

10 October 2014

Review of National Registration and Accreditation Scheme for Health Professions  
Australian Health Ministers' Advisory Council  
Via email: [nras.review@health.vic.gov.au](mailto:nras.review@health.vic.gov.au)

Dear Sir/Madam

## Review of National Registration and Accreditation Scheme for Health Professions

The Health Consumers Alliance (HCA) is the peak body for health consumers in South Australia. Established in 2002 as an independent alliance of health consumers and health consumer organisations, we work together with our members to achieve our vision of consumers at the heart of health care. A strong and effective voice for the promotion and protection of health consumer wellbeing and rights, HCA promotes health equity and provides systemic advocacy to inform, shape and sustain consumer centred care. Health consumer and community engagement informs all of HCA's work – we seek out the lived experience of health consumers and carers to inform our policy and advocacy positions.

### Introduction

Health care is a profoundly personal experience that has immense public consequences and is acknowledged by the World Health Organisation as a human right. The health care we get, or do not get, affects our ability to lead long and healthy lives. Health has ripple effects throughout our society, influencing the ability of children to succeed in school, the productivity of Australian workers, and the lifestyles of our ageing population.

Historically, the health system has evolved as a practitioner-centred system, developed around the needs, preferences and priorities of health care practitioners. Health care is not a low risk activity. 'Trust me, I'm a doctor, nurse, administrator' is no longer persuasive to Australians. Improving the safety and quality of health care involves everyone: politicians, administrators, doctors, nurses, allied health professionals and support staff. Importantly the needs, wishes and preferences of consumers, families, carers and communities should be central to any change agenda in health.

Transparency and openness to other knowledge, experiences, perspectives and values is critical for quality, safety, equity and sustainability. This can only be achieved if our health system is consumer-centred.

Based on our policy and advocacy work and engagement with health consumers, families, carers, communities and other stakeholders over the past 12 years, HCA understands that consumers look for health care to promote health and wellbeing; and seek a health system that is appropriate, effective and efficient.

HCA acknowledges that with current legislative and taxation arrangements, Australian governments (Commonwealth, State and Local) have a shared responsibility for the funding and delivery of health care and prevention services. We also acknowledge the important role of

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private practitioners, private hospitals and the non-government or charitable sector in the delivery of health care and prevention services in Australia.

Based on this input, we have chosen the most relevant questions from the Consultation Paper to answer that support the primary principles of our submission.

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

Independent oversight and reporting on the Scheme is warranted, given the number of vested interests involved in the delivery of health services in Australia. Independent oversight and reporting should be charged with the purpose of providing accountability back to health consumers and the community as the funders, owners and consumers of health services in Australia. Such accountability should also seek to ensure that the processes, actions and determinations of the Scheme meet community expectations and standards, rather than just the standards of professional groups and the legal fraternity. Improved transparency and accountability back to health consumers and the community is required for the Scheme to build community trust acceptance. With the demise of Health Workforce Australia there is certainly a need for independent oversight and advice regarding the health workforce and the Scheme.

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

This is not supported. This would pull resources away from the vision of a reconstituted AHWAC to provide independent advice and reporting to Ministers. Furthermore, moving this function to another body would complicate an already complicated notifications resolution process. AHPRA should take on the role of assisting in the resolution of cross-professional issues, as it is already established as the entity above the National Boards. The expansion of AHPRA's authority to resolve cross-professional issues should be done by expanding its authority to work more closely with Health Complaints Entities, or similar co-regulatory bodies, to facilitate the resolution of notifications that have complaint components.

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

This is supported. A regular review of the functioning of the single Board should be conducted to check that it is still meeting the needs of consumers and the community. The new National Board should have profession-specific advisory panels.

**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?**

This is not supported. This role should properly be undertaken by AHMAC, and only after stakeholder consultation as to what potential new thresholds might look like.

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

There are several changes that are required to improve the management of complaints and notifications. There needs to be very clear communication with consumers about the difference

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between a complaint and notification, and the pathways each will take. This information should be available, as practicable, at any point of contact a consumer may have with the health system. Our survey found that most consumers, when they make a complaint or notification, do so at the level of their health provider as opposed to other Scheme entities.

There also needs to be better management of complaints and notifications that intersect, either by professions or by jurisdiction (ie, to be managed by a Health Complaints Entity or a National Board and AHPRA). The Scheme currently silos the handling of complaints and notifications, and does not provide easy facilitation of

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

HCA believes this would be facilitated most appropriately by a single point of entry model. HCA supports in principle the establishment of a national entity that can oversee the performance of the National Boards and AHPRA while being able to report on performance by jurisdiction. However, if the co-regulatory approach were adopted across all States and Territories, then they should have consistent criteria for assessing and reporting on the performance of the Scheme so that Ministers, stakeholders, and the public can transparently evaluate the performance of the States and Territories.

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

Yes, the principle of there being no wrong door for health consumers is supported. If the easiest way to achieve this is through a single entry point, then this is supported.

A single entry point must serve the critical function of informing people about the process their complaint or notification will undergo, the criteria for its evaluation, and what resolutions the person might expect at the end of the process. This would be aided by mandating specific timeframes for key milestones, eg, the decision of a body to accept a complaint, the assessment of the complaint, the initiation of an investigation, and periodic communications with the person throughout the investigation process up to and including its conclusion.

The point of entry should be comprehensive, to allow for complaints about practitioners, services, facilities, etc and allow the appropriate regulatory authority to take over behind the scenes. Health consumers should not have to become experts in legislation and regulations to figure out where to go to make a complaint.

Information about the single point of entry should also be available at all health care services, and there should be very clear instructions promulgated throughout the health system on how to direct a person who wishes to make a complaint or notification on how to access the complaint entity.

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

Yes, HCA believes the shortest timeframes ought to concern decisions on accepting and assessing complaints and notifications, communicating back with the person raising the issue, and initiating the investigation. It is vital for promoting public confidence in the health system that complaints be resolved transparently, and open lines of communication with those who make

complaints and notifications are essential in this task. Furthermore, open communication is critical in managing expectations with those who make complaints, otherwise they might feel like the system ignored their desired outcome. HCA believes that prescribed timeframes for managing complaints and notifications, in conjunction with prescribed timeframes for communications with notifiers and complainants, would go a long way to improving public confidence in the system and outcomes for complaints and notifications.

**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?**

This is a great deficit of the current Scheme in the eyes of health consumers and the community. There is insufficient transparency and accountability to both notifiers and the community about the outcomes of disciplinary processes. There are many reasons for this, but the key issue is that there is no consistent, national requirement for National Boards, AHPRA, or other entities to keep consumers and notifiers informed about the disciplinary process. Moreover, there is not readily accessible data on the outcomes of disciplinary actions; and much of the work done to date to quantify these outcomes has had to come at the result of dedicated Parliamentary inquiries or academic-supported reviews. These are labor intensive, subject to variable criteria, and inconsistent across jurisdictions.

It is not in keeping with the overall mission to protect public safety to have a system that is difficult to understand, access, and audit. Fortunately, the resolution to these problems is straightforward.

First and foremost, the Scheme's success ought to be measured against very clear desired outcomes. The Consultation Paper and consultation forums drew significant attention to the key performance indicators for health regulation used by the United Kingdom's Professional Standards Authority; and while not all of their indicators are applicable to the disciplinary process, the general principle of "right touch" regulation can be applied. It is not burdensome to require entities under the Scheme to mandatorily communicate with notifiers at key milestones – and their performance against these timelines can be measured and reported.

Furthermore, consumers and practitioners should be informed of the route their complaint or notification will take at the outset. This can be accomplished by establishing a single point of entry to the system. If it should be later determined that the notification or complaint ought to be transferred to another entity, then that should also be communicated back to the initial person.

On the disciplinary processes itself, notifiers should be regularly updated on the progress of their notification – even if the investigation and deliberations are still pending – and be properly informed of the reasons behind any decisions or delays.

Finally, there ought to be an entity with broad oversight, reporting, and auditing authority for the Scheme. HCA supports a reconstituted AHWAC having auditing authority to ensure there is transparency and accountability across the Scheme.

**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?**

Alternate dispute resolution such as mediation could improve consumer and community satisfaction with the Scheme and meet consumer needs related to being listened to, supported

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and acknowledged through complaints processes. Alternate dispute resolution processes should not compromise the purpose of the Scheme to promote public safety. If a notification presents a serious risk to the public, then that ought to be fully pursued, and the sanctions appropriate. However, if the notification could be resolved through the complaints resolution process, then National Boards should either be able to facilitate that resolution, or have more authority to work in connection with Health Complaints Entities, or similar dispute resolution entities, and the stakeholders to resolve the complaint.

**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?**

Health consumers are concerned that the National Code of Conduct for unregistered health practitioners may not go far enough to protect the community from unregistered practitioners. Remedy under the Scheme might be found in amending and expanding advertising prohibitions to include any person who, under the guise of promoting a health care service, makes “false, misleading or deceptive or is likely to be misleading or deceptive” claims about the efficacy of their treatment; and AHPRA could collect and maintain information about unregistered health practitioners who receive complaints under this section. Alternately, or in tandem, should a jurisdictional Health Complaints Entity (or similar) issue a prohibition order against an unregistered health practitioner, the prohibition order could be posted by AHPRA under an unregistered health practitioner section to ensure public awareness. This would be done in conjunction with the States and Territories mutually recognizing each other’s prohibition orders.

**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?**

HCA supports the principle of exempting mandatory notification of registered health practitioners who are undergoing treatment in that HCA supports ensuring that health practitioners are able to continue performing their work safely and with minimal risk to the public.

Due to a lack of public data about how routinely health practitioners avoid seeking care for fear of triggering a mandatory notification – although we have heard anecdotal evidence to this point – we cannot form an opinion based on the scale of the problem that warrants a blanket exemption. HCA encourages the Independent Review to explore the potential for a middle ground between the options it presented, whereby health practitioners might be afforded a probationary period of treatment where, lacking evidence of imminent risk to public safety, they can receive care without triggering a notification. If the care becomes ongoing, the practitioner demonstrates a risk to public health, or unilaterally terminates treatment before resolving the underlying health issue and risk to their practice, then a mandatory report ought to be triggered.

Furthermore, we believe that a large issue in practitioner reluctance to seek care when required has to do with a fear over vexatious reporting if they are discovered. There are insufficient penalties for practitioners who are found to have made vexatious reports against their colleagues or across professions. Currently, National Boards are only required to take “no further action” against such notifications. HCA therefore recommends that Section 151 of the National Law be



amended to contain clear penalties for practitioners who are found to have made unsubstantiated or vexatious reports against those seeking care.

Whatever the course chosen, HCA is concerned that the Independent Review has looked too narrowly at the costs associated with mandatory notifications – in terms of regulatory burden – rather than the outcome on public health.

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

HCA believes there is a strong need for national leadership in this area and that Ministers and Government ought to reconsider and reverse the decision to have abolished Health Workforce Australia as a driver of workforce reform priorities and addressing forecasted health service access gaps.

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

This is supported. Allow persons such as consumer and community representatives of National Boards to become chairpersons may provide balance and independence to this role. Consumer representatives on National Boards help ensure that a notifier is not being ignored in the review process, or that the general public is not being put at risk by allowing an unsafe practitioner to continue practicing. It is important that the Review has recognized the importance of this role consumer and community representatives have to play.

However, we believe that professions' ultimate accountability ought to be with their colleagues. It is also important in giving registered health practitioners the confidence that notifications made against them are being reviewed by persons with experience in the details of their profession.

If the Independent Review wants to make recommendations for improving the ability for consumers and community representatives to have on the notifications review process, then HCA would encourage the Review to examine proposals to create consumer juries or advisory panels under the National Boards that can review notifications from the consumer perspective and make recommendations on outcomes and sanctions. Moreover, the reconstituted AHWAC should be structured to include consumer representation in order to ensure that the body's reports to Ministers includes evidence about how the Scheme's performance against its objectives is impacting consumer confidence in the Scheme as a whole.

### **Mandatory communications by National Boards to notifiers**

HCA strongly supports the amendments proposed to require National Boards to inform notifiers of key milestones regarding the notification, and to provide detailed explanations when a National Board determines that no further action will be taken on a notification.

### **Commonwealth Reforms to Freedom of Information Legislation**

HCA supports amending the Scheme to come into compliance with national reforms to privacy and information laws. This is in keeping with our general principle that the National Scheme ought to be as nationally consistent as practicable, so that consumers and practitioners in each jurisdiction can have similar expectations about the security of their personal information, how it will be used and potentially reported.



When it comes to the Scheme specifically, however, HCA would strongly discourage and disapprove of using privacy and information laws to exclude consumers who have made notifications about inappropriate or unsafe conduct from being duly informed about the progress of their notification. While this information should be properly kept confidential from persons not directly involved in the review and adjudication of notifications, consumers are entitled to full and open disclosure about how their health information is being used.

### **Actions following suspension**

HCA holds that practitioners who are suspended from practicing ought to be required to reapply for reinstatement and registration. Unless a National Board has good reason to believe that the suspension was made on erroneous or misleading information, practitioners who were suspended should be required to demonstrate through reapplication that they are able to practice safely. This might be where the proposed review period comes into play, whereby a National Board could review the evidence that was made to support a decision to suspend, and whether that evidence was valid.

### **Notice of a decision to take action**

HCA supports a broader definition to notify all places of practice about actions taken against a registered health practitioner.

As we have identified, there are many opportunities to improve the functioning of the Scheme. All changes should be considered through the lens and needs of health consumers and the community with a view to increasing accessibility, transparency and accountability back to the owners, funders and users of our health system – the citizens of Australia. Thank you for the opportunity to participate in this important review.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Michael Cousins'.

**Michael Cousins**  
Manager, Policy and Advocacy

