Royal Australasian
College of Surgeons

250–290 Spring Street
East Melbourne VIC 3002 Australia
Telephone +61 3 9249 1200
www.surgeons.org
ABN 29 004 167 766

2.07.25

Sue Dawson
Independent Review of the Complexity in the
National Registration and Accreditation Scheme
Department of Health and Aged Care
Email: NRASComplexityReview@health.gov.au

Dear Sue

Re: Consultation Paper 2 – Consultation Outcomes and Reform Directions: Review of Complexity in the National Registration and Accreditation Scheme (NRAS)
Review of Complexity in the National Registration and Accreditation Scheme

The Royal Australasian College of Surgeons (RACS) welcomes the opportunity to review and provide this submission on Consultation Paper 2: Consultation Outcomes and Reform Directions for the Independent Review of Complexity in the National and Accreditation Scheme (NRAS) – (The Review).

RACS is supportive of reforming the National Registration and Accreditation Scheme (NRAS) where it enhances patient safety and clinical standards, and supports profession-led governance. RACS is opposed to reforming NRAS to accommodate workforce flexibility or bureaucratic efficiency in a way that compromises patient safety or clinical standards.

Background

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism, and education in Australia and Aotearoa New Zealand. It represents close to 8,000 surgeons and 1,300 surgical trainees and Specialist International Medical Graduates (SIMGs). As a not-for-profit organization, RACS funds surgical research, advocating for members and patients, supports healthcare, as well as provide surgical education in the Indo-Pacific. The College trains surgeons in nine main specialties: Cardiothoracic, General, Neurosurgery, Orthopaedic, Otolaryngology Head and Neck, Paediatric, Plastic and Reconstructive, Urology, and Vascular surgery.

Executive Summary

Regulation must be designed for patient safety, not for efficiency. RACS will not support any changes to the NRAS system of regulation that compromises the public's protection with respect to safe, competent, and ethical care, and focuses instead on workforce at the system level. We believe regulation should always be patient safety focused, and not be compromised at the expense of workforce flexibility, bureaucracy, or convenience in regulation systems.

While the Consultation Paper attempts to address genuine complexity in NRAS, from a surgical and regulatory stewardship perspective, the tone and framing of many of the proposals are perceived as confrontational, unduly

technocratic, or dismissive of the central role of specialist medical colleges such as RACS. In particular, the assumption that colleges are monopolistic gatekeepers disregards the wide and independent governance, peer-reviewed examinations, and service-driven mission of RACS. The profession is not immune to reform, but this must be achieved through true partnership, rather than through unilateral action.

RACS Response by Reform Theme

Reform 01: Regulatory Stewardship Model

There is a difference between regulation and workforce policy. Ahpra's extension of its regulatory role into strategy, and workforce planning, represents an unjustifiable regulatory function. Workforce strategies, health system design, and planning responsibilities belong to the government and are the responsibility of clinical professionals like RACS to ensure patient safety, practitioner competence, level of supervision and scope of practice and not the responsibility of a regulatory body. RACS supports a strict distinction between a regulatory function and a workforce policy.

RACS is pleased to welcome this reform in principle. In relation to the *Strategy Assembly* (Action 1.3), we have concerns about the exclusion of colleges as major stakeholders in 1.3 risks perpetuating the very divide the review aims to bridge.

RACS has the view that the government should be formally sharing workforce data with specialist medical colleges as these institutes serve as trainee educators, modelling good clinical practice, maintaining standards, ensuring adequate supervision and contributing to medical curriculum. This would increase the rapport between government and specialist colleges contributing to the expansion of highly skilled workforce in the required locations and specialties, in line with the Australian Government's National Medical Workforce Strategy 2021–2031.[1] The inequities within the health system such as maldistribution of medical specialists and specialised healthcare services access disparities in rural and regional contexts, could be addressed more effectively when regulators and medical colleges collaborate. RACS recognises the vital importance of the rural training experience in its Rural Health Equity Strategic Action Plan, and continues to work toward improving rural surgical issues through various projects on accreditation, training and the rural curriculum.[2] For both regulators and specialist colleges, having clarity in understanding the industry specific needs can augment the relevance and effectiveness of training, ultimately fostering an adequately skilled workforce. The proposal to restrict discussions on strategy to Health Chief Executives is inadequate; specialist colleges, as lead educators and surgical standard setters, must be explicitly represented on the Strategy Assembly and its outputs.[3] As stated in The Reform -

> "Inclusion of professions, colleges and community voice in setting health regulation priorities that align with workforce strategy."[4]

---

[1] Department of Health and Aged Care. National Medical Workforce Strategy 2021–2031 2023 [Available from: https://www.health.gov.au/our-work/national-medical-workforce-strategy-2021-2031]

[2] RACS Rural Health Equity Strategic Action Plan Available from https://www.surgeons.org/News/News/Rural-Health-Equity-Strategic-Action-Plan]
RACS Rural Surgery Section [Available from https://www.surgeons.org/Resources/interest-groups-sections/rural-surgery/activities]

[3] The Reforms pp.27-28

[4] The Reforms p.25

Current training positions must be strengthened and preserved to prioritise sustainable pathways for local trainees and not be manipulated so that training positions, that should be reserved for local trainees are preferentially given to those seeking admission on an expedited pathway. The pathway to specialist recognition in Australia is deliberately robust to ensure the Australian public continues to enjoy the excellent standard of care they are accustomed to, and should expect. These training posts should not be utilised for supervision of an externally trained specialist, on limited supervision, where the expected standards are not met. Implementing a moratorium on Specialist Medical Graduates (SIMGs) on the Expedited Specialist pathway could act as a strategic lever to encourage practitioners to practice in poorly serviced regions. This measure would help bridge service gaps in regional underserviced areas whilst working in parallel on developing a sustainable, locally trained workforce. Once again, this is beyond the remit of the regulator and these complexities between the regulator, Medicare compliance, and Health Quality and Safety Commission amongst other departments, continues to provide a fragmented view to national health policy, which is highly inefficient as the issues are all inter-related.

Actions 1.1 and 1.3 of reform direction 1, propose the formation and co-chairing of a 'Strategy Assembly' by Health Workforce Taskforce (HWT) and Health Chief Executives Forum (HCEF), which is to be conducted biennially. RACS recommends the assembly to also encompass specialist medical colleges. Given the medical colleges' expertise in the healthcare domain, these organisations are well-positioned to advice on optimal practices, forecast challenges and adequately prepare trainees.

Strengthening collaboration across health-related regulatory bodies is discussed and Action 4.1 recommends the representation of Health Complaints Entities (HCEs) within the fundamental level of Australian Health Regulators Network (the Network). In addition to this significant step, it is also vital to expedite the interaction with regulatory bodies particularly concerning management of vexatious complaints.

Reform 02: Integrated Regulation Across the Health Workforce

RACS does not support any proposals that promote overgeneralised comparability between professions in the health system. The premise that risk equates across professions is clinically incorrect. Surgery as a profession is a high-risk endeavour and requires stringent training by experts in the field, regulation and separate governance. Reliance on broad-based regulatory enforcement models, and specifically for low-risk professions, dilutes public trust and exposes patients to risk. RACS reject false equivalence in high- and low-risk professions.

RACS has legitimate concerns with the broad and vague description of "risk" in reform proposals that safeguard definitions. Our professional obligations deserve clear risk management frameworks that rely upon clinical judgement and decision-making. They are evidence-based with respect to patients' safety, and are not for the purposes of bureaucratic reclassification or convenience.

The title of this reform is flawed. The phrasing of "the most significant risk to public health and safety"[5] (Action 2.1) is not evidenced.

Amendment to the scope of practice via the "Approved Professions Registration model" to provide formal pathways to lower risk allied health professions, concurrently increases the risk parity between professions.[6] The proposed new model ought not dilute existing clinical accountability standards and

[5] The Reforms p.6
[6] The Reforms p.56

ought not permit allied health occupations lacking procedural technique to be marketed as being as 'regulated' as doctors.

And in due course, as and when or if these occupations expand to perform more risky scopes (e.g., invasive podiatry or independent radiography), they ought to be under the same high standards and level of watchfulness as medical physicians. “Lower risk allied health professions” expanding into high-risk practice must trigger similar regulatory requirements, not evade them. Any expansion of the National Scheme must protect, not undermine, the clinical standards that are currently upheld by RACS and other specialist colleges.[7]

In pursuing greater comparability and inclusivity, extreme caution must be taken to not streamline the existing evidence-based standards for specialist registration. In default of this, patient safety could be compromised – a non-negotiable priority.

Reform 03: Strengthening Performance, Accountability and Transparency

New bodies like the Health Workforce Taskforce and Strategy Assembly cannot operate without the medical professions directly represented, by the specialist colleges. No regulatory system will have credibility, authority, or trust without clinical leadership.

Item 3.5 is a nod in the direction of transparency without including any definite metrics or timelines.[8] Practitioners undergoing a formal complaints process face significant distress.[9] RACS would want to see transparent publication of AHPRA performance against KPIs agreed, for example, average investigation timelines, complaint resolution rates, and practitioner satisfaction post-investigation. Mechanisms for the rapid evaluation and dismissal of overtly vexatious complaints must occur to reduce practitioner stress and reputational damage. Recent data presented by the regulator suggests that of those thought to be frivolous, 97% were indeed vexatious but yet still took 3-6 months to resolve which is not acceptable to practitioners wrongly accused of patient harm.

In accordance with the specific structural reforms proposed in Action 3.2 via the establishment of a "Scheme Delivery and Development Leadership Group", colleges should be given observer or consultative roles.[10] From a regional and rural health perspective, RACS advises inclusion of regional clinician perspectives when effecting adjustments to the governance framework. The representation of geographical diversity in governance is crucial as it would facilitate comprehensive understanding and adequate management of regional specific workforce and regulatory challenges.

When conducting independent performance auditing, regional and rural-specific metrics should be actively assessed. These may include registration processing times and regulatory decision-making delays which disproportionately affect geographically isolated clinicians and communities.

RACS is receptive to AHPRA commissioning an "Organisation Capability Review".[11] However, the review must explicitly examine barriers that impede effective communication with rural and remote practitioners, particularly during complaints or investigation processes. RACS is actively investigating

[7] The Reforms p.56
[8] The Reforms p.90
[9] Biggar, S, van der Gaag, A, Maher, P, Evans, J, Bondu, L, Kar Ray, M, Phillips, R, Tonkin, A, Schofield, C, Ayscough, K, Hardy, M, Anderson, S, Saar, E & Fletcher, M 2023, ''Virtually daily grief'—understanding distress in health practitioners involved in a regulatory complaints process: a qualitative study in Australia', International Journal for Quality in Health Care, vol. 35, no. 4:1-12.
[10] The Reforms p.88
[11] The Reforms p.89

rural issues such as this through its activities related to the RACS Rural Health Equity Strategy.[12] Additionally, this may aid in identifying and understanding capability gaps of rural and remote health workforce.

The role of medical colleges is integral in establishing professional and clinical training and assessment standards. RACS does not support combining regulatory and workforce planning functions and the possibility of further centralisation also raises concerns. Specialist medical colleges must not be relegated in their pivotal role of setting and sustaining high standards of surgical training and assurance within the proposed reform. Accreditation functions should not be watered down or centralised in a governing scheme but must be steered by the profession with regulatory backing.

Reform 04: Best Practice Health Complaints Handling

RACS support system reform through collaboration, not centralisation. Any collaborative national workforce strategy or reform either bodies path must include Specialist Colleges as coproducers and considered authorities in decision-making, not rubber stamp stakeholders.

The Review's focus on the rapid identification and dismissal of obvious vexatious complaints is crucial so that Ahpra can concentrate on the true issue that compromise patient safety. Refining health complaint pathways can rebuild trust of both practitioners and public. RACS strongly supports Actions 4.1–4.3, particularly with respect to the more prompt determination of vexatious complaints, which have a devastating impact on the mental health and career of unjustly accused surgeons.[13] However, these reforms must not be aspirational only. This was highlighted in The Reforms-

> *"Ensuring implementation of National Health Practitioner Ombudsman recommendations for improving management of vexatious complaints."*[14]
>
> *"Review and revise the policy and procedure for placing investigations 'on hold'... [consider] the personal and financial impacts on a practitioner."*[15]

Specific KPIs on complaint resolution times, practitioner notification rights, and access to clinical peer advice must be included. Surgeons have always been concerned about delays caused by inter-regulatory tension, to the immediate harm of patient care and the removal or suspension of good surgeons from practice on untried complaints.[16] The Complaints Navigator Service (Action 4.2) is welcomed but must be advised by surgeons in its design and operation.

With respect to regional and remote areas, where networks are close-knit and communities are small and sparsely populated, improved complaints navigation may prove to be highly beneficial. Vexatious or poorly managed complaints can have outsized personal and professional impacts. Consequently,

---

[12] RACS Rural Surgery Section [Available from https://www.surgeons.org/Resources/interest-groups-sections/rural-surgery/activities]
[13] The Reforms pp.120-121
[14] The Reforms p.116
[15] The Reforms p.121
[16] Empey D. Suspension of doctors. The process is badly handled at present, and new guidance is welcome. BMJ. 2004;328:181-2.
Hanganu B, Ioan BG. The Personal and Professional Impact of Patients' Complaints on Doctors-A Qualitative Approach. Int J Environ Res Public Health. 2022 Jan 5;19(1).
Hogben N, Robertson N. How do healthcare professionals experience being subject to complaint? A meta-synthesis of reported psychosocial impacts. Ethics and Behaviour. 2024.

when executing the Complaints Navigator Service the caveat should be that this is easily accessible and adequately resourced for rural and remote practitioners who may lack local peer support or advocacy.[17]

The existence of "investigation case management and case review regimes" reflects a structured oversight and the focus on enhancing reporting practices and handling of high-risk investigations is reassuring.[18] Regardless, timely investigations and procedural fairness are undeniably significant. As indicated in The Reform[19]:

> "*Poor timeliness is an understandably deep concern when a practitioner is subject to immediate action and either prevented from practicing or subject to significantly limitations on practicing."*

Lengthy processes, especially when practitioners are suspended or restricted from practice, can lead to significant service disruptions in areas with no alternate coverage. Acknowledging and effectively managing complaints and misuse trajectories more proactively will improve morale and workforce retention in smaller communities.

RACS Summary Recommendations

RACS has provided recommendations to better promote the inclusion of specialist colleges into regulatory space not as regulators per se, but in an advisory capacity to the regulators if need be. Furthermore, there requires improved sharing of workforce data, strict maintenance of SIMG moratoriums, equitable regulation of new high-risk roles with prejudice, and practical KPIs for regulators like Ahpra. The delivery of collective reform will protect training pathways and produce a timely resolution of complaints and identification of vexatious claims. Central to achieving equitable outcomes is also the meaningful inclusion of perspectives from rural clinicians.

- Mandate representation on all key workforce and regulatory forums by specialist medical colleges, including the Strategy Assembly (Action 1.3).[20]
- Create and maintain SIMG moratoriums to safeguard training pathways and prevent dilution of the local surgical workforce investment.
- Reframe Reform Direction 2 regulatory text to encourage collaboration, instead of implying punitive regulation.
- Implement enforceable KPIs for Ahpra's own performance, especially in complaint handling, responsiveness, and transparency (Actions 3.5, 4.3).[21] [22]
- The scope of AHPRA must be separate from workforce policy, health service planning and intergovernmental strategy; those functions need to sit with government, with clinical input.
- Require equal regulatory focus on new high-risk allied health practitioner roles, in line with the standards applied to surgeons.
- Ensure regulatory measures are appropriately tailored to the risk and competencies of each profession, especially high-risk areas like surgery.
- Introduce faster, more impartial determination of complaints, with mandatory time scales and penalty when complaints are determined to be vexatious.[23]

---

[17] The Reforms p. 121
[18] The Reforms p. 107
[19] The Reforms p. 103
[20] The Reforms p.27
[21] The Reforms p.90
[22] The Reforms p.121
[23] The Reforms pp.120-121

- Provide transparent and accessible complaints navigation services for clinicians operating at areas with minimal local collegial support.
- Ensure procedural fairness and a prompt approach during investigations especially in rural and remote settings where delays mean significant consequences.
- Ensure inclusion of rural clinicians, Indigenous communities and women in surgery when implementing changes focussed on equity in healthcare.
- Explore new models to improve accessibility of clinicians in rural and remote Australia which may include organising and adequately supporting a team of clinicians for relocation and strategies to prevent burnout and increase retention.

RACS advocates for specific reconsideration of reforms:

- Reform 1: Decision-making strategy bodies must be clinically driven, NOT a bureaucracy.
- Reform 2: RACS and the medical professions must own and lead risk-based regulatory frameworks, NOT administrators.
- Reform 3: Accreditation as a centralised process is dangerous and must cease.
- Reform 4: Complaint reforms must be fair and professional with clinicians involved.

Conclusion

RACS acknowledges the need to modernise aspects of NRAS. However, reforms should never compromise clinical leadership, the public trust, or the safety of surgical practice. We urge Health Ministers to clarify NRAS's core purpose: patient protection through rigorous, profession-led regulation—not a mechanism for workforce engineering. The very future of safe, ethical, and competent healthcare relies on it. Strategic focus should be directed at collaborative and partnership models rather than a regulatory-focused compliance model.

RACS applauds thoughtful reform, but cautions exist in that efficiency must not come at the cost of clinical excellence or surgical safety. Reduction of any specialist medical college's contribution to education, standard setting, or workforce planning risks undermining decades of quality assurance in surgical care. We urge regulators and governments to work constructively with the Colleges, not around them, to uphold public trust in Australia's health system. When enacting reforms, we emphasise the importance of including perspectives of rural and remote practitioners, Indigenous voices as well as women in surgery, to uphold equity and fairness.

We thank you for the opportunity to review and provide our input on Consultation Paper 2: Consultation Outcomes and Reform Directions. We welcome any opportunity for further discussion and clarify any aspects of our submission, should it be required.

Sincerely

Stephanie Clota
Chief Executive Officer
Royal Australasian College of Surgeons

Professor Owen Ung
President
Royal Australasian College of Surgeons

Professor Mark Frydenberg
Chair, Health Policy and Advocacy Committee
Royal Australasian College of Surgeons