



89 Nicholson Street, Brunswick East Vic 3057
Phone: +61 3 9416 3111 \ Fax: +61 3 9416 3188
Email: apodc@apodc.com.au \ Web: www.apodc.com.au

Australasian Podiatry Council

ABN: 24 008 488 748

ATTENTION
Practitioner Regulation Subcommittee
NRAIP@dhs.vic.gov.au

As requested in correspondence from the Health Workforce Principal Committee - Practitioner Regulation Subcommittee - 13th August 2008, specific responses to relevant matters as highlighted in the *Consultation Paper on Issues Supplementary to the Intergovernmental Agreement on a National Registration and Accreditation Scheme for the health professions to be included in the first bill* have been addressed by representatives of the profession of podiatry.

Should you have any queries on this submission, I can be contacted by telephone on (03) 94163111 and by email kelli@apodc.com.au.

Yours sincerely

Kelli Cheales
CEO
Australasian Podiatry Council

8th September 2008

Section 1.1 Objects or purposes

Podiatry fully supports the objectives of the national Scheme as described in Clause 5.3 and the principles of the Scheme as described in Clause 5.4.

Section 2 Australian Health Workforce Ministerial Council

Recommendations:

- The title of the Ministerial Council could be modified (*see below*).
- Podiatry's peak accreditation body, the APodC, must hold final responsibility for accreditation standards rather than the Ministerial Council, as suggested in the IGA.
- Increase transparency in interventions by the Ministerial Council could be enhanced by including a time frame for decisions and publication dates.

Explanation

Consideration should be given to the title to the Ministerial Council to accurately convey the intent of the national Scheme, that is, regulation to underpin the objectives of the national Scheme as described in Clause 5.3. For example, the title of the Ministerial Council could be modified to the *Australian Health Workforce Regulation Ministerial Council* with the same approach used for the Advisory Council ie *Australian Health Workforce Regulation Advisory Council*.

The role of the Ministerial Council in providing final approval for registration and accreditation standards is in direct contradiction to the guidance given in the WHO/WFME Guidelines For Accreditation of Basic Medical Education ie.

2. The legal framework

The accreditation system must operate within a legal framework..... The legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government, the medical schools and the profession.

The legal framework must authorize the accrediting body to set standards, conduct periodic evaluations and confer, deny and withdraw accreditation of medical schools and their programme in medical education.

(Source: WHO/WFME Guidelines For Accreditation of Basic Medical Education http://www.ifmsa.org/scome/wiki/images/WHO-WFME_Guidelines_for_Accreditation.pdf)

Transparency in the interventions by the Ministerial Council (*2.1 Publication of decisions*) could be enhanced further by including a time frame to address the duration from the provision of written directions to the time the decision is published on the relevant internet site.

Section 3 Australian Health Workforce Advisory Council

Recommendations:

- Ensure key stakeholders and clinical experts are included in consultation to improve transparency and independent advice provided to Advisory Council.
- To enhance transparent decision-making processes, details of publication timings must be included.
- Termination of appointments under the authority of the Ministerial Council should be consistent across the Scheme and should represent current best practice for the health profession.

Explanation

As addressed in the *Intergovernmental Agreement (IGA)*, the Advisory Council is to provide independent and transparent advice to the Ministerial Council, however consultation with key stakeholders and experts is a key driver for enhancing transparency, and should be incorporated as a component of the process.

Transparency in the decision making process should also be enhanced with the inclusion of a time frame for the publication of advice provided by the Advisory Council and incorporated into the process by the Advisory Council rather than the current proposal that the decision '*will be published as soon as possible*'. The Ministerial Council decision could be published no later than 15 days, in line with the identical time period indicated for circumstances where the Ministerial Council has not been able to reach a decision ie

1.14 Where the Ministerial Council has not been able to reach a decision on a matter on which the Advisory Council has provided advice, the Advisory Council's advice will be published no later than 15 days after the Ministerial Council has considered the advice.

(Source: Intergovernmental Agreement (IGA))

<http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/NATREG%20-%20Intergovernmental%20Agreement.pdf>

3.5 Resignation and removal

Termination of appointments under the authority of the Ministerial Council should be consistent across the Scheme, and should represent current best practice for the health profession. At the minimum, bankruptcy and engaging in paid employment that conflicts, or could conflict, with the performance of duties, deregistration, and a questionable Police Check that indicates a conviction relevant to the position held should be considered.

Criteria incorporated into the legislation for resignation and removal should be identical across all health professions incorporated under the Scheme, and across all boards or committee structures.

Section 4 National Agency

Recommendations

- Specified terms of office for Agency senior staff must be detailed in legislation.
- Sitting fees should be addressed as part of good governance
- Conflict of Interest must be spelt out to ensure no loop holes in legislation.
- The indemnity and immunity provisions must be provided in line with health professionals' functions and or engagement.
- To ensure a seamless occurrence of work tasks, staff transfers should be based on the *Australia Post* model.
- Funding must follow function. Fee setting and management of podiatry funds must be the responsibility of the accreditation and registration bodies for and on behalf of the profession.
- Annual reporting by state/territory of accreditation and registration bodies as well as national boards must be included in the legislation to ensure true representation of profession.

Explanation

4.2 Terms of office – length of appointments, sitting fees and allowances

First round appointments should be up to 3 years, with reappointment up to 2 full terms ie a maximum of 6 years in total. The legislation must facilitate a variable replacement of first round appointments to ensure that all Agency Management Committee appointments are not retired at the same time.

Sitting fees should address:

- preparation time and meeting time in recognition of the additional pro bono work positions such as these will generate
- formal face to face meetings and teleconferences
- the difference in roles for the Chair and members

Under the Commonwealth, the fee structures are generally limited to those determined by the Remuneration Tribunal.

Under the Remuneration Tribunal the *Remuneration and Allowances for Holders of Part-Time Public Office* determination should address the sitting fees and travel allowances across the National Agency Management Committee, National Boards, and accreditation and registration committees ie under the *Determination 2008/07: Remuneration and Allowances for Holders of Part-Time Public Office* a level not less than that under Schedule A for the General Practice Education and Training Council should be considered for the Agency Management Committee:

- Chair \$71,150 per annum
- Member \$32,130 per annum
- Travel Tier 1

(Source:

<http://www.remtribunal.gov.au/determinationsReports/Current%20Principal%20Determinations/2008-07%20Determination%2012.8.08.pdf>)

4.5 Conflict of Interest

The legislation must ensure that a full disclosure of pecuniary and professional conflicts of interest is made annually, and revised disclosure whenever the interests of an individual is changed. Guidelines which detail definitions and examples of conflicts of interest must be developed in line with the legislation to ensure comprehension of the current best practice definition for conflict of interest and standardisation across the individual health professions incorporated under the Scheme as well as across all levels of the Scheme.

4.6 Coverage for legal liability – indemnities and immunities

The indemnity and immunity provisions must include any liability aligned with clinical decision making by any of the health professionals engaged in functions conferred to them by the Act.

4.9 Staffing arrangements – capacity to employ, set terms and conditions

Staff transfer from state based schemes into the national Scheme should be based on the ‘Australia Post’ model ie all staff transferred together, thus not losing the expertise of the staff necessary in maintaining public safety across the transition phase.

National Boards should set the criteria of the staff requirements for maintaining and developing the regulation of the profession, and should be able to determine the staff appointments required to maintain function. In addition, the financial provisions made to the National Board must be funded sufficiently to maintain the ongoing functions of the accreditation and registration.

4.10 Financial provisions

Podiatry has concerns that the fees for the profession must be agreed to between the Agency and the Board. The relevance of the Agency to take up the responsibility to agree to the fees and manage the money on behalf of the profession is unclear. Fee setting and management of the funds should be the responsibility of the accreditation and registration bodies on behalf of the profession.

The relevance of the Agency to determine the business rules for the development of professional standards is also questionable, and is compounded by the lack of expertise within the Agency as there is no requirement within the IGA (Clauses 1.18 and 1.19) for Agency staff or the Agency Management Committee members to be expert in the development and/or management of professional standards. This could in part be addressed if extensive experience in the development of standards for podiatry is set as essential criteria for relevant agency staff under *4.9 Staffing arrangements*.

Any Agency role in these functions further isolates the expertise of the profession in driving the quality of professional standards, thus podiatry does not support 4.10 *Financial provisions* as currently proposed.

4.12 Reporting requirements for agency

The proposed annual report of the Agency to be a consolidation of reports from the national boards suggests that detail on the individual professions and the state based nuances of the profession may be absent in a report of this nature. Reports from individual state/territory accreditation and registration bodies as well as the board should be included for the profession within the annual report of the Agency to ensure true representation of the profession.

Section 5 National Boards

Recommendations:

- Members of the National Boards who are experts in professional standards, should provide policy advice direct to Ministerial Council
- Public notices for the recruitment of professional experts to national boards is essential for an open and transparent process.
- The '*Podiatry Board of Australia*' addresses the full range of podiatry professionals.
- Sitting fees be paid to experts who are engaged by National Boards
- Grounds for resignation and removal must be consistent across all National Boards, Committees and members of the Agency Management Committee.
- Legislation must detail coverage for legal liability – indemnities and immunities
- Annual reporting by state/territory of accreditation and registration bodies as well as national boards must be included in the legislation to ensure true representation of profession.
- Podiatry Accreditation Board receives the decision on the accreditation status of a particular professional education program or school that the accrediting body has reached without outside influence from the profession, the registration bodies and/or other interested parties.
- The assessment of individual health practitioners (including overseas applicants) should be independent.
- Adequate funding for Accreditation Councils/Boards is required in order to continue functioning both during and after the transition period.

Explanation

The National Boards for the professions will be experts in professional standards and the policy requirements to further develop the profession, and thus should provide policy advice directly to the Ministerial Council. The role of the National Agency is to administer the Scheme and not provide advice and guidance on policy matters impacting on the regulation of a profession and the standards for the profession.

The nominations process for the appointment of Board members by the Ministerial Council has not been determined other than “following an open and transparent process” (Clause 1.24(b) IGA). In attaining an open and transparent process, the profession supports the use of public notices or advertisements in national newspapers, thus enabling professional organisations to nominate those professionals expert and interested in the relevant roles, and interested individuals who may not be strongly aligned to relevant professional organisations to self nominate.

5.1 Names of Boards

The title for the Board should address the profession as a whole and not as a single group within the profession. Thus, the title of the Podiatry Board of Australia is the most appropriate title for the national board with responsibility for the profession of podiatry.

5.3 Sitting fees and allowances, and length of appointment

- preparation time and meeting time in recognition of the additional pro bono work positions such as these will generate
- formal face to face meetings and teleconferences
- the difference in roles for the Chair and members.

Under the Commonwealth, the fee structures are generally limited to those determined by the Remuneration Tribunal.

Under the Remuneration Tribunal the *Remuneration and Allowances for Holders of Part-Time Public Office* determination should address the sitting fees and travel allowances across the National Agency Management Committee, National Boards, and accreditation and registration committees ie under the *Determination 2008/07: Remuneration and Allowances for Holders of Part-Time Public Office* a level not less than that under Schedule A for the General Practice Education and Training Council should be considered for the National Board:

- Chair \$71,150 per annum
- Member \$32,130 per annum
- Travel Tier 1.

A level not less than that under Schedule A for the Aged Care Accreditation and Standards Agency Board should be considered for the individual accreditation and registration committees at state level:

- Chair \$45,130 per annum
- Member \$23,749 per annum
- Travel Tier 1.

A level not less than that under Schedule A for the Professional Services Review Committees should be considered for any committees associated with the state accreditation and registration committees:

- Chair \$1,151 per day
- Member \$1,022 per day
- Travel Tier 1.

(Source:

<http://www.remtribunal.gov.au/determinationsReports/Current%20Principal%20Determinations/2008-07%20Determination%2012.8.08.pdf>)

First round appointments should be up to 3 years, with reappointment up to 2 full terms ie a maximum of 6 years in total. The legislation must facilitate a variable replacement schedule of first round appointments to ensure that all Board appointments are not retired at the same time.

5.6 Resignation and removal

The profession recommends that the grounds for resignation should be consistent across all professions, national boards, committees and for members of the Agency Management Committee.

The profession is supportive of the need to remove members who fail to notify the Chair of their absence. In recognition of the importance of the role of Board Member, the absence for 3 consecutive meetings should apply to meetings whether formal face to face meetings or those conducted by teleconference.

Termination of appointments under the authority of the Ministerial Council should be consistent across the Scheme, and should represent current best practice for the health profession. At the minimum, bankruptcy and engaging in paid employment that conflicts, or could conflict, with the performance of duties, deregistration, and a questionable Police Check that indicates a conviction relevant to the position held should be considered.

Criteria incorporated into the legislation for resignation and removal should be identical across all health professions incorporated under the Scheme, and across all boards or committee structures.

5.7 Coverage for legal liability – indemnities and immunities

The indemnity and immunity provisions must include any liability aligned with clinical decision making by any of the health professionals engaged in functions conferred to them by the Act.

5.8 Reporting requirements

Reports from individual state/territory accreditation and registration bodies as well as the board should be included for the profession within the annual report of the Agency to ensure true representation of the profession.

5.10 Arrangements for Ministerial Council to review composition of boards

The profession supports the proposal that the size and composition of the Boards can be reviewed. Any decisions made to change the size and composition of the Board must be

open and transparent, and not enacted until consultation with key stakeholders has been carried out and responses considered and supported by the profession.

5.11 Responsibility for developing accreditation standards (accreditation committee or bodies)

Accreditation standards must only be developed by the accreditation body or committee assigned by the Ministerial Council to perform the relevant function. Existing accreditation agencies – agencies actively accrediting the profession prior to the COAG signing of the IGA and with the ability to meet the standards required within the initial 12 month period should be assigned by the Ministerial Council for implementation of the Scheme.

Continuing professional development (CPD) requirements should be determined by the Board, and developed by accredited providers of education for the profession. Over time, CPD should be compulsory for all health professions under the Scheme, however the structure to CPD, type and compulsory modules should be specific to the requirements of individual professions.

Additional point for consideration

Further to the role of the National Boards in overseeing registration and accreditation functions of the profession, implementation of the national Scheme enables a national approach to addressing Clause 1.32 of the IGA:

1.32 State and Territory drugs and poisons legislation will, at the discretion of States and Territories, provide a mechanism through which suitably qualified registrants of the nursing and allied health professions may be authorised to possess, administer and prescribe scheduled medicines, with:

- (a) responsibility for determining qualification requirements and endorsing qualified individuals residing with the relevant board; and
- (b) authorisation for particular professions (or sub-groups within professions) to obtain, possess, use, sell or supply (administer or prescribe) medicines to be granted under State and Territory drugs and poisons legislation.

Non-medical prescribing should be developed and administered nationally through the new Scheme with the development of national credentialing courses with the credential listed on the national register. Quality use of medicines practices would ensure the separation of prescribing, dispensing and administration of medicines for the individual health professional.

Using this approach the competence for non-medical prescribers should be consistent across all health professionals as would the management of the individual patient with individual medications or therapeutic categories of medications for specific medical conditions.