to re-iterate that doctors’ health programs are an important part of a collective effort to protect and promote patient safety by keeping our medical practitioners healthy. To succeed doctors’ health programs must provide non-punitive and confidential services, tailored to the needs of the individuals seeking assistance.

That is, doctors’ health programs must not become in any way an extension of the national Medical Board’s roles and responsibilities. To do so would only exacerbate the profession’s existing fear that seeking help will lead to adverse personal and professional consequences. Inevitably, it is the RACGP’s position any regulated health programs so linked would suffer from a lack of practitioner uptake (in favour of independent, industry services or alternatively nothing).

6. Workforce reform and access

The RACGP does not believe the NRAS should be used for workforce reform purposes. It should focus on maintaining high standards for practitioner registration and monitor compliance to ensure patient safety.

Despite this, the NRAS is being used as a vehicle by some health professions (most notably the nursing profession) to rapidly transform their scope of practice and professional standing through new or revised:

- education and training programs accreditation standards
- registration standards
- codes of conduct, and
- a range of policies and guidelines.

Much of this is occurring without:

- providing clear evidence of the benefits for the reforms they are pursuing, and
- regard for the impact on other health professions ability to maintain the quality and safety of their patients’ care.

The RACGP believes there is a need for the establishment of an independent entity to evaluate health workforce needs in response to community needs, and the level of healthcare expenditure that the Australian community can sustain. This position is supported by other key industry bodies such as the Australian Medical Association.

Within such an entity, expanded scopes of practice could be assessed to determine that:

- the required competencies are predetermined and accredited training and education programs are available to deliver those competencies
- there are documented protocols for collaboration with other health practitioners
- there are no new safety risks for patients
- the change to scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models
- the training opportunities for other health practitioner groups is not diminished, and
- the cost to the health care system will be lower than the current service offering, taking account of supervision costs.

The assessment group should comprise the following members:

- a Chairperson who is a non-practising clinician
- a specialist general practitioner
- a specialist medical practitioner
- a nurse
- a former President of a Medical College
- a community member, and
- a health economist.

A member of the health practitioner group that is the subject of the assessment would be a temporary member of the assessment group, as would any other registered health practitioner group that would affected by the proposal.

7. **Assessment of overseas trained practitioners**

**Question 24:** How effective are the current processes with respect to assessment and supervision of overseas-trained practitioners?

The RACGP acknowledges the success of collective efforts to improve the registration standards and assessment of overseas trained practitioners since 2006 – particularly international medical graduates. The RACGP also acknowledges AHPRA’s and the MBA’s recent efforts to further improve the following since then:

- identity / international criminal history checking
- English language proficiency, and
- orientation and supervision.

The RACGP believes that there is still opportunity for improvement, as per submissions made to AHPRA / MBA earlier in 2014. For example, the current arrangements for international medical graduates (IMG) orientation and supervision are fragmentary and highly variable in their quality and accessibility. To improve the current situation the AHPRA should ensure all IMG have:

- access to a comprehensive and nationally consistent orientation program, and
- supervision equivalent to that for Australian vocational trainees.

8. **Cost and sustainability**

The transition to NRAS has been accompanied by a significant increase in registration fees, despite the expectation that the amalgamation of the state and territory medical boards would lead to operational efficiency gains and cost reductions.

The RACGP believes that the national medical board should be able to perform the pre-existing state and territory medical boards’ duties, and any new activities, within the new budgetary allocation.

Further, clear reporting of the costs associated with administering the national legislation and regulation of the profession would improve transparency, accountability and possibly acceptability of current and any future pricing structures.

9. **Proposed changes to the National Law**

**Question 28:** The Review seeks comments on the proposed amendments to the National Law.

9.1 Preliminary assessment / later assessment

The RACGP welcomes in principle the clarification to the notification requirements in the preliminary assessment and investigation provisions. It is considered this will make the NRAS’s operations more transparent and responsive to the general public.
We query however the proposed provision permitting the referral of the matter to another “entity”, and query – considering health complaints entities are mentioned separately, who this other entity would be.

We consider further changes to these provisions are also warranted to clarify the threshold above which a decision to deal with the matter or refer it to another entity including a health complaints entity. It may also be appropriate to require practitioner input to this step to enable a quick dismissal where a simple explanation would suffice.

The RACGP considers the section 177(b) referral following investigation may excessively prolong the overall process and effectively lead to a second investigation. For the health practitioner involved this would involve recurring anxieties as the inquiry repeats. Further, there is no guarantee the report of the National Board’s investigator will be accepted (or even acceptable) by the relevant referral entity, leading to a complete duplication. In the current review, consideration should be made to ensure this transition process is streamlined and avoids duplication of efforts.

The RACGP also picks up on the reference to key milestone reporting. Currently, the National Boards are required to update only on 3 monthly intervals (such as in clause 161(3)). The RACGP considers it appropriate for this 3 monthly interval to exist only as a backup to milestone responses.

9.2 Conditions on registration

The RACGP supports both of the proposed amendments to these provisions.

The RACGP considers undertakings are an equally effective way to ensure health practitioner compliance with National Board / National Law requirements. The ability to obtain undertakings is consistent with other aspects of the National Law. However, given the outcomes between these two mechanisms are similar, we query who is appropriate to decide to apply one or the other. The RACGP considers health practitioners should be given that opportunity to decide. There are differences in the enforcement effects of breaching an undertaking as opposed to a condition of registration, and the election should be made by an informed decision of the practitioner.

9.3 Abrogation of right against self-incrimination

The RACGP strongly supports these measures. Practitioners should be able to recount their version of events in a productive manner without requiring legal oversight stymieing the process.
References


3 Ministerial Review on Victorian Public Hospital Medical Staff (2008).