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

   There is insufficient information regarding the proposal to reconstitute the Australian Health Workforce Advisory Council. In order to comment, details regarding proposed terms of reference and function of the Advisory Council would need to be known. It would assist if the rationale for disbanding the previous Advisory Council was provided.

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

   Please see response to question 1.

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**

   This is considered a question for the professions themselves, although, if implemented, it would be important to ensure that there was no cross subsidisation between professions of the costs to registrants of registration.

   In regard to broader considerations of managing conduct issues that involve more than one category of health professional, it should be the case that the individual Boards should be able to cross refer concerns and, where appropriate, hold joint sittings and investigations.

   The NSW case of RN Piper & Dr Haertsch provides an example of conduct issues involving more than one category of health professional.

4. **Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? Estimated cost saving $7.4m pa.**

   Please see response to question 3.

5. **Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?**

   Please see response to question 3.

6. **Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefits analysis?**

   The threshold for inclusion in the National Scheme should be based on risk and patient safety considerations with all professions that treat, prescribe or intervene in patient care subject to consistent standards and requirements.

   The Allied Health professions requiring registration based on risk and patient safety considerations may be Nutrition and Dietetics, Speech Pathology and Exercise Physiology.

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

   Please see response to question 6.
8. Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?

Please see response to question 1.

9. What changes are required to improve the existing complaints and notifications system under the National Scheme?

In terms of the broader performance of the National Scheme, the following issues and suggestions are noted:

a) Mandatory reporting requirements, including reporting in relation to impairment, should be reinforced with penalties for non-compliance.

b) Inconsistent advice has been received from the APHRA central number and often strong resistance to disclosing what is deemed ‘personal information’ of the registrant. Such resistance is experienced even in cases where the employer has a role in supporting the registrant and information has been requested from the employer.

c) Inconsistent service levels between locations, i.e. quicker processing for prospective registrants in Adelaide in comparison to Sydney.

d) Lengthy registration processing times, which impact on clinical service delivery.

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

A co-regulatory approach already exists within NSW, albeit different to Queensland. The NSW Health Care Complaints Commission model is operating adequately.

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

Yes. Furthermore, the entry point should be at State level with capacity for complaints and notifications to be made by email, telephone, and letter as well as potentially via web portals.

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

It is agreed that performance measures and prescribed timeframes should be set nationally. The timeframes should apply to all parties involved in a notification with a requirement to communicate when timeframes and performance measures will not be met.

In regard to current timeframes for dealing with impaired practitioners, they are unacceptable. A process exceeding 4-5 months does not meet the public safety obligations of the National Scheme.

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 current approach places too much weight on privacy consideration in regard to the individual professional leading to a lack of transparency. This lack of transparency damages confidence not only in the notification process and outcomes, but the registration and accreditation scheme as a whole.
It must be recognised that employers in particular are significant stakeholders in the notification process. Without adequate transparency and communication, employers can be compromised in respect of either their employment or safe patient care obligations.

There is also a further issue in regard to the information publicly provided when it is likely that a health professional’s registration is to be suspended or revoked and the registrant surrenders their registration before such action occurs. In such circumstances, the details of the practitioner are no longer shown on the APHRA website without notice that had they not resigned, conditions would have applied to their registration.

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

All options for resolution of complaints and notifications should be available for use as appropriate.

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

The adverse finding and record of associated intervention should be removed on expiry. The record should also include a date of expiry so that it is clear when specific conditions will no longer be required.

16. **Are the legislative provisions on advertising working effectively or do they require change?**

No comment.

17. **How should the National Scheme respond to differences in States and Territories in protected practices?**

No comment.

18. **In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?**

Please see response to question 6.

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?**

In the interests of patient safety, there should not be exemptions regarding mandatory reporting of impaired health practitioners.

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?**

The National Boards and Accrediting Authorities have shown no significant influence in these areas.

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

Please see response to question 1.

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

The NSW Ministry of Health is best placed to respond to this question.

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

It is essential that educational institutions remain aware of registration standards/entry requirements for professions.

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

It is agreed that the appointment should be merit based.

25. 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?

The NSW Ministry of Health is best placed to respond to this question.

26. Is there sufficient oversight for decisions made by accrediting authorities?

There is a need for greater transparency and accountability for variances in processes. External bodies’ influence should not create a monopoly, as is current practice with Medical Colleges having undue influence, with no avenue for resolution.

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

It is anticipated that the Legal Branch of the NSW Ministry of Health will comment on the proposed legislative changes.