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Australian Health Workforce Ministerial Council's
**Review of the National Registration and Accreditation
Scheme for health professions**

Comments on the scope of the Review

July 2014

This Paper represents the agreed views of the National Rural Health Alliance, but not necessarily the full or particular views of all of its Member Bodies.

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Comments on the scope of the Review

The National Registration and Accreditation Scheme (NRAS) for the health professions has been in force in each State and Territory for about four years.

The Scheme's objectives include two of particular importance to the people of rural and remote areas:

- facilitation of workforce mobility and high quality education and training; and
- promotion of access to health services.

An independent review is being undertaken. The purpose of this National Rural Health Alliance (NRHA) paper is to report some early reflections on the NRAS and to emphasise the importance of the review considering how the NRAS relates to accessibility to health services - particularly for people living in rural and remote areas.

The NRAS provides a national framework for the registration of health professions. Currently, only those professions that have historically been registered are included in the NRAS.

The majority of allied health practitioners self-regulate¹. That is, the peak professional body for the health profession administers functions equivalent to those of the NRAS boards. These include formally recognising qualifications, administering minimum entry practice standards, assurance of practice standards, providing a code of conduct and investigating complaints. These arrangements are not recognised in national law.

Equity - and access

The fundamental rationale for the work and the very existence of the NRHA is that the current situation relating to health outcomes is inequitable. This basic unfairness is referred to both implicitly and, usually, explicitly in all public documents from the NRHA. (All of the Alliance's publications can be found at www.ruralhealth.org.au) Recently, for example, the Alliance appeared at a public hearing of the Senate Standing Committee on Community Affairs' Inquiry into the Australian National Preventive Health Agency (Abolition) Bill 2014 and the Health Workforce Australia (Abolition) Bill 2014. In its opening statement the Alliance said:

"- - the Alliance's purpose is to ensure that in all processes relating to policies and programs which impact on health and wellbeing, the particular circumstances and

¹ <http://www.aopa.org.au/documents/item/123>

needs of rural and remote communities are not only understood but are taken account of in action that ensues.

More than 6.7 million people live in rural and remote Australia. Members of the Committee will agree about the importance of winning the national challenge to improve their health and wellbeing. It is unjust, unnecessary and un-Australian for them to have poorer health and poorer access to health services than people who live in the major cities."

There are many reasons for the poorer health of people in rural and remote areas, including greater exposure to a number of 'upstream' health risk factors. Another of the specific reasons is poor access to health services. It is generally the case that there is a very good idea about the means by which health services can be delivered to people in more remote areas. What stands between rural and remote health consumers and better services is the poor distribution of the health workforce, reflected in rural and remote areas by serious shortages of almost all health professionals.

In the best interests of the people who live in rural and remote areas, the NRHA is therefore vitally interested in any means by which the national *distribution* of the health workforce can be improved. Central to this are the means by which the number of health professionals who can be recruited to and retained in such areas can be increased.

One of the significant benefits it has been assumed national registration will bring is some improvement in the supply of health professionals to rural areas and thus enhanced access to health services.

The view from outside the NRAS

It is clear that a number of health professions regret the fact they have not been subject to the provisions of national registration.

Speech Pathology Australia (SPA) was one of those organisations to advocate for the inclusion of its profession in the NRAS and it regrets that this has not yet happened. It believes that the lack of inclusion of speech pathology in NRAS "undermines the public confidence in the evidence based practice of speech pathologists and the unique role speech pathologists play in the Australian health care system."

Further, SPA believes "that professions included in NRAS are at a distinct advantage in attracting government funding investment in programs, innovations and professional supports to maintain and improve the quality of care they provide to the Australian public".

SPA believes the registered professions also enjoy an advantage in relation to investment in data governance and workforce planning and sustainability initiatives. These advantages extend to investment in programs aimed at improving health care delivery to rural and remote Australians.

Allied health professions

One of the objectives of the national scheme is "*to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practice in a*

competent and ethical manner are registered” with/by the Australian Department of Health or by self-regulating professional bodies .

This has resulted in a public expectation that all health professionals are registered. Consequently, there is a disparity between public expectation and the legislated approach to regulation of health professions.

To address this disparity, eight allied health professions (including SPA and ESSA) have aligned through the National Alliance of Self-Regulating Health Professions (NASRHP) to facilitate the development of a National Framework for Self-Regulation for Health Professionals. Where possible, this national framework mirrors that required by NRAS in relation to monitoring and systematic self-regulation mechanisms for quality and safety in the delivery of health care by these professions.

This framework augments the existing operations of the individual professional bodies to develop and maintain the clinical, educational and ethical standards that promote high quality and safe care.

The speech pathology profession continues to face what it calls "an underwhelming policy response" in relation to investments into the professional supports, systems and funding mechanisms that could enhance access to and delivery of service, promote the profession and recruitment and retention in the profession.

"The speech pathology profession, our rural practitioners and our rural clients have not benefited from the operations of NRAS."

Exercise & Sports Science Australia (ESSA) is another of the self-regulating professional bodies. It accredits the allied health profession of exercise physiology.

In rural and remote areas allied health practitioners play a vital role in delivering health services to the community. Self-regulating allied health professions (such as accredited exercise physiologists) need to be recognised within national law so they are not subject to disadvantage. Self-regulating professions are recognised through some government-funded schemes and are able to receive rebates (i.e Medicare, DVA and Comcare) and so, logically, should also be recognised through the national registration framework.

Evidence of the effects of the operation of NRAS

It is likely that workforce mobility across Australia has been enhanced through the NRAS by its reduction of the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one. It has made it easier for health professionals to undertake locums outside the jurisdiction in which they normally practise.

The benefits of national registration are particularly evident for clinicians who work on or near jurisdictional borders.

Australia's geography dictates that this means the benefits are felt in rural and remote areas, not in the capital cities. It was rural practitioners in border communities who had to bear the administrative burden and confusion of conflicting systems - in places such as Mungindi,

Tweed Heads and Albury-Wodonga. National registration has increased portability for rural and remote practitioners.

The operation of the NRAS has reduced expenses for cross-border practitioners in many circumstances, and would have facilitated programs such as the National Rural Locum Scheme (although this has had only a modest uptake).

In the past, patients in two contiguous jurisdictions may have attended for practitioner services under quite different regulations and guidelines on either side of the border. These differences may have been particularly important where there were any complaints or complications, and in relation to professional conduct, training, education and employment standards.

National standards are very beneficial for rural health services. They provide the basis for local governance and clinical management and reduce the risk that small services become centres of lower quality services. They also help in those cases where Fly in, Fly Out service delivery is necessary.

National Registration may have helped reduce paperwork and costs for volunteer organisations such as the SOS Health Foundation (<http://soshealth.org.au/>), to facilitate the sending of volunteers to remote communities.

Student registration may have had a negative effect on rural student placements had it not been introduced along with national registration.

Challenges that remain

It is clear from preliminary responses from some of the NRHA's constituents, especially some of the allied health professional bodies, that a very significant unresolved issue is the non-inclusion of a number of professions. This will presumably be considered in the review, including in relation to the future sustainability of the National Scheme and its funding arrangements.

One of the remaining problems for GPs and registrars is the state jurisdiction and for their provision of in-hospital and procedural services. With national registration a doctor may be able to provide GP-type services in various jurisdictions, but procedural or inpatient services are regulated locally and have to be applied for at each site. Credentialing for procedural and inpatient services is site-specific ie not transferable between jurisdictions or between hospital services.

There is a strong case to be made for the principles of the NRAS to apply to all health professions. There should be national consistency in policies around professional conduct, education and training and clinical supervision for all professions.

A major issue is the difficulty or impossibility for professionals in more remote areas to access continuing professional development (CPD) to maintain their registration and accreditation. The NRHA has very strong and clear evidence of this through its management for the Department of Health of Stream 2 of the Rural Health Continuing Education (RHCE2). This valuable scheme is always seriously over-subscribed and through its

management the NRHA has become more closely aware of the real challenges for professionals in obtaining the CPD they want and frequently need.

We note the reference in the review documentation to the opportunities that AHPRA and the National Boards have to work effectively in partnership with other parties that influence workforce, including Health Workforce Australia. The NRHA's strong support for and concerns about the future of the streams of activity initiated by and run by Health Workforce Australia are on the public record

(http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ANPHA_Abolition/Report/index).

The NRHA has heard very little about the impact of the NRAS on practising and would-be overseas trained health professionals. Given the large extent to which rural communities rely on such people (around 40 per cent of the GPs in more remote areas are OTDs, for example) there is considerable interest in this matter.

To date the NRHA has also heard little about the complaints and notification process relating to professional conduct and behaviour.

Judgments about the NRAS's impact on the community's confidence in the quality of health professionals and care are difficult for the NRHA to make. Given time, the NRHA could undertake some sort of data gathering exercise on rural health consumers' perceptions of service safety and quality.

A strong case can be made for the principles underpinning the NRAS to apply to all health professions. AHPRA should be consistent in its policies around professional conduct, education and training and clinical supervision for all professions under its jurisdiction. Currently this is not the case. For example there are no standards for clinical supervision of medical practitioners.

16 July 2014

Note: for a list of organisations in the NRHA: <http://ruralhealth.org.au/about/memberbodies>