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National Rural Health Conference
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Submission to

the Health Workforce Committee
on

the Proposed Registration and Accreditation Scheme

July 2009

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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Introduction

The National Rural Health Alliance is the peak non-government body concerned with rural and remote health issues in Australia. It is comprised of 28 Member Bodies, each a national body in its own right, representing health professionals, service providers, consumers and educators.

The Alliance welcomes this opportunity to provide comment on the new Draft Bill ('Bill B') setting out the proposed operations of the new National Registration and Accreditation Scheme. Overall, the Alliance is strongly supportive of this national framework for professional workforce registration and accreditation. We consider that the Scheme has the potential to be of considerable benefit in the provision of health services in rural, regional and remote (hereafter rural) areas of Australia.

However, we consider that there are certain provisions as expressed in Draft Bill B which warrant further consideration.

Objectives
In light of the longstanding shortages of health professionals in rural Australia, and the reliance on good workforce education and training, workforce mobility and induction of overseas trained health practitioners, the Alliance considers that the objectives of the proposed Act generally provide a commendable framework of goals and objectives for the scheme. They include:

> (a) to provide for the protection of the public …….,
> (b) to facilitate workforce mobility across Australia…..;
> (c) to facilitate the provision of high quality education and training…;
> (d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners,
> (e) to facilitate access to services provided by health practitioners in accordance with the public interest; and
> (f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

However, we consider that objective of "access to services…" in clause (e) be clarified or strengthened by rephrasing as "*equitable* access to services….". A clearly defined goal of equity of access would also give clearer purpose to other objectives, including those of mobility, responsiveness and sustainability. With this inclusion, these objectives would provide a comprehensive basis for interpretation of what is in the public interest, especially as the public interest applies to rural Australia.

Representation Including Consumer and Community Interest

The introduction of provisions to broaden the perspectives of registration and accreditation so as to include community and consumer interests is commendable in itself, and also in providing precedent for health professionals and communities working in collaboration in future across all domains of the national health system.

While we acknowledge the provision for representation on National Boards by at least one member with rural practice/residence (clause 45 (7)) and at least two community representatives, we consider that rural workforce and health service delivery issues are sufficiently different to clearly warrant a minimum of proportionate representation ie about 30 per cent of membership, and to include both health professional and community representation across the national registration and accreditation scheme..

We would strongly advocate for similar provisions for rural and community representation at the state/territory level to ensure that the particular perspectives and needs of rural Australia are adequately reflected in continuing state level deliberations and operation.

Ministerial Council Policy Directions

Clarity in the reasons for Ministerial Council policy directions and approval of accreditation standards will be important to ensure widespread acceptance of the national arrangements and effective implementation. In similar vein to our comments on standards applying in areas of need below, we are also concerned to ensure that people in rural Australia enjoy the same standards as apply in urban areas.

In this regard, we consider that Ministerial Council directions on accreditation standards (clause 10 (4)) should not be confined to workforce supply issues , but should meet the broader public interest test as defined in the objectives of the legislation and give the reasons for the decision to issue the policy direction.

Complaints and Mandatory Reporting

The making of complaints is of particular interest for rural Australia, where there is less scope for anonymity and for access to alternative providers than in major urban areas. We support the proposed arrangements that provide for both profession-led and Public Interest Assessor consideration of complaints, with particular support to assist people making a complaint while also providing strong privacy provisions for both health professional and complainant.

However, care needs to be taken to apply the complaints and mandatory reporting provisions in a way that focuses attention on substantial issues, does not waste resources and does not create or promote more difficult and untenable work environments for health professionals.

We therefore consider that there be a publically available annual report from the Agency that analyses the operation of the schemes and makes recommendations on any changes required for systemic improvement or to address any adverse consequences of these provisions.

Provision for limited registration in areas of need

We support provisions to enable a responsible Minister to determine whether there is an area of need for health services if there are insufficient health practitioners practising in a particular health profession to meet the needs of people living in the area (clause 85), as well as for applications for registration for teaching/research and visitors acting as locums (clause 86, 87). Regrettably, area-of-need considerations are required in rural Australia.

However, people in rural and remote areas need to have the same skill level of practitioner (of all disciplines) as those in metropolitan areas. Indeed a strong case can be made that rural

practice requires the highest level of competency and independence and that those who do not meet full registration standards can in fact be more easily supported in the city.

Accordingly, we would strongly advocate for arrangements that provide a defined, supportive and progressive pathway for such registrants to progress to full registration, rather than simply impose a two year limit (clause 91).

There are undoubtedly a number of health professionals, e.g. overseas trained doctors from some countries, who are well trained and who must enter under the provisional registration system. It is critical that registration processes are streamlined so that applicants are assessed and fully registered promptly if they meet acceptable criteria.

Recognition of Nurse Practitioners

The proposed Bill provides for endorsement of registration as a nurse practitioner, but does not require specific identification within the register, either as a separate register (as for midwives) or as a division within the nursing register (as for registered and enrolled nurses). While we recognise that numbers of nurse practitioners are currently small, the new policy in allowing nurse practitioner services to be eligible for MBS rebates makes them of particular interest, warranting at least a Division within the Nursing Register.

Provision for New Professions

The Bill provides explicitly for the addition of Aboriginal Health Workers, Chinese medicine and medical radiation practitioners but does not provide a defined and dynamic path for other professions to seek and gain registration. We are not aware of any reason why the Bill remains prescriptive and why there would therefore need to be new or amended legislation in all jurisdictions to include a new profession in the future, such as Occupational Therapists, Physician Assistants and paramedics. We consider that there should be a clearly defined pathway for such professions to be considered for and go through the registration process.

We consider there is merit in making provision in this Bill whereby Ministers could be given power to agree in future on the registration and accreditation of new professions with effect being given by regulation under the Act.

Criminal History Checks and Identification

Given the reliance in rural Australia on the recruitment of health professionals from a wide range of sources and on visiting and locum arrangements, we strongly support the strengthened requirements for criminal history checks and for improved identification processes. On criminal checks, the draft Bill provides that a National Board must check the applicant's criminal history. While Crimtrac or a Police Commissioner report may suffice for Australian resident or trained professionals, we would seek an assurance that effective processes will be put in place to enable similar standards of checking on overseas trained applicant for registration.

The Alliance also notes the importance of effective identification processes for registered health professionals. Rural Australia relies heavily on overseas trained doctors, on visiting

professionals and on other temporary arrangements. It is highly useful in such circumstances that the employer and the community have access to good identification of the registrant. The November discussion paper foreshadowed photo identification, although Draft Bill B is silent on the details of identification, and photo identification is not specified on the certificate of registration. We consider that photo identification should be an inclusion on the certificate of registration to readily enable identification at the stage of initial registration and also to enable ready identification by subsequent employers or community being served by the health professional.

Workforce Planning

Workforce planning is a critical national issue. For rural Australia, it is about ensuring the attraction, retention and ongoing training of all health professions in ways that meet the particular health needs of rural Australia. Retention and turnover rates are particularly important measures of performance in this regard.

The November 2008 discussion paper recognised the important contribution to workforce planning of data that could be collected as part of the registration process, recognising also the requirement for de-identification for privacy and also for expert interpretation of such data through the AIHW.

It is regrettable that the draft Bill B does not reflect these proposals, dropping reference to possible data on principal role, sector and setting and hours worked. While such information is subject to change, the suggested minimum data set approach canvassed in the discussion paper would at least establish the national importance of the information, and seem to be less cumbersome and costly to all concerned than the proposed alternative arrangements relying on annual labour force surveys (see Health Workforce Australia News Issue 3 May 2009), supplemented by provisions (Clause 263 of Bill B) enabling Ministers to request workforce planning information but with no requirement for practitioners to provide such data.

We would argue strongly for inclusion of data for workforce planning purposes and believe that failure to do so would be a major opportunity lost.

Costs of the Scheme

It is concerning that estimates of cost of the new national arrangements have not been made available or policies enunciated on ensuring that costs of the arrangements are maintained within defined boundaries rather than an open-ended way. This system, as with every part of the health sector, needs to be delivered in the most efficient and effective way if Australia is to achieve a sustainable and equitable system for all areas and communities.

In this regard we consider that the costs of the range of new elements of the national system be borne by Government rather than the professions in the first two to three years of transition so that any unforeseen unwieldy or over-costly elements can be quickly considered and addressed and not leave registration fees subject to undue fluctuations.

Attachment 1:

Member Bodies of the National Rural Health Alliance

ACHSE	Australian College of Health Service Executives (rural members)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Rural Sub-Committee of the Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association of Australia
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Members Network
APS	Australian Paediatric Society
ARHEN	Australian Rural Health Education Network
CAA (RRG)	Council of Ambulance Authorities - Rural and Remote Group
CRANA	Council of Remote Area Nurses of Australia
CRHF	Catholic Rural Hospitals Forum of Catholic Health of Australia
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
RDAA	Rural Doctors' Association of Australia
RDN of the ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Australian Council of the Royal Flying Doctor Service of Australia
RHWA	Rural Health Workforce Australia
RIHG	Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
RNMF of RCNA	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
RPA	Rural Pharmacists Australia - Special Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health