Regulating for Results

Review of complexity in the National Registration and Accreditation Scheme

Submission Template

This template is provided to assist in the structuring of responses to the Consultation Paper.

There are 11 Topic Areas, around which we request that Submissions be structured. These are supported by guiding questions that may assist you to structure your input.

You may also wish to provide a cover note highlighting key issues – if you do so, please ensure this is no more than 2 pages.

If you wish to attach additional supporting material please do so, but please indicate in the body of your response what is attached.

You need only address those Topics on which you wish to comment. There is no expectation that all submissions address all Topics, although you are of course welcome to do so.

The deadline for submissions is **14 October 2024**.

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TOPIC 1: Evidence and Issues

Are there any aspects of the information provided on the issues and challenges discussed in section 2 of the Consultation Paper that you wish to comment on or add to?

General practice accreditation – National General Practice Accreditation Scheme and Standards for general practices

The National General Practice Accreditation Scheme (the NGPA Scheme) supports the accreditation of Australian general practices to the RACGP *Standards for general practices* (the Standards).

The NGPA Scheme and the Standards exist to address the safety and quality of general practices in Australia – their environment, processes, and systems. While the NGPA Scheme does not impact the registration of health professionals or accredit educational programs (which are core functions of the National Boards under the National Registration and Accreditation Scheme [NRAS]), the NGPA Scheme shares a role with the NRAS and aligns with various guiding principles of the Health Practitioner Regulation National Law (the National Law) in relation to protecting the public and upholding public confidence in the safety of services provided by registered health practitioners. Accreditation in the context of the NGPA Scheme impacts the settings (specifically general

practices) in which health professionals, including general practitioners (GPs), nurses and allied health professionals, work and provide care to patients.

The NGPA Scheme and the Standards do not employ a ‘set and forget' approach (as described in the literature review of regulatory stewardship on page 22 of the consultation paper). The RACGP periodically updates the Standards in consultation with GPs, practice managers, nurses, consumers, technical experts and other stakeholders. Both the RACGP and the Australian Commission on Safety and Quality in Health Care administrate the NGPA Scheme, including the approval of accreditation agencies that assess general practices under the Standards, and regularly monitor compliance to the requirements for general practice accreditation and respond to the accreditation needs of practices (eg in response to emergencies).

The NRAS seeks to address a ‘whole of system perspective' (page 20 of consultation paper), so therefore may wish to consider the impact that the NGPA Scheme and general practice accreditation have on quality and safe care provided to Australian patients.

Interrelation of NRAS and NGPA Scheme

While the NRAS regulates the registration and practice of individual GPs, general practice accreditation focuses on the broader practice environment. Together, they ensure both professionals and the facilities where they work meet high standards. Both systems aim to protect patients and improve healthcare quality. The NRAS ensures that GPs are competent, while general practice accreditation ensures that the clinical environment supports best practice and patient care.

Improvements to general practice accreditation and the Standards do not directly change or affect the NRAS, but there is an indirect influence between the two. Changes to the Standards often reflect evolving best practices in healthcare. The Standards can indirectly impact the expectations placed on individual health professionals, including GPs registered under the NRAS.

The NGPA Scheme supports the overall goals of the NRAS. For instance, when robust general practice accreditation requirements are implemented, this creates a higher-quality practising environment for GPs, which reinforces the NRAS's aim of maintaining competent and ethical health practitioners. Accredited practices with good mechanisms of patient feedback and quality improvement could be used by the Australian Health Practitioner Regulation Agency (Ahpra) to better triage notifications. RACGP member feedback indicates that Ahpra's triaging processes have not been fully effective, particularly regarding harmful (vexatious) notifications. These issues are explored further under topics 8 and 9.

The NRAS supports the safe and competent practice of individual practitioners, while the NGPA Scheme ensures that the systems and processes within general practices support high-quality care. Both emphasise workforce quality, competence, and safety.

Touchpoints between the NRAS and NGPA Scheme are part of a changing regulatory landscape where there is growing recognition of the need for better alignment and collaboration between different regulatory and accreditation bodies. As the health workforce continues to face pressures (eg workplace shortages), alignment between the schemes would support a unified, high-quality health service environment.

Ministerial Council powers of direction

Page 48 of the consultation paper refers to the inability of the Ministerial Council to issue a policy direction directly to an external accreditation entity or to another body that delivers accredited training programs for registration purposes. It suggests a power to direct is likely to have a more

immediate impact when it is delivered without attenuation through other entities such as Ahpra or a National Board.

The RACGP **does not support** expanding the powers of the Ministerial Council due to the risk of fragmentation between states and territories.

TOPIC 2: Governance and Stewardship – Strategic connection

Do you think that a stronger strategic connection between workforce planning / strategy and health practitioner regulation is an important reform priority?

The RACGP is proactive in prioritising workforce planning in the regulation of the GP profession.

Page 23 of the consultation paper refers to the establishment of the Medical Workforce Advisory Collaboration. The RACGP is a member of this group and views its remit as a positive step forward to align medical workforce planning to community need.

Expedited pathway

The RACGP has raised concerns about the Medical Board of Australia's (MBA) expedited pathway for overseas-trained medical specialists. These concerns relate to the program's readiness, safety and the impact it may have on existing expedited pathways.

Regulatory best practice principles for NRAS entities

Page 28 of the consultation paper cites 'transparency' as one of the best practice principles for NRAS entities proposed in the Kruk Review. However, the Australian Medical Council (AMC), the MBA and Ahpra have not committed to key performance indicators for specialist international medical graduate (SIMG) assessment, nor have they confirmed a cost for applicants. Information is urgently needed on:

1. how those deemed 'unsuitable' are going to be identified in the expedited pathway (+/- 19% in RACGP's experience)
2. targeted placements, to ensure SIMGs are placed in areas of greatest need
3. long-term retention strategies, to encourage SIMGs to remain in underserved areas or specialties.

Return to work

Ahpra's return to work pathway for practitioners who have been out of the workforce for a period of time (eg those on maternity leave) may be excessively onerous and reduce access to highly trained health professionals for patients. This pathway should be considered in the context of current workforce shortages, and the disproportionate impact of bureaucratic requirements on female practitioners.

TOPIC 3: Governance and Stewardship - Regulatory Connection

Do you think there is a need for the National Scheme to work more closely with other regulators and agencies?

In the context of GP training, the RACGP cautions against enhanced regulation through the NRAS. The RACGP currently manages the accreditation of 13,600+ accredited supervisors working across 6,400+ accredited training sites. It is critical that the accreditation of GP training sites and supervisors remains profession-led and within the remit of the professional GP colleges.

Any establishment of cross-profession regulatory structures which impedes the professional GP colleges' ability to manage training practice and supervisor performance will risk patient safety, frustrate training progression and negatively impact on training outcomes.

Non-evidence-based products and services

GPs are regulated to high professional standards and their practices, if accredited, have a focus on patient safety and quality improvement. The NRAS should protect patients from the huge volume of non-evidence-based health claims made by the complementary and alternative medicine industry. Therapeutic Goods Administration (TGA) processes should be strengthened so that health claims are much more strongly based on evidence. One way to implement this is to hold practitioners of alternative medicine accountable for the claims made for their services, and to hold company boards accountable for claims made about unverified products.

The pursuit of commercial gain by healthcare providers can promote poor practice and undermine patient safety.

Do you have a view about what structure or process should be used for this purpose?

The RACGP has integrated with the Ahpra Practitioner Information Exchange to ensure we have daily oversight of new conditions applied to registrars and supervisors engaged in GP training that should be considered or acted upon as they relate to accreditation standards.

Do you have a view on what success would look like if reforms to build connection across regulators were implemented?

The sharing of high-level data between regulatory bodies would flag consistent themes, issues to be addressed and the quantum of the problem. National reform provides the opportunity to create appropriate reporting of critical data points that can inform required investment and the sharing of information.

TOPIC 4: Governance and Stewardship – Community Voice

Do you see the need to strengthen the community input in setting strategic direction and priorities for the National Scheme?

Yes. Community input in setting strategic direction and priorities for the NRAS needs to be strengthened.

There is currently a lack of community representation on committees such as Ahpra's Agency Management Committee, as well as on National Boards.

If yes, how do you think this could be done?

- Changes to the structure of committees to address imbalances.

- Expanding Ahpra's Community Advisory Council to incorporate broader opportunities for community input.
- Reviewing the National Law objectives to ensure they prioritise community interests.

TOPIC 5. Operational accountability and efficiency - Scheme wide objectives and priorities

General comments – Aboriginal and Torres Strait Islander health workforce

One of the objectives of the NRAS under the National Law is to build the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander persons.

Broad references to workforce tend to refer to the health workforce in rural and remote areas, where shortages are particularly pronounced. Consideration must also be given to the workforce for Aboriginal and Torres Strait Islander communities specifically, as well as socioeconomically disadvantaged areas.

As a starting point, adequate representation of Aboriginal and Torres Strait Islander health professionals (across all regulated professions) and consumers is required. Board and committee members, as well as Ahpra staff, must include Aboriginal and Torres Strait Islander people. It may also be useful to engage representatives from Aboriginal Community Controlled Health Organisations (ACCHOs) and other Aboriginal Medical Service (AMS) settings.

TOPIC 6: Operational accountability and efficiency - Boards and Committees

General comments

Consideration should be given to the structure of the MBA and processes for appointing members. Boards must have strong, consistent and effective governance arrangements put in place to ensure currency of membership and fresh perspectives. This should include having up to date terms of reference, expressions of interest for appointments and succession planning. There should be representation from all specialties in addition to doctors in training and medical students, as well as adequate representation from rural/remote doctors. It is also important that the majority of members are practising doctors.

TOPIC 7: Operational accountability and efficiency – Accreditation Functions

Do you think that additional measures are required to make sure that accreditation functions support workforce strategy and planning priorities? If so, what measures do you suggest being considered?

The RACGP suggests additional measures would be appropriate to consider workforce planning nationally. The measures stated on page 45 of the consultation paper lack detailed metrics and actions. Further consultation and engagement on appropriate metrics and actions is required.

TOPIC 8: Coherent and Effective Complaints handling - Simplifying structures and processes.

Do you think it is necessary to simplify complaints handling?

The effective management of complaints is complex, requires a particular skill set, consistent application of methodology and industry knowledge. The triage and management of complaints should be sophisticated enough to afford timely review and outcomes. However, even more important than timeliness is that all parties to the complaint have confidence that the process observes the traditional principles of natural justice, objectivity, consistency and confidentiality.

Initial assessments of notifications to Ahpra could be made more efficient by determining whether a practitioner has already been deemed to pose a threat to patient safety. These clinicians often have multiple areas of concern, or have multiple reports made against them. This does not mean that all complaints are not taken seriously, however triaging could be improved according to the risk posed to patients and the likelihood of a particular allegation being true.

Do you support a single front door for lodging complaints within State and Territory Health Complaints Entities?

The RACGP supports measures to simplify or streamline complaints handling in principle, however we require more information regarding the costs and benefits of a single front door process.

Do you have other suggestions for simplifying the processes for lodging and assessing complaints?

It would be a positive step to provide a breakdown by discipline/specialty of complaints lodged about medical practitioners. Complaints about doctors are currently reported under a single ‘medical practitioner’ category, whereas allied health professional complaints are reported by individual discipline (eg physiotherapy, occupational therapy).

Do you see risks in a single front door approach and if so, what are those risks?

A single front door for each jurisdiction without harmonisation may exacerbate inconsistencies in the assessment, management and processing timeframes of complaints. Adequate resources and national consistency with regional supports is likely to deliver better outcomes.

TOPIC 9: Coherent and Effective Complaints handling - high-risk notifications

What do you see as the problems if any, with the way high-risk notifications are currently managed? If you think there is a need for reform what should this look like?

The consultation paper focuses heavily on consumers and their understanding of healthcare complaints processes. The RACGP supports a notifications system that balances patient safety with sensible processes that do not unduly impact the delivery of high-quality care.

Despite this, there are several issues with the management of notifications, including those deemed high-risk. These include timeframes for cases to be resolved, reputational damage and a lack of support provided to doctors.

The impact of vexatious notifications on practitioners should not be underestimated, even if these are eventually dismissed. In late 2022, the RACGP provided a submission to the National Health Practitioner Ombudsman (NHPO) on Ahpra’s vexatious notifications framework. Extensive feedback was received, and the following issues were identified:

- Insufficient processes to separate frivolous or trivial complaints, vexatious complaints, and those that raise genuine concerns about patient safety and the behaviour of health practitioners.

- Prematurely releasing details of complaints and restrictions, which can lead to reputational damage and significantly harm a practitioner's mental health. There have been several cases of notifications leading to suicide by practitioners.
- A lack of concern for practitioner wellbeing and inadequate linkages/referrals to support services.
- A lack of timeliness and transparency.

The RACGP has previously recommended an overhaul of the notifications process with the intention of easing pressure on Ahpra and the National Boards. A revised process can ensure that complaints are directed appropriately for vetting and assessment, freeing up resources for Ahpra to appropriately manage legitimate notifications. We acknowledge Ahpra has reportedly taken steps in recent times to address this issue, including accepting 15 recommendations to help reduce the risk of suicide and harm to practitioners subject to notifications.

While we have heard anecdotally about Ahpra triaging complaints, solid data is needed to demonstrate whether processes have indeed improved.

TOPIC 10: Scope and Expansion of the National Scheme

Do you see any risks and challenges with an additional pathway into the national Scheme via an Accredited Register Model?

The reference to 'lower risk professions' on page 11 of the consultation paper is a fraught concept. It is unclear how this would be defined – for example, a group of practitioners may be unable to prescribe medications (so cannot cause harm in that way) but may be able to direct the population away from proven therapies (and hence cause harm).

Broadly, the concept of introducing an additional pathway seems incongruent with the review's objectives to simplify the NRAS and remove complexity.

TOPIC 11: Possible Reform Concepts

Do you have any other comments or suggestions in relation to Reform Concept 3 (A fully integrated 3-tier model of health practitioner regulation)?

Non-registered practitioners

The use of terms such as 'health services' and 'health practitioners' to describe the non-registered health workforce (including massage facilities and cosmetic parlours) is not appropriate. These services would seemingly fall under 'negative licensing' arrangements, but it is unclear how they would be regulated. Figure 4 on page 88 of the consultation paper indicates non-registered practitioners are governed by a code of conduct with a register of prohibited practitioners, however we expect that regulation of non-registered practitioners would be challenging and reactive.

Many of the issues could be addressed by regulating which services and practitioners are part of 'health' and describing other services in a different way. The suggestion to include more consumer representation may help to address this as there is low health literacy around what constitutes 'healthcare'.