

***Health Consumers  
Queensland ... your voice in health***

**Health Consumers Queensland Response To  
National Registration and Accreditation Scheme 2012, Project  
Team's Paper on the  
Size and Composition of National Boards for the 2012 Health  
Professions and  
Accreditation Arrangements for the 2012 Health Professions**

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## ABOUT HEALTH CONSUMERS QUEENSLAND (HCQ)

HCQ comprises a 12-member Ministerial Consumer Advisory Committee (Committee) and a Secretariat supported by the Office of the Director-General, Queensland Health. The Committee is comprised of a mix of health consumers from a broad range of health populations and social groupings.

HCQ's Terms of Reference and Mission are to support the voices of Queensland consumers to achieve better health outcomes. HCQ contributes to the continued development and reform of health systems and services in Queensland, by providing the Deputy Premier and Minister for Health with information and advice from a consumer perspective, and by supporting and promoting consumer engagement and advocacy. HCQ aims to strengthen the consumer (patient) perspective in health policy development and system reform and improvement.

As part of its role in contributing to national health reform, HCQ has had ongoing involvement in the National Registration and Accreditation Scheme (NRAS) for health professionals, and provided feedback in relation to the:

- NRAS Proposed Registration Arrangements consultation paper: October 2008
- NRAS Proposed arrangements for handling complaints and dealing with performance, health and conduct matters: November 2008
- Exposure Draft of the *Health Practitioner Regulation National Law 2009*: July 2009

## ABOUT HCQ'S SUBMISSION

In line with our priority area of quality and safety, HCQ has developed this paper in response to the information papers on 'Size and Composition of National Boards for the 2012 Health Professions' and 'Accreditation Arrangements for the 2012 Health Professions' issued by the NRAS 2012, Project Team [NRAS2012]. Feedback was garnered from HCQ Committee Members, as well as HCQ's state-wide network of health consumers.

It is intended that this paper provide direct feedback to NRAS2012 on the information paper and inform Queensland health consumers and other stakeholders on HCQ's position on these matters.

## KEY COMMENTS

Overall, HCQ strongly supports the progressive implementation of a national registration and accreditation framework for health practitioners.

HCQ believes the implementation of a national framework offers an excellent opportunity to deliver standardised ongoing, safe and quality health services to all Australian health consumers. According to the *Australian Charter of Healthcare Rights*, people who use the Australian health system have a right to receive safe and high quality care, to comment on their care and have their concerns addressed.

HCQ supports the inclusion of four further health professional groups under NRAS. It also supports the overall size and composition of the national boards with the exception of the Aboriginal and Torres Strait Islander health practice board (to be discussed in the following sections).

In line with the eight consumer engagement principles in the Consumer Engagement Framework (Attachment 1), HCQ reinforces its preference that at least one of the community members on the four national boards be a health consumer, given consumers' unique ability to provide invaluable insights, feedback and advice in relation to health practitioner matters.

From a health consumer perspective, the new boards need to facilitate timely outcomes in a cost effective manner, be user friendly around consumer issues and be transparent and accountable to the broader community in relation to their work. HCQ supports a structure which delivers on these principles.

HCQ notes that there are still a number of health care professions not captured within NRAS. HCQ acknowledges that there is current work being undertaken to incorporate unregistered practitioners and is supportive of this work.

## **NATIONAL BOARDS - SIZE AND COMPOSITION**

Overall, HCQ supports the size and composition of the national boards with the exception of the Aboriginal and Torres Strait Islander health practice board. Feedback to HCQ indicates that the size and composition for the four national boards should be determined keeping in mind the specific attributes of each of the professions. The size and composition of the national boards needs to take into account the specific subcategories of the relevant profession.

HCQ reinforces its preference that the three community members on the four national boards include a specific consumer member. Given the main functions of the national boards includes developing standards, codes and guidelines which impact on the nature and quality of services received by health consumers, it is important that consumers are proactively engaged in their development. A consumer member would promote effective consumer engagement on processes around these matters.

Feedback to HCQ indicates that the proposed size and composition of three of the boards (Chinese medicine, Medical radiation practice and Occupational therapy) should allow them to effectively undertake their work. HCQ notes that NRAS is a self funded scheme. However, HCQ stresses that the final board size decided upon should not pass any additional costs to consumers via an increase in practitioner fees to meet the overall costs associated with operating the national boards.

### **Aboriginal and Torres Strait Islander health practice**

HCQ commends the decision to include Aboriginal and Torres Strait Islander Health Workers as a regulated profession under the 2012 proposal. However, we note that the expected size of the professional workforce to be covered is less than 1,000, making this the smallest workforce to be regulated under the national scheme. HCQ perceives that there is a possibility that increase in registration fees might deter some health practitioners away from this profession. A sustainable nationally regulated model with such a small professional workforce is likely to be questionable.

The financial implications of being regulated under NRAS appear to be significant for this developing profession. However, HCQ does note that NRAS also has the potential benefits of standardising qualifications. As such, HCQ proposes that the government consider proactive strategies to reduce the gap and explore additional funding options that may be required to meet the costs of having an operational national board.

In addition to the above, HCQ is asking that the national board for this group have a mandatory jurisdictional representative from Northern Territory. To date, this is the only jurisdiction in Australia that has registration requirements for this profession a representative from the Northern Territory would bring to the table the lessons learnt while working under a regulative framework.

HCQ also asks that the proposed standard composition be reconsidered. The standard composition requirement of having 'at least one practitioner member from each large participating jurisdiction (NSW, Qld, Vic, WA and SA)' be amended to reflect jurisdictions with large indigenous population.

The standard composition of having 'at least one member from regional or rural area' should also be amended to include remote areas. Many of the Aboriginal and Torres Strait Islander communities are established in remote areas which cannot be classified as either regional or rural.

### **Suitable mix of practitioner members**

HCQ would consider a suitable mix of practitioner members for the Chinese Medicine and Medical Radiation boards to be similar to the Dental and Nursing boards. Such a composition would enable an equal spread across the three distinct scopes of practice.

The boards should also have consumer and community representation.

## **ACCREDITATION**

HCQ reinforces that members to accreditation authorities and the national boards should have:

1. relevant governance experience;
2. developed competency in clinical policies and oversight; and
3. have association/membership to the professional colleges in Australia.

With regards to health practitioners who are members on the Chinese Medicine boards, some feedback has indicated the value of having a board member with experience in general medical practice and Chinese therapies. It would be useful to have such a membership given the number of General Practitioners who also undertake acupuncture and other herbal related therapies.

## **CONCLUSION**

HCQ reinforces that consumer representation should be included in the community membership of the four national boards.

The size and suitable mix for the four further national boards should be determined keeping in mind the specific attributes of each of the professions. HCQ acknowledges that NRAS is a self funded scheme. However, HCQ would not endorse the likely transfer of increased cost onto consumers.

With regards to the Aboriginal and Torres Strait Islander national registration, HCQ proposes that the government consider funding options to support this developing profession.

HCQ will continue to monitor and engage with the process of consultation of the implementation of NRAS by providing the consumer perspective on the issues that affect Queensland health consumers.

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Extract from Health Consumers Queensland's Consumer Engagement Framework, June 2010

### The principles

*When people are involved in making the decisions which affect their lives, their self esteem and self confidence rise, in turn improving their health and wellbeing.<sup>1</sup>*

The following principles provide the foundation for health consumers, individually or collectively to be involved and have a say in their healthcare and the health system, and for health practitioners and agencies to engage consumers in a meaningful and respectful way.

The eight principles reflect and support international and national health charters and principles which reinforce the importance of health consumers in the development, implementation and review of the health services they receive.

The 1978 World Health Organisation's *Declaration of Alma Ata* and the 1986 Ottawa Charter for Health Promotion identified that health practices require the involvement of consumers and communities in health-related initiatives. This right of civic participation is also enshrined in international human rights instruments, like the International Covenant on Economic, Social and Cultural Rights. Australia is a signatory to these documents.

### Principle

1	Consumer participation	Consumers have the right to engage, be engaged and participate
2	Consumers are the central focus	Consumers are central to the engagement process
3	Consumer potential	Consumers have the potential to engage with the health system
4	Consumer choice	Consumers choose how they participate in the engagement process
5	Support to consumers	Consumers are supported to engage with the healthcare system
6	Shared responsibility	Consumer engagement processes involve participants working together in an open way, and sharing ownership and responsibility for outcomes
7	Mutual respect and value	Consumer engagement involves participants showing mutual respect and valuing each other's contributions
8	Diversity	Consumer engagement processes recognise and support diversity

Nationally, the Australian Charter of Healthcare Rights, launched by the Deputy Premier on 17 March 2010 in Queensland, and currently being implemented across public and private health services in Queensland, strongly reinforces the right of health consumers to be heard and included in decisions and choices about their individual healthcare and in local, regional, state and national health initiatives. The Design and Governance Principles which are contained in the National Health and Hospitals Reform Commission Report, *A Healthier Future For All Australians: Final Report June 2009* also recognise the importance of seeking input and involving the community and the people who use health services, in the development and delivery of their healthcare and the health system.

1. Campbell, F., Hughes, L. and Gilling, T. (2008). *Reaching out: Community engagement and health*. London, UK: Improvement and Development Agency.