

# Palliative Care Australia

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**Submission to Review of the  
National Registration and  
Accreditation Scheme for  
Health Professionals**

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**Palliative  
Care  
Australia**

Palliative Care Australia (PCA) is the peak national organisation representing the interests and aspirations of all who share the ideal of quality care at the end of life. Our mission is to influence, foster and promote the delivery of quality care at the end of life through ongoing policy and advocacy, education, and developing collaborative relationships in Australia and internationally.

We believe that palliative care must be available regardless of location, age, income, diagnosis or prognosis, social and cultural background, to support Australians to live well at the end of life.

But we remain a very long way from achieving our goals. In 2011, nearly 147,000 Australians died. Of these 70% would have benefitted from access to palliative care services, yet only 30-50% did.

The National Palliative Care Strategy endorsed by the Australian Government in 2010 signalled the combined commitments of the Commonwealth, State and Territory Governments to the development and implementation of palliative care policies, strategies and services that are driven by standards and consistent across Australia. This sent a clear message that in order for Australians to live well at the end of life, its implementation is necessary if Australia is to continue to be a world leader in the provision of first class palliative care services.

PCA supports the National Registration and Accreditation Scheme (NRAS) in order to protect public safety, particularly people who are vulnerable. People with a life limiting condition or illness and people at the end of life are vulnerable to exploitation and need to have confidence that the health professions and services they access are providing safe and appropriate health care.

This submission from PCA addresses each of the questions from the Review of NRAS for health professions consultation paper.

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

The consultation paper discusses the need for an independent assessor or body to provide advice to Ministers and the Health Workforce Ministerial Council. Given the Australian Health Workforce Advisory Council (AHWAC) was intended to perform this function, reconstituting this body would appear to be an appropriate course of action. A key issue that requires clarity and further detail is how this reconstituted body would be resourced to undertake the work that is envisaged, and what areas its membership would be drawn from.

The functions that should be performed by an independent advisory body would include research, analysis, liaison and collaboration with other relevant parties that influence workforce strategic management and development.

The consultation paper states that AHCW could undertake research, analysis or consultation to provide advice on the performance of the regulator and assisting with complex policy issues involving multiple professions and stakeholders. It is worth noting that this is a function that Health Workforce Australia (HWA) would have been ideally positioned to provide, as it already had the expertise, existing research work and data, and was formed as an independent workforce body. The terms of reference for the inquiry also included:

Consider the opportunities that AHPRA and the National Boards have to work effectively in partnership with other parties that influence workforce, including but not limited to state, territory and Commonwealth health departments, *Health Workforce Australia*, education providers.

It is recognised that the legislation to cease the operation of Health Workforce Australia (HWA) has been enacted in the Australian Parliament. It would have been prudent to have allowed the NRAS review to be undertaken and awaited the outcomes of this before ceasing the operation of HWA. It could have played an integral role to NRAS and the functions being sought with regards to advice and research could have been performed by an existing body. This would seem to fit within the scope of the review looking at the future sustainability of NRAS, as the review has a strong focus on cost and efficiency.

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

The AHWAC could be used to address unresolved cross-professional issues, however it would need to be resourced and provided with the appropriate expertise to do this. Another option to consider would be to give the Australian Health Practitioner Regulation Authority (AHPRA) the jurisdiction over such matters, as they already deal with the National Boards and complaints bodies in each jurisdiction and would therefore have the existing background knowledge and resolution expertise. The point was made at the NRAS Consultation Forum on 23 September in Canberra that independence from the registration and regulation process was a consideration, which would make AHPRA ineligible to perform this function.

## **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.**

In terms of public safety and dealing with any complaints in a fair and effective manner, the most appropriate option for the future regulation of health practitioners may be the third option posed in the consultation paper, to maintain the current 14 National Board structures. There is strong emphasis in the consultation paper on cost efficiencies with NRAS. While this is important, it would seem that the most significant issue should be achieving the aims of NRAs to deliver safe and appropriate quality health care to the public.

It is recognised that there are benefits that come with consolidation, however all factors and functions associated with the scheme need to be given equal consideration. While costs might be viewed as one of the largest problem with NRAS, as noted by the reviewer at the 23 September Consultation Forum, it is vital to

ensure that consolidation doesn't lessen the other guiding principles of NRAS. It was also noted on 23 September by the reviewer that evidence from the UK where consolidation occurred showed there was no reduction in fairness or safety. As there is such a strong focus on reducing costs in the consultation paper and other information from overseas experience is included in the paper, this evidence from the UK should have been included.

An issue to consider if consolidation was to occur is what strategies could be put in place to ensure fairness and safety is paramount. For example, cost reductions in administrative processes could be beneficial in reducing the pressure to cut costs in service delivery areas.

PCA supports NRAS and the proposed National Code of Conduct for Healthcare Workers (the National Code of Conduct) to protect public safety, particularly for people who are vulnerable. People with a life limiting condition or illness and people at the end of life are vulnerable to exploitation and need to have confidence that the health professions and services they access are providing safe and appropriate health care. At the 23 September Consultation Forum the point was raised a number of times about the importance of NRAS to protect people who are vulnerable, including older people.

The consultation paper notes with Option 3 that it 'would not be delivering against the guiding principles of the National Scheme as they relate to effectiveness, efficacy and the minimum level of regulation necessary'. The paper doesn't state why this would be the case. The guiding principles also state that the National scheme is to operate in a transparent, accountable and fair way, and that restrictions are only imposed if it is necessary to ensure health services are provided safely and are of an appropriate quality. Therefore as important as minimum levels of regulation are, issues of safety and fairness, and each of the aspects of the guiding principles should be considered equally in this review process.

Issues around timeliness of responding to complaints have been raised and are noted in the consultation paper. Moving to a larger regulatory body where there would be an increased workload and potentially less resources to deal with the range of complaints from different professional groups may increase such problems. Should consolidation occur there would need to be adequate resources to respond to complaints, particularly if benchmarks are introduced.

**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.**

This option may be more appropriate than the option to have a single Health Professions Australia Board. However, it would be useful to have some analysis of impacts, other than cost, of this and the other options on the other guiding principles and objectives of the review. Other issues such as patient safety, quality of health care and handling of complaints are vitally important to the future of NRAS.

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

As per the answers above, the decision to proceed with other options which might result in lower fees needs to be balanced with the overall guiding principles of NRAS.

**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 benefit analysis?**

The process that is currently employed through NRAS is appropriate. It should be noted, as is recognised in the consultation paper, that the National Code of Conduct is in development to apply to health care workers who are not registered through NRAS. Therefore the existing process for registration seems to be appropriate and can operate in the knowledge that there will be protections for consumers through the National Code of Conduct. The consultation paper notes an important point, in that NRAS was established to fulfil the key objectives of the scheme and not provide status or credibility to health practitioner groups.

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

The main consideration should be what is appropriate when balancing the key criteria for entrants to NRAS and the need for public safety. If adequate protections are available through other means, such as the National Code of Conduct, and that is appropriate considering all other circumstances for a particular profession, then that may be adequate. As noted in previous answers, all factors needs to be considered along with cost-effectiveness. Cost should not be the deciding factor if public protection warrants a profession to be registered.

An important point was made at the 23 September Consultation Forum regarding those professions that are self-regulated but not included in NRAS and the unintended consequences that can occur through not being a part of NRAS, such as not being given the same opportunities that registered professionals receive or key services for allied health not being included in health strategies or planning. This is where recognising other regulatory means, such as self-regulation, could be incorporated.

**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 would appear to be an appropriate course of action given the need for an independent assessor or body to provide advice to Ministers and the Health Workforce Ministerial Council. AHPRA could also potentially be resourced to undertake this role. As they are the organisation responsible for the implementation of NRAS, they could logically also provide advice on measures around entry to NRAS.

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

Option 1 in the consultation paper, which proposes to retain the existing configuration of notifications handling, but improve the process via a range of administrative and legislative changes, is a good option. As noted in the consultation paper, a key problem with the existing system is that complaint notifiers have an expectation of being actively involved in resolving the dispute, but are not. The changes suggested in Option 1 to make notifiers more integral to the process, prescribed performance measures and timeframes for notifications, and using alternative dispute resolution, would address some of the key problems identified.

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

This option may be more complex to implement and require higher level legislative and structural changes, as not all jurisdictions have these structures and mechanisms in place. The resource implications would also fall on the jurisdictions. An important point made at the 23 September Consultation Forum was the issue of resourcing bodies such as the Ombudsman and Complaints Commissioners. AHPRA generates its own funds but an Ombudsman or Complaints Commissioner relies on government funding. If these other bodies aren't resourced properly then a co-regulatory approach wouldn't work.

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

Having a single entry point for complaints and notifications in each State and Territory would be preferable. As stated in the consultation paper, one of the criticisms of the current process is that there is not one point and that it is difficult for consumers to navigate. Having a single entry point would need the agreement of existing complaints agencies and potentially require legislative change with those relevant jurisdictions. Any change would need to consider the impact on the existing complaints bodies in the relevant jurisdictions, in particular the functions and benefits that are available to consumers.

The consultation paper uses international comparisons from New Zealand, where there is a single entry point. However, these comparisons are not entirely relevant as New Zealand does not have a federated model of government and their national government is responsible for health.

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

National performance measures and prescribed timeframes for dealing with complaints and notifications would be preferable and achievable. There is a need for similar outcomes for people regardless of where they live. Currently there are poor performances across each jurisdiction. While this would be a challenge, performance measures and prescribed reporting mechanisms exist in other areas of health across the country, even where there are differences in resources, population and the size

of the health system. Developing benchmarks would raise the performance level across the country and represent a best practice measure for NRAS.

As noted in the response to Question 10, the point was made at the 23 September Consultation Forum that bodies involved in dealing with complaints and notifications would need to be properly resourced to meet any timeframes or performance measures.

**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?**

As noted in the consultation paper, some of the criticisms of the current process have been that complainants do not receive adequate information if their matters are referred to AHPRA for notification. Also, notifiers are provided with minimal information about the progress of investigations and have limited or no involvement. AHPRA's communications are also seen as difficult to understand and don't explain the reasons for decisions.

PCA recognises that there is a need to balance the rights and privacy of practitioners with the need for public disclosure and protection. The processes used in New Zealand and Ontario, Canada, as outlined in the consultation paper, could provide increased transparency to NRAS. This includes:

- Registration suspension details, such as conditions, and other relevant information for consumers such as the health services that are a part of a profession and areas where a practitioner is fit to practice (NZ);
- Complaints under investigation or subject to disciplinary proceedings that are unresolved; the results of decisions where the committee makes a finding; and a note if a matter is under appeal or if a member has resigned and won't practice in the region again (Ontario, Canada).

Overall it would be useful and make sense to examine similar schemes operating in other countries, in particular those that have been in existence for longer periods and addressed problems as they arose over the life of 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?**

Adopting more flexible powers through alternative dispute resolution would be a sensible and useful addition to NRAS. As outlined in the consultation paper, New Zealand has the ability to refer matters to independent conciliation, and the United Kingdom and Ontario, Canada have the power to adopt alternative dispute resolution to assist in managing complaints. As these schemes have existed for a longer period than NRAS, it would seem that flexibility in addressing disputes has been adopted to provide alternative means and that it would make sense to do the same in Australia.

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

The point at which an adverse finding and the intervention is removed should be dependent on the seriousness of the matter and intervention required, and the associated impact on public safety. As it the case with monitoring and compliance, where the length of time that restrictions are in place on a health practitioner's or student's registration varies with each individual, this should also be the case with adverse findings. Each case will be different along with the associated findings and interventions, and it would be difficult to put in place a specified timeframe. As it is the case for monitoring and compliance, where some restrictions may be in place for a short period of time and others for many months or years, so would also be the case for adverse findings.

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

PCA supports retaining a ban on inappropriate testimonials. People who are diagnosed with a terminal or life limiting condition or illness are particularly vulnerable to exploitation and may seek health services that are not required or effective. Option 2 suggested in the consultation paper would seem to be the most logical while still offering the same level of protection to the public. This involves amending the provision on testimonials to clarify for practitioners and consumers when comment is permissible. The benefit of this option is that it retains the protections through the testimonial ban but is less confusing.

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

Some differences between the States and Territories may need to be tolerated to take into account particular situations or practices that have required action in different jurisdictions. The consultation paper provides the example of South Australia and birthing practices which resulted from Coronial findings, and therefore led to particular practices being adopted in that state.

**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?**

Two specific issues addressed in the National Code of Conduct that are relevant to NRAS advertising provisions are experimental or unproven treatments, and displaying qualifications. Both these provisions are proposed for the National Code of Conduct and may need to be more explicitly recognised, primarily through NRAS advertising provisions.

The consultation on the National Code of Conduct proposed including a clause along the lines of 'A health care worker must take special care when a treatment they are offering to a client is experimental or unproven, to inform the client of any risks associated with the treatment'. PCA's submission on the National Code of Conduct<sup>1</sup>

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<sup>1</sup> Palliative Care Australia, Submission to the Australian Health Minister' Advisory Council on a National Code of Conduct for health care workers, April 2014

supported addressing the issue of experimental or unproven treatments, particularly for people who are diagnosed with a terminal or life limiting condition or illness or at the end of life, being vulnerable to exploitation. It was proposed that along with addressing claims made to cure an illness, there could also be a provision whereby health care workers must disclose if the treatment is experimental or unproven.

With regards to health care workers displaying the National Code of Conduct, their qualifications and avenues for complaint, PCA's submission to the National Code of Conduct<sup>2</sup> raised the issue of people receiving services in their home. The clause in the National Code notes that a health care worker must display documents in a manner which is visible. However many people at the end of life receive services at home and how this information should be communicated in this situation must be considered. PCA suggested addressing this issue by displaying the code electronically on a web site, where a health care worker has a website. However, where a health care worker is providing services in a person's home, there must be a requirement that they display the relevant documents directly to the person receiving the treatment or service.

**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?**

The exemptions in place in Western Australia (WA) and Queensland, whereby a treating practitioner is exempt from making a notification where the practitioner was undergoing active treatment and did not pose a risk to the public, seem appropriate and should be reflected in the NRAS notification provisions. As noted in the consultation paper, the data on mandatory notifications in WA and Queensland compared with the rest of the country shows no discernable differences in notification patterns.

**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 an important role to play in health workforce reform and determining priorities. This includes providing access to services, assisting with strategic workforce development and potentially access to useful data on workforce numbers. In terms of what extent they are meeting these objectives, the consultation paper does not provide sufficient information to make comment on this. The consultation paper notes that discussions have been undertaken with National Boards, Accrediting Authorities and AHPRA, where it would be assumed information to address this question has been obtained and can inform this part of the NRAS review.

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<sup>2</sup> Palliative Care Australia, Submission to the Australian Health Minister's Advisory Council on a National Code of Conduct for health care workers, April 2014

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

Given the AHWAC was intended to provide advice to Ministers, reconstituting this body would appear to be an appropriate course of action. It is again worth noting that HWA would have been ideally positioned to undertake functions related to health workforce priorities and service gaps, as these issues were within its remit and it had the expertise, existing research work and data.

**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?**

The Accrediting Authorities have an important role to play in addressing training and education and looking at a range of future needs for the workforce. In terms of what extent they are meeting these objectives, the consultation paper does not provide sufficient information to make comment on this. The consultation paper notes that discussions have been undertaken with National Boards, Accrediting Authorities and AHPRA, where it would be assumed information to address this question has been obtained and can inform this part of the NRAS review.

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

A strong working relationship between regulators and educational institutions would be of great benefit to future workforce planning and in reference to education and training needs. It would make sense for these two sectors to have a strategic working relationship in terms of future planning. It would be a lost opportunity if the connections between the two sectors were not utilised.

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

PCA is not able to comment on the specifics of this issue. As is noted in the consultation paper, any changes or streamlining to the existing process should have public safety as the main objective.

With regards to palliative care, in some instances overseas trained doctors have no experience or understanding of palliative care, or the appropriate management of opioid and other medications in managing the symptoms of life limiting illness. This needs to be considered in the processes put in place regarding assessment and supervision of untrained doctors.

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

PCA believes the appointment of a Chairperson to any Board should be on the basis of merit. The consultation paper states that flexibility in making merit based appointments to the National Chair position is being considered, including community

members and non-registered health professionals. Members of the community and consumer representatives are integral positions to a Board and NRAS should be no different, including having community members as a chair.

**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?**

The current division of roles does seem to be reasonably effective. A change that may increase the effectiveness of NRAS could be as is suggested in the consultation paper, i.e. for complaints bodies in states and territories, such as the Ombudsman or Health Complaints Commission or other such agencies, to have clearer jurisdiction over complaints raised about processes undertaken by Accrediting Authorities or committees. This would be for these agencies to examine the process followed in reaching decisions. This would add to the transparency and accountability of the scheme and the processes followed. As per the answers to Questions 10 and 12, any added responsibility for other agencies would need to include additional resources.

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

As per answer to question 26.