
AMA Submission: Independent Review of Accreditation within the National Registration and Accreditation (NRAS) Scheme

The AMA welcomes the opportunity to make a submission to this review. The AMA has consistently advocated in the previous reviews of the NRAS for a scheme that supports:

- registration arrangements that enable medical practitioners, who are qualified and safe, to work anywhere in Australia;
- independent accreditation of medical education and training that meets international guidelines;
- medical practice registration standards set by the Medical Board, with clear jurisdiction over all health care provided by medical practitioners; and
- a notification process for the Medical Board to receive, consider and determine concerns about the health, performance or conduct of individual medical practitioners where there is a risk of harm to the public, and which is efficient and affords due process to the medical practitioner under review.

The AMA is satisfied that the NRAS has met the expectations of the medical profession in respect of the first three points above. We continue to work collaboratively with the Medical Board of Australia and the Australian Health Practitioner Regulation Agency (AHPRA) to improve the compliance functions.

Health workforce

Policy setting

Health workforce reform must be developed and managed outside the national scheme.

Health Workforce Australia (HWA) had been established for this purpose and had, over time, put in place structures and processes to ensure that key stakeholders were able to provide meaningful input into this advice.

With the demise of HWA, consideration of expanded scopes of practice has largely been left to State and Territory governments, and the individual health practitioner boards, and these entities do not appear to work collaboratively and constructively on the issue:

- State governments have expanded roles for certain groups e.g. nurse endoscopists, pharmacist vaccinations, and midwifery without any reference to the relevant board to ensure the expanded scope is underpinned by the appropriate training and education; and
- Boards have acted as champions for their practitioner group (rather than protecting the public) by allowing expanded scopes of practice without reference to health ministers.

As such, the NRAS has failed to provide the appropriate mechanism to support the workforce reform agenda by providing a robust forum for scrutinising the need and evidence for, and public debate of, changes to the roles and responsibilities of health professionals.

The AMA seeks that this review recommends an independent authority is established to provide the appropriate advice to Health Ministers on health workforce reform to ensure Australia develops the health workforce it will need. It is not reasonable to ask the regulator to provide this policy advice.

Other professions entering the scheme

The AMA does not support other health practitioner groups, or health care workers, joining the scheme, merely to enjoy a perceived status and credibility of being regulated by the scheme. Any mis-perception by health entities that not being regulated by the National Law “disqualifies” the other health practitioner groups from particular benefits needs to be addressed through information which explains that the scheme deals with the professions that have higher safety risks.

Only those that have a scientific basis to their practice should be included in the scheme.

The National Code of Conduct for the health care workers to be governed by State and Territory health care complaints entities has been finalised and is in the process of being implemented. If there is some concern by governments about the cost of administering the code of conduct mechanism, they 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 also available, namely the consumer protection laws, small claims courts and legal suits.

Health workforce reform – scopes of practice

The scheme has failed to achieve the objective in paragraph 3(2)(a) of the National Law 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.

Further, the AMA is of the view that health practitioner boards are mis-using the objectives in paragraph 4(2)(f) of the National Law, which is for the scheme:

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.

Some boards appear to be applying this objective in the broadest sense, acting as champions of their practitioners and not as protectors of the public, by permitting 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 risks to patients; the impact on training for and care provided by other practitioners; or the costs to the health care system.

The Nursing and Midwifery Board of Australia has proposed to expand its registration standards for endorsement for scheduled medicines to all nurses and midwives working in situations “*where there is a low level of medical, nursing or midwifery supervision, the clinical risk is relatively high and there is a requirement for a high level of complexity in both the assessment and diagnostic processes*”. The Board has not specified the approved training programs for endorsement in these high risk situations.

Pharmacists have secured the right to provide patients with medicines without a prescription from a medical practitioners under ‘medication continuance’ arrangements in the Pharmaceutical Benefits Scheme. As an example of State governments altering practice, the Queensland Health Department funded a trial of community pharmacists administering the influenza vaccine, which has since been expanded to whooping cough and measles, despite the fact that the Pharmacy Board of Australia had not issued a registration standard for endorsement for scheduled medicines or approved any programs of study for vaccination by pharmacists.

Pharmacists have also commenced providing screening and risk assessment services. The AMA argues that pharmacists must limit screening and risk assessment services to those that:

- provide a demonstrated benefit to patients (actually lead to better health care outcomes)
- complement and do not duplicate existing services provided by other health professionals or services (e.g. general practitioners, community-based clinics)
- do not lead to higher out-of-pocket costs for patients or higher costs to the health system as a whole.

For example, it is not effective or cost effective for patients to receive ‘skin spot’ checks at pharmacies where patients self-determine the ‘spots’ to be ‘checked’, pay a fee to the pharmacist, and then must be referred to a general practitioner for a full skin check and treatment, or potential specialist referral. In cases where the self-determined spots are assessed as benign, patients have a false sense of assurance and do not seek a full skin check through their general practitioner.

The Pharmaceutical Society of Australia (PSA) have recently reviewed the *Professional Practice Standards*. The draft standards, which have not been updated since 2010, are commended for their comprehensiveness and for setting a high bar for pharmacist practice.

In addition, the Optometry Board of Australia (OBA) is proposing to remove the list of scheduled medicines (including prescription-only medicines) that is currently attached to the standard, and attach it instead to the *Guidelines for endorsement for use of scheduled medicines*. Changes to the standard must be approved by the Australian Health Workforce Ministerial Council, while changes to the guidelines do not. Moving the list of medicines from the standard to the guidelines would mean the OBA could make changes to the list of medicines without Ministerial approval.

The OBA argues that the current situation is slow, inefficient and causes unnecessarily delays to patient access to new medicines.

The AMA strongly opposes this proposal.

Administrative efficiency should not compromise patient safety. No evidence has been provided to support the claim that patient access to appropriate eye care is been compromised because the list is attached to the standard or that removing the list from the standard will enhance delivery of care.

Finally, the Australasian College of Podiatric Surgeons applied to the Medical Services Advisory Committee (MSAC) for Medicare funding. MSAC was to assess “*the comparative safety and efficacy of the various surgical procedures when performed by a podiatric surgeon as compared to an orthopaedic surgeon*”. This would have required an evaluation of the standards and competencies of surgical training of Australian podiatrists, which is not the remit of MSAC. Only the Australian Medical Council (AMC) is able to evaluate whether the training and education programs that are provided by the Australasian College of Podiatric Surgeons meet the standards set by the AMC for orthopaedic surgeons.

MSAC did not support the claims by the podiatric surgeons, stating:

After considering the strength of the available evidence in relation to the safety, effectiveness and cost-effectiveness of podiatric surgery vs orthopaedic surgery for 39 foot-related MBS items, MSAC did not support public funding for podiatric surgeons to access the items due to uncertainty about:

- *unmet need for podiatric surgeons’ services;*
- *the evidence for podiatric surgeons’ services non-inferiority to orthopaedic surgeons; and*
- *the application’s scope of practice, as identified by PASC and ESC¹.*

The Australian College of Podiatric Surgeons argued that they were comparable to orthopaedic surgeons due to similar training requirements. However MSAC questioned the strength of the evidence behind these claims.

In respect of optometrists, nurses and pharmacists, there has been no assessment that their independent prescribing conforms with the Health Workforce Australia *Health Professionals Prescribing Pathway* (HPPP) or the NPS *Competencies Required to Prescribe Medicines*.

The approaches used by the pharmacists and podiatrists to expand their scope of practice lie completely outside the arrangements in the National Law and are progressing in various fora unchecked by the regulatory protections that the National Law purports to offer the public or the COAG Health Council, which has ultimate oversight of the scheme.

This review offers the opportunity to put in place the appropriate framework to allow a proper and robust cross-profession assessment of proposals for expanded scopes of practice where it can be determined that:

¹ <http://www.msac.gov.au/internet/msac/publishing.nsf/Content/1344-public>

- the required competencies are predetermined and accredited training and education programs are available to deliver those competencies;
- there are documented protocols for collaboration with other health practitioners;
- there are no new safety risks for patients;
- the change to scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession;
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models;
- the training opportunities for other health practitioner groups is not diminished; and
- the cost to the health care system will be lower than the current service offering, taking account of supervision costs.

Australian Health Workforce Ministerial Council approval of the standards and the medicines list is an important safeguard ensuring that there is sufficient scrutiny at the highest level of any changes to scopes of practice, particularly the prescribing of medicine.

Overseas trained medical practitioners

The AMA is satisfied with the current arrangements for the assessment and supervision of overseas trained medical practitioners.

The MBA has a National Specialist Committee for overseas trained medical practitioners. The Committee provides advice and recommendations to the MBA on the nationally consistent assessment pathway for overseas trained specialists. This established process is the most appropriate avenue for monitoring the arrangements and their operation.

The fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities should not be used to cross-subsidise accreditation functions for on-shore programs. This masks the true cost of the accreditation program and is inequitable.

Governance

Accountability of the scheme

The 2014 review into the NRAS noted that there is “neither obligation nor accountability for the operation of the National Scheme as a whole”. The AMA agreed with the reviews finding, but contends that the NRAS should also be accountable to both the Health Ministers *and* the health practitioners who meet the costs of, and whose livelihood is determined by, the scheme.

The AMA seeks that this review determine if AHPRA is sufficiently accountable to the Boards. The Boards can enter into a health profession agreement with AHPRA about the services to be provided to the National Board by AHPRA, fees and the Board’s annual budget.

However, if after making that agreement the Board requires additional services from AHPRA, or wants AHPRA to improve efficiency and productivity, the AMA is not convinced that the Board has that authority.

It appears there are insufficient accountability mechanisms in the National Law in this regard.

The roles of the specialist colleges and post-graduate medical councils

The process for recognition of medical specialties is not the same as recognition of non-medical specialties. For medicine, the AMC accredits education and training programs for medical specialties according to world leading standards. Given that the accreditation bodies for the other health professions are relatively young – most having only been set up at the time the national scheme commenced – they are yet to mature to the extent that they can now determine specialties for their respective practitioner groups.

The desire that the scheme takes a ‘one size fits all’ approach to most issues is not always appropriate. Health Ministers have in the past rejected the recommendations of the Medical Board (recognised by the AMC under long standing processes) for two new pathology specialties, solely on the basis that a process was being developed for the other practitioners.

In this case, bureaucracy has trumped one of the objectives of the scheme – the “*development of a flexible responsive and sustainable workforce*”. Both pathology specialties were developed to meet clinical need – clinical pathologists in regional Australia where there is a workforce shortage and genetic pathologists to ensure standards as genomic medicine enters Australian medical practice.

The AMA contends that the scheme should not be interfering with the long standing arrangements for medicine that have served the Australian community well.

A single accreditation agency

The AMA does not support the option of the creation of a single accreditation agency for the NRAS scheme and it is uncertain how the other option in the discussion paper of expanding the role of the AHPRA’s Agency Management Committee to include policy direction and approval of accreditation standards would operate in practice.

The report has sought to portray this as an issue of governance with expertise bought in as required. For its part, the AMA does not believe that separating governance and expertise is feasible. Health professional groups and individuals have considerable investment in professional autonomy and individuality. National consolidation of accreditation will lead to the homogenisation of the health profession. This in turn may lead to disengagement by professional groups in the provision of the expertise required for appropriate standards setting.

The usual argument for a cross-professions approach is that if professions are educated in a “silos”, they will not work together – the AMA disagrees with that theory. If the professions won’t work together, a change in governance will not alter that.

The health professions have shown that they can work together, despite the many barriers to collaborative teams. In addition, it is the AMA’s view that the profession-specific accreditation bodies are needed to engage the necessary level of expertise and that this expertise will be lost if the professions are denied “ownership”.

Were the review be inclined to support the idea of an over-arching accreditation agency, then the AMA would consider it imperative that the new agency adopt the principles which now guide AMC processes.

Work Ready Graduates and a National examination

The discussion paper also queries the requirements for supervised practice as a precondition of general registration, noting that this applies to some professions and not others.

The AMA notes the extensive COAG Review into Medical Intern Training conducted in 2015. The AMA's position is that the following elements of the intern year should not be fundamentally changed:

- Graduates of AMC-accredited medical schools must continue to gain 'provisional' registration upon graduation and be required to complete an accredited 47-week equivalent internship.
- An accredited internship must continue to be comprised of mandatory accredited terms in medicine, surgery and emergency medical care in an acute care setting. Other non-mandatory terms must also be accredited. There is scope for flexibility on categories of mandatory terms, as detailed below.
- Terms must meet the requirements of the AMC with respect to what constitutes a medical, surgical or emergency medical care term. The AMA does not support using sub-specialty terms inappropriately as core medical/surgical terms as this puts at risk the generalist experience.
- Sufficient options should be available to trainees to allow a vocational emphasis in their training to occur. The opportunity to undertake several related rotations to explore a particular discipline as part of an overall career development plan is appropriate.
- Interns should not be placed in a position where they are not adequately supported by senior medical staff and registrars. While non-medical professionals may be involved in the immediate supervision of some teaching and training activities within their scope of professional and clinical practice, they should not assume the role of term supervisor.
- Competency-based assessments should complement, but not replace, the apprenticeship model of experiential, time-based internship training. It would be inappropriate for a system of progression through training to be based on skill acquisition rather than time served as this would very much undermine the experiential aspects of learning.
- Assessment during internship should be limited to end-of-term assessments consistent with the AMC National Internship Framework.
- A national exit examination is not necessary in the Australian context, and would unnecessarily homogenise the Australian undergraduate medical education system.

The AMA also supports the use of general practice and expanded private and community settings for prevocational terms, subject to meeting relevant accreditation standards. There is general support for greater use of community settings, particularly in general practice, provided that mandatory terms in surgery, medicine and emergency medicine are maintained.

Any changes to the current model of prevocational training in Australia must be incremental and evidence-based. Systems that provide data on the quality and effectiveness of training are essential to drive evidence based improvements to training. This will assist in preparing young doctors for the transition from medical school to vocational training, support innovation in

education and training, and align training with the health care needs of the community. The AMA has recently revised its position statements on prevocational medical education and training and pre internships in medical school. For further information these can be found at:

- <https://ama.com.au/position-statement/prevocational-medical-education-and-training-2011-revised-2017>, and
- <https://ama.com.au/position-statement/pre-internship-medical-school-2017>

Summary

The AMA has consistently called for health workforce reform to be developed and managed outside the national scheme. It is imperative in order to maintain the confidence of the professions regulated under the scheme, that policy development in this space is completely independent of the accreditor and regulator.

The AMA strongly opposes scope creep by other professions and requests the governance and regulations around accreditation support vigorous analysis of any proposed changes to the professions standards. The AMA believes that only those that have a scientific basis to their practice should be included in the scheme.

The AMA is satisfied that the accreditation arrangements under the NRAS have met the broad expectations of the medical profession. The accreditation functions, whilst they appear expensive, are thorough and provide an assurance to educators and students that there is an accepted standard across Australia. A standardised accreditation function across the whole of the scheme is not supported.

The intern year is an important component of prevocational medical education which allows medical graduates to consolidate and apply clinical knowledge while taking increasing responsibility for the safe and high quality patient care. It needs to remain with sufficient oversight by the accrediting agency.

Finally, the governance of the scheme should ensure that AHPRA is sufficiently accountable to the professions that fund it. It is difficult to establish if a suitable amount of accountability mechanisms within the current scheme.

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