10 October 2014

Mr Kim Snowball
Independent Reviewer
Review of the National Registration
And Accreditation Scheme for health professions
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MELBOURNE VIC 3001

Via nras.review@health.vic.gov.au

Re: RACMA Submission to the Independent review of the National registration and Accreditation Scheme for Health professions – October 2014

The Royal Australasian College of Medical Administrators (RACMA) welcomes this opportunity to make comments on the AHMAC consultation document, “Review of the National Registration and Accreditation Scheme for health professions”.

RACMA has developed responses to the specific questions in the consultation document and these follow in the paragraphs below. The responses reflect the views of several senior College fellows who participated in an internal College discussion.

Q1 Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?

Response:
RACMA supports clarity of responsibility and the practice of accountability by individuals and bodies with governance authority for the safety and health of communities.

The proposal to reconstitute an Australian Health Workforce Advisory Council (AHWAC) is supported in principle provided there is stronger engagement with health ministers and other appropriate jurisdictions. Visible processes of consultation and review, together with advice from those with expertise to comment will underpin preparation of comment will underpin capacity to be independent.

Independent reporting would require multi-level changes:
   a) Clarity and agreement on the function of the AHWAC, and what it has legitimate responsibility and accountability for reporting on. This needs to be enshrined in legislation.
   b) Clarity about what is to be independently reported, to whom, and for what purpose.
   c) Clarity of the process of reporting, given the AHWAC is likely to rely on other agencies, particularly jurisdictions, for source data.
d) Finally, appointment of a properly credentialed committee by a process that stakeholders (especially health ministers) perceive to be credible and reflective of the intended independence of the Committee.

The Council would need to adopt principles to underpin its independent reporting activity e.g. transparency, timeliness, accuracy, collaboration, fairness.

**Q2. Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross professional issues are addressed?**

Response:
Yes, RACMA supports this recommendation. The Council should develop and publish a clear process for resolution of such matters and clear criteria by which they will be assessed. The publication of such guidance might serve to diminish the incidence of such issues.

**Q3. 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.

**Q4. 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.

Response Q3 & Q 4
RACMA agrees with the principle that the regulatory processes and infrastructure should be cost effective and efficient and that some combination of the nine smaller professions may be appropriate on this basis.

An important consideration in this matter is the need to ensure that the regulators have sufficient opportunity to deal with the difficult and complex matters of assessing notifications and complaints. Development of robust and consistent processes and allowing for appropriate skills development is critical to achieve performance excellence. This may be facilitated by retaining the 9 Boards but amalgamating the ‘back-of-house’ functions e.g. having shared notification management pathways.

**Q5. Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?**

Response:
Savings achieved through shared regulation, if it reduces bureaucracy and delivers better administration and standards of performance should be used to improve functionality of the
national scheme e.g. timeliness of response to issues, and ultimately flow through to registrants’ benefits.

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 an associated cost benefit analysis?

Response:
Yes. Essential for transparency and to make evidence based decisions about professions included in the National Scheme.

In addition to basing entry on risk to the public, there are groups where having a Framework (for work roles/SoP) would provide benefits.

Q7. Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?

Response:
RACMA does not support this proposed amendment. Currently those professions not recognised under the National Law comprise a range of associations governed by codes of conduct and practice and accreditation arrangements. These organisations are often associated with employment and special interests where regulation as proposed may not be appropriate.

It is the case that natural medicines and complimentary medicines currently lack regulation but unless there is a demonstrated health and safety risk self regulation may be sufficient.

There should be greater clarify and more investigation should be undertaken ahead of such a proposed amendment to the National Law. It is important to avoid any inconsistency which might arise from a ‘grandfathering’ process to embrace other occupations.

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?

Response:
Agree. RACMA supports the comments from CPMC in this regard.

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

Response:
Changes should aim to improve the timeliness of response to complaints and subsequent review, and availability of information concerning progress in dealing with complaints. RACMA also favours a single point of entry model and effective communication of this to the general public and the relevant professions. RACMA supports the principal of a more local complaints management process (for example, at State and Territory level) providing such processes are consistent with national standards of complaints management, resolution and public reporting. The body overseeing the national scheme (for example AHWAC) could have a role in periodically reviewing and accrediting jurisdictional complaints management bodies, procedures and processes to ensure compliance with national standards.

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

Response:
Without further evidence it is not possible to assess fully if the co-regulatory QLD actually works.

11. Should there be a single entry point for complaints and notifications in each State and Territory?
12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?
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?

Response to Q 9-Q13
Currently there is a lack of clarity around social justice, timeliness and communications for both notifiers and the clinician at the centre of complaints. There are cases where this has been extremely damaging to the parties.

A revamp of the process, the support systems and expectations about performance need to be established to ensure the system is robust and fair.

There should be timely and regular advice to health services, employers and colleges about notifications or serious complaints of complaints about a clinician.

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?

Response:
Yes. However, if changes consistent with RACMA views in Q9 are adopted, the role of the National Scheme (and its governance body) would be regulatory oversight of complaint
management and resolution, and jurisdictional complaint management bodies would have discretion to utilise ADR as appropriate.

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

Response: 
RACMA does not agree that an intervention order should remain in place for ever. We suggest there should be opportunity for review ahead of return to work after rehabilitation to a set standard/performance.

Depending on the adverse event and finding a risk level based schedule of penalty periods might be developed and a minimum period before review established.

As a matter of principle, RACMA believes that public health and safety must be the primary consideration in determining what advice is provided publicly and for how long. Patients and their families/carers must be able to make informed decisions regarding their care provider, and history of adverse findings is an important factor which may influence such decision making.

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?

Response: 
RACMA supports a national scheme to govern protected practices. State and Territory differences should be eliminated over time.

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?

Response: 
RACMA suggests there should be a Code of Conduct for unregistered practitioners with oversight by the national board, legislated and empowered to ensure governance of all practices.
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?

Response:
It appears that, with respect to mandatory notification provisions, including exemptions (in the WA and Qld legislation), has equivalent coverage in the national legislation and therefore consequently there is no need to change. There should be consistency across the jurisdictions.

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?

Response:
There are three broad activities relevant here and no single agency can do them all:
   a) Policy & Planning; - AHWAC
   b) Setting Standards; - National Boards
   c) Monitoring attainment of Standards

RACMA believes that the National Scheme is about setting standards and implementing those standards in respect of professional registration.

Policy and Planning is the province of health ministers and related health departments. AHWAC has a role to play in this area. Assessment of the impact of the regulator on health workforce, innovation etc should be assessed independent of the regulator by the policy-makers. Efforts to improve the health workforce may or may not involve regulatory change.

Assessment of compliance with standards could be part of the role of the regulator or it could be undertaken by an independent agency (public sector such as AHWAC or private sector such as with hospital accreditation). This assessment of compliance is a weakness of the current national scheme.

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

Response:
Regulation is a consequence of policy and planning. There needs therefore to be a clear separation of the roles of AHWAC and other regulatory bodies and between regulatory and accreditation bodies. AHWAC should advise Ministers about NRAS.
AHWAC has a role to look at the regulatory implications of COAG reforms without becoming the regulator itself. Policy and planning doesn’t sit with the regulatory.

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?

Response:
Currently accrediting bodies are probably not accommodating multidisciplinary education and training environments with co-ordinated accreditation processes. This is a ‘hot’ area for more research and policy work before regulatory considerations can be had.

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

Response:
Refer to responses to Q 20 and Q 21.

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

Response:
Much recent work has been undertaken to make these processes more effective by clarifying the roles of the various parties involved (e.g. medical colleges) however there appear to remain some jurisdictional issues e.g. concurrent general registration and limited specialist registration in QLD. RACMA’s recommendation would be for consistency in allowing those who are eligible or hold general registration to also be considered for limited specialist registration in parallel.

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

Response:
Yes. The principle of merit as well as skills base and experience including an understanding of health professions based appointments is always supported; open and transparent recruitment and acceptance of the process by the stakeholders is important.

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?

Response:
RACMA has strong regard for the work of the Australian Medical Council (AMC). It has adopted a transparent consultative process and oversaw both the University Medical Schools and then Medical College accreditation activities with professionalism. Its work has created significant development and enhanced rigour in these training systems.

With the implementation of the National Law the AMC is transitioning to an accreditation model with clearer requirements and capacity to enforce the standards. RACMA would not support the development of a committee structure within the various professional boards to handle this. There should be a separated function.

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

Response:
Oversight of these bodies is not achieved by another regulator or committee structure. Accreditation systems should have a degree of independence from regulators. Accreditation standards need to be clearly available and open to both comment and challenge.

It is appropriate that external expertise including periodic international benchmarking be used so that the requirements for accreditation are robust and evidence based as far as possible.

Thank you for the opportunity to comment.

Yours sincerely

Dr Karen Owen
Chief Executive