# AUSTRALIAN MEDICAL ASSOCIATION

K;\2009\uly\pb.pj.national registration submission cover ltr 140709.doc

WESTERN AUSTRALIA

C-59-1

17 July 2009

Senate Community Affairs Committee
Community.affairs.sen@aph.gov.au

Dear Sir/Madam

**RE: Inquiry into the National Registration and Accreditation Scheme for Doctors and other health workers AMA (WA) Submission**

Please find enclosed the submission of the Australian Medical Association (WA) Incorporated in relation to the above Inquiry.

AMA(WA) would be pleased to elaborate on any aspects of its submission.

Yours sincerely

PROFESSOR GARY GEELHOED
PRESIDENT

Attachments: 1

14 STIRLING HIGHWAY, NEDLANDS, WESTERN AUSTRALIA 6009
TELEPHONE: **(08) 9273 3000** • FACSIMILE: **(08) 9273 3073**
Email: mail@amawa.com.au

Australian Medical Association (WA)

# Submission: Exposure Draft

# Health Practitioners Regulation National Law

July 2009

AMA

WESTERN AUSTRALIA

# HEALTH PRACTITIONER REGULATION NATIONAL LAW

## OVERALL COMMENTS:

The Exposure Draft of the Bill is 187 pages and has gone through at least 17 drafts without substantive consultation with the AMA on the Bill itself. It represents the most comprehensive and potentially far reaching change in the "Regulation" of Health professions ever seen in Australia. It could have profound effects on the professions and standards of care enjoyed by patients.

Fundamental to the changes is the centralisation of registration, defining and codifying standards of professional conduct, regulating accreditation under a National Ministerial Council and National Agency and the diminution in the independence of professional regulation for both registration and accreditation functions relative to current and the role of State jurisdictions.

The proposals go far beyond the position agreed to in the Ministerial Communiqué of 2004 and falls far short of the concerns expressed in the joint letter of the professions dated 7th May, 2009 (Appendix 1) and the NSW Labor Minister's proposed model (Appendix 2).

The proposals also appear to go beyond the IGA and the last Communiqué of the 8th May, 2009 (Appendix 3). Some of the NSW Labor Minister's statements are particularly compelling and justify a far simpler, less bureaucratic approach which would achieve the stated objectives in a more appropriate way. e.g.:

*"...a national index of medical practitioners (effectively a national register)."*

*"...can be achieved through adoption of a "driver's licence" model of registration. This will ensure there are appropriate registers to link to the Health Workforce Agency Australia database to assist and support workforce planning and reform."*

*"National registers can ... provide a basis for uniformity of provisions relating to specialist titles and qualifications."*

*"...state amendments will support full information sharing and notifications/updating of Registers through the State/Territory boards as necessary."*

*"The costs of the operation of National Boards ... be met via a fee levied through retained state registration systems, adopting the existing approach for funding of the Australian Medical Council and the Australian Dental Council."*

*"...revise the role of the National Boards to focus more directly on these nation-wide issues."*

*"...means the retention of State/Territory boards to continue to perform the main day to day operational functions inherent in running a registration system, including the disciplinary system."*

*"The advantage of this approach is that the delineation of State/Territory vs. national roles will occur in legislation rather than rely on delegations from the national to State/Territory level. This means certainty for both professional groups and the community on exactly who does what at the national and local level – something not available under the delegated system."*

*"...there is limited justification for the extensive National Agency (including the National Office and State/Territory Offices) referred to in the IGA."*

*"The higher level of policy role for National Boards will only require policy support and a small administrative secretariat."*

*"...revise the Agency Management Committee, to operate more as a forum for boards, professions and jurisdictional representatives to consider and advise AHMC on cross professional issues. Given the substantial reduction proposed in the national bureaucracy, there is no cogent justification for a substantial oversight group as originally proposed."*

The WA Minister has also previously expressed similar concerns and advocated a bottom up approach. The Bill however still adopts a top down centralist approach.

The proposals also have a long way to go to become Law given they have to pass through every State House of Parliament both Lower (except Qld), and Upper. Various Elections; State and indeed even Federal are also approaching. Clearly it is important that broad agreement is reached on the final form of the Bill if it is to progress through these processes without substantive variation between States.

**Key Concerns:**

1. In its present form, the medium / long term implications for professions, standards and patient care remain adverse.

2. National Law based on temporary delegations and controls can change over time. The Bill also provides that Laws on different jurisdictions will change automatically if the Queensland base Act is changed in that jurisdiction and regulations can only effectively be disallowed by a majority of States.

3. Registration- Excessive centralisation with delegation rather than delineation.

4. Task Substitution- Use of title "Doctor" not protected and will confuse if PhD's in other professions use title "Doctor". Title of "Surgeon" and "Physician" should be preserved for use by qualified Medical Practitioners only.

5. Accreditation- Lack of independence, lack of protection for continuation of AMC, lack of recognition of Colleges and capacity for substitution.

6. National Agency- Role – effective bureaucratic control of Boards re: staffing, budgets, funding, with future cost concerns and potential growth in bureaucratic control.

7. Medical Boards- Structure – control by Ministerial Council etc. appointment of Chairperson, loss of independence, re. staffing and budgeting etc.

8. Ministerial Directions- Based on opinions not circumscribed or subject to appeal.

9. New requirements and controls e.g. reporting and competency requirements.

10. Complaints Management- Seemingly centralised with temporary delegations contrary to IGA.

**General Summary of Issues State and National Perspectives:**

Whilst some changes have been made to addressing some concerns raised in general information, the Bill still falls far short on a number of issues.

The Bill is inconsistent with both the WA and NSW Minister's position and remains top down not bottom up with significant albeit somewhat more qualified potential for central control.

**Specific comments in the order the provisions appear in the draft Bill:**

1. Students will be registered –do they have a view? S3 etc.

2. S4.2(c) (pg.2) Task Substitution

> "(c) *restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality."*

i.e. Is not based on best practice but safety and "appropriate" quality which could diminish standards suggesting provision down to a "Holden", down to a price with task substitution and extending prescribing rights on the premise is appropriate (and coincidently cheaper?). Patients deserve to be treated according to "best practice" which may also save overall costs.

**Recommendation: Amend by deleting "and are of an appropriate quality" and replace with: "consistent with best practice standards."**

3. S6 (pg.2) Definitions

Accreditation authority means "an accreditation entity approved by a National Board under S62."

There is no protection for the continuation of the AMC.

The National Board is also effectively serviced by the National Agency which employ its staff rather than the Board. The Board's will potentially and almost certainly over time have to use Agency staff (further reducing independence and raising conflicts) and negotiate with the Agency over its budget. This provides increased controls which, in tandem with the integrated appointment systems, will be controlled by the Ministerial Council and the bureaucracy, centralising and increasing control. This contradicts the NSW and WA Minister's proposal for bottom up rather than top down approaches.

**Recommendation: That Board's continue to appoint their own Registrars and senior staff.**

4. "Approved accreditation standard" (p.3) and "external accreditation entity" appointed by the Ministerial Council (p.4) suggest, notwithstanding some improvements, continuing concern re. controls. See comments hereunder re. S60-68.

   **Recommendation: Amend to delete "Ministerial Council" and replace with recognition of the AMC and Colleges roles.**

5. S6 (p.6)

   "Local registration authority" refers to State Boards, but they are truly subservient and seemingly lose their staff. This is a significant and potentially irreversible change to what they have asserted. It is strongly argued that State legislation and State Boards should remain not as Committees, pursuant to a delegation that can be removed, but by statutory right i.e. State Boards are recognised not as Committees called Boards, but remain Boards under State legislation appointed under State legislation by the State Minister with the State Board nominating its representative on the National Board and the National Board electing its Chair. This would reduce the concern re. political interference.

   **Recommendation: That the legislation be amended accordingly.**

6. Definitions of "professional misconduct" (p.7), "unprofessional conduct" (p.9) and new definition of "unsatisfactory professional performance" (p.10).

   Need to be reviewed to ensure standards have not changed and won't result in further increases in rising indemnity/representation costs etc.

   Similarly, "reportable conduct" (p.10) needs careful consideration as it appears to be fairly broad and unlike existing jurisdictions, extends the requirement to all registered practitioners rather than the profession concerned, to report on another profession member.

   **Recommendation: Review provisions across Bill to address the above concerns.**

7. Part 2: Ministerial Council (p.11)

   Is very top down-The Ministerial Council under Section 10 can give Policy "directions to National Agency (about policies to be applied by the National Agency in exercising its functions under the Law" which the NSW Minister said was two big and cumbersome.

*Note: The Ministerial Council's "Direction" can be given based on a mere "opinion" (S10 (4)) (p.11) which must be complied with and can not be challenged (S10 (6)). This can amongst other things include giving a direction in relation to "a particular accreditation standard for a health profession "(S10 (3)(d)) if in the MC's opinion it will have a substantive and negative impact on supply etc.*

***Note:*** *S4 (2)(c) Task Substitution (above).*

Such powers if acceptable, in concept or otherwise, should be circumscribed as proposed by the NSW Minister and should be based on proper process, be evidenced based, not an opinion and if countenanced, should be subject to appeal.

**Recommendation: That appropriate amendments reflecting the above be made.**

8. S12(3) (p.12) Specialist Registration

Relative progress, but given other provisions, does not guarantee AMC or College roles versus other bodies set up under other provisions. Note also S12(4) re. Ministerial Council may give guidance. Currently, the Federal Health Insurance Act recognises the AMC and Colleges (Appendix 4) as does, for example, the new Medical Act 2008 (Appendix 5). As the draft stands, the roles of the AMC and Colleges which are not really as recognised under the Act, could be displaced over time.

**Recommendation: That amendments which secure AMC and College mechanisms be made.**

9. Part 3: Australian Health Workforce Advisory Council (p.14)

Why require legislation for an advisory committee we understood would not proceed. Again, is appointed by Ministerial Council rather than having State representation. Chairperson must not be a health practitioner-neither in fact do any others with just three to have expertise which is different. Also note that the separate "Health Workforce Australia Bill 2009 provides for "Health Workforce Australia" under a separate Act which the AMA, Colleges and others have criticised (see dissenting comments in recent Senate Report (Appendix 6).

**Recommendation: That Part 3 be removed.**

10. Part 4: Australian Health Practitioner Regulation Agency (p.16)

Again central control of functions which should be Board functions. The Boards under this model don't regulate - they are more administrative and titular in nature functioning under the Agency with delegations. This approach contradicts not just the AMA position but several Ministers including NSW. The detail provides the foundations for control rather than self regulation and independent accreditation. Failure to adequately deal with this now will undoubtedly facilitate political control and be to the detriment of standards.

**Recommendation: That amendments, consistent with the previous proposals of the NSW Minister, be inserted.**

11. Division 2: S27 (p.18) Agency Management Committee

The Agency Management Committee under the Bill as it stands, controls the National Agency (S29)(p.19).

Five members are again appointed by Ministerial Council (MC) and again the Chair is appointed by the Ministerial Council and who cannot be a Health professional nor do others need to be, as again they only need expertise in health or education and training rather than medical or other health qualifications. Other members are excluded from being health professionals.

**Recommendation: Role of agency and composition be circumscribed/ appropriately constituted with a majority of health professionals.**

One option worth considering is providing for some positions to be elected (as in New Zealand) from the professions (at the time of registration renewal) rather than political appointments.

12. Division 4: S35 (p.21) Public Interest Assessor

Establishes a member of Agency staff to assess complaints, yet complaints were supposed to be managed at a State level. Appears to be contrary to the IGA (S6.8 (p.4) of IGA) and previous assurances. The Bill is strongly central re complaints management throughout and many pose difficulties for consumers.

**Recommendation: That State management of complaints be reasserted and this section be deleted.**

13. Division 5: S39 & 40 (p.22) Staff, consultants and contractors

National Agency may employ staff and staff may also be seconded to National Agency from local registration authorities.

Boards have always employed their own staff and State Boards remit a component of registration fees to their National Board and do not assign their assets or income to a central entity. The Bill seeks to change this relationship. A bottom up approach is crucial if services are to be responsive at local level and countervailing forces are to be built in so the agency does not dominate over time.

**Recommendation: Amendments be made to reflect actual retention of State Boards, employment of senior staff by the individual Boards, and the agency functioning as a service entity consistent with the previous proposals of the NSW Minister.**

14. Division 6: (p.22) Reporting Obligations

This makes it even clearer so called Boards are largely functionaries rather than genuine Boards with the Agency submitting the Annual Report "and the so called National Board having to provide information the National Agency requires".

**Recommendation: That the Bill be amended to provide that the Board is responsible for its Annual Report.**

15. Part 5: S44 (p.24) National Boards

Medical Radiation Practice Board– presumably this does not include Radiologists i.e. just Radiographers

**Recommendation: That this be made clear.**

16. S45 (p.24) Board Membership

The Bill provides that the Ministerial Council appoints the Board where as it was understood State Boards would be appointed by the State Minister and the State Board would nominate and the Board would then appoint its Chairperson. i.e. Bill proposes top down political control rather than bottom up. It is important that Boards have the confidence of the professions they regulate and are not seen as politically appointed entities.

**Recommendation: Amend to stipulate that the National Board is comprised of State Board Chairs or nominees etc. not just members from State's (there is a substantial difference).**

If this is not accepted then consideration should be given to providing for some elected members (similar occurs in New Zealand) to minimize criticism of political control. (Election could be held at time of Registration renewal).

Ministerial Council also appoints Chair where as it should prescribe that the Board elects own Chair.

**Recommendation: That the National Board elect its own Chair from amongst its number.**

17. ***Note:*** *S47 (p.26) Vacancies on National Board to be advertised*

*Given this submission suggests that States appoint rather than the Ministerial Council, this provision should be deleted.*

**Recommendation: S47 be deleted.**

18. S49 (p.27) Accreditation Standards approved by National Boards

The National Board functions are to "develop or approve standard etc. including accreditation standards submitted by an accreditation authority which the Ministerial Council under S60-S65 may appoint i.e. not necessarily the AMC or Colleges. This raises fundamental issues and contradicts for example, the Health Insurance Act and the WA Medical Act 2008 provisions (Appendix 4 and 5).

**Recommendation: Recognition of the AMC's and Colleges be included**

19. S54 (p.29) State Boards

Provides a National Board, "**may**" establish "a committee" (conveniently called a State or Territory Board but clearly only in name under the new proposal) probably to deal with very small boards where individual State Boards are not viable. The members of a State Board is determined by the individual Minister (S54 (3)) who could therefore abolish what are mere Committees at a future date. The legislation should provide for State Boards for large professions consistent with earlier recommendations re. a bottom up approach including retention of such Boards under State legislation. This Bill should complement or sit along side existing/remaining State legislation including complaints management rather than replacing all of it.

***Note:*** *Provision appears to again displace State Law and requires State appointments to be advertised rather State nomination processes applying. A number of Registration Acts in WA provides for organisations including, for example, the College of Nursing and Deans of Medical Schools to nominate. These could disappear under this proposal.*

***Note:*** *Whilst S45 provides for members of the National Board are drawn from each "large jurisdiction", they are not necessarily drawn from State Boards which are subsequently appointed under S54 by the National Board. To address those concerns it is recommended that:*

**Recommendation: That amendments be made to retain and guarantee State Boards (rather than Committees) for large professions and that those Boards nominate their Chairs or a nominee to the National Board.**

20. S58 (p.31) Use of Registration standards, codes or guidelines in disciplinary proceedings

    Standard, Code or Guideline may be used to prosecute, hence, importance of getting them right. Given the problems with development of the current draft code need to ensure such problems are not repeated following passage of any legislation.

    **Recommendation: The Bill provides that formulating or amending any Code must be undertaken following consultation with the AMA and the Colleges in the case of Medical Practitioners and by analogy with other peak organisations for other groups.**

    ***Note:*** *There are various legislation precedents for this approach.*

21. S60-S63 (p.32) Ministerial Council may appoint an external accreditation agency This provides the means for undermining or replacing the AMC and Colleges. This is a substantial concern. See also Division 3, S64-68 re. development of accreditation standards.

    **Recommendation: That appropriate amendments be formulated to ensure ongoing roles for the Colleges and AMC consistent with the Health Insurance Act. (Appendix 6)**

22. Part 7 (p36) Registration

    Again the scope of provisions suggests replacement of entire Acts rather than part amendment of State Acts and hence is not supported.

23. S73 (p.37) Professional Indemnity Insurance Arrangements

MDO policies have different expiry dates and hence may expire during a registration period.

**Recommendation: The appropriateness of this be ascertained in consultation with MDO's.**

24. S74 (p.38) Period of General Registration (12 months)

Consideration should be given to 3 or 5 yrs registration like drivers licence subject to Maintenance of Professionals Standards (MOPS) or discretion for length to be amended by regulation.

**Recommendation: Consideration be given to advocating a longer period of registration or providing for Boards to be able to offer or increase the period by regulation.**

25. S77 (p.39) Examination or Assessment for Specialist Recognition

Accreditation authority to exam or assess. This raises concerns similar to those summarised at point 21 above.

**Recommendation: Amendments be made consistent with point 21 above.**

26. S94 (p.44) Non-Practicing

No provision for referrals or scripts - contrary to Western Australian State Minister's position etc.

This is contrary to some states. The issue of occasionally practicing Doctors who have retired from remunerative practice but still provide referrals and scripts pro bono without unnecessarily burdening an already stressed workforce e.g. General Practice or ED,s (or less qualified Nurse Practitioner-who are far less qualified than recently retired Drs?) and at no cost to the Commonwealth etc could be provided for example, for 5 yrs from formal retirement.

***Note:*** *S125 (3)(a) refers to "non practicing registration" which under definition e.g. "registered health practitioner" (p.7/8), can not practice at all.*

**Recommendation: Seek amendments providing for occasionally practicing per practice in some states.**

**Recommendation: That if appropriate, this be confined to issuance of prescription and referrals for up to 5 years of retirement from Practice.**

27. S101 (1)(a)(ii) (p.47) Continuing Professional Development etc.

Practitioner can be required to complete a continuing professional development program required by the National Board.

**Recommendation: That appropriate amendments recognising College MOPS programs etc. be included.**

28. Division 7 (p.49) Student Registration

**Recommendation: The implications/practicalities be checked with Deans and AMSA.**

29. Division 8 (p.51) Endorsement in Relation to Scheduled Medicines

Potentially allows (subject to other legislation) non Drs to prescribe as determined by non-medical Board which raises major concern. See also rest of Division re. other potentials for example, Endorsement of Nurse Practitioners (S111 (p.52)). This raises major concerns re process, circumventing for example, the Poisons Act processes and the potential reducing of standards of care.

**Recommendation: That these provisions be removed and existing mechanisms as prescribed under existing legislation, such as the WA Poisons Act etc and its interstate equivalents be maintained.**

30. Division 9: S122 (p.56) Renewal of Registration or Endorsement.

Continuing professional development per S125 (3) requiring a practitioner to complete a CPD program approved by the National Board. This may not correlate with a College's MOPS program.

This reflects a fundamental shift in the orientation of Registration Acts from protecting the public interest to setting and regulating standards. AMA WA) is concerned those provisions undermine the role of Colleges in setting standards and submits the draft

should be amended to prescribe "CPD programs approved by the National Board on the advice of the relevant College".

**Recommendation: The Bill be amended to provide that in the case of Medical Practitioners CPD programmes, shall be approved by the National Board on the advice of the relevant College.**

31. Division 11: S128 (p.61) Title and Practice Protections etc.

There is no protection for use of "Doctor" or "Physician" (which is current not used outside of Medicine) or "Surgeon". Some non Medical Practitioners even refer to themselves as "Doctor" without a PhD which is false and misleading. Government should clearly protect the public from being misled.

AMA(WA) would argue strongly that the term "Doctor" should be confined to registered Medical Practitioners and that where another Health Professional has an Australian recognised PhD, they be allowed to use the title "Doctor of.." in their profession but that it must be made clear they are not a "Medical Practitioner" i.e. PhD (non medical). To protect the public and distinguish Medical Doctors from others who use title "Dr".

There is also confusion re the use of "Chinese Medicine" which could suggest medical as distinct from health qualifications. Presently in WA and most States, Chinese Health Practitioners are not regulated and hence, are not subject to "Protection of Title". It is suggested that the title "Chinese Health Practitioner" be protected to avoid confusion with Medical Practitioners.

In addition, the current structure under "Chinese" is inconsistent with all titles being prefaced by "Chinese" or "Oriental" except 'Acupuncture' which logically, should have either of these prefaces added.

**Recommendations:**

**Provide for protection of titles of "Physician" and "Surgeon" by Medical Practitioners only and;**

**Recognise the title "Doctor" for Medical Practitioners. Provide that only practitioners with recognised PhD's make may use the title of "Doctor of..."**

**"Chinese Medicine" be amended to "Chinese Health" and "Acupuncturist" be amended to either "Chinese Acupuncturist" or "Oriental Acupuncturist".**

32. Subdivision 3: S142 (p.70) Obligation of registered health practitioner to provide information re offences, clinical privileges and billing privileges (under Medicare or by a Private Health Insurer?). This is wider that recent Mandatory Reporting laws and needs critical review in tandem with S156: Mandatory Reporting.

    Billing issues are commercial issues and should be removed from the legislation. The Mandatory Reporting provisions are also for wider than existing laws and enable any health professional to report on another different discipline. They have the potential to lead to unnecessary reports, increased stress and costs. As stated under point 36., issues such as quality assurance activities and health professionals treating other health professionals should be excluded.

    **Recommendation: The provision be reviewed and refined in consultation with the AMA and Medical Defence Organisations to address and reflect the above.**

33. Subdivision 6: S148 (p.74) Person Inciting Unprofessional Conduct

    Only corporate control is welcome, but clearly deficient compared to WA State Medical Act. Is only a business expense fine rather than potential prohibition on corporate licence to practice. AMA (WA) would advocate similar provisions as prescribed presently under WA Law if WA Law is to be displaced.

    **Recommendation: The existing WA law be reviewed and adopted or the issue be left to State Law.**

34. Part 8, S150 (p.75) Complaints,

    Provides, under various provisions that complaints may be made and managed by the National Agency via Independent Assessor nominated by State Minister to the National Agency, S151 (p.75) and National Board may take action S158 (p.78) - contrary to State Medical Boards roles, the IGA and the understanding complaints would continue to be managed at State level.

    Also provides that National Agency must assist a complainant make a complaint about a registered practitioners or student which raises conflict issue S154 (p.75).

    **Recommendation: Whole section needs to be removed and State Complaints Management per IGA, S6 (8) be reasserted.**

35. Subdivision 7: S174 (p.86) Performance Assessment

Again, National Board oversees performance assessment. Major concerns throughout which contradicts State jurisdiction.

**Recommendation: The existing State mechanisms be retained.**

36. S156 (p.76) Mandatory Reporting by Health Practitioners

Needs specific review given scope in tandem with S142.Whilst MDOs appear to have an exemption, many others managing complaints within hospitals and in health care services to the satisfaction of authorities such as the Coroner's Office and undertaking quality assurance processes etc. Complainants within hospitals can complain to external authorities if they wish, could be required by this provision to report beyond the hospital which may not be appropriate for many instances, which are performance management matters, as distinct from disciplinary matters. In addition as detailed earlier, the Bill requires any health professional e.g. Nurses, Midwives to report a Doctor and hence, will considerably increases reports.

**Recommendation: That the Bill provide exemption for such processes but where individuals exercise their discretion and report the indemnity provisions can also apply.**

37. S200 (p.98) Health Panels

This suggests there will be a Medical Practitioner on every other Boards Health Panel - has this been discussed? What will be the level of work involved? How will they be nominated / remunerated?

**Recommendation: Matter be further considered in consultation with the AMA.**

38. S211 (p.102) Investigations

Again by National Board (S212), not State Boards which have no real recognition.

Also substantial powers including power to obtain information (without warrant), demand answers and seize Medical Records (S225) which needs review by MDOs.

**Recommendation: These provisions be reviewed in consultation with MDOs and appropriate amendments made.**

39. Amendments to the Act

The proposal whereby all States except WA adopt the Act passed by a single house in Queensland and by implication, any subsequent legislative amendment in that State circumvents the legislative process in those States. WA is not adopting that approach replicating where appropriate, provisions of the Bill.

A related aspect however, relates to the regulatory powers under the Bill. Bill B at S287 states "the disallowance of a regulation by a House of the Parliaments of a majority of jurisdictions has the same effect as a repeal of the regulation". S 286(2) states however, a regulation disallowed by a single jurisdiction "does not cease to have effect in that participating jurisdiction unless the regulation is disallowed by a House of the Parliaments of a MAJOIRTY of the participating jurisdiction". Thus, a regulation could be imposed on a jurisdiction. This is inappropriate.

**Recommendation: S286 and S287 be amended to enable a single jurisdiction to disallow a regulation in its jurisdiction.**

The foregoing raise significant concerns with the Bill in its current form. The Bill, released for the first time, contradicts previous assurances and the NSW Minister's assessment. If presented to State Parliament's, there is significant potential for vigorous debate, reference to Committees and amendment. In AMA(WA's) view, it would be far better to get the draft Bill in a more acceptable form before goes to various Parliamentary systems.

There are two levels of amendments required; those that are fundamental to protecting the independent regulation, accreditation and standards with minimal political interference and those that increase bureaucracy and costs. Both should be addressed rather than acceding to inappropriate control.

Addressing the detail and ensuring the profession's future independence is not underpinned and patient standards are maintained without increasing bureaucracy, costs and remoteness from patients within each State is vital. AMA (WA) commends the above analysis and seek changes as recommended above.

AMA (WA)

July 2009

# Appendix 1

Australasian Podiatry Council

AUSTRALIAN DENTAL ASSOCIATION

AUSTRALIAN NURSING FEDERATION

AUSTRALIAN OSTEOPATHIC ASSOCIATION

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION
www.physiotherapy.asn.au

The Australian Psychological Society Ltd

CAA
Chiropractors' Association of Australia

OPTOMETRISTS
ASSOCIATION AUSTRALIA

The PHARMACY GUILD of AUSTRALIA

7 May 2009

Minister Paul Lucas
GPO Box 48
Brisbane QLD 4001

Dear Minister Lucas,

HEALTH PROFESSIONS AND THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME

On behalf of some 400,000 health professionals whose practice will be regulated by the proposed National Registration and Accreditation Scheme (NRAS) we request Health Ministers to consider further changes to the scheme's design prior to its implementation.

We all reaffirm our professions' support for the principle of a national approach to registration and accreditation.

We all agree a properly designed scheme would be sensible reform which would have potential to benefit patients.

We all agree the cooperation between health professions and the Council of Australian Governments (COAG) since the NRAS was announced has improved substantially the original design of the scheme.

However, we also all agree that even with these improvements the design of the scheme now proposed by COAG still requires further changes before the scheme is implemented.

Some professions have concerns specific to their own professions. However, in addition, we all agree there are two fundamental changes which are still needed. These are:

- governments and government officials must not have the power to approve accreditation or professional standards as presently proposed. This means that in line with international best practice governments would not be involved in any decisions about registration, practice, competency and accreditation standards or CPD requirements.

- national professional boards must be able to make decisions about human and financial resources needed to implement the scheme within their professions. This is so members of these boards can fulfill their statutory responsibilities. The power to make decisions about human and financial resources is proposed by COAG to be shared between the Australian Health Practitioners Regulation Agency (AHPRA) and the boards. Professions' experience with such arrangements is that they risk creating situations where members of boards may not be able to perform their statutory duties because they do not have clear and undisputed control over the resources involved. When boards and AHPRA disagree, the board views must prevail.

We emphasize, that notwithstanding the significant concerns which some professions have with specific issues, we all regard these two issues as fundamentally important.

Our organizations are ready to continue providing expertise and input into completion of the design of the scheme. We trust COAG will address satisfactorily our concerns so we may continue to work with the NRAS Project Implementation Team to ensure the scheme is in place by July 2010.

Yours sincerely,

Mr. Brenden Brown, President
Australasian Podiatry Council

Dr. Neil Hewson, President
Australian Dental Association

Ms Ged Kearney, National Secretary
Australian Nursing Federation

Mr. Ben Field, National President
Australian Osteopathic Association

Mr. Patrick Maher, President
Australian Physiotherapy Association

Prof. Lyn Littlefield, Executive Director
Australian Psychological Society

Dr. Dennis Richards, National President
Chiropractors Association Australia

Mr. Andrew Harris, National President
Optometrists Association Australia

Mr. Kos Scalvos, National President
The Pharmacy Guild of Australia

# Media Releases and Communiques

## Australian Health Ministers agree on nationally consistent approach to medical registration

Health Ministers agreed to take immediate action to progress reform of the Australian health care system in the areas of after hours GP services; aged care; chronic disease and cancer services; medical workforce planning and renal disease services

23 April 2004

### Joint Communique

## Australian Health Ministers agree on nationally consistent approach to medical registration

All Australian Health Ministers, meeting in Canberra today, agreed to a nationally consistent approach to medical registration to facilitate the mobility of the Australian medical workforce, making it easier for doctors to work across state boundaries.

The approach includes a number of elements that will lead to consistency across all jurisdictions in relation to medical registration processes, categories of registration, public access to medical register information and processes for assessing maintenance of professional competence.

Health Ministers agreed that the new arrangements would benefit the medical profession, members of the public and medical boards in each state and territory.

Specifically, adoption of the new model would:

- Simplify registration arrangements for practitioners who wish to practise in more than one jurisdiction;
- Provide a more understandable, accessible and useful medical register through the use of nationally consistent medical registration categories; and
- Provide clearer data on the number and distribution of doctors practising in Australia, and assist in better medical workforce planning.

Key elements of the nationally consistent approach to medical registration include:

- The introduction of a multi-jurisdictional/national registration system under which a doctor registered in their jurisdiction of primary practice will generally also be eligible to practise in any other jurisdiction on the basis of that registration without having to lodge a separate registration application or pay a separate fee.
- The adoption of standard and consistent medical registration categories across all jurisdictions.
- The development of an online Australian Index of Medical Practitioners which will include all current registered practitioners in Australia.
- The adoption of a uniform set of medical practitioner information items that will be available to the public in all jurisdictions. Public access will be made available online through the Australian Index of Medical Practitioners as well as through the medical boards in each state and territory
- A platform for a greater role for state and territory Medical Boards in assessing maintenance of professional competency.

Ministers strongly endorsed the principle that consumers should have access to reasonable information. However, recognising the concerns raised by the Australian Medical Association around doctors' privacy and the need to balance this with consumers reasonable access to information, Ministers will reconsider, in July 2004, the extent of information about doctors that will be publicly available.

Health Ministers agreed to begin work immediately on implementing the new arrangements for nationally consistent medical registration.

**Media contact: Kay McNiece, Media Adviser, AHMC Secretariat 0412 132 585**

---

Page last modified: 23 April, 2004

# Appendix 2

NSW HEALTH MINISTERS PROPOSAL

# National Registration and Accreditation Scheme – Way Ahead

## Purpose

To put forward a series of proposals which will enable progress to be made in implementing national registration of health professions by the July 2010 timeframe.

Given the diverse views expressed on many key elements of the NRAS, both between jurisdictions, among health professionals and in the broader community, consideration needs to be given to modifying the model, keeping in mind not only the original objects of the IGA, but also the key themes which emerged from the Ministers discussions in March, the latter being:

- All jurisdictions confirmed their commitment to a national registration scheme and a more cohesive national approach in these issues;
- Concerns existed over the loss of state based/local infrastructure, which is considered operationally more responsive to local needs;
- There are difficulties in a uniform approach on complaints management, investigation and prosecution given the disparity of approach amongst the states and territories;
- There is a diversity of views on how the process for accrediting courses should link into the registration system, or indeed, if it should link in at all.

The following recommendations for an alternative way of achieving national registration within the NRAS timeframe have been designed to accommodate these issues having particular reference to an alternative proposal put forward by WA.

## NRAS Revised Model – Recommendations

### *1. National Health Professional Registers as the keystone of the national scheme*

A single register for each profession covered by the scheme will automatically achieve national portability, one of the key objectives of the IGA.

Prior to the development of the IGA there had been considerable work done on a national index of medical practitioners (effectively a national register). As that project demonstrated, a national register or database is not of itself dependent on national boards, but can be achieved through adoption of a "driver's licence" model of registration. This will ensure there are appropriate registers to link to the Health Workforce Agency Australia database to assist and support workforce planning and reform.

National registers can also, over time, also provide a basis for uniformity of provisions relating to specialist titles and qualifications. This proposal will continue to build on the IT work already in train to support the operation of the current NRAS proposal. Additional state amendments will support full information sharing and notifications/updating of Registers through the State/Territory boards as necessary.

*2. Establish 10 National Boards for the 11 professions as per the IGA*

As per of the IGA, this will build on and is broadly consistent with the existing the NRAS legislation and approach adopted to date.

It is proposed however the national boards deal with key national issues, rather than also be responsible for local level operational issues.

The costs of the operation of National Boards would be met via a fee levied through retained state registration systems, adopting the existing approach for funding of the Australian Medical Council and the Australian Dental Council.

*3. Revise the functions of the National Boards to ensure a national focus*

Key issues where a national approach is important include accreditation of courses, development and/or approval of standards, codes of conduct, advice to the Australian Health Ministers Council and control and maintenance of the national registers (see 1 above).

The proposal is to revise the role of the National Boards to focus more directly on these nation-wide issues. This will change the current NRAS approach, but will ensure the NRAS retains a national registration system and a national forum to drive reform and consider key issues impacting on practice and the workforce.

This approach also means the retention of State/Territory boards to continue to perform the main day to day operational functions inherent in running a registration system, including the disciplinary system.

The advantage of this approach is that the delineation of State/Territory vs national roles will occur in legislation rather than rely on delegations from the national to State/Territory level. This means certainty for both professional groups and the community on exactly who does what at the national and local level - something not available under the delegated system.

*4. Reduction in size the current proposed national bureaucracy*

Given the major day to day operational workload will remain with the current State/Territory Boards, there is limited justification for the extensive National Agency (including the National Office and State/Territory Offices) referred to in the IGA.

The higher level policy role for National Boards will only require policy support and a small administrative secretariat. Reducing the size of the national bureaucracy will address professional concerns that they are being asked to pay substantially increased fees for little result other than additional bureaucracy.

It will also reduce the overall cost of the scheme, including current transitional costs relating to the transfer of staff and assets.

*5. Revise the role of the NRAS Agency Management Committee*

It is also proposed to revise the Agency Management Committee, to operate more as a forum for boards, professions and jurisdictional representatives to consider and advise AHMC on

cross professional issues. Given the substantial reduction proposed in the national bureaucracy, there is no cogent justification for a substantial oversight group as originally proposed. The mechanics of the Management Committee could, however, be adapted to establish a venue for cross-professional discussion of national issues.

### 6. *Retain State and Territory Boards and local State/Territory legislation*

It is proposed to retain the State/ Territory Board structures at local level. The establishment of the National Boards will however involve a reduction in the scope of functions at the State/Territory level, to ensure a clear delineation with the national bodies and to recognise the primary role of the National Boards in relation to accreditation and development of policy/guidelines.

Local boards will however retain primary responsibility for day to day operation, registration decisions and discipline. The aim is to focus the day to day operational work at the State/Territory level, and to do so clearly, via legislation. This may also mean some limited contraction of State/Territory board administration, as they move out of the broader policy role now to be addressed at a national level.

This approach also addresses the disparity in current disciplinary and investigative models, and will allow States/Territories to retain existing disciplinary regimes. It would also ensure that staff working at the State/Territory level (which will be the vast majority) will remain subject to local State/Territory employment and industrial requirement and other laws, including any crime and misconduct legislation that may exist in respective jurisdictions. This last issue has also been a matter of some concern to some jurisdictions.

### 7. *Linkages between State/Territory and national bodies*

There have been some discussions as to how to ensure a linkage between the new national bodies and activities undertaken at the State/Territory level – including suggestions from WA that State/Territory boards provide the membership base for the national boards. A strong degree of linkage is important, however it is also noted that some of the concerns in this regard arise from the current model placing all functionality in the national boards.

The revised model proposed here, whereby operational functions remain clearly delineated at the State/Territory level, arguably goes some way to address these concerns.

The WA "State/Territory based" membership model however, may also be one option Ministers wish to consider further if these concerns remain.

### 8. *Improved consistency of State/Territory elements of the NRAS*

Another aim of any national regime is to enhance and improve consistency across all jurisdictions. The revised model will therefore also involve progressing the following legislative changes at a State/Territory level by 1 July 2010:

- Changes already agreed on through the NRAS process with a primarily operational focus, and therefore in this model of State/Territory relevance. These would cover issues such as consistency in key definitions (practice restrictions, definitions of misconduct and specialist descriptions), criminal record checking, student registration, practice restrictions etc;

- . Given the system will support a national register, there will also need to be enhanced information sharing and information transfer for disciplinary/public safety reasons between local boards and with the national register;
- Registration through state infrastructure on basis of residential address, which would be included in the national register.
- Establish provisions for one jurisdiction to take primary responsibility for day to day registration/renewal and implementation/ enforcement of any disciplinary actions, based on a residence/location of primary practice.
- Progress NRAS position on partially regulated professions at a state level by 1 July 2010.

*9. Revise the Accreditation process adopted in the IGA*

The aim of the changes proposed here is to address both professional and jurisdictional concerns, and retain a 'reserve power' for Ministers if an Accreditation Agency proposes Standards that will have a significant impact on funding or management of a State/Territory health system.

Proposals previously put to both Health Ministers and AHMAC have already proposed a departure from the IGA by suggesting that the National Boards, rather than the Ministerial Council, approve Accreditation Standards. Some medical, pharmacy and dental groups however argue for a further removal from State and Territory governance, with standards to be set by the accreditation agencies. The view is that without this degree of independence jurisdictions could interfere in the development of safe & appropriate courses.

Some jurisdictions including NSW have indicated the difficulties for jurisdictions if courses are developed without due regard to their impact on the health system which provides the clinical placements, or in isolation of broader workforce issues which can have a significant impact on the cost and effectiveness of the health system.

The revised model proposed here is that the only way to effectively address this concern is for jurisdictions to have sign off or a reserve power that enables them to intervene to ensure these issues are satisfactorily addressed.

*10. Establish clear criteria for when jurisdictional reserve powers arise*

Having regard to the issues noted at point 9, above, it is recognised a balance can only be set if there are clear criteria for when reserve powers may operate. On this basis, the following areas for individual jurisdictional sign-off of Accreditation Standards are suggested:

- Where the Standards have not been developed on accordance with any policy guidelines issued by the Ministerial Council;
- Where the Standards significantly alter the duration of courses and/or training previously required for qualification for registration in that profession;
- Where the Standards significantly extend clinical placement hours previously required for qualification for registration in that profession;
- . Where the Standards would result in workplace and work practice changes, or imposition of industrial conditions having significant resource implications for employers.

*11. Seek to build a consensus with key professional groups on Accreditation*

It must be accepted that the discussions with the professions on accreditation have been amongst the most fraught in the NRAS process, and real concerns continue about the current approach. Recognising that the NRAS will require goodwill and co-operation between the regulators and the professions, the scheme needs to be based on a consensus framework. With this in mind it is proposed that the nature and scope of the reserve powers outlined above should be subject to direct discussion with key professional groups, with the aim of reaching an agreement on scope and wording.

*12. Allow local level regulation of cosmetic contact lenses*

The most recent AHMAC recommendation on this issue is to exclude the regulation of cosmetic contact lenses from the NRAS, but allow States/Territories to address the issue at a local level if they wish. This recognises the strongly divergent views amongst jurisdictions.

The aim of the recommendation therefore is to ensure all jurisdictions have a choice in how and if they regulate this area. This means that both "prescription only" and other regulatory models will be able to continue to operate, depending on the local policy approach.

This paper endorses that approach, noting that retention of State/Territory level boards will provide a ready mechanism for pursuing the different policy approaches at State/Territory level.

# Appendix 3

Australian Health Workforce Ministerial Council

# Communiqué
**8 May 2009**

## DESIGN OF NEW NATIONAL REGISTRATION AND ACCREDITATION SCHEME

The Ministerial Council has today reached a national consensus on how the new National Registration and Accreditation Scheme for the Health Professions will work. This will deliver improvements to the safety and quality of Australia's health services through a modernised national regulatory system for health practitioners.

The Ministerial Council acknowledged and welcomed the very high level of participation by consumers, practitioners and regulatory bodies in the consultation process to date. Over 1,000 people have attended forums around the country and over 650 written submissions have been received in response to the consultation papers issued in 2008 and 2009.

As a result of the consultation process and the feedback received, the Ministerial Council has determined that a number of changes should be made to the original proposals put forward, in particular in the areas of accreditation, the role of state bodies and complaints handling. The following sections outline the main matters on which Ministers have made decisions today.

### Independent accreditation functions

The Ministerial Council agreed today that the accreditation function will be independent of governments. Accreditation standards will be developed by the independent accrediting body or the accreditation committee of the board where an external body has not been assigned the function.

The accrediting body or committee will recommend to the board, in a transparent manner, the courses and training programs it has accredited and that it considers to have met the requirements for registration. The final decision on whether the accreditation standards, courses and training programs are approved for the purposes of registration is the responsibility of the national board. The accrediting body will have the ability to make its recommendations publicly available in the circumstance that agreement between the accrediting body and the national board cannot be achieved.

The Ministerial Council will have powers to act, for instance, where it believes that changes to an accreditation standard, including changes to clinical placement hours or workplace and work practice, would have a significantly negative effect.

National accreditation standards which exist prior to the commencement of the new scheme are to continue until they are replaced by new standards.

Existing external accrediting bodies such as the Australian Medical Council and the Australian Pharmacy Council are expected to continue. The specific governance arrangements for these bodies will be a matter for them, although they will be expected to meet modern governance standards.

## Changes to registers

Ministers today agreed there will be both general and specialist registers available for the professions, including medicine and dentistry, where ministers agree that there is to be specialist registration. Practitioners can be on one or both of these registers, depending on whether their specialist qualification has been recognised under the national scheme. Ministers agreed specialist registers will not cover practitioners registered to practice in an area of need.

Ministers have also decided that there will now be separate registers for nurses and for midwives.

## Support for continuing professional development

The Ministerial Council has agreed that there will be a requirement that, for annual renewal of registration, a registrant must demonstrate that they have participated in a continuing professional development program as approved by their national board.

Each profession's requirements will be set by the relevant board. A board may use its accrediting body to set standards for such programs and approve providers of such programs (including, in the case of medicine, specialist medical colleges) where that is the best arrangement for that profession.

## Extension of scheme to other professions

The Ministerial Council also decided that, from 1 July 2012, Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners and medical radiation practitioners will be regulated under the scheme. These are in addition to the ten professions already agreed for inclusion in the national scheme from 1 July 2010 (chiropractors; dental (including dentists, dental hygienists, dental prosthetists and dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists and psychologists).

## Other improvements to quality and safety of health services

The Ministerial Council also agreed a number of other changes to registration arrangements in order to improve the quality and safety of health services being delivered to the public. These are set out below.

*Mandatory reporting of registrants*
The Ministerial Council agreed on 5 March 2009 that there will be a requirement that practitioners and employers (such as hospitals) report a registrant who is placing the public at risk of harm.

Ministers agreed that reportable conduct will include conduct that places the public at substantial risk of harm either through a physical or mental impairment affecting practice or a departure from accepted professional standards. Practitioners who are practising while under the influence of drugs or alcohol, or have engaged in sexual misconduct during practice must also be reported.

This requirement will deliver a greater level of protection to the Australian public.

*Criminal history and identity checks*
National agreement was reached on 5 March 2009 on criminal history and identity checks to apply to registered health professionals.

Mandatory criminal history and identity checks will apply to all health professionals registering for the first time in Australia. All other registrants will be required to make an annual declaration on criminal history matters when they renew their registration and these declarations will be audited on a random basis by an independent source.

Ministers also agreed that national boards will have the power to conduct ad hoc criminal history and identity checks on registrants.

*Simplified complaints arrangements for the public*
Assistance will be provided to members of the public who need help to make a complaint. Ministers agreed that this new arrangement will not affect the services provided by health complaints commissions across the country. However it will help make the complaints process simpler for members of the public.

*Student registration*
The Ministerial Council agreed that national boards will be required to register students in the health professions. Boards will decide at what point during their programs of study students will be registered, depending on the level of risk to the public.

Ministers agreed the national scheme will enable national boards to act on student impairment matters or where there is a conviction of a serious nature which may impact on public safety. This requirement will come into effect at the beginning of 2011.

Students will be registered by a deeming process based on lists of students supplied to boards by education providers

*Handling of complaints*
Given the diversity of arrangements in Australia at this time, Ministers have agreed to a flexible model for the administrative arrangements for handling complaints.

The National Law and/or State or Territory law, depending on each jurisdiction's choice, will provide the legislative framework for investigations and prosecutions and the definitions of offences and contraventions and outcomes will be recorded as part of a single national framework.

Where the national legislative framework is adopted, it will also be up to each State and Territory to decide whether the prosecution and investigation functions remain with the national boards or be undertaken by an existing State or Territory health complaints arrangement.

The Ministerial Council also agreed a number of other elements related to the effective functioning of the new scheme.

## Appointments to national boards

Ministers confirmed the arrangements set out in the *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (the Act), that boards will be appointed by the Ministerial Council with vacancies to be advertised. At least half, but not more than two thirds, of the members must be practitioners and at least two must be persons appointed as community members.

Adding to the Act, Ministers have also agreed that the National Law will require all national boards to contain at least one practitioner member from each of the larger jurisdictions (Queensland, New South Wales, Victoria, South Australia and Western Australia) and at least one other practitioner member drawn from the three smaller States and Territories (Tasmania, the Australian Capital Territory or the Northern Territory). Members of existing boards and State and Territory boards under the national scheme (see below) will be eligible for appointment to national boards. Members of the Agency Management Committee may not hold an appointment to a national board.

Ministers have also agreed that each national board will have at least one member from a rural or regional area.

## State and Territory boards (previously "State and Territory committees")

Ministers agreed that the main committee of a national board in each State or Territory where a committee is appointed will be known as a State or Territory board, for example the South Australian Board of the Pharmacy Board of Australia. Each national board will need to determine where State or Territory boards will be appointed, taking into account the need to provide efficient processes in each profession.

The role of these State and Territory boards will be to oversee registration and complaints processes in that State or Territory where these functions are delegated to them by the national board. State and Territory boards will perform these functions under the national legislation for the scheme. Appointments to State boards will be made by State Ministers following an open and transparent process.

Ministers also agreed that from 1 July 2010 (and subject to the decision of a national board that there will be a State or Territory board of that national board located in a jurisdiction), members of the existing board in that jurisdiction will comprise that State or Territory board for the balance of the terms of their appointment.

## New national regulation of cosmetic lenses

To protect the public from injuries arising from the misuse of cosmetic contact lenses, the Ministerial Council has agreed that the prescribing of cosmetic lenses will be restricted to optometrists and medical practitioners. These are the same restrictions that will apply to the supply of other contact lenses under the new scheme.

## Area of need arrangements

The Ministerial Council agreed that national boards will be required to consider applications for registration from practitioners seeking to work in a location or position that has been declared by the relevant State or Territory Minister as an area of need. Boards will determine whether the practitioner is eligible for registration and, if registration is granted, what conditions will apply.

## Privacy protections for practitioners and consumers

Ministers agreed to build on the Commonwealth's leadership and adopt under the national scheme the Commonwealth National Privacy Principles and privacy regime (or its successor). This will provide practitioners and consumers with the protection needed in relation to information collected by the national boards and the national agency.

## Location of national office

Ministers agreed that the national office of the new Australian Health Practitioner Regulation Agency will be located in Melbourne.

## Next steps

Ministers agreed that these decisions should be included in the exposure draft of the *Health Practitioner Regulation National Law Bill 2009*, which will provide the legal framework for the national scheme. The exposure draft of the legislation will be released by the Ministerial Council later in 2009 for a further round of public consultations.

When comments have been received on the exposure draft, the Ministerial Council will determine the final form the legislation should take.

Melbourne
8 May 2009

# INTERGOVERNMENTAL AGREEMENT

# FOR A

# NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR THE HEALTH PROFESSIONS

## 1. PARTIES

1.1 AN AGREEMENT made on the twenty sixth day of March 2008, between

The Commonwealth of Australia;

The State of New South Wales;

The State of Victoria;

The State of Queensland;

The State of Western Australia;

The State of South Australia;

The State of Tasmania;

The Australian Capital Territory; and.

The Northern Territory of Australia.

## 2. PREAMBLE

2.1 In 2005, the Commonwealth Government asked the Productivity Commission to undertake a research study to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals and propose solutions to ensure the continued delivery of quality healthcare over the next 10 years. The report was delivered in January 2006.

2.2 The report recommended that there should be a single national registration board for health professionals, as well as a single national accreditation board for health professional education and training; to deal with workforce shortages/pressures faced by the Australian health workforce and to increase their flexibility, responsiveness, sustainability, mobility and reduce red tape.

2.3 At its meeting of 14 July 2006, the Council of Australian Governments (COAG) agreed to establish a single national registration scheme for health professionals, beginning with the nine professional groups then registered in all jurisdictions.

2.4 COAG further agreed to establish a single national accreditation scheme for health education and training, in order to simplify and improve the consistency of current arrangements.

2.5 COAG has subsequently agreed to establish a single national scheme, with a single national agency encompassing both the registration and accreditation functions. The national registration and accreditation scheme will consist of a Ministerial Council, an independent Australian Health Workforce Advisory Council, a national agency with an agency management committee, national profession-specific boards, committees of the boards, a national office to support the operations of the scheme, and at least one local presence in each State and Territory.

2.6 At its meeting of 26 March 2008, COAG agreed to establish the scheme by 1 July 2010.

2.7 Stakeholders have been extensively consulted in the development of the scheme. In addition to ad hoc meetings, there have been a number of formal consultations with key stakeholders. Stakeholders were also asked to make a number of submissions on the proposed scheme, including on their preferred regulatory model. This feedback has been crucial in informing the final scope, structure and functions of the new scheme.

2.8 This Agreement identifies the objectives, scope and governance, legislative, administrative and financial arrangements for the scheme.

## 3. DEFINITIONS AND INTERPRETATION

3.1 In this Agreement, unless the context appears otherwise:

(a) 'Advisory Council' means the Australian Health Workforce Advisory Council;

(b) 'Agreement' means this Intergovernmental Agreement;

(c) 'AHMC' means the Australian Health Ministers' Conference;

(d) 'AHMAC' means the Australian Health Ministers' Advisory Council;

(e) 'board' means a national profession-specific board covered by the scheme;

(f) 'COAG' means the Council of Australian Governments;

(g) 'jurisdiction' means one of the Parties to this Agreement;

(h) 'Ministerial Council' means the Australian Health Workforce Ministerial Council to be established as part of the scheme pursuant to part 7 of this agreement and comprising the Commonwealth Health Minister and the Ministers with responsibility for Health from each State and Territory;

(i) 'national agency' is the entity defined in 1.16 of Attachment A;

(j) 'Party' means a party to this Agreement; and

(k) 'scheme' or 'national scheme' means the national registration and accreditation scheme.

## 4. OPERATION OF THE AGREEMENT

4.1 This Agreement commences upon signature by all of the Parties.

4.2 All disputes between the Parties will be resolved in accordance with this Agreement.

## 5. OBJECTIVES

5.1 To establish a single national registration and accreditation scheme for health professionals, beginning with the nine professions currently registered in all jurisdictions. That is, physiotherapy, optometry, nursing and midwifery, chiropractic care, pharmacy, dental care (dentists, dental hygienists, dental prosthetists and dental therapists), medicine, psychology and osteopathy.

5.2 As agreed by COAG on 26 March 2008, all professionals in these nine groups will be covered by the national scheme as of 1 July 2010.

5.3 The objectives of the national scheme, to be set out in the legislation, are to:

(a) provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;

(b) facilitate workforce mobility across Australia and reduce red tape for practitioners;

(c) facilitate the provision of high quality education and training and rigorous and responsive assessment of overseas-trained practitioners;

(d) have regard to the public interest in promoting access to health services; and

(e) have regard to the need to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and enable innovation in education and service delivery.

5.4 The scheme will operate under the following principles, to be set out in the legislation:

(a) it should operate in a transparent, accountable, efficient, effective and fair manner;

(b) it should ensure that fees and charges are reasonable; and

(c) it should recognise that restrictions on the practice of a profession should only occur where the benefits of the restriction to the community as a whole outweigh the costs.

5.5 The legislation will provide that all bodies within the scheme will have regard to the objectives of the national scheme.

5.6 The Parties to this Agreement confirm that they do not intend the proposed national registration and accreditation scheme to have any role in regulating employment conditions, rates of pay or other employment matters with regard to the health professions proposed to be regulated.

5.7 The Parties to this Agreement further confirm that they do not intend the proposed national registration and accreditation scheme to have any role in relation to resourcing, management or governance of State and Territory health institutions.

## 6. IMPLEMENTATION

6.1 For the purpose of ensuring a national registration and accreditation scheme, the States and Territories undertake to use their best endeavours to submit to their respective Parliaments whatever Bill or Bills that have the effect of achieving a national scheme from 1 July 2010.

6.2 The structure and functions of the national scheme will be set out in the legislation establishing the scheme. The legislation will establish a single scheme covering both the registration and accreditation functions and will be framed in such a way to encompass this Agreement.

6.3 The State of Queensland will host the substantive legislation to give effect to the national scheme, which will be subject to the approval of the AHMC. Once approved by the AHMC, the State of Queensland will take the lead in enacting the primary legislation to establish the scheme.

6.4 The State of Western Australia will, as soon as reasonably practicable, enact corresponding legislation, substantially similar to the agreed model, so as to permit the scheme to be established on 1 July 2010. The States of New South Wales, Victoria, South Australia and Tasmania and the Australian Capital Territory and the Northern Territory will, as soon as reasonably practicable following passage of the Queensland legislation, use their best endeavours to enact legislation in their jurisdictions applying the Queensland legislation as a law of those jurisdictions, so as to permit the scheme to be established on 1 July 2010.

6.5 Each of the States and Territories will use their best endeavours to repeal their existing registration legislation which covers the health professions that are subject to the new national scheme. This will have the effect of abolishing the current State and Territory based registration boards for those health professions.

6.6 Each of the Parties will use its best endeavours to repeal, amend or modify any other legislation which is inconsistent with or alters the effect of the legislation to establish the national registration and accreditation scheme.

6.7 Except as agreed by AHMC, a Party will use its best endeavours not to submit a Bill to its legislature which would be inconsistent with, or alter the effect of the legislation to implement the national registration and accreditation scheme, or this Agreement.

6.8 The States and Territories will use their best endeavours to ensure legislation as appropriate provides for entities in their jurisdiction to investigate and hear serious disciplinary matters and the hearing of appeals against less serious disciplinary matters arising from the registration function. Each State and Territory will be responsible for deciding which entity will be responsible for that function in their jurisdiction, in accordance with national criteria agreed by AHMC.

6.9 In the interests of facilitating a smooth transition to the national scheme, the AHMC will administratively establish the national agency, with an interim Chief Executive Officer, as soon as possible to commence the implementation of the scheme. The interim Chief Executive Officer will report every six months to AHMC until the establishment of the scheme.

6.10 To further ensure a smooth transition to the scheme, all existing members of jurisdictional boards and supporting hearing panels for the nine professions will, if they agree, be appointed to a list of persons from which national boards may form committees for a period of two years from commencement of the operation of the scheme.

6.11 A mechanism will also be developed to give first consideration to existing jurisdictional registration board staff to operate the State and Territory presence of the national office of the national agency.

6.12 The responsibility for the implementation of the proposed framework will transition to AHMC upon signature of this Agreement. Until legislation establishes the Ministerial Council, AHMC will be responsible for the implementation of the scheme, including the resolution of any unsettled matters so as to bring it into effect on 1 July 2010. After the establishment of the Ministerial Council, the Ministerial Council will be responsible for the scheme as per part 7 of this agreement, including the resolution of any unsettled matters. AHMC and the Ministerial Council will continue to consult with stakeholders in the development of the scheme.

## 7. THE MINISTERIAL COUNCIL

7.1 The Parties shall establish in legislation the Ministerial Council to be known as the Australian Health Workforce Ministerial Council and will comprise the Commonwealth Health Minister and the Ministers with responsibility for health from each State and Territory.

7.2 The Ministerial Council will meet from time to time, as required.

7.3 The relevant quorum requirements will be that all jurisdictions should be represented by the Minister responsible for health.

7.4 Agreement by the Ministerial Council for the purpose of decisions relating to this scheme will be by consensus. In circumstances where the Ministerial Council is unable to come to an agreement and a decision must be made, there will be a transparent process of review in order to assist it to reach an agreement. This review will be undertaken by the Advisory Council (described in Attachment A).

7.5 Under the proposed legislation for the scheme, the Ministerial Council will be responsible for:

(a) providing policy direction;

(b) agreeing on the inclusion of new professions in the scheme;

(c) proposing legislative amendments through processes of governments, which are consistent with this Agreement;

(d) providing funding as appropriate in the set up phase of the scheme;

(e) appointing members to the Advisory Council, subject to clause 1.10 of Attachment A making appointments to the management committee of the national agency;

(f) appointing members of boards;

(g) approving profession-specific registration, practice, competency and accreditation standards and continuing professional development (CPD) requirements provided by the boards;

(h) requesting boards to review approved profession-specific registration, practice, competency and accreditation standards and CPD requirements;

(i) maintaining a reserve power to intervene on budgets and fees, with any intervention to be transparent; and

(j) initiating an independent review following three years of the scheme's operation.

7.6 In respect to the Advisory Council, the Ministerial Council will:

(a) have the power to refer matters relating to the scheme to the Advisory Council for advice; and

(b) have regard to advice provided by the Advisory Council when making decisions under the scheme, including advice provided by the Advisory Council in accordance with clauses 1.8 (b) and (c) of Attachment A.

7.7 Following the approval of standards and requirements as set out in 7.5 (g) above, these standards and requirements will be publicly available.

7.8 To clarify, the Ministerial Council will not seek to insert itself into the day-to-day operations of the national agency. In particular, the Ministerial Council will not have any power to intervene in registration, examination or disciplinary decisions relating to individuals, or decisions relating to the accreditation of specific courses.

## 8. THE STRUCTURE AND FUNCTIONS OF THE SCHEME

8.1 For details of the structure and functions of the national registration and accreditation scheme refer to Attachment A.

## 9. THE COMPLAINTS AND REVIEW PROCESS UNDER THE NATIONAL SCHEME

9.1 For details of the complaints and review process under the national scheme refer to Attachment A.

## 10. REPORTING REQUIREMENTS

10.1 Each of the Parties will notify AHMC in writing when they have secured the entry into force of the relevant legislation to give effect to the scheme.

10.2 The national agency will submit an annual report to the Ministerial Council. As soon as reasonably practicable, and within two months of receipt, each of the Parties will table the annual report in their respective Parliaments.

10.3 In its first two years of operation, the agency will submit six monthly reports to the Ministerial Council, outlining in reasonable detail the progress that has been made in implementing the scheme.

## 11. THE INCLUSION OF OTHER HEALTH PROFESSIONS

11.1 For details relating to the inclusion of other health professions in the national scheme refer to Attachment B.

## 12. FUNDING

12.1 The resources of the scheme will comprise fees received for registration functions and accreditation functions, appropriate resources of the registration boards, current Commonwealth, State and Territory contributions to registration, accreditation and related workforce functions and a contribution of $19.8 million to the establishment of the new scheme agreed by COAG.

12.2 The Commonwealth will not reduce its contributions and subsidies to the scheme for the first two years of its operation.

12.3 The Parties will meet the initial costs of establishing the national registration and accreditation scheme, but it is intended that in the longer term the scheme will be self-funding.

12.4 There will be a single national set of fees for each profession in the scheme. These fees will:

(a) be agreed between the boards and the national agency; and

(b) where agreement is unable to be reached the matter will be referred to the Ministerial Council.

12.5 The overarching principle is that the process of setting fees will be equitable and transparent to registrants.

12.6 Where appropriate, registration fees will continue to contribute to the accreditation function and transitional arrangements will apply as necessary.

12.7 The Advisory Council will be funded directly by governments according to the AHMAC cost-sharing formula.

## 13. ALTERATION OF THE SCHEME AND AMENDMENTS TO THE LEGISLATION

13.1 Any of the Parties may propose amendments to the national scheme by communicating the proposed amendments to the other Parties and the justification for seeking them.

13.2 The Ministerial Council will consider any proposed amendments and agree to such amendments as it sees fit.

13.3 If the changes agreed at 13.2 require legislative amendment, the State of Queensland will:

(a) submit to its Parliament a bill in a form agreed by the Ministerial Council which has the effect of amending the legislation in the manner agreed; and

(b) take all reasonable steps to secure the passage of the bill and bring it into force in accordance with a timetable agreed by the Ministerial Council.

13.4 If the amendment is passed through the Queensland Parliament, legislation of the States of New South Wales, Victoria, South Australia and Tasmania and the Australian Capital Territory and the Northern Territory will incorporate the changes by applying the amendment as a law of those jurisdictions. In the State of Western Australia, agreed amendments to the legislation will be carried out via changes to the corresponding Western Australian legislation. The State of Western Australia will use its best endeavours to secure the passage of any agreed amendments and bring them into force to ensure ongoing consistency with the national scheme.

## 14. REVIEW OF THE SCHEME

14.1 For the purposes of the scheme, an independent review will be initiated by the Ministerial Council following three years of the scheme's operation.

14.2 The Parties note that COAG agreed on 14 July 2006 to request the Commonwealth Treasurer to task the Productivity Commission to undertake a further review of the health workforce by July 2011.

## 15. DISPUTE RESOLUTION IN RELATION TO THIS AGREEMENT

15.1 Where a dispute arises in relation to this Agreement, AHMC or the Ministerial Council, as appropriate, will work cooperatively in an endeavour to resolve it.

## 16. WITHDRAWAL AND CESSATION

16.1 The Parties agree that withdrawal from the scheme will be a measure of last resort.

16.2 A Party that proposes to withdraw from this Agreement will notify each of the other Parties by giving at least 12 months written notice.

16.3 In the event of withdrawal from this Agreement by any one of the Parties, this Agreement will be rendered null and void except as otherwise agreed by the Ministerial Council (or in the event that the Ministerial Council has not been established, by AHMC).

16.4 In circumstances where a Party fails to comply with any of its obligations under this Agreement, the Agreement shall be rendered null and void except as otherwise agreed by the Ministerial Council (or in the event that the Ministerial Council has not been established, by AHMC).

16.5 In circumstances where this Agreement is rendered null and void, responsibility for the registration and accreditation of the health professions covered by the scheme will revert to individual States and Territories.

16.6 This Agreement may be terminated at any time by agreement in writing of all of the Parties.

IN WITNESS WHEREOF this Agreement has been executed as at the day and year first written above.

SIGNED by:

The Honourable Kevin Rudd MP )
Prime Minister of the Commonwealth of Australia )

The Honourable Morris Iemma MP )
Premier of the State of New South Wales )

The Honourable John Brumby MP )
Premier of the State of Victoria )

The Honourable Anna Bligh MP )
Premier of the State of Queensland )

The Honourable Alan Carpenter MLA )
Premier of the State of Western Australia )

The Honourable Michael Rann MP )
Premier of the State of South Australia )

The Honourable Paul Lennon MHA )
Premier of the State of Tasmania )

Mr Jon Stanhope MLA )
Chief Minister of the Australian Capital Territory )

The Honourable Paul Henderson MLA )
Chief Minister of the Northern Territory )

# Appendix 4

(7) For the purposes of this section, an internal Territory shall be deemed to form part of the State of New South Wales.

(8) In this section:

***health service*** means:

(a) medical, surgical, obstetric, dental or optometrical treatment; and

(b) any other prescribed service, or service included in a prescribed class of services, whether or not related to treatment referred to in paragraph (a), that relates to health;

but does not include the supply of prostheses otherwise than in connection with the rendering by an accredited dental practitioner of a service to a prescribed dental patient.

***service*** includes the supply of goods.

### 3D Recognition as specialists of members of certain organisations on advice from the organisation

(1) A medical practitioner is taken to be recognised as a specialist in a particular specialty, for the purposes of this Act, if a relevant organisation in relation to the specialty gives the Managing Director of the Commission written notice stating that the medical practitioner meets the criteria for the specialty (see subsection (2)).

(2) A medical practitioner ***meets the criteria for a specialty*** if the medical practitioner:

(a) is domiciled in Australia; and

(b) is a fellow of a relevant organisation in relation to the specialty; and

(c) has obtained, as a result of successfully completing an appropriate course of study, a relevant qualification in relation to the relevant organisation.

(3) The Managing Director of the Commission must notify the medical practitioner as soon as reasonably practicable of his or her recognition as a specialist in the specialty.

(4) This section does not limit section 3DB.

(5) In this section:

***relevant organisation***, in relation to a specialty, means an organisation declared by the regulations to be a professional organisation in relation to the specialty.

***relevant qualification***, in relation to a relevant organisation, means a qualification declared by the regulations to be a relevant qualification in relation to the relevant organisation.

### 3DA Period of section 3D recognition

(1) The recognition of a medical practitioner as a specialist in a particular specialty under subsection 3D(1) has effect, or is taken to have had effect, on and from the day specified in the notice given to the medical practitioner under subsection 3D(3).

(2) The day specified may be before the day on which the notice is given, but must not be before the day specified by the relevant organisation to be the day on which the medical practitioner first met the criteria for the specialty.

(3) The recognition of a medical practitioner as a specialist in a specialty under subsection 3D(1) ceases if:

(a) a relevant organisation in relation to the specialty gives the Managing Director of the Commission written notice stating that the medical practitioner no longer meets the criteria for the specialty, or has ceased to practise medicine in Australia; or

(b) the medical practitioner requests that he or she cease to be so recognised.

Note: A medical practitioner's recognition as a specialist cannot cease under this subsection if that recognition is due to Schedule 3 to the *Health and Ageing Legislation Amendment Act 2004*.

### 3DB Alternative method of recognition as a specialist

(1) A medical practitioner may apply to the Minister for a determination that the medical practitioner is a specialist in a particular specialty if:

(a) the medical practitioner is domiciled in Australia; and

# Part V—Committees

## Division 1—Specialist Recognition Advisory Committees and the Specialist Recognition Appeal Committee

### 47 Interpretation

In this Division, unless the contrary intention appears:

*Committee* means a Specialist Recognition Advisory Committee or the Specialist Recognition Appeal Committee.

*member* means a member of a Committee, and includes a person appointed under section 53 to act in the place of a member.

### 48 Establishment of Specialist Recognition Advisory Committees

(1) The Minister shall establish for:
  (a) each State;
  (b) the Australian Capital Territory; and
  (c) the Northern Territory;
a Specialist Recognition Advisory Committee.

(2) Each Specialist Recognition Advisory Committee shall consist of five medical practitioners appointed by the Minister in accordance with section 50A or 50B.

(3) The exercise or performance of the powers or functions of a Specialist Recognition Advisory Committee is not affected by reason only of there being a vacancy or vacancies in the membership of the Committee.

(4) A member of a Specialist Recognition Advisory Committee holds office for a period of 3 years.

(5) A member of the Specialist Recognition Appeal Committee is not eligible to be appointed under this section to a Specialist Recognition Advisory Committee.

Section 49

### 49 Establishment of Specialist Recognition Appeal Committee

(1) There shall be a Specialist Recognition Appeal Committee, which shall consist of five medical practitioners appointed by the Minister in accordance with section 50A or 50B.

(2) The exercise or performance of the powers or functions of the Specialist Recognition Appeal Committee is not affected by reason only of there being a vacancy or vacancies in the membership of the Committee.

(3) A member of the Specialist Recognition Appeal Committee holds office for a period of 3 years.

(4) A member of a Specialist Recognition Advisory Committee is not eligible to be appointed under this section to the Specialist Recognition Appeal Committee.

### 50 Panels for appointments to Committees

(1) Before making appointments to a Committee, the Minister must ask each of the following bodies to nominate a panel of at least 3 medical practitioners for the Minister's consideration for appointment to the Committee:
  (a) the Australian Medical Association;
  (b) the Royal Australasian College of Surgeons;
  (c) the Royal Australasian College of Physicians;
  (d) the Royal Australian College of Obstetricians and Gynaecologists;
  (e) the Royal Australian College of General Practitioners.

(2) The request must:
  (a) be in writing; and
  (b) specify the date by which the body must nominate a panel.

### 50A Compliance with request

(1) If each body nominates a panel for a Committee in accordance with the request by the date specified in the request, the Minister must appoint to the Committee one medical practitioner from each panel.

| Item | Service |
|---|---|
| 11 | Osteopathy |
| 12 | Physiotherapy |
| 13 | Podiatry |
| 14 | Psychological therapy |
| 15 | Psychology |
| 16 | Speech pathology |

### 4 Relevant organisations and qualifications (Act s 3D)

(1) For the definition of ***relevant organisation*** in subsection 3D (5) of the Act, the organisation specified in column 2 of an item in Schedule 4 is declared to be a professional organisation in relation to each specialty specified in column 3 of that item.

(2) For the definition of ***relevant qualification*** in subsection 3D (5) of the Act, the qualification specified in column 4 of an item in Schedule 4 is declared to be a relevant qualification in relation to the organisation specified in column 2 of that item.

### 5 Prescribed fee — subsection 3D (1) of the Act

For the purposes of subsection 3D (1) of the Act, the prescribed fee is $30.

### 6 Prescribed fee — subsection 3E (2) of the Act

For the purposes of subsection 3E (2) of the Act, the prescribed fee is $30.

### 6A Recognised Fellows of the RACGP

(1) An applicant is eligible for a determination under paragraph 3EA (2) (b) of the Act if the RACGP certifies that the applicant meets the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance.

# Schedule 4 Relevant organisations and qualifications

(regulation 4)

## Part 1 Current organisations and qualifications

| Column 1 Item | Column 2 Organisation | Column 3 Specialty | Column 4 Qualification |
|---|---|---|---|
| 101 | Australasian College for Emergency Medicine | Emergency Medicine | Fellowship of the Australasian College for Emergency Medicine (FACEM) |
| 102 | The Royal Australasian College of Physicians, Division of Adult Medicine and Division of Paediatric and Child Health | General Medicine<br>General Paediatrics<br>Cardiology<br>Clinical Genetics<br>Clinical Pharmacology<br>Endocrinology<br>Gastroenterology and Hepatology<br>Geriatric Medicine<br>Haematology<br>Immunology and Allergy<br>Infectious Diseases<br>Intensive Care<br>Medical Oncology<br>Nephrology<br>Neurology<br>Nuclear Medicine<br>Palliative Medicine | Fellowship of the Royal Australasian College of Physicians (FRACP) |

| Column 1 Item | Column 2 Organisation | Column 3 Specialty | Column 4 Qualification |
|---|---|---|---|
| | | Respiratory and Sleep Medicine | |
| | | Rheumatology | |
| 102A | The Royal Australasian College of Physicians, Australasian Chapter of Palliative Medicine | Palliative Medicine | Fellowship of the Australasian Chapter of Palliative Medicine (FAChPM) |
| 103 | The Royal Australasian College of Physicians, Australasian Faculty of Occupational Medicine | Occupational Medicine | Fellowship of the Australasian Faculty of Occupational Medicine (FAFOM) |
| 104 | The Royal Australasian College of Physicians, Australasian Faculty of Rehabilitation Medicine | Rehabilitation Medicine | Fellowship of the Australasian Faculty of Rehabilitation Medicine (FAFRM) |
| 105 | The Royal Australasian College of Physicians, Australasian Faculty of Public Health Medicine | Public Health Medicine | Fellowship of the Australasian Faculty of Public Health Medicine (FAFPHM) |

| Column 1 Item | Column 2 Organisation | Column 3 Specialty | Column 4 Qualification |
|---|---|---|---|
| 106 | Australian and New Zealand College of Anaesthetists | Anaesthesia<br>Intensive Care | Fellowship of the Australian and New Zealand College of Anaesthetists (FANZCA)<br>*Note* This qualification has been awarded since 7 February 1992. |
| 106A | Australian and New Zealand College of Anaesthetists, Faculty of Pain Medicine | Pain Medicine | Fellowship of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (FFPMANZCA) |
| 107 | Royal Australasian College of Surgeons | Cardio-thoracic Surgery<br>General Surgery<br>Neurosurgery<br>Orthopaedic Surgery<br>Otolaryngology — Head and Neck Surgery<br>Paediatric Surgery<br>Plastic and Reconstructive Surgery<br>Urology<br>Vascular Surgery | Fellowship of the Royal Australasian College of Surgeons (FRACS) |

| Column 1 Item | Column 2 Organisation | Column 3 Specialty | Column 4 Qualification |
|---|---|---|---|
| 108 | The Australasian College of Dermatologists | Dermatology | Fellowship of the Australasian College of Dermatologists (FACD) |
| 109 | The Royal Australian and New Zealand College of Radiologists<br>*Note* This organisation was formerly called by the name specified in column 2 of item 205. | Diagnostic Radiology<br>Diagnostic Ultrasound<br>Nuclear Medicine<br>Radiation Oncology | Fellowship of the Royal Australian and New Zealand College of Radiologists (FRANZCR)<br>*Note* This qualification has been awarded since 27 October 1998. |
| 110 | The Royal Australian and New Zealand College of Psychiatrists | Psychiatry | Fellowship of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP) |
| 111 | The Royal Australian and New Zealand College of Obstetricians and Gynaecologists<br>*Note* This organisation was formerly called by the name specified in column 2 of item 206. | Obstetrics and Gynaecology<br>Gynaecological Oncology<br>Maternal-fetal Medicine<br>Obstetrics and Gynaecological Ultrasound<br>Reproductive Endocrinology and Infertility<br>Urogynaecology | Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG)<br>*Note* This qualification has been awarded since 23 October 1998. |

| Column 1 Item | Column 2 Organisation | Column 3 Specialty | Column 4 Qualification |
|---|---|---|---|
| 112 | The Royal Australian and New Zealand College of Ophthalmologists<br>*Note* This organisation was formerly called by the name specified in column 2 of item 207. | Ophthalmology | Fellowship of the Royal Australian and New Zealand College of Ophthalmologists (FRANZCO)<br>*Note* This qualification has been awarded since 21 December 2000. |
| 113 | The Royal College of Pathologists of Australasia | General Pathology<br>Anatomical Pathology (including Cytopathology and Forensic Pathology)<br>Chemical Pathology<br>Haematology<br>Immunology<br>Microbiology | Fellowship of the Royal College of Pathologists of Australasia (FRCPA) |
| 114 | The Royal Australasian College of Dental Surgeons | Oral and Maxillofacial Surgery | Fellowship of the Royal Australasian College of Dental Surgeons (Oral and Maxillofacial Surgery) (FRACDS (OMS)) |
| 115 | Australian and New Zealand College of Anaesthetists and Royal Australasian College of Physicians, Joint Faculty of Intensive Care Medicine | Intensive Care Medicine | Fellowship of the Joint Faculty of Intensive Care Medicine (FJFICM) |

# Part 2 Former organisations and qualifications

*Note* The organisations and qualifications specified in this Part are the former names of relevant organisations and relevant qualifications specified in Part 1. The organisations and qualifications specified in this Part are relevant organisations and relevant qualifications for the purposes of subsection 3D (5) of the Act.

| Column 1<br>Item | Column 2<br>Organisation | Column 3<br>Specialty | Column 4<br>Qualification |
|---|---|---|---|
| 201 | Australasian College of Rehabilitation Medicine | Rehabilitation Medicine | Fellowship of the Australasian College of Rehabilitation Medicine (FACRM)<br>*Note* This qualification has not been awarded since 28 April 1993. |
| 202 | Australian and New Zealand College of Anaesthetists, Faculty of Intensive Care | Anaesthesia<br>Intensive Care | Fellowship of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists (FFICANZCA)<br>*Note* This qualification has not been awarded since 22 February 2002. |
| 203 | The Royal Australasian College of Physicians<br>*Note* This organisation is now called by the name specified in column 2 of item 102. | General Medicine<br>Cardiology<br>Clinical Haematology<br>Clinical Immunology (including Allergy)<br>Clinical Pharmacology<br>Endocrinology<br>Gastroenterology<br>Geriatrics | Fellowship of the Royal Australasian College of Physicians (FRACP)<br>*Note* Although this qualification is still awarded, the name of the relevant organisation has changed (see column 2 of item 102). The specialties in relation to which this qualification is currently awarded are specified in column 3 of item 102. |

| Column 1 Item | Column 2 Organisation | Column 3 Specialty | Column 4 Qualification |
|---|---|---|---|
| | | Infectious Diseases<br>Intensive Care<br>Medical Oncology<br>Neurology<br>Nuclear Medicine<br>Paediatric Medicine<br>Renal Medicine<br>Rheumatology<br>Thoracic Medicine | |
| 204 | Royal Australasian College of Surgeons, Faculty of Anaesthetists | Anaesthesia<br>Intensive Care | Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (FFARACS)<br>*Note* This qualification has not been awarded since 7 February 1992. |
| 205 | The Royal Australasian College of Radiologists<br>*Note* This organisation is now called by the name specified in column 2 of item 109. | Diagnostic Radiology<br>Nuclear Medicine<br>Radiation Oncology | Fellowship of the Royal Australasian College of Radiologists (FRACR)<br>*Note* This qualification has not been awarded since 26 October 1998. |

| Column 1 Item | Column 2 Organisation | Column 3 Specialty | Column 4 Qualification |
|---|---|---|---|
| 206 | The Royal Australian College of Obstetricians and Gynaecologists<br>*Note* This organisation is now called by the name specified in column 2 of item 111. | Obstetrics and Gynaecology<br>Gynaecological Oncology<br>Maternal-fetal Medicine<br>Obstetrics and Gynaecological Ultrasound<br>Reproductive Endocrinology and Infertility<br>Urogynaecology | Fellowship of the Royal Australian College of Obstetricians and Gynaecologists (FRACOG)<br>*Note* This qualification has not been awarded since 22 October 1998. |
| 207 | The Royal Australian College of Ophthalmologists<br>*Note* This organisation is now called by the name specified in column 2 of item 112. | Ophthalmology | Fellowship of the Royal Australian College of Ophthalmologists (FRACO)<br>*Note* This qualification has not been awarded since 20 December 2000. |

# Schedule 5 Matters specified for Register of Approved Placements

(regulations 6E and 6EA)

## Part 1 Specified bodies and courses

| Item | Body | Qualification |
|---|---|---|
| 1 | Australasian Chapter of Palliative Medicine | FAChPM |
| 2 | Australasian College for Emergency Medicine | FACEM |
| 3 | Australasian College of Dermatologists | FACD |
| 4 | Australasian Faculty of Occupational Medicine | FAFOM |
| 5 | Australasian Faculty of Public Health Medicine | FAFPHM |
| 6 | Australasian Faculty of Rehabilitation Medicine | FAFRM |
| 7 | Australian and New Zealand College of Anaesthetists | FANZCA |
| 8 | Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists | FFPMANZCA |
| 9 | Joint Faculty of Intensive Care Medicine | FJFICM |
| 10 | Royal Australasian College of Physicians | FRACP |
| 11 | Royal Australasian College of Surgeons | FRACS |
| 12 | Royal Australian and New Zealand College of Obstetricians and Gynaecologists | FRANZCOG |
| 13 | Royal Australian and New Zealand College of Ophthalmologists | FRANZCO |
| 14 | Royal Australian and New Zealand College of Psychiatrists | FRANZCP |
| 15 | Royal Australian and New Zealand College of Radiologists | FRANZCR |
| 16 | Royal College of Pathologists of Australasia | FRCPA |

## Part 2 Specified bodies and programs

| Item | Body | Program |
|---|---|---|
| 1 | Queensland Department of Health | Queensland Country Relieving Program |
| 2 | RACGP | RACGP Training Program |
| 3 | Commonwealth Department of Health and Ageing | Rural Locum Relief Program |
| 4 | NSW Rural Doctors Network Ltd. | Rural Locum Relief Program |
| 5 | Rural Workforce Agency Victoria Ltd. | Rural Locum Relief Program |
| 6 | Queensland Rural Divisions Coordinating Unit Inc. | Rural Locum Relief Program |
| 7 | South Australian Rural and Remote Medical Support Agency Inc. | Rural Locum Relief Program |
| 8 | University of Western Australia — West Australian Centre for Remote and Rural Medicine | Rural Locum Relief Program |
| 9 | Tasmanian General Practice Divisions Inc. | Rural Locum Relief Program |
| 10 | NT Remote Workforce Agency Inc. | Rural Locum Relief Program |
| 12 | Commonwealth Department of Health and Ageing | Assistance at Operations Program |
| 13 | Australasian College of Sports Physicians | Australasian College of Sports Physicians Training Program |
| 14 | Commonwealth Department of Health and Ageing | Approved Medical Deputising Service Program |
| 15 | Australian College of Rural and Remote Medicine | Rural and Remote Area Placement Program |

| Item | Body | Program |
|---|---|---|
| 16 | Commonwealth Department of Health and Ageing | Approved Private Emergency Department Program |
| 17 | Commonwealth Department of Health and Ageing | Temporary Resident Other Medical Practitioner Program |
| 18 | General Practice Education and Training Limited (ACN 095 433 140) | Australian General Practice Training Program |
| 19 | Commonwealth Department of Health and Ageing | Metropolitan Workforce Support Program |
| 20 | Commonwealth Department of Health and Ageing | Special Approved Placements Program |
| 21 | Commonwealth Department of Health and Ageing | Approved Placements for Sports Physicians Program |
| 22 | Australian College of Rural and Remote Medicine | Pre-vocational General Practice Placements Program |
| 23 | Royal Australian College of General Practitioners | Pre-vocational General Practice Placements Program |
| 24 | General Practice Education and Training Limited (ACN 095 433 140) | Pre-vocational General Practice Placements Program |
| 25 | Remote Vocational Training Scheme Limited | Remote Vocational Training Scheme |

# Appendix 5

Western Australia

# Medical Practitioners Act 2008

**No. 22 of 2008**

**An Act to —**

- **provide for the regulation of the practice of medicine and registration of persons as medical practitioners; and**
- **repeal the *Medical Act 1894*; and**
- **make consequential amendments to various Acts,**

**and for related purposes.**

[*Assented to 27 May 2008*]

The Parliament of Western Australia enacts as follows:

(c) is competent to practise in the specialty (that is, the applicant has sufficient physical capacity, mental capacity and skill to practise the specialty); and

(d) has knowledge of, and experience in the practise of, the specialty that the Board considers are sufficient as a basis for specialist registration in the specialty.

(5) In making its decision under subsection (1), the Board may have regard to the advice and recommendation of any one or more of the following —

(a) the Australian Medical Council;

(b) an Australian specialist college or institution for the specialty.

(6) The Board may, by written notice to the specialist, impose such conditions on registration under subsection (1) as the Board reasonably requires to ensure the safe and competent practise of the specialty by the specialist.

(7) Subject to section 39, a condition imposed under subsection (6) may apply indefinitely or for a period specified by the Board in the written notice.

(8) Subject to section 39, the Board may, on its own motion or on the application of a person the subject of a condition imposed by the Board under this section, on reasonable grounds, revoke or vary the condition.

(9) It is a condition of a specialist's registration under subsections (1) and (3) that the specialist can practise only the specialty in relation to which the specialist is registered.

(10) Subject to this Act, registration of a person as a specialist confers on that person the right to carry on in the State the practice of the specialty for which the person was granted registration as a specialist under the title or titles prescribed by the regulations as the title or titles under which the specialty may be practised.

(b) grant the applicant conditional registration for the type referred to in section 34(2)(b) requested by the applicant.

(3) Section 34 applies in relation to a person granted conditional registration under subsection (2)(b).

**37. Specialties to be prescribed**

(1) The Governor, on the recommendation of the Board, may make regulations prescribing —

(a) branches of medicine that are specialties with respect to which a person may be registered as a specialist; and

(b) the title or titles of the specialty.

(2) Before making a recommendation to the Governor, the Board is to seek advice from, and have regard to any advice provided by, the Australian Medical Council as to whether or not a branch of medicine should be prescribed as a specialty.

**38. Registration of specialists**

(1) The Board is to register an applicant as a specialist in a specialty if satisfied that the applicant has —

(a) complied with a set of requirements in subsection (2), (3) or (4); and

(b) paid the registration fee, if any, prescribed by the regulations.

(2) A set of requirements for registration as a specialist is that —

(a) the applicant is registered under section 30; and

(b) the applicant —

(i) has an Australian or New Zealand qualification, in the specialty, that is prescribed by the regulations for the specialty; or

(ii) has a qualification in a specialty that the Board considers is substantially equivalent to, or based

# Appendix 6

The Senate

# Community Affairs Legislation Committee

## Health Workforce Australia Bill 2009 [Provisions]

June 2009

# MINORITY REPORTY BY COALITION SENATORS

## HEALTH WORKFORCE AUSTRALIA BILL 2009

1.1 The Coalition notes that the Chair's Report on the Health Workforce Australia Bill 2009 canvasses many of the serious concerns raised by submitters to the Committee's Inquiry.

1.2 It is true that there is strong support for the establishment of an organisation such as Health Workforce Australia within the health community but this support was strongly tempered by concerns by the majority of submitters and witnesses about the structure and practical operation of the Government's proposals and for HWA to dictatorially override proven and existing systems.

These concerns included:

- The lack of supporting regulations accompanying the Bill
- The potential for WHA to attempt to usurp the role of professional colleges and other organisations in accrediting clinical education and training for health professionals.
- The deliberate lack of involvement of medical and health professionals in the governance of HWA.

1.4 In regard to the lack of supporting information from Government, Ms Magarry of Universities Australia noted:

> Our concern is that the bill does not currently provide any substantive detail on the powers and responsibilities of Health Workforce Australia, and this aspect requires greater clarification before we believe it would be able to be supported widely.[1]

Similarly, Professor White of the Clinical Placements Advisory Group of Universities Australia commented:

> It is the lack of clarity in the bill, the lack of information and detail in the bill that is of concern in relation to governance but also in relation to the structure and the way in which the organisation will interact with clinical placements per se.[2]

---

[1] Ms Angela Magarry, Universities Australia, *Proof Committee Hansard*, 11 June 2009, p. 2.

[2] Professor Jill White, Clinical Placements Advisory Group, Universities Australia, *Proof Committee Hansard*, 11 June 2009, p. 2.

1.3 Comments by the Australian Medical Council, the body responsible for Australia's robust and independent medical accreditation system since 1985, typify the lack of clarity about responsibilities:

> We are not sure what the relationship will be between the bodies that currently fulfil a function related to clinical training and something like Health Workforce Australia. There have also been some new proposals put on the table through things like the National Health and Hospitals Reform Commission, the Bradley review, and the Garling inquiry in New South Wales, which again suggests the establishment of bodies whose mandates would relate to clinical education and training and the quality thereof. This is why it is not clear to us, at this particular juncture...as to what those relationships and linkages will be.[3]

1.4 This uncertainty made many of the professional organisations concerned that, because of its relative size and dominance by Government representatives, HWA would seek to replace the sector's existing and highly respected clinical training and accreditation standards.

Professor Metz of the Committee of Presidents of Medical Colleges commented:

> ...best value for money for the workforce initiatives, a more rapid and substantive workforce planning policy development environment...that sort of wording could easily be interpreted as saying that 'value for money' may mean that we do not necessarily need to have the high standard, highly trained professionals doing the work that has hitherto been done.[4]
>
> If you ask is there a real danger? The real danger, if you look at the wording currently, is that the HWA has the ability to go into the area of delivery of clinical training. As I said before, the wording suggests that it can have legislative instruments specifying the kinds of clinical training eligible. That really is getting into the area that the AMC does so very well.[5]

1.5 Mr Hough of the Australian Medical Association commented:

---

[3] Ms Drew Menzies-McVey, Australian Medical Council, *Proof Committee Hansard*, 11 June 2009, p. 27.

[4] Professor Geoffrey Metz, Committee of Presidents of Medical Colleges, *Proof Committee Hansard*, 11 June 2009, p. 15.

[5] Professor Geoffrey Metz, Committee of Presidents of Medical Colleges, *Proof Committee Hansard*, 11 June 2009, p. 17.

> As it is currently drafted, the bill could allow the agency to interfere with the accredited undergraduate medical education courses for the use of funding conditions, the overall placement coordination et cetera. It could expand its role into the prevocation specialist education training.[6]
>
> It is interesting to note that, in the department's submission, it gives clear assurances that the agency will not interfere with accredited training courses, nor will it try and set standards for clinical placements, but the submission also says that postgraduate education is out of the scope of the agency. Given these assurances are not in the bill, we would submit that it could fall to this committee to recommend that amendments in the bill could go to make sure that those assurances are there.[7]

1.6 Ms Stronach of the Australian Council of Pro-Vice Chancellors and Deans of Health Sciences further commented on concerns about the natural tendency for large organisations to stifle diversity:

> The caution would be that, as all the participants have alluded to, clinical placement is incredibly diverse. There is a huge amount of work involved in it. There are a number of students and a huge number of clinical placement events that take place. It would be tempting, I think, for an organisation that had national responsibility to try and look for efficiencies and impose efficient models that might work in some of the larger disciplines, but would be catastrophic to smaller disciplines and smaller geographical areas.[8]

1.7 These issues relating to HWA's potential to dominate all aspects of health workforce delivery led a number of witnesses to express serious concerns about the composition of the HWA Board and its dominance by Government, Federal and State, representatives. Witnesses were not reassured by the view that health professionals would be represented on Advisory Committees.

1.8 Professor Metz of the Committee of Presidents of Medical Colleges used the example of poor UK practice to underline his Committee's concerns that the current HWA structure would lead to similarly unsatisfactory outcomes.

---

[6] Mr Warwick Hough, Australian Medical Association, *Proof Committee Hansard*, 11 June 2009, p. 37.

[7] Mr Warwick Hough, Australian Medical Association, *Proof Committee Hansard*, 11 June 2009, p. 37.

[8] Ms Pamela Stronach, Australian Council of Pro-Vice Chancellors and Deans of Health Sciences, *Proof Committee Hansard*, 11 June 2009, p. 13.

> The second point that I am concerned about, to go with that, is that if you look at the constitution of the board, there is a chair, there is a Commonwealth member, eight members – one from each state and territory – which totals now 10, and then three others. The three others may or may not be jurisdictional; I suspect that they are not jurisdictional. If we assume that they may be professionals, they would not all be doctors obviously. There may be a doctor and a nurse and a something else. This really means, to my reading of it, that the health workforce authority will have almost no professional input into its deliberations and recommendations.[9]
>
> It is a real concern to us that we are going down the same path that the UK went down. The former chairman of PMETB, who has just stepped down and became chairman of the General Medical Council, is Professor Peter Rubin. His observation to me was that, under his direction, as chairman of the PMETB, because they were in a straitjacket with a statutory authority and did not have professional input into their deliberations – I think they had three professional people on a board of 15, and this looks like the potential for three professional people in a board of 13 – they really lost the plot in terms of the direction that they were going in relation to how they should engage with the professions and how they should train people. His view, which is certainly held by the colleges in the UK, is that postgraduate medical training in the UK has gone backwards in the last six years, and they are only now changing the legislation this year.[10]

1.8 Ms Stronach of The Australian Council of Pro-Vice Chancellors and Deans of Health Sciences also noted:

> The lack of clarity in how HWA would operate and the proposed composition of the board with not enough health education and training representation is of concern to us. There is already significant bureaucracy associated with clinical placement of students.[11]

1.9 Mr Laverty of Catholic Health Australia also noted that the Board structure was not likely to encourage innovative or equitable development:

> Greater balance needs to be given to those who work outside the government sector. Greater balance needs to be given to the university

---

[9] Professor Geoffrey Metz, Committee of Presidents of Medical Colleges, *Proof Committee Hansard*, 11 June 2009, p. 15.

[10] Professor Geoffrey Metz, Committee of Presidents of Medical Colleges, *Proof Committee Hansard*, 11 June 2009, p. 16.

[11] Ms Pamela Stronach, Australian Council of Pro-Vice Chancellors and Deans of Health Sciences, *Proof Committee Hansard*, 11 June 2009, p. 3-4.

sector. Greater balance needs to be given to private hospitals, to not-for-profit hospitals, to aged care. There should be an acknowledged provision for a space on the board of governance to address the needs of the aged care community. If it is not there, it will become the second cousin to the hospital network.[12]

## CONCLUSION

2.1 Medical and other professions have developed robust education, training and accreditation systems that suit their individual professions and geographic situations.

These groups are justly concerned that a large bureaucratic organisation, such as HWA, could "dumb down" education and training unless strictly controlled by law and strong and diverse governance.

## RECOMMENDATIONS

### Recommendation 1

That the Health Workforce Australia Bill 2009 be amended to clearly state that Health Workforce Australia has no responsibility for the accreditation of clinical education and training.

### Recommendation 2

That the regulations clearly spell out the composition and governance purpose of the Health Workforce Australia Board.

Senator Sue Boyce
LP, Senator for Queensland

Senator Judith Adams
LP, Senator for Western Australia

[12] Mr Martin Laverty, Catholic Health Australia, *Proof Committee Hansard*, 11 June 2009, p. 19.