RANZCO The Royal Australian and New Zealand College of Ophthalmologists

THE MEDICAL EYE SPECIALISTS

10 October 2014

Mr Kim Snowball
Independent Reviewer
GPO Box 4541, Melbourne, VIC 3001
By email: nras.review@health.vic.gov.au

Dear Mr Snowball

Australian Health Ministers' Advisory Council (AHMAC) Consultation – Review of the National Registration and Accreditation Scheme for health professions

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) welcomes the opportunity to comment on the AHMAC consultation document 'Review of the National Registration and Accreditation Scheme for health professions'.

RANZCO's mission is to drive improvements in eye health care in Australia, New Zealand and the Asia Pacific Region through continuing exceptional training, education, research and advocacy. Underpinning all of the College's work is a commitment to best patient outcomes, providing contemporary education, training and continuing professional development, evidence-based decision making, collaboration and collegiality. RANZCO also seeks to educate the general public in all matters relating to vision and the health of the human eye and advocates for accessible ophthalmology services for patients.

Background

The National Registration and Accreditation Scheme (NRAS / the National Scheme) for the health professions began in July 2010. Before then each State and Territory had its own system for registering health professionals, meaning there were 97 different health boards across the States and Territories. NRAS oversees the regulation of more than 618,000 health professionals.

Six objectives:

- Protection of public safety
- Facilitation of high quality education and training
- Facilitation of assessment of overseas-trained health practitioners
- Promotion of access to health services
- Facilitation of workforce mobility
- Development of a flexible, responsive and sustainable workforce.

The guiding principles of the National Scheme state that it must operate in a transparent, accountable, efficient, effective and fair way. Fees payable by practitioners must be reasonable and restrictions on the practice of health professionals must be guided by patient safety. APHRA works with 14 health practitioner boards. RANZCO experience is that these boards operate independently of each other.

The terms of reference of the NRAS Review state the scope is to be focussed on matters relevant to [1]

- identifying the achievements of the National Scheme against its objectives and guiding principles;
- the future sustainability of the National Scheme, any recommended changes and the specific matters articulated below;
- the administration of the National Scheme;
- the interface between the National Scheme and jurisdictional practices; and
- an assessment of the extent to which the National Scheme meets its aims and objectives.

Executive Summary

- RANZCO is disappointed that a number of key objectives outlined in the terms of reference of the review have not been sufficiently explored.
- The NRAS review paper states 'the National Scheme seeks to achieve a balance between safety and quality through protection of title, without restricting competition or limiting access to services' [2]. The review does not question whether NRAS has achieved this objective in a fair and transparent manner.
- RANZCO considers that cross professional issues should be resolved by an independent body not AHWAC. Refer to our response to question 2 for details.
- RANZCO does not support the establishment of a single Health Professions Australia Board to manage the regulatory functions.
- State-based health care complaints entities can offer protection for dissatisfied consumers and better triaging systems would significantly improve the process for all stakeholders.
- RANZCO supports the Australian Medical Council as the accreditation body responsible for medical courses and vocational training.
- Through our attendance at consultative forums, recommended structural changes to AHPRA also appear to be a 'pre-determined outcome' driven by a priority to achieve overall cost saving of the National Scheme. Importantly, RANZCO believes recommended changes are likely to result in significant increase in notifications and overall costs to the health care system.

The Royal Australian and New Zealand College of Ophthalmologists ACN 000 644 404
94 - 98 Chalmers Street, Surry Hills NSW 2010 Australia
T 61 2 9690 1001 F 61 2 9690 1321 E ranzco@ranzco.edu
ranzco.edu

Balance between Public Protection and Access to Health Services

1. Objectives of the National Scheme – Public Protection

The NRAS scheme aims to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. Public protection within the National Scheme is intended to include consistent and approved national standards about practitioners' safety to practice. RANZCO considers the NRAS has failed to achieve this aim.

1.1 Title protection

The NRAS review paper states that the use of title protection model in the National Law enables registered health practitioners to practice to the full scope available and consistent with their education and competence [2]. RANZCO does not believe that reliance on the system of protection of title is adequate protection for the public. Although 'specialist surgeon' is protected, this is not understood by the public who continue to attach equivalent meaning to the word 'surgeon'. Consideration should be given to protecting the title of surgeon to those who have specifically trained in a recognised surgical educational program.

1.2 National Standards

The independent reviewer states that "While the National Scheme sets the minimum standard for safe practice by health professionals, it does not take away the capacity for individual States and Territories, or employers, to add further regulation, where they see fit" [2]. RANZCO believes the governing principle of the National Law should be that the same standards and evidence levels is to be utilised by all healthcare professionals included within the National Scheme and their overseeing Boards.

The Optometry Board of Australia has permitted optometrists to independently diagnose and manage the treatment of chronic glaucoma, and patients who are at high risk of developing the disease, simply by changing its Guidelines for Use of Scheduled Medicines [3]. This independent practice is not aligned with the NHMRC Guidelines for the Screening, Prognosis, Diagnosis, Management and Prevention of Glaucoma [4]. Importantly, NHMRC Guidelines use international standards developed by the Cochrane Collaboration group to assess clinical safety and make informed decisions and were developed by a multi-disciplinary team [4]. This team included; ophthalmologists, optometrists, ophthalmic nurses, pharmacists and general practitioners.

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The Optometry Board Guidelines list medicines for use by optometrists does also not accord with the Pharmaceutical Benefits Scheme which also requires collaborative management with Ophthalmologists [5].

1.3 Suitably trained and qualified to practice

In the first four years of its function, AHPRA has brought into place a uniform approach to registering health practitioners. It has been highly successful in now having quite a stable system given the complexity and lack of comparability that existed prior to creation of the agency. RANZCO congratulates AHPRA for this.

One of the stated aims of the National Scheme is to promote innovation in the education of, and service delivery by, health practitioners. Since the introduction of the Scheme, all other boards compared to the Medical Board have become focussed on workforce dynamics rather than maintenance of the minimum standards required for patient safety. This has in effect, promoted movement of the traditional medical scope of practice to the 13 other National Boards without further oversight by the Medical Board of Australia or any other body.

As discussed, the Optometry Board of Australia (OBA) has permitted optometrists to independently diagnose and manage the treatment of chronic glaucoma. Fifty hours of clinical supervised training are required by both the University of New South Wales and the University of Melbourne to complete the Graduate Certificate of Therapeutics. A relocating overseas optometrist seeking accreditation is only required to complete a therapeutics exam, even where their clinical training and experience may be vastly different [3]. This is compared to an ophthalmologist who currently acquires 12,000 hours of clinical training based around pathology and the treatment of eye disease (or the equivalent thereof for overseas trained ophthalmologists) before being authorised to responsibly initiate treatments for patients [7].

2. Objectives of the National Scheme – Access to Health Services

Based on the guiding principles of National Scheme, restrictions on the practice of a health profession are to be imposed if it is necessary to ensure health services are provided safely and are of appropriate quality [2]. RANZCO considers the NRAS is currently falling drastically short of this safety and quality goal and has prioritised Federal and State Government workforce agendas at the expense of public interest. This failure to consider public interest as a priority, has resulted in RANZCO taking legal action against the OBA through the Queensland Supreme Court.

2.1 Inappropriate treatment resulting in medical harm

As discussed, the OBA has permitted optometrists to independently diagnose and manage the treatment of chronic glaucoma in 2013. This decision was made without agreement with the Medical Board.

2.2 Management of patient co-morbidities and the elderly

Prevalence of glaucoma is associated with increased age [9]. The University of South Australia in collaboration with the Commonwealth Department of Veterans Affairs (DVA) completed a retrospective study to identify the extent of use of medicines recommended to be used with caution in glaucoma patients with specified comorbidities and to determine evidence of associated harm [10]. DVA database indicates that in 2008 approximately 10.6% of veterans were receiving treatment for glaucoma which is comparable to the general Australia community of similar age[11].

The cohort analysis included 25,984 veterans and concluded that the use of glaucoma eye drops recommended to be used with caution in co-morbidities is common; heart failure, airways disease, and depression. An increased risk of hospitalization for bradycardia following initiation of a specific glaucoma medicine was observed (ASR 2.22, 99% CI 1.15-4.31). The authors of the study including Dr Graeme Killer AO (DVA Principal Medical Advisor) concluded that awareness of co-morbidities is required in the selection and prescription of glaucoma eye drops[10].

Glaucoma Australia, the peak glaucoma patient association in Australia believes that all anti-glaucoma medicines have side effects and should be initially prescribed by ophthalmologists to ensure patient safety [12].

2.3 Increased treatment from misdiagnosis resulting in medical harm

Based on the recent experience of referral-refinement schemes for screening glaucoma in the United Kingdom, referral from expert trained optometrists utilising diagnostic testing resulted in identification of a false positive rate of approximately 50% [13-15]. Without the collaboration with an ophthalmologists a significant proportion of patients are likely to be over treated resulting in unnecessary adverse effects. If optometrists were also allowed to initiate treatment, the costs to the Australian health system from glaucoma medications would likely increase: from the current $1.3 million per annum to $2 million per annum (2013/14 financial year PBS Statistics, data processing).

2.4 Increased spread of communicable diseases impacting the overall Australian community

"Without urgent, coordinated action by many stakeholders, the world is headed for a post-antibiotic era, in which common infections and minor injuries which have been treatable for decades can once again kill," says Dr Keiji Fukuda, WHO's Assistant Director-General for Health Security [16]. In an effort to slow the development of bacterial resistance, restrictions on the use of fluoro-quinolones (antibiotic) in humans and animals were introduced in Australia in the 1990s [17]. Australia now benefits from a remarkably low rate of resistance to these agents for a range of pathogens. The OBA has endorsed independent prescribing of fluoro-quinolones by optometrists despite the profession not having the medical training to specifically identify the pathogen responsible for the infection [3]. This is another clear example of the failure of the National Scheme.

The future sustainability of the National Scheme, any recommended changes and the specific matters articulated below;

The National Scheme is funded by health practitioners. They are consequently a vital component to its success. Effective collaboration with health professionals is essential to ensure all stakeholders have full confidence in the regulatory system. RANZCO is concerned the proposal to establish a single health professions board will undermine the spirit and intent of the NRAS. It is most important that this review of the implementation of the National Scheme in Australia should not complicate, fragment or undo some of the benefits derived from the current system.

There is a risk that if these standards are set for nine health professions by one board, eventually there will be a "harmonisation" of practice. At this point it time, this does not seem to be a sensible path on which to embark on a journey of health workforce reform.

The National Law seeks to promote change and innovation in health care and this goal alone demonstrates why a historic assessment of UK regulatory performance is inappropriate and may be misleading. It is well accepted in the realm of finance that "past performance is not a guide to future returns" and this is also valid when considering the future regulatory risk of any health profession that is likely to innovate, change and develop its nature and scope of practice. Indeed, the prospect of innovation and change should suggest the need for regulation and oversight to be maintained or heightened, until the safety of new innovations and changes has been demonstrated. The cost comparison of the Australian and UK schemes is also only based on regulatory operational costs and does not consider a robust cost effectiveness analysis including the impact of changes in health outcomes including safety risks.

RANZCO has identified significant issues with the current NRAS Scheme's ability to sufficiently balance public protection compared to workforce issues. Low numbers of registrants does not necessarily equate to lower potential risk of harm, and the professions identified in the Consultation Paper are different health care disciplines as distinct by virtue of what they seek to do. For example, a chiropractor conducts his/her work in a vastly different manner to a psychologist. RANZCO's experience and given the current health care climate, cross-professional issues need overarching oversight. The civil courts are an inappropriate forum for these disputes as proceedings are slow and may even be subject to tactical delay so as to preserve the influence of a decision under challenge for as long as possible. RANZCO therefore rejects any proposal which is based on consolidating functions solely for cost savings purposes which in fact results in having insufficient expertise to safely govern all the health professions.

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ranzco.edu

RANZCO Responses to Listed Questions

Accountability

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

No. The NRAS review states that there is "neither obligation nor accountability for the operation of the National Scheme as a whole". The consultation paper proposes that the Australian Health Workforce Advisory Council (AHWAC) provide specific information to Health Ministers and their parliaments on the performance of the regulators and the health professionals themselves. The Commonwealth Regulator Performance Framework offers a more independent approach to measuring and reporting on the performance of the regulators under the scheme that provides accountability to health practitioners.

The review has not provided a rationale for AHWAC to report on the performance of the health professionals themselves. RANZCO cannot support this proposal based on the current information provided. A summary of the outcomes of notifications is currently contained in the AHPRA Annual Report.

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

No. Unfortunately there is little transparency on the criteria for how consideration will be given to changes in scopes of practice. RANZCO does not believe that resolving cross-professional issues is the domain of the AHWAC. Given cross-professional disputes regarding scope of practice are about the protection of public safety, AHWAC lacks the appropriate clinical and health economic expertise.

RANZCO believes that there needs to be an oversight function (overseeing all 14 constituent boards), performed by an independent body constituted by appropriately skilled members. Disputes should be investigated and determined in an urgent manner given the public interest. This oversight function could be performed by a seven member advisory Council, constituted by a non-registrant independent chair (perhaps a retired Supreme Court judge), a specialist medical practitioner, a general medical practitioner, chair of the CMC, a nurse, a community representative and a health economist.

The terms of reference for such an advisory Council would need to be determined and the precise role to be undertaken by this advisory Council would need to be clearly delineated. This will ensure issues are resolved in a transparent, accountable, efficient, effective and fair way.

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.

No. There is no requirement to increase the complexity of the AHPRA structure. RANZCO is concerned the proposal to establish a single health professions board will undermine the key objective of the regulatory scheme which is designed to protect the public. Low numbers of registrants does not necessarily equate to lower potential risk of harm.

Amalgamation of the "low regulatory workload professions" boards with a single mechanism does not acknowledge the unique differences in practice and accreditation requirements between these professions. It is unreasonable and dangerous to expect a single board to understand the intricacies of governance necessary to oversee physiotherapy, optometry and the other related professions. Regulatory oversight necessary to protect the public safety ought to be reflective of boards with the skills and attributes to do so.

The governing principle should be that the same standards and evidence base is utilised by all healthcare professionals included within the National Scheme and their overseeing boards. This proposal will lead to increased service delivery risks for the public. This warrants greater not less regulation. We note the estimated cost savings of $11m per annum are based on a simple analysis of operational costs with the UK. A comprehensive cost benefit analysis inclusive of increased patient harm is likely to yield increased costs to the National Scheme and healthcare system.

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.

No. RANZCO believes each profession should have its own board and further details are required in relation to the sharing of regulatory functions of notifications and registration. We agree that increased efficiencies in ‘back-office’ tasks could be highly beneficial as regards to costs of the National Scheme.

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

Predicted financial savings through shared regulation assume there is no impact to patient safety or the number of notifications. The realisation of these fiscal savings is highly uncertain, without the completion of a more robust cost effectiveness analysis incorporating potential impacts to patient safety and effectiveness. Fees payable by practitioners should always be structured to solely cover the costs of the scheme within that profession.

For Professions seeking entry to the National Scheme

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?

The criteria and process for including health professionals in the NRAS scheme are not evident. An agreed criteria should consider; the number of practitioners, educational requirements, risk of harm to the public and cost-benefit analysis. Greater transparency is required by AHPRA and should be approved by the Australian Health Ministers.

Many groups without scientific training would wish to be covered by regulatory arrangements given the achievement associated with falling into the category of 'health professional'. Much work has already been devoted to developing a code of conduct for the health care workers to be governed by State and Territory health care complaints entities. This code covers issues around delivery of services, false claims, infection control, record keeping and information provided to patients. For public protection it includes prohibition orders for breach, public warnings and naming if of serious risk. This should be implemented as planned.

If there is some concern by governments about the cost of administering the code of conduct mechanism, it could consider a system of health care workers paying an application fee to be "recognised" as a practitioner who practises according to the code of conduct, which would give them a market advantage. Other avenues of redress are available, namely the consumer protection laws, small claims courts and legal suits.

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

No. As stated in question 6, the State-based health care complaints entities can offer protection for dissatisfied consumers. The governing principle of the National Law should be that the same standards and evidence base is to be utilised by all healthcare professionals included within the National Scheme and their overseeing boards.

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?

No. The principles of this should be developed by AHPRA and approved by the Australian Health Ministers.

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

To the members of the public, the ability to differentiate the difference between notifications and complaints is very difficult. RANZCO therefore supports one common 'entry' point. The boards, and their registrant stakeholders, AHPRA and health complaints entities should work together to make improvements to the process for triaging complaints and notifications and to the process for managing and completing notifications.

Confidentially should be respected for both the notifier and the complainant. In this context it should be noted that professional reputation is highly valued by most health practitioners and that there is potential for injustice to be done if details of a complaint against a practitioner are made public and the complaint is then determined to be incorrect, mistaken or even malicious. In such situations the complainant may suffer no consequence but the practitioner may sustain reputational damage that cannot be undone, even if the complaint is withdrawn or a correction is published. All complaints should be held in confidence until a threshold of evidence is reached. There should be appropriate implications for vexatious claims so that such potentially malicious abuse of the notifications scheme is strongly discouraged and has consequences.

Communication and support is vital. There needs to be a substantial move from the adversarial and legally based system that is currently evident to one that is focused on conciliation and rapid resolution wherever possible.

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There is no doubt that the concerns, aggravation and angst of complaints is magnified enormously when delays are multiplied and the process becomes adversarial. This is both for the public who have raised the concern and the practitioner about who the concern is made. These notifications/complaints are often devastating to both parties. Everything should be done to reduce this stress and the time over which any investigation lasts. It is important to protect the public but also to support the professions in a caring and insightful manner.

It is noted in the Reviewer's consultation paper that Ontario in Canada appears to achieve the benchmark in resolving complaints with a required completion at 150 days.

Extensions can be allowed but only for specific reasons. None of the complaint mechanisms within Australia be they State based, co-regulatory or through AHPRA come close to achieving this type of benchmark. This is substantially increasing the costs of the system and is the one area that with reform will substantially reduce costs. RANZCO strongly recommends that substantial reform is required in the complaints area with KPIs that are closely monitored and are reported to the professional groups, the public and to the Ministers of Health.

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

No. Complaints should managed by an independent health care complaints entity. The Queensland co-regulatory model that includes notifications is not yet proven, and the costs are as yet unknown and could lead to fractioning of the system.

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

Yes. RANZCO believes this would be an advantage to the public, but would need to be supported by a substantially superior triage, communication and support methodology.

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

Yes. Performance measures should be adopted. RANZCO is concerned that currently AHPRA is not meeting the KPIs. We are cautious about agreeing to additional prescribed timeframes until we know that the National Scheme is well placed to accommodate them.

Health practitioners should not be asked to fund more resources, rather than being involved in a continuous improvement process with AHPRA and the boards.

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?

RANZCO advocates for AHPRA to write a guide to notifications so that the process is transparent to practitioners and the public. This document should clearly set out the requirements for all AHPRA staff in handling any investigation with appropriate and due process. Additionally, such a document would benefit from periodic review and improvement.

In terms of transparency of outcomes of disciplinary process, notifiers should have no right to more information about the outcomes for individual practitioners than the general public does through the public register.

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?

Yes. More flexible means for dispute resolution would be desirable as different approaches are likely to work in different circumstances and for different parties. RANZCO considers the major concern about the current complaint / notifications approach is timeliness and the adversarial approach. Both of these lead to more increased costs. It is well established that having flexible dispute resolution leads to a more effective and efficient use of the legal system.

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

For medical practitioners, adverse findings in relation to matters proven on the basis of rules of evidence, a rigorous evidence base and due process, comparable to those applying in court proceedings can be permanently published. Allegations and unproven matters should not be published. Disciplinary sanctions should be published while they are current but removed when no longer current.

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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?

Advertising, inducements, commissions and similar commercial practices have the same potential to corrupt good medical practice as they do to corrupt business practice. Perhaps the ACCC or ASIC should be partnered with AHPRA so as to provide advice and expertise in the vigorous enforcement of commercial practices by health practitioners. It may prove more effective and more cost-effective for the ACCC and ASIC to provide their expertise than for AHPRA to develop the same.

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

Protected practices should consider the best interest of patients. Unless there are critical geographical reasons, then all States and Territories should move to uniform practices across the regions. It is a core part of being able to improve workforce mobility and also to appropriately train international medical graduates who are relocating to this country. Areas of difference between the regions should be highlighted to the Health Ministers with a commitment by them to progressively align the legislation.

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?

No. The report on the consultation on the National Code of Conduct should identify what legislation is needed to support the proper implementation of the Code to protect the public. It does not need to be considered within changes to the National Law. RANZCO considers the National Code of Conduct for unregistered health practitioners to be a good idea, but questions how unregistered individuals could be regulated. Amending the National Law may result in the legitimisation of scientifically unfounded practices that increase risk of harm to patients.

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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?

RANZCO supports the AMA position that treating doctors should be exempt from the mandatory reporting provisions of the Health Practitioner Regulation National Law Act (the National Law).

There should be national consistency in as many aspects of the law as possible. There is no demonstrable or published benefit from having the mandatory reporting arising from the treating practitioner – health professional interaction. It appears appropriate to adopt the Western Australia and Queensland provision in the National context.

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?

RANZCO supports the statements in the consultation paper suggesting that workforce reform and regulatory measures must balance to ensure public safety. However, RANZCO is of the view that some health practitioner boards are misusing the objectives of facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery to act as champions of their practitioners. Applying this objective in the broadest sense have resulted in changes to scopes of practice without any robust assessment of: need; the existence of accredited education and training programs that deliver the required competencies; the safety risks to patients; the impact on training for and care provided by other practitioners; or the costs to the health system. This position is shared by the Australian Medical Association (AMA).

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

RANZCO does not agree that AHWAC should be reconstituted to address workforce reform priorities or scope of practice changes. At the moment the function of Health Workforce Australia appears to be incorporated into the Commonwealth Department of Health. Issues pertaining to access to services are multifactorial and also largely within the jurisdiction of the State and Territory health departments.

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The training of a sustainable health workforce is also funded primarily at state/territory level. Health services gaps will become evident as judged by outpatient and surgical waiting lists. Key stakeholders currently involved in determining health services already have the capacity to complete cost effectiveness analysis and public/private sector comparisons.

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?

Each medical discipline has key para-medical and nursing related bodies with whom multi-disciplinary working is important, for example ophthalmology and optometry and orthoptics, orthopaedics and podiatry. The need for multi-disciplinary education varies widely across medical and paramedical disciplines and is difficult to mandate.

It is critical that patient safety and protection are foremost so that if 'team' care is better for patients it is supported but if 'new models' do not deliver better quality care they should be viewed critically, as discussed.

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

Accreditation of undergraduate and postgraduate medical courses, as well as vocational training through the various Colleges is undertaken through the Australian Medical Council. The Australian public has grown to trust the standards of education. It is the history of health care that standards and the educational requirements to achieve them and maintain them are increasing. RANZCO considers that is vital to retain the AMC as an independent accrediting body, rather than 'accreditation committees' appointed by the Board and/or government.

Educational bodies are in the best position to provide advice on educational standards and ensure Australia's health work force continues to be educated according to world's best practice. There is an inherent conflict of interest in establishing a formal link between educational institutions and minimum qualifications required. Regulators must protect patient safety standards and the institutions must ensure a high enough baseline standard so that all qualified professionals in that profession have a demonstrated ability to deliver those expected safety standards as a minimum.

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Assessment of overseas trained practitioners

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

RANZCO has significant concerns around the high use of International Medical Graduates within Australia. Australia and New Zealand rank amongst the highest 'importers' of medical expertise globally. Area of Need posts need to be assessed by the relative professional group before they are declared and approved through various Departments of Health. Often positions are not tenable from the perspective of a surgical practice with regards to operative practice opportunities or after hours (safe-hours) requirements.

Unfortunately, AHPRA continues to fragment and have inconsistent approaches at the management level to requirements of medical practitioners who are coming to Australia to train in supernumerary positions and then return to their home-country. This needs to be either centralised or more consistently handled across the various States. AHPRA function would benefit from clear KPIs and measures.

Governance of the National Scheme

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

Yes. All appointments should be on the basis of merit and should be defensible as such. It is essential for the Chairperson to have experience and familiarity with healthcare models and processes to protect core quality of services for patient safety.

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?

The role of the AMC in accrediting medical training programs throughout the country has served the country well for decades. Such a rigorous system must be insisted upon by all 14 health boards to ensure consistent standards to protect the public.

Since the overarching purpose of the National Scheme is to promote workforce reform and since the flow of changes in scope of practice, amongst the constituent health care professions will be overwhelmingly from orthodox medicine to the other 13 national boards, it can be strongly argued that AMC should have oversight of the accreditation of all 14 boards, not just the MBA.

There must be independent verification that training standards are adhered to by all 14 national boards. This is of particular importance in boards such as physiotherapy, optometry, podiatry and chiropractic treatment, where extended scope of practice will see these paramedical boards seeking to treat patients in whom misadventure/complications has real potential for permanent disability or mortality. Checks and balances are essential to ensure safe and fair application of decisions for accreditation.

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

Unfortunately, the failure of the current system to provide sufficient accrediting oversight has resulted in RANZCO having to take legal action through the Queensland Supreme Court to ensure patient safety. Under the provision of the National Scheme, accrediting authorities (other than the AMC) answer only to their national boards. It is essential that clinical experts with a societal perspective in public safety should have a role in determining expansions in scope of practice.

It is by recognition that the standards required need to be clearly transparent and open to both comment and challenge. A report of the AMC was undertaken in the last two years. However, RANZCO does not believe it has been released as it was an 'internal report'. This methodology should be re-considered so that reports are always available with concerns clearly being addressed.

Enquiries
For any enquiries in regards to this submission, please contact RANZCO Advocacy Officer Ms Suzanne Lyon at 02 9690 1001 or via e-mail slyon@ranzco.edu.

Yours sincerely

Dr David Andrews

RANZCO CEO

The Royal Australian and New Zealand College of Ophthalmologists ACN 000 644 404
94 - 98 Chalmers Street, Surry Hills NSW 2010 Australia
T 61 2 9690 1001 F 61 2 9690 1321 E ranzco@ranzco.edu
ranzco.edu

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7. An ophthalmology trainee undertakes 30 hours of clinical training a week for 48 weeks a year for a total of 5 years before becoming an ophthalmologist. Clinical training hours = (30 hours) x (48 weeks) x (5 years) = 12,000 hours of clinical training. Undergraduate Student = [(12 days of clinical training in the first two years) x 8 hours] + [(50 hours of clinical training) x (18 weeks) x (2 semesters) x (4 years). Undergraduate Student = 7392 hours of clinical training.

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