Australian Government

Department of Health and Ageing

SECRETARY

Mr Elton Humphery
Committee Secretary
Australian Senate Community Affairs Committee
PO Box 6100
PARLIAMENT HOUSE
CANBERRA ACT 2600

Dear Mr Humphery

Submission to the Senate Community Affairs Committee inquiry into the National Registration and Accreditation Scheme for Doctors and Other Health Workers

The Department is pleased to provide a submission to the Senate Community Affairs Committee inquiry into the design of the National Registration and Accreditation Scheme. The submission is at Attachment A.

Thank you for the opportunity to contribute to the Senate Community Affairs Committee inquiry. I would note that the Department's submission can not be as fulsome as would usually be the case as some key components of the proposed new scheme are still to be determined by all Health Ministers. The submission is prepared in the light of the proposed arrangements that have been determined to this point.

Yours sincerely

Jane Halton PSM
Secretary

6 May 2009

Attachment:
A: Response to terms of reference of the inquiry.

MDP 84 GPO Box 9848 Canberra ACT 2601
Telephone: (02) 6289 8400 Facsimile: (02) 6285 1994

ATTACHMENT A
Submission to the Senate Community Affairs Inquiry into the design of the National Registration and Accreditation Scheme

---

Introduction

The Council of Australian Governments (COAG) agreed on 14 July 2006 to establish a national registration scheme for health professionals and a national accreditation scheme for health education and training. COAG subsequently agreed to establish a single national scheme, with a single national agency encompassing both the registration and accreditation functions. At the COAG meeting on 26 March 2008, the Prime Minister and all Premiers and Chief Ministers signed an Intergovernmental Agreement (IGA) to implement the National Registration and Accreditation Scheme (NRAS) by 1 July 2010.

The NRAS is not a Federal Government initiative as stated in the Terms of Reference for the Senate Inquiry. Rather, it is a national scheme agreed by all governments.

Health Ministers from all States and Territories and the Commonwealth are now responsible for implementation of the NRAS. A Ministerial Council for the NRAS has been formed, comprised of all Health Ministers. The Ministerial Council has considered stakeholder feedback in the development of the detailed registration and accreditation arrangements to be included in the second stage of national legislation for the NRAS (Bill B). Once a number of outstanding policy issues have been progressed by Ministers, an exposure draft of Bill B will be released for further consultation. Bill B will include the main detailed arrangements for the new scheme, and it is premature to comment in detail on the proposed arrangements for the new scheme prior to release of the exposure draft of this Bill.

COAG agreed that national legislation for the NRAS will be hosted by the State of Queensland, and Western Australia will enact corresponding legislation and the remaining states and territories will each enact legislation to apply the law passed in Queensland as a law of its own, with the expectation of the NRAS to commence on 1 July 2010. The Commonwealth will make amendments to existing legislation to support the NRAS, but will not pass any new legislation.

The NRAS will address the current inconsistencies in registration standards between states and territories. Patient safety will be improved by recording registration details on a single system accessible across Australia. A strong state and territory presence will enable the agency to respond quickly to threats to patient safety.

A National Registration and Accreditation Implementation Project (NRAIP) team has been established, led by Dr Louise Morauta as the Project Director, to work with all governments to develop and implement the NRAS. The website providing updates on the NRAS and access to submissions and tenders, is www.nhwt.gov.au/natreg.asp.

A response to each of the terms of the inquiry follows.

(a) The impact of the scheme on state and territory health services

Individual state and territory governments are best placed to provide advice on the specific impact of the scheme on state and territory health services.

One of the objectives of the NRAS, as specified in the IGA, is to have regard to the public interest in promoting access to health services. The NRAS will make it easier for health practitioners to move across state and territory borders to respond to the need for health services in times of need or emergency.

There are currently well over 70 registration boards across the states and territories for the ten professions that will initially be covered by the NRAS. The NRAS will harmonise the standards for registration of health practitioners and accreditation of their education and training across states and territories.

The NRAS will also improve the ability for governments to undertake health workforce planning to determine where there are gaps in the health workforce or particular areas of need. Establishment of a national registration system for the ten professions will produce a highly valuable data source of nationally registered health professionals that will enable more accurate analysis of current workforce supply and projections for future supply.

(b) The impact of the scheme on patient care and safety

One of the objectives of the NRAS, as specified in the IGA, is to 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. If a health practitioner is deregistered or has conditions placed on the registration, this will automatically apply across all states and territories.

The current system for registration of health practitioners is inconsistent across the states and territories. This system has the potential to put patients at grave risk of harm. There have been some incidences where a health practitioner has moved from one state to another to avoid scrutiny. This is one of the disadvantages of the current system of mutual recognition, as the system is only as strong as the weakest jurisdiction.

The greater consistency in registration and accreditation across states and territories will provide assurance to members of the public that all health practitioners are subject to the same high quality professional standards regardless of where the health service is accessed.

On 5 March 2009 the Ministerial Council agreed to include the following two key safety features:

- Mandatory reporting of practitioners who are placing the public at risk of harm. This means that other practitioners or employers must report conduct which puts patients at harm, including practising under the influence of drugs or alcohol, or sexual misconduct; and
- Mandatory criminal history and identity checks for all health practitioners 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.

(c) The effect of the scheme on standards of training and qualifications of relevant health professionals

One of the objectives of the NRAS, as specified in the IGA, is to facilitate the provision of high quality education and training and rigorous assessment of overseas trained practitioners. In upholding the principle of protection of public health and safety, Ministers will not approve a lowering of standards that in any way threatens the wellbeing of the community.

Existing national accreditation bodies will continue to undertake accreditation functions for at least the first three years of operation of the NRAS. For the medical profession, the specialist colleges are also expected to continue to play a crucial role in specialist education and training and assessment of international medical graduates. This is consistent with the strong role taken by specialist medical colleges supporting implementation of the COAG agreement around nationally consistent assessment for international medical graduates.

(d) How the scheme will affect complaints management and disciplinary processes within particular professional streams

The proposed model for complaints management and disciplinary processes under the NRAS is yet to be determined by the Ministerial Council. Stakeholders were invited to make submissions on the proposed arrangements for handling complaints and disciplinary matters late in 2008. Stakeholder feedback is currently being considered by all Health Ministers. It is premature to comment on the proposal for complaints management and disciplinary processes under the NRAS until health Ministers consider these issues and release the exposure draft of the second stage of national legislation.

(e) The appropriate role, if any, in the scheme for state and territory registration boards

As noted earlier, ten national profession specific boards will replace the existing individual state and territory registration boards for the ten professions from 1 July 2010. In recognition of the expertise of existing board members and to facilitate a smooth transition to the NRAS, clause 6.10 of the IGA indicates that all existing board members and supporting hearing panels would, if they agree, be appointed to a list of persons from which national boards may form State and Territory committees to determine the registration status of individual practitioners for a period of two years from commencement of operation of the NRAS.

(f) Alternative models for implementation of the scheme

The Department is aware that the Australian Medical Association (AMA) has recommended that governments should retain state registration boards and deliver a system of national registration recognition, with a national registration database and information sharing, so that doctors will register in one state and achieve national registration. This would retain the more than seventy existing Boards and their associated costs.

The current system of mutual recognition has proven to be flawed through recent cases of practitioners moving between states and territories to avoid scrutiny from registration authorities. For this reason, the Department does not consider the AMA's proposal will achieve the COAG objective of greater protection of public health and safety. It should also be noted that prior to the COAG agreement, for the past ten to twelve years, the Australian Medical Council had been trying, without success, to achieve the sort of harmonisation proposed by the AMA.