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# **Submission by the Health Services Union of Western Australia (Union of Workers)**

## **On the Health Practitioner Regulation National Law (Bill B)**

**1. Part 2 : 10.4 Minister's powers to ultimately decide what the standards of accreditation will be for the health professions covered by this legislation.**

**Part 2 Ministerial Council - currently reads:**

**10 Policy directions**

- (1) The Ministerial Council may give directions to the National Agency about the policies to be applied by the National Agency in exercising its functions under this Law.
- (2) The Ministerial Council may give directions to a National Board about the policies to be applied by the National Board in exercising its functions under this Law.
- (3) Without limiting subsections (1) and (2), a direction under this section may relate to:
  - (a) a matter relevant to the policies of the National Agency or a National Board, or
  - (b) an administrative process of the National Agency or a National Board, or
  - (c) a procedure of the National Agency or a National Board, or
  - (d) a particular accreditation standard for a health profession.**
- (4) However, the Ministerial Council may give a National Board a direction under subsection (3)(d) only if, in the Council's opinion, the accreditation standard will have a substantive and negative impact on the recruitment or supply of health practitioners to the workforce.**
- (5) A direction under this section cannot be about:
  - (a) a particular person, or
  - (b) a particular qualification, or
  - (c) a particular application, complaint or proceeding.
- (6) The National Agency or a National Board must comply with a direction given to it by the Ministerial Council under this section.

**Eg. Area of Need and the Protection of Titles.**

Under excuses such as "Area of Need", the Minister could justify allowing people without the currently accepted standard of accreditation to practice in remote areas.

For eg, in the UK apparently they are employing Assistants to perform Mammography rather than employ a fully trained Radiographer. Apparently Qld health is trying to introduce these "Mammography Assistants" from the UK into Qld to perform the actual mammograms instead of Mammographers.

This would result in undermining the Radiography profession within Australia, and mean that women in regional areas would be offered mammograms of a lesser overall quality than their sisters in metropolitan areas. There would be the potential for lower quality mammograms, with a potentially higher breast dose and less diagnostic information obtained within the images. The posterior margins of the breast can be easily missed through inexperience, and without the full understanding of the dynamics of ionising radiation obtained through our extensive training and specialisation in breast imaging. Breast compression during mammography is both vital to image quality, patient dose and patient discomfort. There is a fine art to balance these competing factors in obtaining the best images - adequate (not brutal) compression, to maximise image data without discouraging further patient participation in screening mammography.

MITs / Radiographers undergo extensive supervised training, with repeated quality control in their mammography performance, and to think that you can just train up assistants over a couple of months then send them out there to perform this task is a big step backwards in patient care.

When imaging the breast, there is a huge variation in both doses used and image quality obtained, which is extremely dependent upon the radiographer to ensure consistent quality control. Letting inexperienced operators perform mammograms will increase the likelihood of irradiating patients excessively whilst missing breast cancers. Repeat images would be higher in number. There is no point in irradiating women if a substandard exam results. Women in the country are entitled to the same level of care as those in the major cities of Australia.

There is no justification to accept any percentage in the reduction in the accuracy detection rate of breast cancer, nor to accept any percentage increase in the patient dose absorbed through mammography.

Similar justifications could be used to allow use of para professionals and unskilled assistants in remote areas. It should be specified in the legislation that best practice standards should be applied.

We submit that the following is added to the legislation.

**(4) However, the Ministerial Council may give a National Board a direction under subsection (3)(d) only if, in the Council's opinion, the accreditation standard will have a substantive and negative impact on the recruitment or supply of health practitioners to the workforce, and only if, it is alignment with 'best practice' (and doesn't lower health care standards) as determined by the national board of each profession. Healthcare standards provided should be maintained at all times, regardless of where patients within Australia are serviced.**

**2. In regards to 'Area of Need', the professional body should be consulted prior to declaring one, and the process of declaring an 'Area of Need' needs to be clarified.** The proposer should have to demonstrate to the board that you can't fill the position first.

**3. The Minister can arguably drive down Accreditation Standards to solve workforce problems.**

The problems at Bundaberg Hospital which resulted in the deaths of multiple patients is a good example of what can happen as a result of allowing this legislation in its current form.

Yes a change to an existing standard has to be put forward to the Board, however ultimately this legislation allows the minister to override the board if it suits his own purposes.

**4. There needs to be indemnification of people who do the assessments of courses/overseas applicants who seek registration.** Currently this has been missed from the legislation.

**5. The Minister will be appointing the Chair of the Board.**

The board should be appointing the Chair themselves, as Boards can be stacked for political purposes and the minister can exert control to solve workforce problems at the expense of standard of care.

**6. The public register should not show the Health Professional's Home address, but the address of their practice or workplace.** There are plausible risks to practitioners who may be treating mental or drug challenged patients.

**7. Student Registration.**

**There are currently no mandatory reporting requirements regarding the impairments of the student in the Clinical Training setting they are to be placed in.**

There was some discussion concerning the Universities being compromised by their own self-interest in reporting to the board about their students. The financial incentive to have international students accepted for registration is immense. There is also a potential 'breach in privacy' that the Uni would face by reporting their students impairments to the Board. By not fully disclosing to the Board the Uni would be preventing legal action against themselves, but this would undermine the value of a student being registered.

The approach proposed in this legislation is a broad 'register all your students en-masse and not individually'. Thus you would give the Registration Board all their names, and that is it. There would not be any checks prior to clinical practice, and no fee would be charged to register the students. The whole process seems pointless in terms of safeguarding the public.

Registration at the end of their course doesn't automatically rollover from a Student Registration to a General Registration, they then have to undergo the set accreditation process to gain Registration once qualified. '

Other than having the names of all the students in the Register, it seems an ineffective way of safeguarding the public - which is what this legislation is all about.

## **Continuing Professional Development**

We have included below the text of an earlier email exchange with your office.

Dear Mr Barlow

Thank you for your enquiry of 6 July 2009. I apologise for the delay in responding.

The questions you raise are important ones and will need to be taken into account by the new national boards in developing and setting the continuing professional development requirements. I will ensure these matters are taken into consideration. In terms of the requirements, any problems should be raised with boards in the first instance. However, if the matter became a registration issue, the practitioner would have the normal rights of review set out in clauses 243 (Reviewable decisions) and 246 (Appellable decisions) of the Bill.

regards

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cc

06/07/2009 06:51 PM

Subject NRAS - CPD

Dear NRAS

I attended a seminar in Perth today on the new versions of the NRAS Bill .

Included in the material is the intent to apply continuing professional development (referred to in the Communique dated 8th May ) .

I acknowledge that many professions have current standards, but as far as I am aware some like Physiotherapy and Podiatry in WA, do not have legally mandated CPD.

This has the potential to impose significant costs on practitioners, both in time and money. Questions have also been raised by our members about the equity of CPD where Boards are often dominated by members of a professional association and the only CPD available is through that professional association.

1. Has your team considered guidelines / parameters for CPD for Boards ?
2. What steps have you considered to minimise the financial and time costs of CPD for practitioners ?

3. Is there any special thought being given to rural and remote practitioners who may not be able to access affordable CPD ? I assume that this could include approaches such as remote learning and on the job CPD.
4. Are there any appeal / complaint processes contemplated for practitioners who may feel that the Board has over reached with its CPD requirements ?

**Richard Barlow**  
***Acting Secretary***  
**Health Services Union of WA**

**17<sup>th</sup> July 2009**