



audiology australia ltd

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

Attention - Kim Snowball, Independent Reviewer

**Submitted by Audiology Australia
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Introduction

Thank you for the opportunity for Audiology Australia to provide a submission in relation to the *Consultation paper, Review of the National Registration and Accreditation Scheme for Health Professions, (August 2014)*¹ and the questions it presents for discussion.

Audiology Australia² is the peak body representing audiologists in Australia. Audiologists are the primary specialists responsible for the non-medical management of ear disorders including hearing loss, tinnitus, hyperacusis and vertigo. Audiologists are the only hearing health practitioners which provide services to people of all ages, from babies to older adults.

We note the consultation paper's overview of the National Registration and Accreditation Scheme for Health Professionals (the National Scheme) and some selected statements from the document which highlight the status of health professions not regulated by the National Scheme (such as Audiology Australia):

Page 71: The National Registration and Accreditation Scheme for the health professions was established (in 2010) to achieve six key objectives:

- *protection of public safety*
- *facilitation of workforce mobility*
- *facilitation of high-quality education and training*
- *facilitation of assessment of overseas-trained health practitioners*
- *promotion of access to health services*
- *development of a flexible, responsive and sustainable workforce*

Page 8: Consideration must also be given to how to determine if other professions ought to be added to the National Scheme. Regulation under the National Scheme is expensive for registrants and so must carry an economic benefit or a need for community protection if inclusion is to be considered.

Page 11: A number of health practitioner groups wish to join the National Scheme. It must be remembered that the National Scheme was established to fulfill four (sic) key objectives, not to provide status and credibility to health practitioner groups.

Representatives of unregulated professions have raised with the Review that because theirs is not a regulated profession members have been excluded from involvement on boards, or even tenders and employment, because these opportunities have been restricted to health professionals registered under the National Scheme. This is certainly an unintended consequence of the National Scheme.

At the time the National Scheme was conceived the Council of Australian Governments (COAG) established threshold criteria relevant to risk to assist in assessing the need for statutory regulation of unregulated health occupations.

¹ Australian Health Ministers' Advisory Council, *Review of the National Registration and Accreditation Scheme for health professions, Consultation Paper*, August 2014

http://www.ahmac.gov.au/cms_documents/Consultation%20Paper%20-%20Review%20of%20the%20National%20Registration%20and%20Accreditation%20Scheme%20for%20health%20professions.pdf

² Audiology Australia <http://www.audiology.asn.au/>

It is also important that the risk profile for additional professions carefully considers the context in which the practitioners operate. For example, if the majority of practitioners are in employment – rather than self-employed – then an additional layer of regulation already exists. The COAG criteria have been described as 'gateway criteria' required to be met prior to further regulatory impact assessment in accordance with the COAG best practice regulation requirements, assessed by Office of Best Practice Regulation.

Inclusion in the National Scheme, and the additional regulation that it imposes, must only occur where community safety is at significant risk and no alternative, more cost-effective means of regulating the profession is available.

Page 26: Work is currently being undertaken on behalf of the Australian Health Ministers' Advisory Council (AHMAC) to consult on the terms of a proposed National Code of Conduct for health care workers (the National Code).

The National Code is proposed to cover any individual who provides a health service that is not subject to regulation under the National Scheme for the health professions; in some circumstances this will include registered health practitioners, to the extent that they provide services that are unrelated to or outside the typical scope of practice of their registration as a health practitioner.

The National Code is designed to protect the public by:

- *specifying minimum acceptable professional standards that are generally applicable to all health care workers, and below which they must not fall*
- *having the ability to enforce the National Code under regulation in each State and Territory*
- *where a health care worker is found to have breached the National Code, and his or her conduct presents a serious risk to public health and safety, then a prohibition order will be issued.*

It is proposed that this model will provide a tool to respond to those unregistered health care workers whose conduct is placing the public at risk, without the need for full registration. Health Ministers are expected to consider the national consultation report in November 2014.

While the Review is not consulting on the National Code directly, it is important to consider the potential impact and interface it may have with regulation applied under the National Scheme.

Audiology Australia also notes the guiding principles (below) and the criteria (see link ³) determined for use by the National Scheme to assess the need for statutory regulation of unregulated health occupations:

While it is acknowledged that occupational regulation may have a number of benefits, both for the occupation and for its individual practitioners, for the development of the criteria the following principles were adopted:

- *the sole purpose of occupational regulation is to protect the public interest; and*
- *the purpose of regulation is not to protect the interests of health occupations.*

³ Council of Australian Governments, Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (2008), Attachment: *Criteria for assessing the need for statutory regulation of unregulated health occupations.* https://www.coag.gov.au/sites/default/files/iqa_health_workforce.pdf

Audiology Australia has been an active participant in the National Alliance of Self Regulating Health Professions (*NASRHP*) under the auspices of Allied Health Professions Australia ⁴. The professional associations that constitute NASRHP are the peak body for their respective allied health profession. They administer functions equivalent to those of the National Scheme boards. Many manage or contribute to the following processes and functions on a national scale:

- accreditation of tertiary courses which grant entry to the profession
- determination of entry level practice standards (alternatively known as competency standards)
- assessment of the qualifications of international health practitioners
- codes of ethics (or conduct) and complaints system
- assurance through continuing professional development (CPD) and recency of practice.

The NASRHP's core objective is to provide a forum for allied health professions that are not nationally registered to:

- seek clarity regarding regulation for their respective professions;
- benchmark their self-regulatory environment;
- advocate on behalf of the public for an improved health regulatory environment; and
- address the challenges and consequences for the professions and health agencies of the current fragmentation in health practitioner regulation

The professions which constitute NASRHP are also recognised under Medicare and a range of other government funded programs (eg for audiology this includes the Office of Hearing Services, Department of Veterans Affairs, State workers' compensation schemes) so have been identified as having high quality standards of practice requirements for their members.

Comments re Consultation Paper Questions

Please note that our responses are from the perspective as a professional body and as a profession which is not currently regulated by the National Scheme so we have limited direct experience to make fully informed comment. However, as a self-regulated profession mindful of improving our own accountability, standards and procedures to ensure our members deliver on patient safety, quality and high standards of care and as a keen observer of national regulation of health professions, we wish to comment on the consultation paper.

Part I Reflections from the Independent Reviewer

Accountability

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

This seems a reasonable course of action, particularly given that the consultation paper has highlighted the need for State/Territory governments to be better informed of performance of both regulators and health professionals within their own jurisdictions, and to reflect the ultimate responsibility of State/Territory governments for health.

⁴ Allied Health Professions Australia. <http://www.ahpa.com.au/>

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

The consultation paper makes specific reference to the broader health workforce reform agenda and circumstances where there may be complex policy issues, and where cross-profession responses or initiatives are sought.

We note the current Commonwealth government's decision to close down Health Workforce Australia in August this year. We are mindful that within health, there can be a myriad of entities and agencies at the governmental level operating in various roles. There needs to be a peak entity that has the capacity to engage with all health professions (not just those regulated within the National Scheme) to gather information and data, and undertake any further analysis or consultation with multiple professions.

As an allied health profession, the health reform agenda can become dominated by the medical profession and the larger allied health professions which have the resources to match. For this reason, Audiology Australia has valued its membership within Allied Health Professions Australia and its participation in the National Alliance of Self Regulated Health Professions to keep informed, highlight issues of concern and have a representative voice across professions.

If the Health Workforce Advisory Council is to be considered as its name suggests, it should also have mechanisms in place to have regular dialogue with, and to be readily accessible by, the health professions/peak representative bodies not currently regulated or represented through the National Scheme.

The future for regulation of health practitioners in Australia

3. Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? (Estimated cost saving \$11m per annum)

A single, more efficient regulatory body would seem to be a worthwhile opportunity to manage the nine low regulatory workload professions.

We note that this would result in a much higher number of total registrants for these nine professions (just over 73,000 registrants based on figures supplied for 2012-13 in Table 2) yet still not as many as either the medical profession (95,690 registrants) or nursing/midwifery boards (345,955 registrants). Based on these numbers, this proposal would seem to be manageable and potentially more efficient.

However, we value the capacity for professions to have leadership and ownership of their own standards and also the ability to protect the public through meaningful insight into the nature of any complaint or 'notification' from the community in order to consider the degree of any risk of harm to the public.

Under this proposal, the paper indicates respective professions would remain with protected title and have direct input into matters affecting the regulation of the profession through dedicated subcommittees of the Board. However, they would share common regulatory functions including managing complaints and notifications, accreditation (with professional input) and registration. Under this option, professional input into specific elements of the courses of study, and other discipline specific areas would be preserved.

We note under current governance structures for a National Board, at least half but no more than two thirds of Board members must be practitioners. There may be challenges in reaching consensus in how a Board for this single combined professional group may be structured without any profession feeling they have 'lost a voice' or representation and without becoming too large and unwieldy to function efficiently.

Under the National Scheme, complaints or 'notifications' are reviewed by a Board. A Board whose directors are not necessarily from the particular profession upon which a 'notification' of a clinical nature is made may not be able to grasp the nature of the complaint as readily as a Board with representation from within that profession. A dedicated subcommittee (as the consultation paper advises) from a particular profession would be required for better insight.

An equitable and robust sub-committee structure for each of the member professions would be required in this proposal but would be somewhat limited given the over-arching authority and ultimate decision making of a Board.

4. Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? (Estimated cost saving \$7.4m pa.)

Under this proposal, the nine separate National Boards are retained but consolidate the functions underneath them (to the maximum extent possible) into a single national service to the nine professions.

This model would also realize significant savings and may better suit these health professions to feel empowered through retained representation at a Board level, retained ultimate ownership of standards for their profession, and more readily having insight into the nature of any notifications of a clinical nature at a Board level rather than through a dedicated subcommittee.

This model would be simpler to implement without the need for further reform of the structure and governance of the functions and responsibilities of bodies within the National Scheme. It would also avoid a likely protracted discussion in how to best structure a Board (as in the previous proposal of a single Board for all nine professions) without it becoming too large in size or a profession feeling they have lost a voice at Board level.

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

Yes (consistent with the aims of the National Scheme to keep registration fees as low as practicable).

6. Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?

Yes. Audiology Australia notes the requirements of the National Scheme and that the guiding principles of risk determination and cost benefit analysis are robust in themselves. It is important to maintain the threshold for a profession to be considered for inclusion as a regulated health profession.

However, Audiology Australia believes the current framework is not completely robust and does not afford the community complete confidence and protection that when an individual

engages with a recognised allied health professional that they are engaging with a professional who is properly trained, abides by professional standards, ensures patient safety and quality in service provision, undertakes continuing professional development, and is subject to a transparent complaints mechanism.

Consequently, Audiology Australia believes there is a need for a more robust and complete regulatory framework by the addition of a level of recognition or accreditation for self-regulated health professions which may not meet current standards of registration under the National Scheme. Standard criteria thresholds for both registration and self-regulation of professions would be indicated.

Refer to further discussion of self-regulated health professions in the next Question (7) and in Additional Comments at end of this submission.

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

Yes.

We wish to raise a number of issues which support the need for the recognition and the authority of self-regulating health professions to be integrated within the National Scheme. We advocate amending the National Law to include self-regulation in addition to registration in an overarching and strengthened regulatory scheme. Registration and self-regulation would each have their own threshold criteria for a profession to be included.

Self-regulating Professions

As the consultation paper states in its opening remarks of Part I (p 5):

Regulation should not interfere with the day to day duties of health practitioners, but it should make sure that the community is protected against unprofessional practice and that consumers can be confident the nation's health professionals are properly trained and qualified to treat them.

Audiology Australia is concerned that despite the introduction of the National Scheme, there remains a number of allied health professions and a significant number of allied health professionals that are not currently recognised by the National Scheme. These allied health professions through their peak professional associations fulfill an obligation of and desire for public protection through self-regulation but only to the extent that self-regulation permits.

Under the current National Scheme, these self-regulated allied health professionals whose clinical expertise is drawn from relevant and accepted scientific and evidence bases are otherwise regarded as 'unregistered health practitioners' by government. For example, audiologists, sonographers, dieticians, perfusionists, speech pathologists, exercise and sports scientists, orthotist/prosthetists, diabetes educators and social workers.

These self-regulating professions have well developed roles and functions which mirror or aspire to the regulatory expectations of National Boards under the National Scheme. They have demonstrated high to very high levels of representation of practitioner numbers relative to those understood to be practising in their respective field across Australia.

Community Expectations of Public Protection

It is a reasonable community expectation that a member of the public upon engaging with a professional health practitioner would have a level of assurance that a professional

qualification and accreditation is in place and that the practice is ethical and safe. That is, there is an expectation there is some form of standard regulation which affords public protection.

The health professions that invest heavily in public protection via self-regulation (typically through their professional association) do so to engender safety and quality in the care provided by their practitioner members according to their qualifications, experience, scopes of practice, standards of practice and ongoing professional development.

Although the degree of risk of harm from self-regulating health professions may be perceived or shown to be low, these professions are self-regulating for the very same reason as reflected in the consultation paper *'that the community is protected against unprofessional practice and that consumers can be confident the nation's health professionals are properly trained and qualified to treat them'*.

Confusing Language – Unregistered v Regulated

There is an element of risk in the community that the public may perceive an 'unregistered' health practitioner as someone who is acting without due care, without appropriate or proven qualifications, beyond accountability and beyond their area of expertise. It implies a practitioner maybe has not (yet) achieved a high enough standard to become registered, chooses not to be registered perhaps to avoid some level of professional accountability or possibly has even been 'deregistered'.

The term 'unregistered health practitioner' could raise a degree of unnecessary anxiety and erode confidence by some members of the public.

This risk is particularly an unintended consequence in premises of self-regulated audiologists in jurisdictions (eg NSW and SA) where mandatory notices 'Code of conduct for unregistered health practitioners' are on display in headings of bold letters without due reference by the public to the full text or understanding the context^{5, 6}. A reasonable practitioner in a self-regulated environment would, of course, also draw public attention to adherence to the practitioner's professional codes and standards of practice. However, this then presents a dilemma. Would the public then perceive an inconsistent or mixed message and confusion to comprehend where does the greater and ultimate authority sit which genuinely affords the public protection and instills public confidence – from a government regulatory authority (simply a government Code of Conduct for Unregistered Health Practitioners) or from a self-regulated profession (and its more extensive but currently limited protections for the public)?

The National Scheme should be strengthened so that the authority of self-regulating professions becomes recognised and more integrated through an overarching regulatory scheme and legislated framework.

⁵ NSW Health Care Complaints Commission, Code of Conduct for Unregistered Health Practitioners
<http://www.hccc.nsw.gov.au/Information/Information-for-Unregistered-Practitioners>

⁶ SA Health, South Australia, Code of Conduct for Unregistered Health Practitioners
<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/governance+for+safety+and+quality+in+health+service+organisations/credentialling/unregistered+health+practitioners+code+of+conduct>

The National Law needs to be amended to articulate this and afford the community the additional protections of self-regulated professions alongside registered professions.

Limitations of Self-regulation – Need for Improved Regulatory Framework

Although self-regulation can provide reasonable levels of public protection, it has limitations.

We do not believe that the general public can easily differentiate between practitioners who are members of self regulating professions and those who are not, so an informed choice of provider may not always be apparent and they may place themselves at risk.

There are limitations to self-regulation in that only those practitioners who wish to participate (or obliged to participate due to accreditation requirements of third party funded programs) will invest in the requirements, obligations and associated cost. As experienced by Audiology Australia, we only have authority to regulate practitioners who choose to be members of our association.

The consultation paper also suggests (p 11):

It is also important that the risk profile for additional professions carefully considers the context in which the practitioners operate. For example, if the majority of practitioners are in employment – rather than self-employed – then an additional layer of regulation already exists.

However, more specifically in the provision of audiological and hearing services, a small but significant number of practitioners are self-employed. This aspect of employment-related regulation does not then fully apply across the audiology profession, hence a gap already exists.

Without third party regulation of all healthcare practitioners, neither professionals nor members of the public are protected in all healthcare contexts.

Audiology Australia has past examples of non-qualified audiologists who have set-up or offered hearing services and would (knowingly or unknowingly):

- perform inaccurate, incomplete or inappropriate diagnostic audiological assessments, or
- exploit or mislead potential clients and other health professionals through false or misleading advertising as an audiology practice or as having audiological qualifications.

In NSW, since the provision of the Code of Conduct, there have been examples of hearing health care practitioners who were not members, nor eligible to be members, of Audiology Australia. Audiology Australia was able to refer to the NSW Code of Conduct for Unregistered Health Practitioners to address such concerns. This highlights the limitation of self regulation but the strengthening of protection by reference to such a code which was helpful in that it covered all practitioners, not only our members.

We note there are moves to a National Code of Conduct for health care workers ⁷ (currently mandatory codes of conduct are in place in NSW ⁵ and South Australia ⁶). However, we point out this is a reactionary model in which enforcement of a health worker to

⁷ Australian Health Ministers Advisory Council <http://www.ahmac.gov.au/site/home.aspx>

demonstrate compliance or action may only be necessary and subject to verification following a complaint or breach of the code.

By contrast, self regulated health professions offer a more proactive and accountable model of protection through:

- assurance of skills and knowledge based on an accepted evidence base
- assurance of safety and quality
- evidence of continuing professional development
- a complaints process

There is a need for a strengthened and consistent framework of regulation by inclusion under the National Scheme of agreed standards across professions operating in a self-regulating environment. A level of recognition or accreditation for self-regulated health professions should have its own standard criteria thresholds in addition to those for a registered health profession.

Audiology – a Self-Regulating Profession But Is the Community Still at Risk?

Audiologists provide clinical services in hospitals, community health centres, hearing aid clinics, private practice, university clinics and medical practices. Many audiologists are involved in research, helping to develop new hearing aids and cochlear implants, hearing health therapies and testing procedures. Some work in industry, providing hearing conservation programs to protect and educate workers at risk from noise injury. They may also advise on compensation for noise related work injury. Some audiologists work in Aboriginal and Torres Strait Islander ear and hearing health programs, often in remote locations.

Employers of audiologists often advertise vacant positions with criteria including 'eligibility for membership of Audiology Australia'.

Audiology Australia members who work clinically are required to hold a current Certificate of Clinical Practice (CCP) and are unable to provide a whole range of audiological services without a CCP. Adherence to the highest standards of safe professional and clinical care is supported by the requirement to hold a current CCP. Evidence of ongoing continuing professional development is required as evidence for a CCP.

Self-regulation of audiology by Audiology Australia for many years has been accepted widely as a means of accreditation of audiologists by third party funders of services (for example, Medicare, the Office of Hearing Services, Department of Veterans Affairs, State workers' compensation schemes).

Consequently, Audiology Australia has over 98% of the profession of audiologists in Australia as its members.

Other workforce groups that have varying scopes of practice in hearing services include audiometrists, nurse audiometrists, ear-nose-throat specialists and medical practitioners (albeit typically with minimal training). Other workforce groups may be trained in hearing screening (eg newborn hearing screeners, Aboriginal Health Practitioners, school nurses, occupational hearing screeners) but do not have the expertise or scope of practice for standard audiometry unless formally trained.

Audiology Australia along with the Hearing Aid Audiometrists Society of Australia (HAASA) and the Australian College of Audiology (ACAud) manage their respective standards for the spectrum of hearing health care practitioners. These groups have had preliminary discussions in recent years to establish a combined 'Hearing Health Care Practitioners Accreditation Board'. Such an entity would manage the clinical standards for all providers of hearing services in Australia and therefore the outcomes of all those in the community with hearing health needs.

It seems evident that under the National Scheme, and based on Audiology Australia's previous submissions to State government (prior to the National Scheme) regarding accreditation/licensing of audiologists, that audiology is regarded as a profession of low risk of public harm so full government regulation has not been justified. It would be expected to have a low regulatory workload similar to the low regulatory workload professions identified under the current National Scheme in the consultation paper.

Audiology's key risks from within the audiology profession would arise from poor clinical practice or unethical behaviour which in turn results from an audiologist's failure to maintain the clinical and conduct standards expected of Audiology Australia members. This is an area in which Audiology Australia is able to influence and regulate but only to the extent of a self-regulated profession with our own members.

Audiology Australia is unable to regulate the conduct of an audiologist who is not a member and who may not be adhering to professional standards or behaving ethically.

In addition, other risks to the community exist from outside the audiology profession. There is potential for harm if an individual engages with a practitioner who does not hold the appropriate qualifications or skills or behaves unethically as would be deemed by Audiology Australia (or by breaches of the government's proposed National Code of Conduct for Unregistered Health Practitioners if fully implemented).

Examples of how this harm may be potentially manifested include misdiagnosis of hearing health conditions, failure to identify signs of related disease for further specialist investigation, inadequate or poor hearing health care or vulnerability to financial harm or exploitation.

More specifically, diagnostic hearing assessments have a crucial preventative health function. Signs of disease or malfunction are frequently detected through complex or advanced audiological assessments. However, unless these advanced assessments are accurately performed and the results competently interpreted, signs may be easily overlooked or disguised, leading to a failure to refer for appropriate medical treatment and for further audiological management.

Patients receiving a recommendation for a hearing device as a result of an inaccurate hearing assessment by a non-audiologist may be falsely reassured that there is no underlying disease or malfunction in their auditory system, when they may actually require otological/medical management. Or alternatively they might benefit from non-medical follow up and management by audiologists rather than prescription of a device.

Only audiologists have the skills to accurately undertake and interpret complex or advanced audiological assessments.

In previous submissions by Audiology Australia to government to advocate for the licensing of audiologists⁸, we have identified cases where members of the public have been exposed to or were vulnerable to harm:

- Adults needing complex or advanced diagnostic audiological services who have been placed at risk of physical and/or financial harm from the incompetent provision of services by non-audiologists.
- Children have been placed at risk of physical harm from the incompetent provision by non-audiologists of both standard and advanced audiological diagnostic assessment techniques which required for children. Cases include instances in which non-audiologists have been unable to obtain results, or have obtained inaccurate results.
- Advertisements, letters and cases in which the public and medical professionals were misled as to the qualifications and expertise of non-audiologists in providing advanced audiological services. These cases highlight the risk posed by the actions of persons who are (knowingly or unknowingly) unaware of the limitations of their scopes of practice and the serious consequences of their actions.

The audiology profession through Audiology Australia invests heavily in self regulation to afford the community the assurances that would otherwise be provided by the regulated professions under the National Scheme. It is important the community has the confidence when they engage with any audiologist across Australia that the audiologist holds appropriate professional qualifications, maintains appropriate accreditation and that the practice is ethical and safe.

Hence, we experience the limitations of self regulation and the limitations of where the authority of Audiology Australia may be enforced to regulate conduct, professional standards and afford the public safe, quality audiological service.

Audiology Australia advocates for stronger authority and recognition of self-regulating health professions and supports the proposal made previously by the National Alliance of Self Regulating Health Professions (NASRHP). (See next section.)

An Improved Model – Recognition of Self-Regulatory Framework

We draw your attention to their proposal in 2012 regarding a model for the regulation of all health practitioners – '*Harnessing self-regulation to support safety and quality in healthcare delivery, March 2012*'⁹.

Professionals and the public alike deserve a regulatory system that is proactive, objective, transparent, consistent and fairly adjudicated. Ideally this would be achieved when a government body regulates the conduct of all currently registered and unregistered healthcare professionals similarly.

⁸ Audiology Australia. Submission to Minister for Health. *Licensing of Audiologists, A Proposal to Protect the Health Of Adults and Children Needing Complex Audiological Services (Revised 1999)*. www.audiology.asn.au

⁹ Allied Health Professions Australia. Proposal by the National Alliance of Self-Regulating Health Professions. '*Harnessing self-regulation to support safety and quality in healthcare delivery*', March 2012. http://www.ahpa.com.au/Portals/0/Documents/0318_AHPA_NASRHP_Submission-low%20res2.pdf

Acknowledgement of the status of the self regulating health professions representing high quality practitioners of health care services is required. They should have the authority by which the community has confidence that consistent accreditation is in place and which can be exercised within the profession.

A standardised form of recognition or authority from a national entity such as the National Scheme should apply across different professions that operate in a self-regulating environment. This would give the community confidence in the qualifications, expertise, experience and scope of practice of the self regulating health professions and their members.

Hence, Audiology Australia supports the NASHRP model ⁹ of an improved, more robust framework under the National Scheme with three tiers of regulation available for all health care workers:

- Nationally registered professions.
- Nationally accredited or certified self-regulated professions (which mirror the accountability of registered professions but do not demonstrate as much risk of harm or require as high levels of regulation).
- A 'catch-all' of all other non-accredited health practitioners and who at minimum must abide a National Code of Conduct.

Within this model:

- When determining which health professions are registered or accredited as self-regulating, it is important that threshold criteria include only identified professions whose expertise and practice is drawn from a widely accepted clinical evidence base. Practitioners whose activities have very limited or poor clinical evidence should continue to be regarded as '*unregistered health practitioners*'.
- Any profession would be subject to negative licensing (where the right to practice has been withdrawn from registered or regulated practitioners or where poor practice is exhibited by unregulated practitioners in breach of a code).

The addition of an authorised self regulatory tier within the existing national model will not require the same impost of regulation, administrative burden and cost for the National Scheme as the existing National Boards.

Additional information is attached to this submission which summarises the essence of the NASRHP proposal.

8. Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?

Yes. This would seem logical and a sensible process.

Complaints and notifications

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

Audiology Australia is not able to comment as we have no direct experience to reflect on.

We note the following from the consultation paper only for our own information:

- *There is some overlap between the State/Territory complaints system and the National notification system. If a person raises their concern with one it may be referred to the other.*
- *The test for deciding whether the matter will be considered by the state or territory complaints agency or by AHPRA and the relevant National Board is that whichever system proposes the most serious action will take on the matter – 'the most serious action proposed by either must be taken'. In practice the State/Territory agencies and AHPRA regularly work together to decide which system should take on the matter.*
- *NSW is a co-regulatory jurisdiction under the National Scheme. All complaints about NSW health practitioners and providers are handled by the NSW Health Care Complaints Commission together with the NSW Health Professional Councils Authority. The current system in NSW has established a system of co-regulation with professional bodies while preserving the independence of the HCCC complaints body.*
- *From 1 July 2014, Queensland became a co-regulatory jurisdiction under the National Law. The Health Ombudsman is the single point of entry for all health complaints in Queensland in relation to individual health service providers (both registered and non-registered) and health service provider organisations across the public, private and not for profit sectors. A key difference is that all complaints and notifications (voluntary and mandatory) are made to the Health Ombudsman, rather than being split between the Health Complaint Entity and AHPRA, as was the case before 1 July 2014. The Health Ombudsman must keep complainants and health service providers informed when the Health Ombudsman takes action. In addition, the Health Ombudsman is to provide 3-monthly progress reports on investigations to a complainant and health service provider. Reports can be made public. Where an investigation report is to be made publicly available, a health service provider must be given the opportunity to comment on any adverse findings. Employers are to be advised of serious allegations in relation to their employees.*

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

Audiology Australia is not able to comment as we have no direct experience on hand to reflect on.

We note from the consultation paper '*This option would be the easiest to navigate from a consumer's perspective*'. Our expectation is that any process is accessible, transparent, timely, fair and accountable to all parties involved.

Part II Areas highlighted for review

Complaints and notifications

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

The process for complaints and notifications needs to be clearly understood by practitioners and consumers alike, and it needs to be easy for consumers to navigate.

Complaint and notification processes should be consistent across professions that are regulated, but also relevant to the specific profession. Individual professions may have

their own notification processes, but need to ensure effective communication between the regulatory body and the profession (i.e. reporting of data, actions taken etc). There also needs to be mechanisms for people to take their complaint directly to the regulatory body and so the profession can answer/be answerable.

A single entry point may be an advantage. However, with a clear, simple co-regulatory model for notifying, actioning, following up, and reporting complaints, then many of the reported issues could be overcome.

We note the following from the consultation paper for our own information only and to better understand the processes:

- *Under the National Law there is delineation between the role of the National Boards (supported by AHPRA) and the Health Complaints Entity (HCE) in each jurisdiction.*
- *National Boards (supported by AHPRA) are responsible for the investigation and management of notifications about the health, performance and conduct of regulated health practitioners. These concerns often relate to the practitioner's health, conduct or performance.*
- *Under the National Scheme, a complaint about a registered health practitioner is called a 'notification' and the person who made the complaint is a 'notifier'. The National Boards assess notifications with a focus on public safety and managing risk to patients.*
- *When a National Board takes action, it must use the minimum regulatory force needed to keep the public safe and manage the risk to patients.*
- *The Health Complaints Entities deal with issues relating to: health systems (such as hospitals or community health centres) and fees and charges. The focus of HCEs is to resolve complaints through a voluntary process that involves both the person making the complaint and the person or organisation subject to the complaint. The possible outcomes from this process are: an opportunity for the complainant to a face-to-face meeting with the provider; an apology; provision of remedial treatment; or payment of compensation.*
- *There is a significant difference in the role and status between a notifier and a complainant.*
- *Under the National Scheme, a notifier is not a party to the process but considered a witness to the process the National Board undertakes in assessing and/or investigating the concern.*
- *If a complaint about a registered practitioner is received by a HCE there is a joint consideration process between the HCE and AHPRA to determine which entity should manage the issue.*
- *There is a perception that the current arrangements under the National Scheme are difficult for consumers to navigate.*
- *There have also been criticisms that under the current process:*
 - *there is not one point of receipt for complaints and notifications*
 - *the role of notifier, as opposed to complainant, is not well understood and is unsatisfactory for consumers*
 - *complainants do not receive adequate information if their matter is referred to AHPRA as a notification*
 - *notifiers are provided with minimal information about the progress of the investigation process and are not routinely involved in processes of either Boards or tribunals.*
 - *AHPRA's communication to consumers is overly bureaucratic and legalistic and does not adequately explain the reasons for decisions.*
- *National Boards assess notifications to determine if they meet the threshold for professional misconduct or public risk that may result in, for example, a caution, suspension or cancellation of the practitioner's registration.*
- *Under the National Scheme, 60 per cent of notifications assessed by National Boards result in a finding of No Further Action because they do not meet this risk threshold.A significant number of consumers who, as a result of having had their concerns dealt with by the National Scheme, are unsatisfied with their experience and/or the result of the process.*

- *Compounding this confusion and frustration are the provisions of the National Law that limit the information that National Boards can provide to notifiers.*
- *An HCE has the ability to resolve matters by conciliation. In a number of cases, a consumer who raises a concern about their experience with a health practitioner may want access to a process that allows them to feel heard or receive an apology. It is noted that there is nothing in the National Law that prevents the National Boards or AHPRA from referring a matter back to the HCE to be managed as a complaint.*
- *In addition, there is a requirement for a register of cancelled practitioners to be available to the public, this includes a direct link from the register to the record of the tribunal hearing that led to the cancellation.*

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

Yes. This would be worthwhile and important in the interest of transparency and accountability.

13. Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?

The consultation paper suggests that this is an issue and we concur it needs improvement. We have no specific suggestion.

14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

This would seem a reasonable and sensible approach.

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

We note from the consultation paper:

- *There is some debate regarding the type and extent of information that should be available about practitioners on the register, particularly in relation to the historical details of disciplinary proceedings. There is a need to balance the competing rights of the practitioner versus public disclosure to enable informed decisions and public protection.*

To some extent this should be determined by the severity of the type and nature of the notification and any consequences relating to personal or financial harm experienced by the notifier or complainant.

Public protection – protected practice, advertising, cosmetic procedures and a national code of conduct

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

Audiology Australia is not able to comment as we have no direct experience to reflect on.

We note the interesting discussion from the consultation paper for our information only:

The National Law places the following requirements on the advertising of regulated health services. 'A person must not advertise a service, or a business that provides a regulated health service, in a way that:

- a. is false, misleading or deceptive or is likely to be misleading or deceptive; or*

- b. offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer; or*
- c. uses testimonials or purported testimonials about the service or business; or*
- d. creates an unreasonable expectation of beneficial treatment; or*
- e. directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.'*

The intent of the provisions is to prevent advertising that contains false and misleading information that may compromise health care choices and that is not in the public interest.

The National Law does not define 'testimonial', so the word has its ordinary meaning of a positive statement about a person or thing. In the context of the National Law, a testimonial includes recommendations, or statements about the clinical aspects of a regulated health service. The risks to consumers from inappropriate testimonials is that it may lead to the unnecessary and indiscriminate use of regulated health services that they may not require, or that is not in their best interest.

The ban on the use of testimonials means it is not acceptable for a practitioner to use testimonials in their own advertising, such as their Facebook page, in a print, radio or television advertisement, or on a website.

There has been some debate regarding whether the restriction on the use of testimonials in the National Law aligns with the use and impact of social media, and the increased availability of online platforms to share information as well as health service experiences.

While the obligations for practitioners to monitor comment does not extend to comments made by consumers on a social media site not controlled by the practitioner, this appears not to have been well understood, resulting in notifications made to AHPRA regarding alleged advertising breaches that were beyond the control of the practitioner.

In addition, consumer representative groups have reported to the Review that consumer feedback – positive or negative – should be allowed on any online platform, and that the current ban overly restricts the rights of consumers to share their experiences publicly.

Guidelines for advertising regulated health services were jointly developed by the National Boards to help practitioners and others understand their obligations when advertising a regulated health service. These Guidelines were updated May 2014 to provide clarity to practitioners on the requirements of the National Law and how it relates to postings via social media sites. The Review provides an opportunity to seek feedback from stakeholders as to whether changes in the National Law are required to make this clear.

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

Audiology Australia has no relevant comment to make.

18. In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

Yes.

Please refer to our discussion in Question 7) re the role self-regulating professions and the need to strengthen the regulatory framework by recognition of self-regulated professions and the additional assurances they afford public protection.

Mandatory notifications

19. Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

Audiology Australia has no comment to make.

Workforce reform and access

20. To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?

Audiology Australia is not able to comment significantly as we have no direct experience with these agencies to reflect on.

However, the issues of health reform continue to be areas of interest to us with respect to models of flexible service delivery and funding, patient-centred pathways for care, workforce planning, inter-professional learning, scopes of practice, access to integrated electronic patient health networks and systems, research and clinical teaching.

We note some of the interesting discussion only for our information:

The following describes the perspective from AHPRA, Accrediting Authorities and National Boards on their role in workforce reform:

'The National Scheme supports and enables health workforce innovation and reform in two key ways:

- the objectives and guiding principles of the National Law facilitate health workforce reform and*
- the National Law is based on a title protection model and imposes very few restrictions on the practice of registered health practitioners.*

AHPRA and the National Boards also recognise there are many aspects of workforce reform that do not require a regulatory response. We are aware that the National Scheme was not intended to have a role in industrial issues.

National Boards have noted the opportunities for their leadership to support and drive innovation and practice, including by supporting expanded scopes of practice, multidisciplinary teams and inter-professional learning.

Nationally consistent data produced by the National Scheme plays an important role in informing workforce policy and planning. There is potentially a very significant role for AHPRA to support workforce reform in this area, particularly in the context of the phasing out of Health Workforce Australia.

National Boards are actively examining the ways in which practitioner regulation under the National Law can play its part in workforce reform and want to be clearly focused on the priorities of governments and the roles and responsibilities of National Boards.

The recent establishment of a Health Workforce Reform Committee across National Boards provides a mechanism for engagement with AHMAC on reform priorities of cross profession significance.'

There would appear to be two areas in the reform agenda in which regulators have a role to play. The first is addressing the present workforce issues surrounding poor access to services, maldistribution of the workforce and increased specialisation of the workforce.

The second is a focus on producing a future health workforce capable of responding to the increased demand for health services from an ageing population with significant growth in chronic disease. These trends will need to be addressed through new ways of working across professions and using new technologies to enhance access and quality of services.

Workforce reform is focused on initiatives that maximise the skills and flexibility of all health professionals to address the challenges of workforce shortages. This can require change to the models of care and the practices of individual practitioners, and over time, to professions as a whole .

However, decisions relating to: the approval of registration standards; accreditation standards; codes; guidelines; and endorsements, have the potential to impose restrictions on professions and can act as a barrier to workforce flexibility or access.

In line with the objectives of the National Scheme, regulatory measures should not constrain workforce reform, except when needed to ensure public safety. Therefore, an important role for regulatory bodies is to ensure they remain focused on setting standards at a minimum for public safety and ensuring that the accreditation of education and training is fully weighted to ensure access to services is increased and not diminished.

In addition, there appears to be a growing trend towards universities establishing higher levels of qualification in several of the professions, for example postgraduate entry to medicine and physiotherapy, in excess of the qualification requirements of registration. It would seem this introduces an additional cost of entry in those professions beyond minimal regulatory requirements and it is unclear what degree of assessment is needed, or what bodies are responsible, for monitoring these developments.

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

If it has a brief as an advisory council, Audiology Australia needs to inquire: to what extent would such an entity engage with the full spectrum of allied health and its representative peak body? How would allied health professions who are not currently registered under the National Scheme be able to also engage in such issues?

If reconstituted, AHWAC should have mechanisms in place to have regular dialogue with, and to be readily accessible by, the health professions/peak representative bodies not currently regulated or represented through the National Scheme

22. To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?

Audiology Australia undertakes an accrediting function with Australian universities providing entry level coursework for audiology. We cannot specifically comment on this question regarding the Accrediting Authorities but we are always interested to continually improve and compare processes and issues with other professions.

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

Audiology Australia values a close relationship with relevant Australian universities.

As above - Audiology Australia maintains regular communication with, and undertakes regular accreditation of the Australian universities offering masters degrees in audiology.

Assessment of overseas trained practitioners

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

(NB – This question does not appear in Consolidated Questions at end of Part II)

Audiology Australia is responsible for administering the processes of recognition of overseas-trained audiologists in the hearing healthcare sector. Eligibility for membership of Audiology Australia is the benchmark for employment in Australia

Audiology Australia frequently reviews this issue for applicants who have trained overseas and applying for membership. It is interesting and worthwhile for us when we compare processes with other professions/regulatory bodies.

Governance of the National Scheme

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

(NB – this appears as Qn 24 in Consolidated Questions at end of Part II in Consultation Paper)

This seems reasonable but we offer no constructive comment.

26. Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?

(NB – this appears as Qn 25 in Consolidated Questions at end of Part II in Consultation Paper)

We offer no constructive comment.

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

(NB – this appears as Qn 26 in Consolidated Questions at end of Part II in Consultation Paper)

We offer no constructive comment.

28. The Review seeks comment on the proposed amendments to the National Law.

(NB – this appears as Qn 27 in Consolidated Questions at end of Part II in Consultation Paper)

We offer no constructive comment.

Attachment

We wish to note some selected key messages and elements for additional reference from the National Alliance of Self Regulating Health Professions (NASRHP) submission from 2012 '*Harnessing self-regulation to support safety and quality in healthcare delivery*'⁹.

Executive Summary – The issue (P 1)

There is a community expectation that Australian healthcare delivery meets a governed standard, with established public protection processes in place.

This expectation is met for a quarter of recognised health professions through the National Registration and Accreditation Scheme (NRAS) for Health Professions, which commenced under National Law in July 2010. The remainder of practitioners operate outside of a formalised framework, with public protection offered only through practitioner voluntary membership of a self-regulating professional association.

This situation, however, runs contrary to public expectation that a formal regulation structure exists which provides recognition of qualifications, minimum entry standards, assurance of practice standards, a code of conduct and ethics, and an avenue for complaints.

The primary concern of a robust health regulatory system is public safety through the assurance of quality service provision. Unfortunately, self-regulation in its current form is not sufficiently far-reaching because it cannot mandate standards beyond entry level, nor ensure that all practitioners submit to a code of ethics/conduct and a complaints management system. Current self-regulatory systems only regulate members or those who seek voluntary accreditation.

Most self-regulated professions have examples of serious public complaints in which the practitioner was either not a member or chose to resign membership, providing no avenue to pursue the complaint and ensure public safety. This highlights the gaps in the current health practitioner regulatory system in which there is a high level of regulation for the professions partnering with AHPRA in NRAS, but no enforceable public protection for the other three-quarters of Australia's health professions.

The impact of fragmented regulation (P 7)

The NASRHP has identified shortcomings in the current Australian health regulatory framework that include:

- *limited public awareness of the lack of breadth in the current NRAS*
- *an absence of public knowledge regarding the lack of coverage of NRAS as many consumers assume that those providing healthcare services have the appropriate qualification and competency, and practise within a regulated environment*
- *the self-regulating processes implemented by professional associations are not enforceable across the entire profession nor are they standardized*
- *limited avenues for complaints management, prevention of practice and subsequent public protection for those practitioners outside of the NRAS, the self-regulatory professional associations memberships and those who practise in non-regulated professions*

- *fragmented or ad hoc regulation of health professions creating an inconsistent administrative burden, with government agencies and authorities having to approach each sector in a different manner and independently.*

Introduction (P 4)

The NASRHP contends that to protect the interests and safety of the public a single national authority, such as AHPRA, should be responsible for managing the regulation of all health practitioners. This will involve a framework covering the registered professions (NRAS), authorised self-regulating professions and negative licensing of those practitioners who do not otherwise fit within the regulation processes. Authorised self-regulation, with reserved/protected title legislation, will require practitioners utilising the protected title to meet standards for practice set by the professional association. All regulation will be managed by AHPRA and the framework will be fluid, such that on AHPRA's recommendation a profession may move out of or into the NRAS should its demonstrated risk profile change.

Solving the dilemma of health practitioner regulation in Australia (P 5)

In the absence of NRAS inclusion for other health professions, the NASRHP proposes a model of authorised self-regulation for increased protection of the public.

Executive Summary - Proposed solution (P2)

The NASRHP proposes that the Australian Health Practitioner Regulation Agency (AHPRA), a single national body, should be responsible for managing a framework that regulates all health practitioners. This framework should include three components:

- *nationally registered professions via NRAS boards*
- *authorised self-regulating professions via a Health Professions Panel*
- *negative licensing.*

The proposed model for authorised self-regulating professions detailed in this paper calls for the Australian governments, through AHPRA, to:

- *authorise the self-regulation of designated health professions*
- *implement reserved/protected title legislation*
- *require all practitioners working under the reserved title of a profession to meet standards for practice set by the self-regulated profession.*

This model of regulation will provide numerous benefits to both the public and governments.

Importantly, it will ensure all practitioners are held accountable against enforceable profession specific standards of practice supported by a complaints handling process. It will address current consumer expectations and provide assurance of consistently safe and high quality standards in healthcare from a greater proportion of health professions. The model will also provide a minimum qualification standard for each of the professions, ensuring the most appropriate level of skill and expertise is available to the consumer. Further to this, the implementation of mandated continuing professional development will ensure oversight and greater certainty about the quality and currency of practice of those who are not currently members of a professional association.

The model represents benefits to both the consumer and governments. The Australian governments will benefit from a reduction in the inconsistencies between self-regulating professions with respect to the quality and coverage of standards. A clear definition of 'health practitioner' under the 'authorised self-regulation' model will mark a boundary between evidenced-based health practitioners and unregulated health workers. The current lack of clarity leads to confusion – for consumers, government departments, agencies and employers.

Finally, the authorised self regulation model will alleviate concerns regarding imposing regulation which has the level of administrative burden associated with NRAS boards.

Proposed model: Authorised self-regulation (P 11-12)

Legislative change is essential as the Competition and Consumer Act 2010 dictates that membership of a professional association cannot be mandatory. The NASRHP advises the Australian governments of the necessity to require all graduated practitioners seeking professional employment to be accredited or credentialed and abide by the standards required by their professional associations

It is recommended that AHPRA create a Health Professions Panel. This panel will be responsible for assessing the standards for the professions to ensure they meet AHPRA guidelines. For most professions these standards already exist and are broadly in line with those of registered professions. Therefore, the panel's primary task will be to determine the assessment criteria for accrediting/assuring that the authorised self-regulator's professional standards meet AHPRA standards, and that any gaps in standards are rectified.

AHPRA will not be asked to create a range of standards for each profession, but rather the benchmarks for these standards.

Amelioration of risk for government of an authorised self-regulation model (P 16)

Although AHPRA and AHMAC have assessed many of these professions as medium to low risk, there is still a risk in applying a self-regulation model with indirect oversight that needs to be ameliorated. Decisions regarding amelioration strategies will depend on governments weighing up cost effectiveness against the risk.

Possible strategies are:

- *reporting by each professional body to AHPRA on a 6- or 12-monthly basis the significant data and results of audits of at least 5% of practitioners*
- *panel audit of policies, procedures, complaints management systems on a triennial timetable.*

Conclusion and Recommendations (P 17)

The NASRHP contends that it is unacceptable for almost three quarters of Australia's health professions to remain outside a regulated environment and that it is the responsibility of Australian governments to establish a framework that will ensure the safety of Australians and provide them with access to high quality health services.

Key Features of the Proposed National Health Practitioner Regulation (P 10)

- *AHPRA is responsible for regulation of all health practitioners.*
- *AHPRA regulation will protect the public against poor practice, inappropriate advice, intervention and exploitation from registered (statutory regulation), self-regulated and unregulated health practitioners.*
- *AHPRA collects and utilises evidence to determine the level of risk a health profession poses to the public and recommends the most appropriate level of regulation.*
- *AHPRA determines the criteria of quality self-regulation and assesses self-regulating professional associations against those criteria to determine authorised self-regulation status.*
- *All health practitioners can be subject to negative licensing for non-compliance with the quality and safety standards (conduct, health and performance matters).*
- *As national evidence is gathered, AHPRA may recommend that a profession move into or out of statutory registration.*
- *Unregistered practitioners are encouraged to collaborate with similar practitioners and work towards meeting AHPRA criteria for authorised self-regulation, if appropriate.*

We also note for further reading by reference to the original document:

- **Appendix 1: Mapping the self-regulated professions against AHPRA functions and the NRAS**