Regulating for Results

Review of complexity in the National Registration and Accreditation Scheme

Submission Template

This template is provided to assist in the structuring of responses to the Consultation Paper.

There are 11 Topic Areas, around which we request that Submissions be structured. These are supported by guiding questions that may assist you to structure your input.

You may also wish to provide a cover note highlighting key issues – if you do so, please ensure this is no more than 2 pages.

If you wish to attach additional supporting material please do so, but please indicate in the body of your response what is attached.

You need only address those Topics on which you wish to comment. There is no expectation that all submissions address all Topics, although you are of course welcome to do so.

NAME OF ORGANISATION / INDIVIDUAL: Australasian Sonographers Association

CONTACT INFORMATION

Name: Elissa Campbell

Position (if on behalf of organisation): Advocacy and Policy Manager

Email: elissa.campbell@sonographers.org

TOPIC 1: Evidence and Issues

Guiding Questions

Are there any aspects of the information provided on the issues and challenges discussed in section 2 of the Consultation Paper that you wish to comment on or add to?

As a general comment, the ASA considers that much more information is needed about Tier 2 and the proposed co-regulatory pathway under Concept 3. For instance, how co-regulated professions might be ranked or categorised based on their risk profile/needs, and how their risk profile and unique challenges might be resolved.

More information is also needed about the further levels of suggested and supported intervention within Tier 2 as well as the assessment process for new professions and actual costs of statutory regulation – whether co-regulatory or AHPRA registered - of a new profession.

The ASA also notes that there is some confusion about terminology between “registered” and “regulated” practitioners. In Australia, health professionals registered with AHPRA are referred to as “registered health practitioners” under the National Law.

However, members have given feedback that they view a "registered practitioner" as one who voluntarily chooses to be registered with a professional body as an act of good will whereas a "regulated practitioner" is one where health practitioners must comply to statutory standards.

In the UK, statutory regulation refers to health professions that must be registered with a professional regulatory body by law. This group is referred to as regulated health professionals. The titles used by regulated professionals are also legally protected. It is an offence for an individual to describe themselves as, or hold themselves out to be a regulated healthcare professional without holding the appropriate registration with the relevant regulator.

By contrast, there is also a group of health professionals, including sonographers who can choose to register with a voluntary register accredited by the Professional Standards Authority. This group is referred to as registered health professionals.

We note that if the co-regulatory model under Concept 3 is introduced as proposed, it will involve health professionals being part of a voluntary register with the professional authority accredited by AHPRA. In the ASA's view, this will lead to a lot of confusion on the part of practitioners and patients about who is a "registered health professional" and who is a "regulated health professional" and what this actually means.

TOPIC 8: Coherent and Effective Complaints handling - Simplifying structures and processes.

Guiding questions

1. **Do you think it is necessary to simplify complaints handling?**

Yes. As noted in the Consultation Paper, the National Scheme will be ultimately judged by its ability to manage the concerns of consumers in a timely and appropriate manner as well as ensuring that there is fairness and transparency for practitioners throughout the complaints process.

Ideally complaints made by patients against health practitioners should be handled in a consistent manner, regardless of the profession, setting, or jurisdiction. This includes the complaint process from end to end as well as the outcomes, possible penalties or implications for practitioners and communication of outcomes to the public.

Ideally any public record of outcomes should be on an easy to find single register that covers all Australian jurisdictions and all registered and self-regulated health professions.

Knowing that all health practitioners are held to the same or equivalent high standards, and that the consequences for failing to meet that standard are the same is imperative if the public is expected to have any genuine faith in a national approach that protects patient safety.

However, this is far from the current reality. Different states and territories operate different kinds of complaints systems with different powers and approaches. After nearly 10 years since its introduction, the National Code of Conduct for Health Care Workers has still not been fully implemented and there is still no national register of complaints or prohibition orders - something that has been promised for some time.

Another source of frustration for consumers in terms of complaint schemes is that they have difficulty working out where to make a complaint and become frustrated when they have ended up in the wrong place to have their issue resolved. It is also clear that the purpose and scope of AHPRA and the Health Complaints Entities (HCEs) are not well understood by consumers in the sense of what kinds of complaints each body covers or the kinds of resolutions and sanctions they have the power to apply against health practitioners to help them resolve their complaint.

This is feedback that the ASA commonly receives when a patient has contacted the ASA to make a complaint about a sonographer. As the ASA does not have the power or processes to receive or investigate complaints against sonographer members, we aim to give guidance to the patient about who best to contact but the appropriate forum depends on whether or not the sonographer is registered with AHPRA, where the sonographer is located and the kind of outcome the patient is seeking.

2. Do you support a single front door for lodging complaints within each State and Territory Health Complaints Entities?

Yes. Centralising information about the conduct of health professionals, both in terms of what standards they are required to meet, a clear 'front door' for complaints, and meaningful, consistent treatment of misconduct across health professions is essential.

Transparent public reporting about complaints outcomes would send a strong signal to the public that quality and safety of care is genuinely the number one priority for all health regulation.

The point of entry for complaints against health practitioners should be straightforward and nationally understood. Across the entire health system, it may not be necessary or appropriate that all complaints are received or handled by the same body, but the point of entry should be clear and unambiguous regardless of which health profession is involved.

A single point of entry for complaints would also recognise that patients often do not distinguish between health practitioners easily in a clinical setting, often mistaking age for seniority, and uniforms for job titles. Many are also unlikely to understand whether or how the clinicians they interact with are regulated nor who does it, nor does this question have much relevance to them. Their key concern is whether they can trust the person examining or advising them to do their job properly, and if something goes wrong, that there is a reliable and purpose-built process set up to deal with it.

The division that has emerged in Australia between registered and self-regulating health professions has multiple confusing consequences for patients that vary depending on the profession and location.

A particular anomaly of regulation exists in sonography which makes complaints handling consistency almost impossible, without moving sonography into the National Scheme. It is incongruous that a sonographer who performs ultrasounds who entered the profession via a medical radiation pathway (which is about 30% of sonographers) has by virtue of their radiographer qualification only, mandatory registration to a board (MRTB), is answerable to that board under AHPRA, has their recency of practice and criminal history checked regularly and can be performance managed following complaints, or even deregistered.

By contrast, 70% of sonographers have no such requirements, other than needing to be registered with the Australian Sonography Accreditation Register (ASAR) if they want to perform Medicare rebated examinations. ASAR can only deregister a sonographer if their qualifications are not up to date. While formal complaints through HCEs are possible, and this can lead to deregistration, that is reliant on action by a patient, and only actionable by reference to the Code of Conduct, not important measures such as whether the practitioner is actually working appropriately within their scope of practice, maintaining their skills through regular and recent practice, or even whether they have any criminal convictions Having two parallel and inequivalent definitions and regulatory systems for a single profession has multiple consequences. Unclear and unequal complaints handling and quality and safety standards is a major one.

More broadly, given the goal of consistency between the HCEs in different states and territories, it would seem logical to streamline the front end.

3. **Do you have suggestions about what would be required to make this single front door model of complaints handling work?**

It would make sense for all complaints to go through a single entry point that helps a complainant relay and document the complaint in a useful way, which would then need to be assessed to determine how the complaint should be handled.

Ideally complaints would be treated as an opportunity for either quick action (where there are serious misconduct or unsafe practices) or thoughtful intervention to ensure the patient is heard and compensated as appropriate, and that the organisation or individual professional is given an opportunity to improve their practice through formal requirements. Failure to do so should have real consequences, such as notifications and cancellation of registration.

If registration is voluntary as proposed in Tier 2, the threat of this action may simply push underperforming practitioners into other sectors, possibly into corners of the health system that are less visible, which may mean working with more vulnerable people. This does not seem like a good outcome, so the voluntary aspect of any proposal needs to be assessed thoroughly.

An important factor in the receipt, triaging and referral of complaints will be the nature of the complaint, and the patients understanding about who they are complaining about. This should be handled delicately as patients are often complaining about sensitive matters, and may not have a huge understanding of the health system, or may simply not be able to remember details immediately due to the confronting nature of the complaint. They should be offered assistance in understanding what happened, what professional was involved, and they may also need language services or other supports. Navigating the health system from the outside can be confronting and intimidating, especially when raising complaints of an intimate nature. This needs to be reflected in the approach to patients, through the language used, and the design of interfaces that they interact with.

4. **Do you see risks in a single front door approach and if so, what are those risks?**

A major risk resulting from a broad one size fits all approach to complaints handling is the risk that nuances of each profession and practice, and failure to capture knowledge of circumstances, technicalities or practices which a specialist board (or equivalent) would be better placed to handle. Key here will be engaging with the relevant professional bodies and seeking the expertise of the relevant health profession as appropriate.

This kind of arrangement may also mean missed opportunities for the sector to learn about emerging poor practices or patient issues. Good communication channels about these issues between HCEs and the sector would need to be arranged to ensure the system continues to improve.

Another key challenge is how this system would work in practice – it would require another layer of cooperation and parallel implementation of a consistent process across entities that are at various stages of implementation and are already under-resourced in terms of staff and money.

The Victorian Health Complaints Commission currently has a notice on its webpage that there will be “significant delays” in the processing of complaints. While we acknowledge the need to inform the general public that there are current issues with progressing complaints, it seems more likely to put people off actually making the complaint in the first place – which is not a good outcome for anyone.

5. Do you have a view on how joint decisions would be made between the health complaints entity and AHPRA about those complaints that should be referred to AHPRA as a Professional Standards breach?

The ASA envisages that a joint decision between a HCE and AHPRA about how to handle complaints would be based on guidelines developed through sector consultation and partnership with each profession.

Once developed, a potential professional standards breach would be reviewed against those guidelines and the code of conduct and scope of practice for that profession.

Consideration would also need to be given to the appropriate consequence for the professional standards breach. We consider that HCEs would respond to less complex matters and where the outcome/consequence sought involves, for instance, requiring the practitioner to undertake and reflect on a particular area of learning.

AHPRA – as is the case now – would investigate and respond to complaints about more serious matters of professional or ethical conduct.

Regardless of how joint complaints are managed, it is essential that whatever body responds to notifications or complaints has the necessary power to deal with them, and that these powers are consistent across health professions so as to deliver consistent outcomes for patients and practitioners.

Ideally the system will also aim to offer a pathway to enable practitioners of concern to be identified and engaged with earlier in their career rather than waiting for a complaint to be lodged.

Our anecdotal experience with patient complaints is that the vast majority relate to poor communication between practitioner and patient – it may be that the practitioner or the practice has not adequately communicated what happens during a particular procedure so that the patient was aware of what to expect and/or there is misunderstanding about other aspect of the clinical service that has been delivered such as cost.

TOPIC 10: Scope and Expansion of the National Scheme

Guiding Questions

1. **Do you think the current two staged assessment process is appropriate for considering adding professions to the National Scheme and if not, what changes would you recommend?**

   The ASA supports the idea of a rigorous, transparent assessment for health professions to join the National Scheme with the health and safety of the public being the overriding consideration.

   The Consultation Paper states that the process for entry to the National Scheme reflects well established principles and disciplines for assessing the impact and benefits of regulation to inform decision making.

   It also notes that there is some evidence that many allied health professions with a significant risk profile are outside of the National Scheme and believe that they should be included. The examples of social workers, naturopaths and audiologists are listed.

   For over a decade, the ASA has been advocating for sonographers to be regulated under AHPRA in the interests of patient health and safety. In 2023, a sector Working Group for Sonographer Regulation put together a detailed case submission, responding to the criteria for new professions to join AHPRA and setting out evidence of the need for change. Further information can be found here.

   This detailed submission outlined that as there is no national regulation of sonographers:

   - patients' health and safety are at risk. Where a sonographer fails to produce quality images or identify pathologies, there are currently no enforceable standards of practice to measure the quality of ultrasound examinations provided by Australian sonographers.
   - other patient safety and quality controls, such as the recency of practice requirements, do not currently exist for sonographers.
   - complaints handling for sonographers is fragmented and ineffectual. There is a growing list of situations where complaints are raised against a sonographer, the complaint is insufficiently investigated, and the situation becomes a criminal prosecution to be resolved.

   The submission concluded that the most effective and practical solution was for sonographers to be regulated under AHPRA, through the Medical Radiation Practice Board of Australia (MRPBA), where the other diagnostic imaging professions are already regulated.

   In particular, there is an ongoing lack of consistency between the sonographers who fall under AHPRA due to their dual qualifications as radiographers and sonographers (30% of the profession) and most who are qualified as sonographers only and who do not fall under AHPRA (70% of the profession).

   As highlighted by the recent Scope of Practice Review, whether health practitioners are registered with AHPRA or not has very significant outcomes and impacts on their ability to work to their full scope of practice and potential in Australia. In practice, this means that sonographers who are not registered with AHPRA and who have the same skills and experience as their AHPRA registered colleagues - which again is 70% of the profession – are significantly inhibited in their day to day clinical work.

Outside of the health regulatory space, there are also wider impacts and implications in terms of professional recognition and equality of access to opportunities that attach to the fact of registration but are not related to the National Scheme's purpose.

In the ASA's view, understanding the best regulatory response for a profession must go beyond applying rigid parameters set by the current assessment of what is and is not appropriate to constitute an AHPRA registered profession. Definitions of risks and benefits used to assess suitability for inclusion must be kept broad to understand the workforce context and challenges faced by each particular profession to ensure that decisions are made which are future-focused and do not default to the status quo.

If there is evidence that non-registered professions do not make use of or fully understand the suitability and extent of self-regulation mechanisms available, this review is a good opportunity to explore and articulate them, as this will be critical to designing and implementing any new model and deciding which professions sit where in the tiered system, and what kinds of mechanisms are appropriate.

2. Do you have a view as to whether an additional pathway into the National Scheme based on the United Kingdom Accredited Voluntary Register Model would be a useful reform?

The ASA notes that similarities already exist between the UK and Australian model which suggests that something similar could be implemented here.

The title of 'sonographer' is not protected under statute in either country – meaning that anyone could theoretically call themselves a sonographer.

The majority of people who perform ultrasounds for a living are statutorily registered in the UK with the Health and Care Professions Council (HCPC) as clinical scientists, radiographers or nurses, much like in Australia where nurses and radiographers are registered with AHPRA. The only real difference is that in Australia AHPRA reports directly to the government whereas the HCPC report to the Professional Standards Authority for Health and Social Care who then report to government.

In the UK, there are also over 3000 sonographers who are 'unregulated', which is almost exclusively due to their professional background and the only register available to them is the Register of Clinical Technologists. This is similar to Australia in that ultrasound practitioners who are not covered by AHPRA fall under the National Code of Conduct for Healthcare Workers.

3. Do you see any risks and challenges with an additional pathway into the national Scheme via an Accredited Register Model?

There are several risks and challenges with an Accredited Register model.

Firstly, a voluntary register presumably will always be first and foremost voluntary. Therefore, it cannot be used as a mechanism for behaviour change, or as a guarantee of compliance.

What does "voluntary" here actually mean? Is it truly voluntary? Or meant in the sense that a health professional would not be eligible to access government funded benefits such as Medicare if they are on the register?

This proposal is also likely to reinforce the difference in perceived status between “registered professions” and “the rest”. COAG issued a 2018 communique to highlight that the status of a health profession’s registration was no reflection on its ability to deliver high quality health services. It is difficult to see how a “voluntary” register would change that perception.

Secondly, a voluntary register (however defined) carries the risk that those who do not practice to a sufficient high standard and wish to fly under the radar can continue to do so, and simply not register. Unless enforced by employers (which may happen in some cases) or persuaded by some other mechanism (such as the incentive of Medicare rebates for sonographers), this is not an ideal or reassuring solution for patients, who should be able to rely on our health system to ensure that people performing ultrasound exams are all equally responsible and accountable for their conduct.

An accredited register model may be a suitable transitional state for sonographers, which we still consider are most appropriately regulated under the existing MRTB, if it provides a genuine pathway toward this end. Without any changes to the way inclusion is assessed however, including recognition of the dual-nature of sonography regulation, and broader consideration of other challenges faced by self-regulated health professions, or support to facilitate transition, it is not clear how this model will make any material difference or improvement for sonographers in practice, given it does not promise to protect title, or enforce professional standards beyond the code of conduct. It is also arguable that adding a new layer of temporary administrative requirements and costs for a sector that already has workforce shortages and barriers to entry is not the best use of resources, and that instead the complexity review could consider that inclusion of sonographers in the NRAS would actually make the overall health system less complex.

It is difficult for stakeholders to give informed feedback without some idea of costs. As noted in the Consultation Paper, this is something that needs further consideration. What would a “sample health profession” undertaking a voluntary register scheme approach need to take into account under this proposal? What would it mean for the practitioners involved and any health professional associations?

It is also important to provide a comparison between different regulatory options. What are the costs of a profession being registered under AHPRA? This is often cited as a barrier or disincentive for additional professions joining the National Scheme in addition to any risk profile or other related issues. The ASA would strongly support further information on this front so we and other sector stakeholders can have further informed discussions about the proposals in the Consultation Paper.

4. Do you have a view about the importance of the National Code of Conduct for non-registered practitioners in the broader regulatory framework?

The ASA considers that the National Code of Conduct and its negative licensing approach provides a good baseline. It helps to ensure that – for most health professions - patients have a standard against which to measure health practitioner behaviour and that patients have a complaint mechanism which to use.

However, in practice, the inconsistent approaches as to how the Code is implemented and the extent of its application undermines its effectiveness.

5. **Do you see a need for additional focus on implementation of the National Code of Conduct for non-registered practitioners and if so, what would that involve**?

   Yes, there needs to be additional focus on the implementation of the National Code of Conduct national public register of disciplinary action. In the ASA's view, it should include consistent information for all practitioners in all jurisdictions, including alternate names of the practitioner. We also recommend a FAQ with descriptions of what each health profession does as this is not always clear to a patient. The public register should also be available in the same place, without navigating to multiple websites.

6. **Should there be a regular cycle of review of the professions in the National Scheme or is the flexibility for professions to bring forward proposals at any time preferable?**

   Yes, the ASA considers that there should be both.

   Regular and continual improvement is vital to ensure that the context in which people work, and are treated, are considered.

   Currently issues such as workforce shortages, ageing population and increasing demand for services as well as technological change are changing the nature of health work itself. Scopes of practice are being tested, and public expectations are changing too. It is imperative that the health system and its institutions and processes are as responsive and flexible to change as possible and that they can adapt to address the demands or barriers faced by specific professions.

   Given the centrality of the National Scheme to health professions and the structure of the Australian health system, this has the potential to address some of the systematic flaws and inefficiencies that exist in the current system and deliver some considerable cost savings and benefits to government and the public, ultimately ensuring public health and safety.

7. **Do you think that there should be any avenue or process for considering removing a profession from the National Scheme (e.g. if evidence shows that there are very few complaints, the costs of registration outweigh the benefits, or it is established that alternative registration methods are adequate to protect the public).**

   The ASA considers that all professions in the National Scheme should be there for the appropriate reason – advancing public health and safety.

   At present, there appears to be an arbitrary line between those professions are registered and those that are not. Entry of professions into the AHPRA system has been driven by public health safety concerns, the perceived risk associated with each profession, whether historically those professions were regulated under statute as compared to reliable ongoing assessment of their day to day work, based on both risks and benefits.

TOPIC 11: Possible Reform Concepts

3. Do you have any other comments or suggestions in relation to Reform Concept 3 (A fully integrated 3- tier model of health practitioner regulation))

As outlined above, ASA has advocated for AHPRA registration for the sonography profession for many years.

In the absence of this, the ASA welcomes the opportunity to explore other kinds of regulatory models for sonography and is supportive in principle of initiatives that align the regulatory structures for registered and non-registered health professions as well give greater recognition to self-regulating health professions.

In ASA's view, a co-regulatory model should have the following features as a minimum:

- Legislative title protection for the health profession – making it illegal for any non-certified practitioner to identify themselves as a member of that profession or to use a similar title with the intention of misrepresenting themselves as a member of that profession.
- Title recognition by other regulators or funders, ensuring that self-regulated health professions are afforded equivalent recognition as their AHPRA registered colleagues when applying requirements for registration or recognition by other schemes.
- All practitioners within a given profession are required to be certified, regardless of the setting or funding stream in which they are practising
- Self-regulating activities, including certifications of practitioners and other associated regulatory functions are carried out by certifying entities
- Certifying entities are recognised by and protected in legislation and are the peak professional membership body for the profession.
- All certifying entities to collect workforce data and this workforce data is for all health professions, not just the AHPRA registered ones.

On this basis, the ASA has several concerns and questions with the proposed model outlined in Concept 3:

- Tier Model: Concept 3 proposes a 3 tier system to classify professions in a hierarchy of regulatory intervention based on risk. The definitions and criteria that sit under any risk and intervention continuum will have practical implications in terms of deciding which profession sits in what tier. While a tier system model is useful in having something to comment on, for the purposes of this Consultation Paper, it suggests a hierarchy of AHPRA professions at the top of the tier and the professions lower down, leading to inevitable comparisons about the level and quality of health professions in each tier and who is in the "top tier" and who is not. We suggest revising this concept as this kind of comparison between health professions is already a significant problem in terms of legislative and structural barriers and differing perceptions between the quality standards underlying the "registered" versus the "unregistered" health professions. The proposed 3-tier model kind would only reinforce this comparison and the resulting problems.

- Tier 2: It is unclear which health professions fall into Tier 2. The ASA considers that sonographer would at a minimum be viewed at the higher end of the risk/regulation intensity profile and, therefore, fall into Tier 2. This is due to the highly skilled nature of the work, the heavy reliance on ultrasounds for diagnosis across the health system and the intimate clinical procedures that ultrasound procedures may involve. However, much more information is needed to determine what would be the implications of being in Tier 2, including the potential costs of setting up a register, how it would be managed, the impact on professional association members and so on.

  If Tier 2 is reformed to be consistent with our recommended model and in particular has statutory protection of title, this would pave the way for health professions to gather evidence to build the case for them to progress to Tier 1 – AHPRA registered professions as well as potentially demonstrate that the co-regulatory model is appropriate for certain health professions.

The ASA notes that based on the current regulatory structures, one third of the profession is already considered of sufficient risk profile to be regulated by AHPRA. We consider that since medical radiation practice came under the AHPRA system in 2012, the risk profile of the sonography profession has increased given that ultrasound procedures are the highest utilised diagnostic imaging modality in Australia and frequently involve intimate examinations. In the ASA's view, these are crucial aspects reinforcing the need for the sonography profession to be appropriately and consistently regulated

At the same time, the ASA also recognises the point that the system of boards and committees that currently exist in the National Scheme is costly and complex, and indefinite expansion may be unsustainable. However, significant reform of that system will take some time. In the interim, is important that regulation between similar professions and within the same professions is consistent. Essentially, medical imaging professionals should be regulated in the same way, and held to the same level of account as other specialised clinical professionals, especially when their work - if done poorly - can lead to enormous delays, costs and health implications from misdiagnosis or missed diagnosis.

We also consider that that a broad view of 'risk' must be applied so that the full suite of risks and positive policy outcomes for patients and the wider health sector are taken into consideration in assessment for inclusion of sonographers in the National Scheme. This requires the process to more streamlined, and we hope that the papers mention of 'clearer processes' can lead also to improved flexibility in this regard, facilitated by a genuine pathway with support from AHPRA.

- Costs: Crucial to the success of the model is further information about costs. What would the specific costs be and who would pay them? A user pays model is a commonly accepted one for health registration both in Australia and New Zealand.

4. Do you wish to put forward any reform concepts for consideration – if so please attach detail

As outlined at Q3, if the co-regulatory model were to be introduced, the ASA would advocate for registration to be made mandatory and accompanied by legislative backing, including protection of title.

Regardless of what co-regulation model is proposed for health professions not registered with AHPRA, sector challenges must be addressed. The existing split within the sonography profession – with some individuals being held to the AHPRA standards due to their dual radiographer/sonographer qualifications – and others being held to another inconsistent set of standards continues to cause tension, complexity and confusion for both practitioners and patients on an ongoing basis.