

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

10 October 2014

## Introduction

The Victorian Healthcare Association (VHA) is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services, aged care facilities and Medicare Locals. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

A consultation paper was released on the *Review of the National Registration and Accreditation Scheme for health professions*. The VHA welcomes this opportunity to provide input into the review.

The VHA agrees to the submission being treated as a public document, and the information being cited in the final report.

## The VHA's Response

The National Scheme is important for supporting the health sector to access a workforce that can deliver care safely, competently and cost effectively. In the response, the VHA has focused on the areas of workforce reform, the complaints and notifications process, and the minimisation of costs of the National Scheme. The VHA has also commented in other areas where appropriate, such as the processes relating to the assessment and supervision of overseas trained practitioners.

The response does not answer every question in the consultation paper. Where the response does relate to a particular question, then the question will be bracketed next to the statement. For example, (Q1) relates to Question 1 of the consultation paper.

### 1. Supporting workforce reform

In order to meet the demands of delivering health services now and in the future, health services are developing new models of care that may encompass a broad range of professional roles, or changes in existing roles by extending the existing scope of practice of practitioners. This is particularly important in rural areas where the flexibility of the local health service and health professionals to work across the continuum of care enables people to receive responsive and professional care in their community.

However, health services encounter significant barriers to implementing workforce change, particularly changes that involve extending the scope of practice of health professionals. Many of the difficulties in workforce change are created by a disconnection between state health workforce needs and national workforce training, restrictions from state and federal based protections and legislation such as the Poisons Act, resistance to change from unions and professional boards, and barriers formed by entrenched professional cultures.

The VHA is supportive of the reconstitution of the Australian Health Workforce Advisory Council (AHWAC) to provide independent reporting on the operation of the National Scheme, for it to be the vehicle through which any unresolved cross professional issues are addressed, and for AHWAC to carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps.

The VHA recommends the role of AHWAC to be further extended to provide national workforce planning based on the workforce needs of both state and federally funded agencies, thereby creating a stronger link between national workforce training and largely state based health workforce needs. The VHA also recommends that workforce reform becomes a standing item on the Standing Council on Health (SCoH).

In the longer term, there needs to be consideration whether the current approach to health profession registration supports changing workforce needs and reforms in Australia. In a recent paper, “*Changing health professionals’ scope of practice: how do we continue to make progress?*”, Leggat recommends that in order for scope of practice change to be enabled and encouraged through health profession registration, then registration will need to change from the current approach focused on established professions to the regulation of services and practices that have the potential for harm. She cites the approach used in the province of Ontario in Canada where the legislation recognises 14 controlled acts, such as communicating a diagnosis, performing a procedure, and administering a drug. She says this approach allows health professions to delegate controlled acts to other registered and unregistered health professionals that do not have the statutory authority to perform such services, and by doing so medical practitioners, for example, can delegate acts to other health profession through direct order for individual patients and through medical directives for all patients<sup>1</sup>. The VHA views this as a possible approach for facilitating health workforce reform in the longer term, and recommends approaches such as this for further consideration.

#### VHA’s Position

1. Reconstitution of the Australian Health Workforce Advisory Council (AHWAC) to provide independent reporting on the operation of the National Scheme (Q1).
2. AHWAC is the vehicle through which unresolved cross professional issues are addressed (Q2).

<sup>1</sup> Leggat S, “*Changing health professionals’ scope of practice: how do we continue to make progress?*”, Australian Healthcare and Hospital Association, 2014, p20-21

3. The reconstituted AHWAC's carries responsibilities for informing regulators about health workforce reform priorities and key health service access gaps (Q21).
4. The role of AHWAC is further extended to provide national workforce planning based on the needs of both state and federally funded agencies, thereby creating a stronger link between national workforce training and largely state based health workforce needs (Q20).
5. Regulation affecting the health workforce, such as controls in the Poisons Act and protected practices, is harmonised across jurisdictions (Q17).
6. Workforce reform is a standing item on the Standing Council of Health.
7. Longer term consideration is given to the approach to health profession registration.

## 2. *Unregistered health practitioners*

Many health practitioners, such as occupational therapists and speech pathologists, are not registered as one of the 14 professions regulated under the National Registration and Accreditations Scheme.

This is beneficial to the sector as these professions represent low risk to public safety, and the cost of regulating these professions under the Scheme is likely to outweigh the benefit. For this reason, the VHA is supportive that 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 associated cost benefit analysis.

However, the VHA is concerned that registration under the Scheme may inadvertently provide increased credibility to those registered under the Scheme compared to those not registered under the Scheme. As such, professions not registered under the Scheme may face discrimination in funding and service arrangements compared to those registered under the National Scheme.

There needs to be a mechanism for reviewing arrangements where a profession is excluded from receiving funding or providing services simply because they are not registered under the National Scheme. The professional bodies can play an active role in this through identifying evidence supporting these claims, and through the development and implementation of accreditation standards.

A National Code of Conduct for unregistered practitioners would be useful for providing public protection without the need for full registration, and breaches could be managed through the state and territory based health complaint mechanisms in a nationally consistent way.

### VHA's Position

8. 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 (Q6).
9. Mechanisms exist for reviewing arrangements where a profession is excluded from receiving funding or providing services where it is capable and safe for those professions to deliver those services, but they are excluded as they are not registered under the National Scheme.

10. Implementation of a National Code of Conduct for unregistered health practitioners is progressed in order to provide a degree of public protection without the need for full registration. Breaches could be managed through the state and territory based health complaint mechanisms. This needs to be performed in a nationally consistent way (Q18).

### ***3. The complaints and notifications process***

From the VHA's perspective, the main concern with the complaints and notifications process is the communication to all parties through the process and at the conclusion of the process is inadequate and is not timely.

The VHA is supportive of AHPRA's key performance indicators for the management of notifications which were developed in 2013, and public reporting of AHPRA's performance against these indicators. VHA is of the view that the KPI's should represent similar timeframes as those in other jurisdictions in both Australia and overseas.

The VHA supports a single entry point for complaints and notifications in each State and Territory, and there is consistency in approach in the management of complaints and notifications.

The VHA is supportive of further consideration being given to provide National Boards with more flexible powers to adopt alternative dispute resolution, such as settling matters by consent between the Board, the practitioner and the notifier. However, while worthwhile considering, it should not further delay the process of investigation and resolution (Q14).

The VHA is supportive of mandatory notification provisions to be revised to reflect the exemptions included in Western Australian and Queensland legislation covering health practitioners under active treatment (Q19).

#### VHA's Position

11. There is a single entry point for complaints and notifications in each State and Territory. This could be the State or Territory health complaints entity (HCE), and the HCE could play a role in further establishing the basis of the complaint or notification if this is required (Q10 and Q11).
12. Performance measures and prescribed timeframes for dealing with complaints and notifications are adopted nationally, and the prescribed timeframes are set according to best practice (Q12).
13. There is further transparency for the public and for notifiers about the process and outcomes of disciplinary processes at all stages of the process, and particularly at the conclusion of the process in respect to findings, actions, and the basis of the findings and actions (Q13).

### ***4. Minimising the costs of the National Scheme***

Pressures on the health sector in terms of rising demands and cost pressures means it is becoming increasingly important to contain costs associated with healthcare delivery.

In the consultation paper, the Review discussed options for structural changes to the regulation of health professions, including:

- Option 1:- Establishment of a Health Professions Australia board which carries regulatory responsibility for the nine lower regulatory workload professional groups and thereby replacing the existing nine National Boards, and
- Option 2:- Retain the nine National Boards representing the lower regulatory workload professional groups, but consolidating the functions underneath them (to the maximum extent possible) into a single national service to the nine professions.

The VHA is supportive of Option 2. However, VHA is not supportive of the establishment of a Health Professions Australia board. The VHA believes that the establishment of a single board may affect development in each of the professional areas and may act to further inhibit changes in scope of practice with the professions represented by the Health Professions Australia board, compared to those professions in the remaining five boards.

The VHA is concerned that AHPRA may be seeking to raise revenue for some services, including the potential charging of fees for checking registration of practitioners by employers. Healthcare providers don't have control over the cost of providing the service, and there is no marketplace for AHPRA's services where they can seek the services from an alternative provider. For this reason, it is important that this cost is contained within AHPRA and that the burden of the cost of these services is not borne by healthcare providers.

#### VHA's Position

14. The nine National Boards overseeing the low regulatory workload professions are required to share regulatory functions of notifications and registration through a single service is VHA's preferred option for reducing the costs associated with regulation of low regulatory workload professions (Q4). The VHA does not support a single Health Professions Australia Board being established to manage the regulatory functions that oversee the nine low regulatory workload professions (Q3).
15. The cost of a National Registration and Accreditation Scheme is not borne by healthcare providers by means of fees or levies on healthcare providers.

#### **5. Other areas for comment**

	<b>The question in the Consultation Paper</b>	<b>VHA's Position</b>
16	Are the legislative provisions on advertising working effectively or do they require change?	VHA's preferred option is Option 2 (ie To amend the National Law provision preventing the use of testimonials to clarify when comment is permissible).

	The question in the Consultation Paper	VHA's Position
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?	Yes, the mandatory notification provisions should be revised to reflect the exemptions included in Western Australian and Queensland legislation covering health practitioners under active treatment.
24	How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?	<p>Overseas trained practitioners have contributed to addressing workforce shortages in Australia.</p> <p>However, the current processes with respect to assessment and supervision of overseas trained practitioners are currently poor.</p> <p>The main issues are:</p> <ul style="list-style-type: none"> <li>• Health services find that international practitioners are significantly more labour intensive to support to the point of clinical competency. Their proficiency in the English language and cultural differences are the main contributors to additional supervision required for overseas trained practitioners and their readiness to practice without supervision</li> <li>• The education provider gives health services insufficient notice of the makeup of students requiring clinical placement and supervision. This can place the health service under increased pressure to provide adequate supervision during clinical placement.</li> </ul>

## Further information

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