



Review of the
National Registration
and Accreditation
Scheme for health
professions

Consultation paper
August 2014

This Consultation Paper has been prepared by Independent Reviewer Mr Kim Snowball who has been commissioned by the Australian Health Ministers' Advisory Council to review the National Registration and Accreditation Scheme for the health professions.

August, 2014

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Australian Health Ministers' Advisory Council

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Introduction

The National Registration and Accreditation Scheme (the National Scheme) for the health professions represents a significant achievement that delivers many benefits to the Australian health system. Since its inception with the agreement of all Australian governments in 2008, much work has been done to deliver the National Scheme to the point it is at today – overseeing the safe practice and regulation of more than 618,000 health professionals all over the nation.

The National Scheme was established to achieve six key objectives:

- protection of public safety
- facilitation of workforce mobility
- facilitation of high-quality education and training
- facilitation of assessment of overseas-trained health practitioners
- promotion of access to health services
- development of a flexible, responsive and sustainable workforce

Further to the objectives of the National Scheme it has guiding principles that state that: it must operate in a transparent, accountable, efficient, effective and fair way; fees payable by practitioners must be reasonable; and that restrictions on the practice of a health profession are only to be imposed if that is what is required to ensure that health services provided to the public are safe and of the quality expected in Australia. What this means is that the National Scheme seeks to achieve a balance between safety and quality through protection of title, without restricting competition or limiting access to health services.

The Australian Health Workforce Ministerial Council – made up of all Australian Health Ministers who have ultimate responsibility for the National Scheme – has initiated an Independent Review to consider the achievements of the National Scheme against the mission outlined by the key objectives and guiding principles. The Council has asked for an assessment of the National Scheme’s future sustainability, its administration and to look at how it works at the points it interacts against other regulatory systems operating in States and Territories.

Consideration of the success or limitations of the National Scheme must be applied within the context of these key objectives and guiding principles. That is, to what extent does the National Scheme meet the objectives that Commonwealth, State and Territory Parliaments and Health Ministers had in mind when it was signed into being?

The Independent Review process

The Health Ministers appointed Mr Kim Snowball as the Independent Reviewer, and a small team has been established to assist in conducting the Review. The Review team was set the initial task of compiling this consultation paper so that any issues, concerns and proposed improvements could be more widely canvassed before being ultimately considered by the Health Ministers.

In developing this consultation paper the Independent Review team has:

- gathered information and facts from those agencies responsible for delivering the functions and activities established under the National Scheme. This included National Boards, the Australian Health Practitioner Regulation Agency, Accrediting Authorities and State and Territory governments
- considered previous reports and inquiries into the National Scheme, including those focused on the problems that beset the scheme in its formative years
- commenced a cost effectiveness, efficiency and economic analysis of the National Scheme
- conducted a close analysis of health profession regulation in countries whose health systems are similar to Australia's
- completed a community and consumer engagement strategy to ensure wide and constructive input into the Review.

This Consultation Paper is now released so that people and organisations can provide informed input into the Review. The period for submissions will remain open until October 10, 2014. Consultative forums with invited stakeholder representatives will also be conducted in each State and Territory during September 2014 to provide additional opportunities to consider how to improve the National Scheme into the future.

Consultation arrangements

This consultation paper is available online at the following address: www.ahmac.gov.au

Interested parties are invited to make written submissions commenting on the options and questions in the Consultation Paper via email to: nras.review@health.vic.gov.au.

Submissions should be received by: **Friday 10 October 2014**.

If you are unable to access the website and would like a copy of the paper, please contact the Review team on telephone 03 9096 7356 or at the email address above.

Note: All submissions will be considered public documents and may be posted on the AHMAC website above, unless marked 'private and confidential'.

How the Consultation Paper is organised

The Consultation Paper has been carefully organised into three parts.

The first features the Independent Reviewer's early reflections. These include his thoughts about how the National Scheme currently functions, presents the areas he considers require further attention and scrutiny, and canvasses options that may be included in his final report and recommendations to the Health Ministers.

The second part describes issues the Independent Reviewer is seeking specific input and advice about. This includes detailed descriptions of the many areas of the National Scheme that come under the scope of the Review. This part covers:

- Complaints and notifications
- Public protections
- Mandatory notifications
- Workforce reform and access
- Assessment of overseas trained practitioners
- Governance of the National Scheme
- Cost and sustainability of the National Scheme
- Proposed changes to the National Law.

The third part provides a broad but informative description of the National Scheme to assist those unfamiliar with how it operates so they can provide informed contributions and input into the Review.

Application of best practice regulation principles

Any work undertaken by, or on behalf of, Ministerial Councils is subject to the requirements of the [Council of Australian Governments best practice regulation guide](#).

This is to ensure that where regulatory change is being contemplated there are effective arrangements to maximise the efficiency of new and amended regulation, and avoid unnecessary compliance costs and restrictions on competition.

As such, where an option put forward in this Consultation Paper has a potential regulatory impact, the information and analysis provided is in compliance with these requirements and has been assessed as adequate by the Office of Best Practice Regulation. This includes clear statements on: the problem to be addressed; objectives of government action; the options being considered; and an analysis of the impact of those options. Options with potential regulatory impact have been proposed for the following areas:

- future regulatory structures
- management of complaints and notifications
- advertising restrictions
- mandatory notifications requirements.

Other areas in the paper are not putting forward options for change, but are seeking feedback from stakeholders on the effectiveness of the current arrangements, to determine if there is an issue to be addressed. These include:

- public protection provisions (not including advertising)
- workplace reform and access
- assessment of overseas trained practitioners
- governance of the National Scheme
- proposed changes to the National Law.

Part I: Reflections from the Independent Reviewer

The regulation of health professionals should sit quietly in the background of the health system. Regulation should not interfere with the day to day duties of health practitioners, but it should make sure that the community is protected against unprofessional practice and that consumers can be confident the nation's health professionals are properly trained and qualified to treat them.

In Australia, only four years ago, we saw a sweeping change to the regulatory system that oversees the safe practice of health professions. Was it successful, did it achieve what it was designed to do and are changes required to improve it? My task as the Independent Reviewer is to reach conclusions on each of these questions. In doing so I am embarking on a wide consultation process to inform and shape my recommendations to the nation's Health Ministers about how they can deliver continuous improvement to the health professions' regulatory system.

From the outset it must be acknowledged that the regulation of the health professions sits within a broader context of State and Territory regulation. While the National Scheme sets the minimum standard for safe practice by health professionals, it does not take away the capacity for individual States and Territories, or employers, to add further regulation where they see fit. For example, through employment contracts or other state-based regulation, such as the Poisons Act.

This is an important aspect of the National Scheme: it sets a minimum standard of professional practice and requires a minimum standard of qualification to practice using a protected title, but it does not require standardisation of all other elements of health regulation in the States and Territories. There is a clear distinction between regulators setting minimum standards for registration and the role of employers in determining employees' scope of practice in the workplace.

Another important design feature of the National Scheme is that it sets out a clear requirement for those administering it to ensure it maintains a focus on innovation, flexibility and access to services and it seeks to prevent its use to restrict practices in an anti-competitive manner.

Throughout the Independent Review process so far, I have yet to hear anyone disagree with the view that the introduction of the National Scheme was a positive step forward in the regulation of the more than 618,000 Australian health professionals who are now listed on the national register.

It is however, very clear to me that the National Scheme got off to a shaky start and to some extent this has influenced perceptions about it right up to the current day.

It ought be acknowledged that the National Scheme's introduction, by way of legislation through each Australian State and Territory Parliament, is a unique and substantial achievement. This saw the consolidation of 75 Acts of Parliament and 97 separate health profession boards across eight States and Territories into a single National Scheme.

Four years down the track since the National Scheme began operation, this achievement can be overlooked and the benefits taken for granted.

Other countries are examining the approach taken by Australia and we are seen as an international leader in this redesign of one aspect of our regulatory system.

I appreciate the work involved in the initial effort to establish the National Scheme and acknowledge the continual improvement that agencies operating within it have pursued within their administrative and legislative boundaries. However, my task as the Independent Reviewer is to look for areas where the National Scheme is not achieving the objectives set out for it in the National Law and to examine areas where improvements might be made to both.

For the purpose of this Consultation Paper and to guide submissions, I have set out eight areas of focus that I would like input into. These are:

- Complaints and notifications
- Public protections
- Mandatory notifications
- Workforce reform and access
- Assessment of overseas trained practitioners
- Governance of the National Scheme
- Cost and sustainability of the National Scheme
- Proposed changes to the National Law

The Consultation Paper contains more detail on these issues at Part II.

In addition to these issues I believe the National Scheme has a number of problems in delivering the objectives of the National Law in three broad areas, and thought it would be useful in the consultative phase of this Review to share my early thinking. I must emphasise that I have not settled on a particular direction but wish to canvass various options that I think may address these problems in a sensible way.

Accountability

The National Scheme must be accountable on a national level and also to individual State and Territory Health Ministers.

Despite being described as a National Scheme, there is no current mechanism to measure performance in relation to how it operates to deliver on the four key objectives set out in the National Law. Each party working within the National Scheme is accountable for the operation of its part, but there is neither obligation nor accountability for the operation of the National Scheme as a whole.

An associated and equally pressing issue for the National Scheme is the relationship with the State and Territory governments. Given that it was the States and Territories that established the National Law by passing near-identical Acts through their respective parliaments, it would seem appropriate for Health Ministers and their parliaments to be provided with jurisdiction-specific information regarding the performance of: the regulators who oversee the work of health professionals; and the performance of the health professionals themselves. It can

be argued that the National Scheme needs to better reflect the fact that State and Territory Health Ministers bear ultimate responsibility for the safe practice of health professionals in their jurisdictions.

This paper canvasses options to strengthen accountability via an independent assessor, similar to the United Kingdom Professional Standards Authority, where 24 key performance indicators for good health regulation are applied, examined and independently reported to the UK Parliament.

The State and Territory governments need to find appropriate mechanisms for articulating and assisting the regulators in responding to the broader health workforce reform agenda, especially in circumstances where cross-profession responses are needed. It would be helpful to have a capacity for such matters to be explored and be able to provide Ministers with expert advice on the options.

Such a body was designed by the National Law, but is no longer active. The Australian Health Workforce Advisory Council (AHWAC) was intended to play an advisory role to the Health Workforce Ministerial Council. The AHWAC could be re-established to provide to Ministers:

- an annual assessment of all regulators, by jurisdiction, and based on established performance measures within the National Scheme
- independent advice regarding all proposals for changes in the standards being proposed to the Ministerial Council
- a report on the actions taken within the National Scheme to improve access to services and delivery measured against workforce reform, including cross-profession initiatives. In addition, AHWAC could carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps.

The use of AHWAC to perform these functions does not represent an increase in regulation above the current arrangements. AHWAC will be able to draw on the information, data and reports available about individual components of the National Scheme and undertake any further research, analysis or consultation required to advise Health Ministers on performance of the regulators and assist in resolving complex policy issues involving multiple professions and stakeholders.

Questions

1. **Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?**
2. **Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?**

The future for regulation of health practitioners in Australia

A key question Health Ministers have asked me to consider is, what level of regulation is required for the health professions and how can this be achieved for a reasonable cost?

No-one wants to see health professionals over regulated, with innovation and creativity being stifled at the very time the health system needs it most. On the other hand, insufficient regulation has the potential to place the community and individual patients and clients at unnecessary risk.

The challenge is to ensure these two factors are balanced within an environment where the health needs of the community are changing, costs are rising and technology and new health service delivery models are confronting health practitioners on a daily basis.

Many stakeholders have expressed surprise about the 14 health professions that were selected for inclusion in the National Scheme. The surprise relates to the fact some of the professions have a low regulatory workload, either because of the small number of registered practitioners or because the services they provide are unlikely to cause harm.

This is further borne out by the relatively low number of complaints and notifications of professional misconduct relating to these groups. In fact, over 95 per cent of all complaints and notifications relate to just five of the 14 regulated professions.

The current National Law demands the same level of regulatory force and governance structure for each of the professions included in the National Scheme with little, if any, reference to its risk profile or the regulatory workload required. This means each of the 14 professions has its own National Board, sub-committee structure, and functional roles including accreditation, registration and management of notifications.

A number of attempts have been made to assess the risk profile of each profession. These have focused on ascertaining the potential risk of harm to the public, and largely calculated this risk on the basis of the number, frequency and significance of the complaints and notifications made against members of the profession. The following tables 1 and 2 describe the profile of the professions on the basis of their relative regulatory workload, with the higher cost functions of registration (number of registrants) and notifications, rather than exclusively on risk.

Consideration must also be given to how to determine if other professions ought be added to the National Scheme. Regulation under the National Scheme is expensive for registrants and so must carry an economic benefit or a need for community protection if inclusion is to be considered. Overseas research has also made it clear that the number of members of a profession impacts significantly on both the cost and effectiveness of regulation and the associated registrant fees.

For professions already in the National Scheme

The existing range of professions falls into two clear categories.

1. Professions that, based on their size and the extent of notifications with potential impact on community safety, require the National Scheme’s full regulatory force and resources.

Table 1 below identifies groups that clearly meet these criteria:

Table 1: Higher regulatory workload professions (2012–13) including NSW data

Profession	Registrants	Proportion of total registrants	Notifications	Proportion of total notifications	Notifications per '000 practitioners
Medical	95,690	16.2%	4,709	54.5%	49.2
Nursing and Midwifery	345,955	58.4%	1,598	18.5%	4.6
Psychology	30,561	5.2%	471	5.4%	15.4
Pharmacy	27,339	4.6%	429	5.0%	15.7
Dentistry	19,912	3.4%	1,052	12.2%	52.8
Totals	519,457	87.7%	8,259	95.8%	

2. Professions that have a lower regulatory workload based on their size and the extent of notifications with potential to harm the community. Table 2 identifies the professions within the National Scheme that meet these criteria:

Table 2: Lower regulatory workload professions

Profession	Registrants	Proportion of total registrants	Notifications	Proportion of total notifications	Notifications per '000 practitioners
Podiatry	3,873	0.7%	44	0.5%	11.4
Physiotherapy	24,703	4.2%	83	1.0%	3.4
Occupational Therapy	15,101	2.5%	50	0.6%	3.3
Chiropractic	4,657	0.8%	72	0.8%	15.5
Chinese Medicine	4,070	0.7%	30	0.3%	7.4
Osteopathy	1,769	0.3%	8	0.1%	4.5
Medical Radiation Practice	13,905	2.3%	26	0.3%	1.9
Optometry	4,635	0.8%	42	0.5%	9.1
Aboriginal and Torres Strait Islander Health Practice	300	0.1%	4	<0.1%	13.3
Totals	73,013	12.3%	359	4.2%	

As can be seen, just five of the 14 health professions account for 87.5 per cent of the registrants and 95.5 per cent of all complaints and notifications.

Issue to be addressed

The Review was tasked to ‘examine the cost effectiveness of the National Scheme (including structure and functions), including where efficiencies might be gained and the impact of the model on the small professions’. Arguably, the above analysis represents over-regulation of the remaining nine professions, which account for just 12.5 per cent of registrants and less than 5 per cent of notifications. If this over-regulation could be addressed, a significant fall in regulatory costs could be achieved.

Each of these nine professions is now incurring higher costs than the regulatory workload indicates is warranted and, as a consequence, registrants are paying higher registration fees than is necessary for effective regulation. This contradicts a guiding principle of the National Scheme that states that ‘fees required to be paid under the National Scheme are to be reasonable having regard to the efficient and effective operation of the National Scheme.’

One way to better align resources with the regulatory-demands of these professions would be to share the regulatory functions across the nine professions that have a lower regulatory workload. This successfully occurs in the United Kingdom.

Options and impact analysis

The following options are considered to address the disproportionate regulation between the lower and higher regulatory workload of the professional groups.

Option 1: Establish a Health Professions Australia Board

Estimated regulatory cost reduction of \$11 million per annum

A cost effectiveness study undertaken as part of the Review has estimated that the introduction of a Health Professions Australia Board has the potential to realise saving of \$11 million per annum, this would result in decreased cost of registration fees for practitioners. More detail is provided in the section 'Cost and sustainability of the National Scheme' in Part II.

This option involves the formation of a single Health Professions Australia Board to carry regulatory responsibility for the nine professional groups, replacing the existing nine National Boards.

This option has the potential benefit of achieving economies of scale and shared regulation across the nine low regulatory workload health professions. In this approach the respective professions would remain with protected title and have direct input into matters affecting the regulation of the profession through dedicated subcommittees of the Board. However, they would share common regulatory functions including managing complaints and notifications, accreditation (with professional input) and registration. There would be a single registration fee.

Under this option, professional input into specific elements of the courses of study, and other discipline specific areas would be preserved.

Moving to this model would require a transition process that in itself presents cost in the short term, however this would be offset by the long term potential gains it would provide.

This option provides benefits by protecting the integrity of the professions involved while reducing unnecessary bureaucracy, duplication and cost, this would deliver benefit to the registered professionals and the consumers.

Option 2: Use of common regulatory mechanisms

Estimated regulatory cost reduction of \$7.4 million per annum

Option 2 involves retaining the nine separate National Boards but consolidating the functions underneath them (to the maximum extent possible) into a single national service to the nine professions. This could be relatively easily achieved for registration by setting a single fee. The cost effectiveness study estimated that this option has the potential to realise saving of \$7.4 million per annum, by consolidating registrations and notifications functions. More detail is provided in the section 'Cost and sustainability of the National Scheme' in Part II.

Much of the cost involved in the regulation of the nine lower regulatory workload professions is in the duplication of regulatory functions, such as complaints and notifications and registration fees. The management of notifications and complaints are at such a low level that the annual combined total is currently about 350 notifications, which is lower than each of the remaining five professions accrue on an individual basis.

The transition effort associated with this option is less than for option 1, but with much lower potential cost savings in the long term.

Option 3: Maintain the current 14 National Board Structures

Option 3 is to leave the current structural arrangements as they are now. Based on the cost effectiveness and efficiency work undertaken as part of the Review, this option would result in the potential cost savings of options 1 and 2 not being realised. This would not be delivering against the guiding principles of the National Scheme as they relate to effectiveness, efficacy and the minimum level of regulation necessary.

Feedback is sought on each of the above options and their potential impact.

Questions

3. Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? Estimated cost saving \$11m per annum.
4. Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? Estimated cost saving \$7.4m pa.
5. Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?

For Professions seeking entry to the National Scheme

A number of health practitioner groups wish to join the National Scheme. It must be remembered that the National Scheme was established to fulfil four key objectives, not to provide status and credibility to health practitioner groups.

Representatives of unregulated professions have raised with the Review that because theirs is not a regulated profession members have been excluded from involvement on boards, or even tenders and employment, because these opportunities have been restricted to health professionals registered under the National Scheme. This is certainly an unintended consequence of the National Scheme.

At the time the National Scheme was conceived the Council of Australian Governments (COAG) established threshold criteria relevant to risk to assist in assessing the need for statutory regulation of unregulated health occupations

These criteria must be applied to the consideration of any future entrants into the National Scheme. It is also important that the risk profile for additional professions carefully considers the context in which the practitioners operate. For example, if the majority of practitioners are in employment – rather than self-employed – then an additional layer of regulation already exists. The COAG criteria have been described as ‘gateway criteria’ required to be met prior to further regulatory impact assessment in accordance with the COAG best practice regulation requirements, assessed by Office of Best Practice Regulation.

Inclusion in the National Scheme, and the additional regulation that it imposes, must only occur where community safety is at significant risk and no alternative, more cost-effective means of regulating the profession is available.

Questions

6. Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?
7. Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?
8. Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?

Complaints and notifications

Under the National Law the notification process is designed to alert regulators to registrant performance or conduct that may place the public at risk. The notification system is designed to improve the performance of health professionals and safeguard the community by providing – where appropriate – feedback, intervention and more serious consequences to those practitioners who breach professional standards, including deregistration.

A critical function of the regulation of health professionals is ensuring that notifications received about the health, performance or conduct of a registrant is managed in an effective and efficient manner to protect the public.

One of the key problems with the operation of the current system is that notifiers often see themselves as party to a ‘complaint’ and expect to have an active and ongoing role in the resolution of the dispute. In fact, under the National Scheme, a notifier is similar to a witness who brings their concerns to the attention of the regulator. Regulators are then required to take action to assess, investigate, monitor and manage the performance and conduct of health professionals to protect the public.

Even in the earliest stages of the Review concerns have been expressed by members of the public, ombudsman, jurisdictions and professions about the management of notifications under the National Scheme. These concerns include:

- lack of understanding about the notifications processes and its intersection with State and Territory Health Complaints Entities complaints processes
- lack of information provided to notifiers where the matter has been referred to AHPRA as a notification of professional misconduct
- no single entry point for notifications and complaints
- delays in the preliminary assessment or investigation of concerns raised by notifiers
- delays in the finalisation of notifications
- poor communication with notifiers and practitioners
- notifier issues are not resolved in accordance with notifier expectations.

When the National Scheme commenced, New South Wales decided to continue to operate its own complaints management system in parallel with the National Scheme. This has become known as a co-regulatory arrangement or model. More recently Queensland has also established its own complaints management process for serious professional misconduct by removing this power from the National Boards and vesting it in the newly established Queensland Health Ombudsman. The Health Ombudsman will receive all complaints and make the judgement as to how each is managed. The recent steps taken in Queensland, together with the findings of a recent Victorian Legislative Council inquiry into the performance of Australian Health Practitioner Regulation Agency, are a clear indication of serious concerns that the National Law notifications system has not been operating effectively.

These issues are canvassed in more detail in Part III of the paper.

Options and impact analysis

As I see it, there are three options as to how we can respond to these serious problems:

Option 1: Retain the existing configuration of notifications handling but improve the process via a range of administrative and legislative changes.

The first option is to retain the majority of the roles and functions currently managed by the National Boards and Health Complaints Entities and make adjustments to the existing framework to address and remedy the problems that have been identified. This may involve:

- notifiers becoming more integral to the process and provided with information at each step in the process, including the outcome and reasons for the decisions that led to it

- prescription of performance measures and timeframes for the management of notifications
- providing AHPRA and the National Boards with the ability to utilise alternative dispute resolution (ADR) services.

The benefit of this option is that it utilises existing structures and procedures established to manage notifications under the National Scheme and jurisdiction specific approaches where a co-regulatory model has been adopted. It is likely to improve the performance and accountability AHPRA and the National Boards by prescribing clear performance measures and timeframes for the management of notifications. Most importantly the introduction of ADR processes is likely to address one of the key concerns expressed by consumers – they want the opportunity to resolve their dispute with the health practitioner. This could occur without impacting on the role of the regulator in identifying and managing performance or conduct that may place the public at risk.

This would represent a lower cost option, but may still result in increased costs associated with the model of ADR. Feedback is sought on the potential costs and benefits of this option.

Option 2: Adopting a co-regulatory approach to managing complaints and notifications, along the lines of the Queensland Health Ombudsman model.

Amend National Law and relevant State and Territory Health Complaints Entity (HCE) laws to:

- locate the receipt and assessment of all notifications within the State and Territory HCEs
- locate powers to investigate and take action in serious disciplinary matters with HCEs and give them the discretion to refer matters to National Boards/AHPRA to manage. Under this option the HCE would have an obligation to provide AHPRA with timely information to be recorded on the National Register to ensure it remains as an up-to-date central repository of the registration status of health professionals in Australia.

The key benefit of this option is that it provides a single entry point for notifications related to the performance or conduct of a health practitioner and HCE complaints. It avoids duplication in the preliminary assessment and investigation of matters and gives notifiers access to alternative dispute resolution (conciliation) where the HCE has determined the matter is serious. The HCE could refer less serious health, conduct and performance matters to the National Boards and AHPRA to manage. This option would be the easiest to navigate from a consumer's perspective.

Option 3: Continue with current existing notifications system

Option 3 represents the status quo. It is likely this would result in practitioners and consumers continuing to be dissatisfied with their experience of the notifications system and therefore undermine the confidence both groups have in the regulatory system.

In order to more fully examine the relevant costs and benefits feedback is sought on the most appropriate approach to future regulation. I have posed a series of questions designed to assist me in this analysis:

Questions

- 9. What changes are required to improve the existing complaints and notifications system under the National Scheme?**
- 10. Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?**

Summary

My early discussions with key stakeholders have highlighted these as three key areas requiring action and resolution.

By focusing on these issues this Review process is seeking to: improve accountability within the National Scheme as a whole; consider the introduction of a level of regulatory cost and effort that is more aligned to the regulatory workload posed by professions within the National Scheme and, in turn, reduce the cost to registrants to achieve value for money. Finally, it canvasses options to improve the complaints and notifications process.

This Consultation Paper has been designed to explain the National Scheme and then to tease out these issues via a series of questions and policy options. I invite you to consider each of these in the context of what the National Scheme was designed to achieve and then respond with a written submission.

The Review is also embarking on forums in each State and Territory to seek the views of invited key stakeholders on how to best take the National Scheme forward into the future. I will use all of the information and opinions gathered via submissions and the forums to assist me in making my final report to Health Ministers.

A handwritten signature in black ink, appearing to read 'K. Snowball', with a stylized flourish at the end.

Kim Snowball

Part II: Areas highlighted for review

The Review is required to examine the extent to which the implementation of the National Scheme has met the objectives established in the National Law enacted in July 2010.

The early work conducted by the Review so far has highlighted a number of areas requiring closer scrutiny and these are highlighted in this part to encourage views and input into the potential approaches that may be proposed to Health Ministers.

Part II is divided into the following areas for review:

- Complaints and notifications
- Public protection – protected practice, advertising, cosmetic procedures and a National Code of Conduct
- Mandatory notifications
- Workforce reform and access
- Assessment of overseas trained practitioners
- Governance of the National Scheme
- Cost and sustainability of the National Scheme
- Proposed changes to the National Law.

For each area the Consultation Paper:

- provides background and context
- canvasses the issues
- poses questions and/or options for consultation.

Complaints and notifications

A critical function of the regulation of health professionals is ensuring a healthy complaints and notification system is in place to: monitor their performance; ensure effective feedback and intervention is available to improve performance, where necessary; and to ensure there are consequences for those who breach professional standards, including removal from the National Register.

Part III of the paper articulates the arrangements currently in place under the National Scheme in detail.

A number of issues regarding the handling of complaints and notifications have been raised with the Review team by complainants, ombudsman, jurisdictions and professions. Issues have centred on:

- inadequate communication and responsiveness
- time delays
- lack of transparency and accountability.

There has also been a high level of interest and commentary regarding the co-regulatory arrangements in place in New South Wales since the commencement of the National Scheme, as well as those introduced in July 2014 in Queensland.

This paper will examine the issues relating to the management of complaints and notifications and consider options to address these.

Understanding the complaint versus notification process

Under the National Law there is delineation between the role of the National Boards (supported by AHPRA) and the Health Complaints Entity (HCE) in each jurisdiction.

National Boards (supported by AHPRA) are responsible for the investigation and management of notifications about the health, performance and conduct of regulated health practitioners. These concerns often relate to the practitioner's health (the practitioner is believed to have an illness, mental impairment, addiction or substance abuse problem that impacts on their ability to do their job); conduct (inappropriate behaviour); or performance (poor knowledge, skill or care).

Under the National Scheme, a complaint about a registered health practitioner is called a 'notification' and the person who made the complaint is a 'notifier'. The National Boards assess notifications with a focus on public safety and managing risk to patients.

When a National Board takes action, it must use the minimum regulatory force needed to keep the public safe and manage the risk to patients.

The Health Complaints Entities deal with issues relating to: health systems (such as hospitals or community health centres) and fees and charges. The focus of HCEs is to resolve complaints through a voluntary process that involves both the person making the complaint and the person or organisation subject to the complaint. The possible outcomes from this process are: an opportunity for the complainant to discuss their concerns in a face-to-face meeting with the provider; an apology; provision of remedial treatment; or payment of compensation.

There is a significant difference in the role and status between a notifier and a complainant. Under the National Scheme, a notifier is not a party to the process but considered a witness to the process the National Board undertakes in assessing and/or investigating the concern.

If a complaint about a registered practitioner is received by a HCE there is a joint consideration process between the HCE and AHPRA to determine which entity should manage the issue.

Challenges to be addressed

There is a perception that the current arrangements under the National Scheme are difficult for consumers to navigate. Currently, in circumstances where a complaint to a HCE in a State or Territory includes information that may be considered a professional conduct matter that may impact on public safety, the complaint must be referred to AHPRA as a notification. This often occurs without discussion with the person who reported the concern.

There have also been criticisms that under the current process:

- there is not one point of receipt for complaints and notifications
- the role of notifier, as opposed to complainant, is not well understood and is unsatisfactory for consumers
- complainants do not receive adequate information if their matter is referred to AHPRA as a notification
- notifiers are provided with minimal information about the progress of the investigation process and are not routinely involved in processes of either Boards or tribunals.
- AHPRA's communication to consumers is overly bureaucratic and legalistic and does not adequately explain the reasons for decisions.

As noted above, National Boards assess notifications to determine if they meet the threshold for professional misconduct or public risk that may result in, for example, a caution, suspension or cancellation of the practitioner's registration.

Under the National Scheme, 60 per cent of notifications assessed by National Boards result in a finding of No Further Action because they do not meet this risk threshold. Previous inquiries, and evidence already received by this Review, have identified a significant number of consumers who, as a result of having had their concerns dealt with by the National Scheme, are unsatisfied with their experience and/or the result of the process.

Compounding this confusion and frustration are the provisions of the National Law that limit the information that National Boards can provide to notifiers. Once a decision has been made information can be provided to the notifier, but only to the extent that the information is available on the National Board's register. Under previous legislation, boards in most States and Territories were able to give notifiers more information about the status, progress, and outcome of their notification.

It is important that consumers who make a notification have confidence in the process and that it is seen to be fair and impartial. The limited role of the notifier in the process under the National Scheme, in combination with the limited information available to them, has the potential to undermine public confidence in the investigation and management of notifications.

An HCE has the ability to resolve matters by conciliation. In a number of cases, a consumer who raises a concern about their experience with a health practitioner may want access to a process that allows them to feel heard or receive an apology. It is noted that there is nothing in the National Law that prevents the National Boards or AHPRA from referring a matter back to the HCE to be managed as a complaint.

However, AHPRA has reported to the Review 'there are some issues of concern to Victorian consumers about the interface with the Office of the Health Services Commissioner (OHSC) that are specific to that State. There is more detail on this issue in our submission to the Victorian parliamentary inquiry. Briefly, the OHSC currently believes that their legislation prevents them from dealing with matters which have been dealt with by a Board, even when no further action is being taken. This is not a National Law issue but is clearly significant for consumers.'

What this means is that for a period of time any notification or complaint referred to the National Boards could not be returned to the Office of the Health Services Commissioner in Victoria. This does not occur in any other State or Territory and is not the result of the National Law.

International comparisons

In contrast to Australia, New Zealand has a single point of entry for all notifications involving a complainant – that is, where it is alleged that the practice or conduct of a health practitioner has affected a consumer. These matters must be referred to the Health Disability Commissioner (HDC) for preliminary assessment and/or investigation. The HDC may refer a complaint to the health practitioner’s regulator if it appears the competence, fitness to practice or conduct of a health practitioner is in doubt.

In New Zealand, the Professional Conduct Committee (PCC) may also refer a matter to conciliation as part of the investigation of a complaint. The PCC appoints an independent conciliator to assist the registrant and complainant resolve the matter by agreement.

The Health and Care Professions Council United Kingdom also has the power to adopt alternative dispute resolution processes to assist with the management of complaints, as do regulators in Ontario, Canada.

Information made available on the public register

The National Law sets out information that is to be recorded in the national register. In summary, legislation provides for:

- publication of details of cancelled registrants including grounds for cancellation and details of conduct that led to cancellation (where this results from a hearing open to the public)
- publication of current disciplinary sanctions in place in relation to suspension, reprimand, conditions or undertakings
- exemption from publication details of conditions or undertakings relating to health impairment
- publication of other information the National Board considers appropriate
- publication of a record of decisions made by panels and tribunals.

Essentially the legislation provides a minimal framework but leaves the path open to National Boards to publish additional information where it is considered appropriate.

In addition, there is a requirement for a register of cancelled practitioners to be available to the public, this includes a direct link from the register to the record of the tribunal hearing that led to the cancellation.

There is some debate regarding the type and extent of information that should be available about practitioners on the register, particularly in relation to the historical details of disciplinary proceedings. There is a need to balance the competing rights of the practitioner versus public disclosure to enable informed decisions and public protection.

The National Law provides discretion for National Boards, in circumstances where the practitioner has an impairment, to decide not to include, or to remove information on the register about a condition imposed, or undertaking accepted, if it is deemed necessary to protect the practitioner’s privacy and there is no overriding public interest argument for this information to be published.

International comparisons

Each of the international jurisdictions looked at by the Review has to establish and maintain a public register of health practitioners. Registers provide members of the public with information about: the health services that form part of a profession; and which practitioners are qualified and fit to practice. This information typically includes a practitioner's specialist status, conditions or restrictions on the practitioner, and any sanctions imposed as a consequence of fitness to practice or disciplinary proceedings.

In New Zealand the register includes registration suspension details, including any conditions, and any other matters the authority thinks appropriate to give consumers an understanding of the health services that form part of a profession and the areas in which the practitioner is competent and fit to practice.

In Ontario, Canada the register includes: any terms, conditions and limitations; a notation of complaints that are under investigation or subject to disciplinary proceedings that are unresolved; and the result of the decision of every disciplinary and incapacity proceeding where the committee makes a finding. The register should also contain a note if the matter is under appeal, or if a member has resigned during or as a result of proceedings and agreed never to practise in Ontario again.

The registrar may also refuse to disclose the result of every disciplinary and incapacity proceeding where: the order made was a reprimand, fine or finding of incapacity; more than six years has passed; a committee (on application of a member) believes the refusal to disclose outweighs the desirability of public access; or a disciplinary or fitness to practice committee has directed the information be removed from the public.

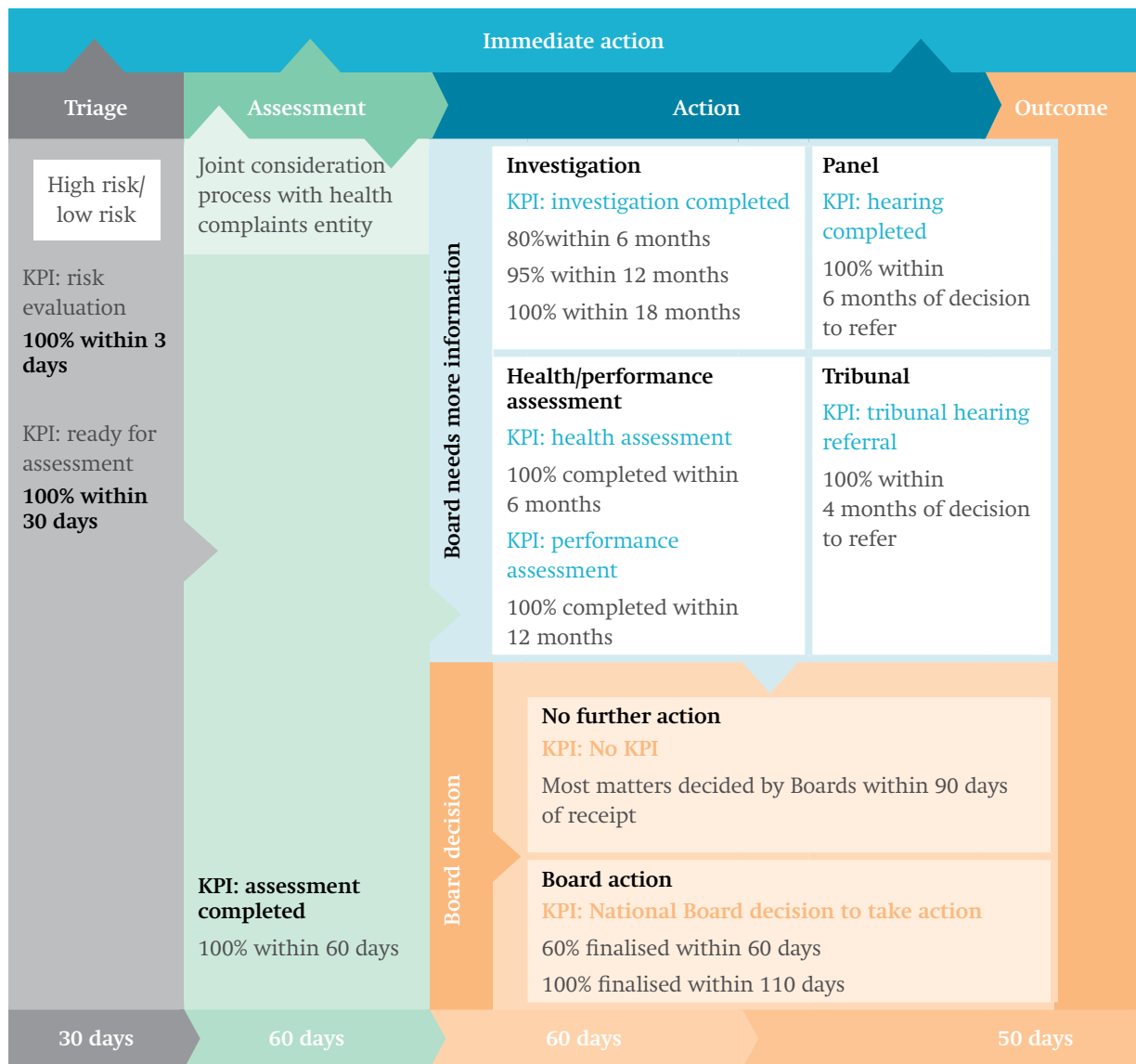
Timeliness

Timely and necessary action in response to notifications is important in providing effective public protection and confidence in the National Scheme. The National Law sets out the following:

- preliminary assessment to be completed within 60 days
- AHPRA must refer a notification to a National Board 'as soon as practicable' after receipt
- investigations should be conducted as 'quickly as practicable'.

AHPRA and the National Boards have been criticised for the length of time taken to reach an outcome for a notification. The *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency Final Report* by the Victorian Legislative Council (VLC) referred to a number of submissions from individuals or organisations that experienced delays in these processes. In 2013, the National Boards and AHPRA developed Key Performance Indicators (KPIs) about the management of notifications, these are presented in diagram 1 on the following page.

Diagram 1: AHPRA’s Key Performance Indicators for management of notifications



For the first time this will enable the National Boards and AHPRA to measure their performance at each stage of the notifications process. AHPRA will begin publishing performance data against the KPIs in 2014–15. However, AHPRA has advised the Review of findings from first 12 months of data that indicate the KPIs are not being met. This is consistent with the anecdotal feedback the Review has been receiving around the relative poor performance in this area:

- Investigation to Completion: Target 80% within 6 months – Result to date 59%
- Establishment of Panel Hearing: Target 100% within 5 months – Result to date 65%
- Panel Hearing Completion: 100% within 6 months – Result to date 73%.

It is noted that AHPRA is examining the underlining issues related to this performance to identify what further action is required to improve results.

Under the new co-regulatory arrangements in Queensland, the Office of the Health Ombudsman (OHO) has the following specific timeframes set down in the complaints management process. These are described in Table 3.

Table 3: Timeframes for complaints management by the Office of the Health Ombudsman (QLD)

Action	Timeframe
Decision to accept a complaint	7 days
Period complainants and practitioners have to supply information requested of them	14 days
Assessment of a complaint	30 days (can be extended by 30 days if necessary due to size or complexity of complaints, or time taken to obtain submissions or other information)
Investigations	Completed within 12 Months OHO must report on investigations that go longer, and is accountable to the Minister for Health and the Parliamentary Committee for investigations not completed in 24 months.

International comparisons

In Ontario, Canada timeframes for the finalisation of complaints are set out in legislation. The regulator has 150 days from the date it receives the complaint to finalise the matter. This period may be extended by 60 days, and a further 30 days, but the regulator is required to provide the complainant, registrant and Health Professions Appeal and Review Board (HPARB) with reasons for the delay. When the HPARB receives a notice from a regulator the legislation also requires the HPARB must action the matter within 120 days, which may be extended by 60 days to avoid unduly prejudicing a person.

In British Columbia, Canada the Minister may prescribe timeframes for the investigation of complaints and the Health Professions Review Board (HPRB) may review matters where there has been delay or failure of the Inquiry Committee to dispose of a complaint or investigation.

Consistent outcomes

Under the National Scheme complaints and notifications originate in the different States and Territories then migrate to AHPRA and the National Boards for assessment and, where applicable, investigation. There is a need that similar notifications, no matter where they originate from, result in similar outcomes. That is, the consequences of poor performance are uniform across the nation. This can prove challenging in the context of:

- joint consideration processes with different HCE's
- different co-regulatory arrangements in New South Wales and Queensland
- first assessment of notifications by AHPRA at a State and Territory level
- use of different State and Territory tribunals.

Co-regulatory arrangements

Background information on the co-regulatory arrangements in New South Wales and Queensland is provided in detail in Part III. Options to improve the complaints and notifications management are canvassed in Part I.

Questions

11. Should there be a single entry point for complaints and notifications in each State and Territory?
12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?
13. Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?
14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?
15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

Public protection – protected practice, advertising, cosmetic procedures and a national code of conduct

An objective of the National Scheme is to provide for the protection of the public. In accordance with its guiding principles it must do this in a transparent, accountable, efficient, effective and fair way.

The following section presents an overview of aspects of the National Scheme related to public protection that the Review. Feedback is sought from stakeholders on those areas, to assess how well the National Scheme is performing in this area, and if any strengthening of these protections is needed.

There are a number of elements in the National Scheme designed to provide public protection, these include:

- a national online register to provide information about registrants to the public and employers
- mandatory identity checking
- mandatory criminal history checking
- mandatory reporting of notifiable conduct for all registered health practitioners
- student registration for all regulated health professions
- consistent and approved national standards about practitioners' safety to practise.

In addition, the National Law legislates for a number of offences under a protection of title and practice model to keep the public safe, these include:

- restriction on use of protected titles and specialist titles, as well use of the title 'acupuncturist'
- claims by persons as to registration as a health practitioner, including as to registration of a particular division, specialty or type.

This means that only registered health practitioners who are suitably trained and qualified are able to use the protected titles and there are penalties for falsely using protected titles or holding yourself out to be a registered practitioner. The protected titles under the National Law are listed in Table 4 below:

Table 4: Professions and protected titles under the National Law

Profession	Title
Aboriginal and Torres Strait Islander Health Practice	Aboriginal and Torres Strait Islander health practitioner, Aboriginal health practitioner, Torres Strait Islander health practitioner
Chinese Medicine	Chinese medicine practitioner, Chinese herbal dispenser, Chinese herbal medicine practitioner, Oriental medicine practitioner, acupuncturist
Chiropractic	Chiropractor
Dental	Dentist, dental therapist, dental hygienist, dental prosthetist, oral health therapist
Medical	Medical practitioner
Medical Radiation Practice	Medical radiation practitioner, diagnostic radiographer, medical imaging technologist, radiographer, nuclear medicine scientist, nuclear medicine technologist, radiation therapist
Nursing and Midwifery	Nurse, registered nurse, nurse practitioner, enrolled nurse, midwife, midwife practitioner

Profession	Title
Occupational Therapy	Occupational therapist
Optometry	Optometrist, optician
Osteopathy	Osteopath
Pharmacy	Pharmacist, pharmaceutical chemist
Physiotherapy	Physiotherapist, physical therapist
Podiatry	Podiatrist, chiropodist
Psychology	Psychologist

It is a guiding principle that restrictions on the practice of a health profession are to be imposed under the National Scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality. The use of a title protection (rather than practice-based restriction) model in the National Law enables registered health practitioners to practice to the full scope available and consistent with their education and competence.

There are currently three national practice protections that restrict certain acts to practitioners with particular training and skills to protect the public. The restricted practices are:

- dental acts (restricted to medical and dental practitioners)
- prescription of optical appliances (restricted to optometrists and medical practitioners)
- manipulation of the cervical spine (restricted to medical practitioners, physiotherapists, chiropractors and osteopaths).

In addition, South Australia and Tasmania have legislative requirements and restrictions about the dispensing of optical appliances. Legislation was introduced in South Australia on 1 February 2014 to restrict 'birthing practices' to a registered medical practitioner or midwife. This change was in response to findings by the South Australian Deputy State Coroner that a person could perform the clinical responsibilities of a midwife without being a registered practitioner.

Further, there are offences relating to advertising of regulated health services. There are also some areas relating to advertising provisions, protected practices and mandatory notifications that the Review is seeking comment on to establish the extent of the problem and what action may be required.

Advertising

The National Law places the following requirements on the advertising of regulated health services.

'A person must not advertise a service, or a business that provides a regulated health service, in a way that:

- is false, misleading or deceptive or is likely to be misleading or deceptive; or
- offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer; or
- uses testimonials or purported testimonials about the service or business; or
- creates an unreasonable expectation of beneficial treatment; or
- directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.'

The intent of the provisions is to prevent advertising that contains false and misleading information that may compromise health care choices and that is not in the public interest.

Challenges to be addressed

The National Law does not define ‘testimonial’, so the word has its ordinary meaning of a positive statement about a person or thing. In the context of the National Law, a testimonial includes recommendations, or statements about the clinical aspects of a regulated health service. The risks to consumers from inappropriate testimonials is that it may lead to the unnecessary and indiscriminate use of regulated health services that they may not require, or that is not in their best interest.

The ban on the use of testimonials means it is not acceptable for a practitioner to use testimonials in their own advertising, such as their Facebook page, in a print, radio or television advertisement, or on a website.

There has been some debate regarding whether the restriction on the use of testimonials in the National Law aligns with the use and impact of social media, and the increased availability of online platforms to share information as well as health service experiences. It has been reported to the Review that these restrictions are no longer practical to enforce. For example, a practitioner needs to monitor every post placed on their Facebook page or other social media platform. While the obligations for practitioners to monitor comment does not extend to comments made by consumers on a social media site not controlled by the practitioner, this appears not to have been well understood, resulting in notifications made to AHPRA regarding alleged advertising breaches that were beyond the control of the practitioner.

In addition, consumer representative groups have reported to the Review that consumer feedback – positive or negative – should be allowed on any online platform, and that the current ban overly restricts the rights of consumers to share their experiences publicly.

Guidelines for advertising regulated health services were jointly developed by the National Boards to help practitioners and others understand their obligations when advertising a regulated health service. These Guidelines were updated May 2014 to provide clarity to practitioners on the requirements of the National Law and how it relates to postings via social media sites. The Review provides an opportunity to seek feedback from stakeholders as to whether changes in the National Law are required to make this clear.

Protected practices

There are currently inconsistencies in the protected practices across Australia. The Review is seeking stakeholders’ views regarding circumstances where a national response may be considered when a State or Territory increases regulatory measures (such as South Australia restricting ‘birthing practices’ to a registered medical practitioner or midwife).

Cosmetic procedures

The Terms of Reference note that the Review should: ‘Make any recommendations to improve the efficiency, effectiveness and accountability of the National Scheme, for example, advertising provisions, whether to extend the practice protections to include cosmetic medicine and surgery, recognising the complexity of defining the scope and who could perform this scope of practice’.

The regulation of cosmetic medicine and surgery is complicated. Concerns about public safety has led to previous work by the Clinical Technical and Ethical Principal Committee of the Australian Health Ministers’ Advisory Council producing ‘Cosmetic Medical and Surgical Procedures – a National Framework’. The report reviewed the adequacy of consumer safeguards in relation to cosmetic medical and surgical procedures and in particular: safeguards relating to advertising; information available to consumers; regulatory coverage; and professional standards of practice.

The Medical Board of Australia (MBA) has undertaken work at the request of Health Ministers to address the recommendations of this report. The MBA proposed to publish specific guidance in relation to the professional standards expected when undertaking cosmetic medicine and surgery. The development of these guidelines is subject to a regulatory best practice assessment to demonstrate the net public benefit that would be derived from any further regulation or restrictions.

Prosecuting statutory offences

The Statutory Offences Unit in AHPRA has been established to advise on potential breaches of the offence provisions of the National Law and to oversee the prosecution of all statutory offence matters.

Between 1 July 2013 and 30 April 2014, AHPRA received 804 notifications alleging breaches of the National Law. Nearly 60 per cent of all alleged offences related to breaches of the advertising guidelines. There has been one successful prosecution under the holding out provisions of the National Law. The outcome of the other offences notifications received in 2013–14 is not yet available, although the Review was advised that AHPRA has progressed seven prosecutions for offences relating to either the use protected title and false claims by persons as to registration as health practitioners. Further assessment will be undertaken by the Review once the additional information is available.

AHPRA also advised the Review that a very low percentage of complaints regarding offences under the National Law are prosecuted due to the effectiveness of the warnings issues to practitioners in the first instance.

National Code of Conduct for unregistered health practitioners

Work is currently being undertaken on behalf of the Australian Health Ministers' Advisory Council (AHMAC) to consult on the terms of a proposed National Code of Conduct for health care workers (the National Code)

The National Code is proposed to cover any individual who provides a health service that is not subject to regulation under the National Scheme for the health professions; in some circumstances this will include registered health practitioners, to the extent that they provide services that are unrelated to or outside the typical scope of practice of their registration as a health practitioner.

The National Code is designed to protect the public by:

- specifying minimum acceptable professional standards that are generally applicable to all health care workers, and below which they must not fall
- having the ability to enforce the National Code under regulation in each State and Territory
- where a health care worker is found to have breached the National Code, and his or her conduct presents a serious risk to public health and safety, then a prohibition order will be issued.

It is proposed that this model will provide a tool to respond to those unregistered health care workers whose conduct is placing the public at risk, without the need for full registration. Health Ministers are expected to consider the national consultation report in November 2014.

While the Review is not consulting on the National Code directly, it is important to consider the potential impact and interface it may have with regulation applied under the National Scheme.

Options for advertising provisions

As noted above, the Review is seeking feedback from stakeholders on the current advertising provisions in the National Law. This will help determine the extent of any problem in this area.

Options in this area are as follows:

1. no change – maintain the existing provisions in the National Law
2. amend the National Law provision preventing the use of testimonials to clarify when comment is permissible
3. remove the ban on the use of testimonials about a health profession service or business.

The objective of any action is to ensure that the restrictions on advertising to protect the public from harm are efficient, effective and fair, in accordance with the guiding principles of the National Scheme. The questions and options put forward by the Review are to assist with determining the extent of the issues in this area, and what if any action needs to be taken.

Impact Analysis

In Option 1 the provisions in the National Law would remain as they are now. As a result, there will be no cost to the regulators or governments associated with changes to the legislation, updating the guidelines and communicating this change to practitioners and the public. It also means that, if there is significant confusion and problems created by these provisions, they will continue. This may include:

- the continued cost to practitioners associated with monitoring online platforms where consumers may post comments, and then taking action to have them removed
- consumers continuing to be prevented from posting feedback on health experiences and therefore potentially decreasing the amount of information available publicly.

Conversely, some stakeholders take the view that a continued ban on testimonials will ensure that consumers are not misled into believing they require unnecessary treatment.

Option 2 involves amending the provision regarding testimonials to provide greater clarity to practitioners and consumers about when comment is permissible. The benefit of this option is that any public protection benefit being delivered by the testimonial ban will be retained, with less confusion and decreased incorrect reporting of breaches to AHPRA.

There is an implementation cost associated with this option, in order to make the amendment to the National Law and then educate stakeholders about the change. It is also possible that given the fast moving nature of developments in social media that any amendment will not maintain its currency before needing to be revisited.

Option 3 involves removing the ban on testimonials all together. Options 2 and 3 have similar implementation costs. Other potential impacts include:

- decreased costs for practitioners who will not need to monitor online platforms for comments that contravene the National Law
- decreased costs to regulators on receiving and assessing unnecessary breaches about advertising
- increased consumer discussion online regarding their experiences
- increased use of testimonials, that may result in some consumers believing they would benefit from services or treatments that are not required.

Feedback is sought on each of the above options and their potential impact.

Questions

16. Are the legislative provisions on advertising working effectively or do they require change?
17. How should the National Scheme respond to differences in States and Territories in protected practices?
18. In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

Mandatory notifications

Under the National Law, health practitioners, employers and education providers have mandatory reporting responsibilities. The National Law requires practitioners to advise AHPRA or a National Board of ‘notifiable conduct’ by another practitioner or, in the case of a student who is undertaking clinical training, an impairment that may place the public at substantial risk of harm. The purpose of these provisions is to ensure the protection of the public.

The Terms of Reference of the Review required an examination of the ‘impact of mandatory notification provisions’ in the National Law. The following section describes the current arrangements that vary across Western Australia, Queensland and the rest of the country and seeks feedback from stakeholders on if the provisions are working effectively, or if any change is required.

Notifiable conduct by registered health practitioners is defined as:

- practising while intoxicated by alcohol or drugs
- sexual misconduct in the practice of the profession
- placing the public at risk of substantial harm because of an impairment (health issue)
- placing the public at risk because of a significant departure from accepted professional standards.

The obligation to make a mandatory notification applies to the conduct or impairment of all practitioners, not just those within the practitioner’s own health profession.

Education providers, including clinical supervisors, have an obligation to make a mandatory notification if they have formed a reasonable belief that a student undertaking clinical training has an impairment that may place the public at substantial risk of harm.

The majority of notifications made to AHPRA are voluntary rather than mandatory. 680 of the 5177 notifications received nationally as at 30 April 2014 (13 per cent) were mandatory notifications. Nursing (323) and Medical (215) make up 79 per cent of these.

Registered health practitioners and employers have a legal obligation to make a mandatory notification if they have formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of their profession.

Data on mandatory notifications

A total of 565 mandatory notification cases were closed by National Boards in 2012/13, compared to 311 cases closed in 2011/12. Of these cases:

- 56 per cent were closed after the assessment was completed
- 24 per cent were closed after an investigation
- 15 per cent were closed after health or performance assessment
- 5 per cent were closed after a panel or tribunal hearing.

In 55 per cent of the mandatory notification cases closed in 2012–13, the relevant Board determined that no further action was required; compared to 59 per cent in the previous year.

In four cases, the issues raised by the mandatory notification were referred to another body for resolution. The most common outcomes were imposition of conditions (82 cases), acceptance of an undertaking (75 cases), and a caution or reprimand (84 cases). In five of the most serious cases, the practitioner’s registration was suspended (two cases), surrendered (two cases) or cancelled (one case). In two cases the registrant was fined. Table 5 provides the outcomes of closed cases in 2012–13 and 2011–12 (Note data under ‘the National Scheme’ excludes NSW).

Table 5: Outcomes of closed cases in 2012–13 and 2011–12

Outcome of closed cases	2012–13				2011–12			
	National Scheme	%	NSW	%	National Scheme	%	NSW	%
No further action	313	55	63	35	183	59	64	66
Conditions imposed	82	15	12	7	46	15	14	14
Conditions by consent	-	-	23	13	-	-	-	-
Accepted undertaking	75	13	-	-	36	12	-	-
Caution or reprimand	84	15	-	-	29	9	1	1
Suspension of registration	2	<1	2	1	8	3	-	-
Referred to another body	4	<1	8	4	5	2	7	8
Surrender of registration	2	<1	14	8	3	1	3	3
Cancellation of registration	1	<1	3	2	1	<1	-	-
Fine registrant	2	<1	-	-	-	-	-	-
Counselling*	-	-	41	23	-	-	8	8
Finding but no orders*	-	-	3	2	-	-	-	-
Resolution process*	-	-	1	<1	-	-	-	-
Withdrawn*	-	-	6	3	-	-	-	-
Changed to non-practising*	-	-	3	2	-	-	-	-
Other/No jurisdiction*	-	-	1	<1	-	-	-	-
Total 2012–13	565	-	180	-	-	-	-	-
Total 2011–12	-	-	-	-	311	-	97	-

* Outcomes available under NSW legislation only.

The following information was provided in AHPRA's 2012–13 annual report

- 1,013 mandatory notifications (of the total 8,648 notifications received)
- 951 practitioners involved in the 1,013 notifications received
- Outside NSW, AHPRA received 782 mandatory notifications
- 17 mandatory notifications were received about registered students.

Compared with 2011–12, there was a decrease in the number of mandatory reports for 2012–13 received in the ACT, the Northern Territory and Queensland; however there were substantial increases in the other States.

Queensland (230) continues to receive more mandatory reports than other States and Territories under the National Scheme, even though fewer mandatory reports were made in this State compared to 2011–12. Marginally more mandatory reports were received in New South Wales (231) in 2012–13 compared to Queensland.

There is variation in the rate of mandatory notifications across the States and Territories, and across professions, as noted in Table 6.

Table 6: Registrants involved in mandatory notifications by jurisdiction (including NSW data)

State	2012-13 ¹		2011-12		2010-11	
	Number of practitioners ²	Rate/10,000 practitioners ³	Number of practitioners ²	Rate/10,000 practitioners ³	Number of notifications ^{2,4}	Rate/10,000 practitioners ^{3,5}
New South Wales	222	12.9	170	10.6	NA	NA
Queensland	208	18.4	229	22.1	85	8.6
Victoria	189	12.3	108	7.5	164	12
South Australia	180	36.1	115	24.8	121	27.3
Western Australia	88	14.2	56	10	33	6.4
Tasmania	37	28.1	18	14.4	15	12.2
Australian Capital Territory	18	17.4	23	24	7	8.6
Northern Territory	9	14.2	13	23.3	3	6.3
Total Australia	951	16.1	732	13.3	428	8.1

Notes:

1. Regulation of four new professions, Aboriginal and Torres Strait Islander health, Chinese medicine, medical radiation and occupational therapy practitioners, commenced on 1 July 2012.
2. Figures present the number of practitioners involved in the mandatory reports received.
3. Practitioners with no PPP are not represented in the calculation of a rate for each state, but are included in the calculation of the total Australia rate.
4. The data for 2010-11 cannot be directly compared with the data for later years as they are based on the number of notifications, not the number of practitioners and do not include data for mandatory notifications received in NSW in that year.
5. Calculation of the rate in 2010-11 was based on the total number of registrants including registrants in NSW.

Different requirements in Western Australia and Queensland

In Western Australia there is no legal requirement to make a mandatory notification when a reasonable belief about misconduct or impairment is formed in the course of providing health services to a health practitioner or student.

The intent of these provisions was that a treating practitioner is exempt from making a notification where the practitioner was undergoing active treatment and did not pose a risk to the public.

Queensland, under the Health Ombudsman Act 2013, now has a similar exemption for treating practitioners. These provisions are intended to ensure that practitioners with impairments do not avoid treatment for fear of being reported, thereby creating a public risk.

The variation in the Western Australian law does not appear to have made a material difference to the rate of mandatory notifications. It is acknowledged that there are many other factors that may make a more substantial impact on notification rates.

The Review is seeking views from stakeholders about making amendments in the National Law on mandatory notifications in line with those in Western Australia and Queensland. This was a recommendation of both the Victorian Legislative Council inquiry final report and the 2011 Senate inquiry into the administration of health practitioner registration by AHPRA.

In 2012, it was recommended to Health Ministers by the Australian Health Ministers' Advisory Council that this matter be included in the three year independent review of the National Scheme to consider whether or not an additional exemption for treating practitioners should be included, as per the Western Australian National Law Act 2010.

International comparisons

Mandatory reporting obligations are a common feature of many international regulatory regimes. These obligations vary but tend to focus on: conduct that is below the required standard (competence) posing a risk or danger of harm to the public; health practitioners who are unable to perform the functions required for practise of their profession due to mental or physical condition; and health practitioners who are admitted to hospital for psychiatric care or treatment, or for treatment for addiction to alcohol or drugs.

Assessing the current provisions

There has been significant commentary on the differences in the mandatory provisions. To assess the extent of any problem in this area, feedback is sought from stakeholders on the effectiveness of both approaches in meeting the objectives of the National Scheme. Further, is having inconsistencies in provisions across jurisdictions a problem and, if so, what are the impacts of this?

Options for mandatory notifications

Options in this area are as follows:

1. maintain the current arrangements across Western Australia, Queensland and the other jurisdictions
2. amend the National Law to include provisions similar to those in Western Australia or Queensland that provide an exemption for treating practitioners.

The objectives of any action are to ensure that the mandatory reporting obligations in place to protect the public from harm are efficient, effective and fair, in accordance with the guiding principles of the National Scheme. The questions and options put forward by the Review are designed to assist with determining the extent of the issue in this area, and what if any action needs to be taken.

Impact Analysis

It has been put to the Review that the impact of not providing an exemption to treating practitioners to make a mandatory notification, is that impaired practitioners will be deterred from seeking treatment. Should this be the case, this would have a detrimental impact on the practitioner. Further, it could see impaired practitioners continuing to practise unsafely and posing a risk to patients. The data on mandatory notifications in Western Australia and Queensland, compared with the rest of the country, does not establish if the different arrangements have resulted in differences in notification patterns. As noted above, Queensland continues to receive more mandatory reports than other States and Territories under the National Scheme. There are likely a number of possible factors contributing to the high rate of notifications in Queensland. One possibility is that the extensive media coverage of high profile cases of health professional misconduct in that State has led to a much higher awareness of the notifications process across practitioners and the public.

Option 1 will result in arrangements remaining as they are. A possible impact of this option is that if practitioners with an impairment are being deterred from seeking treatment in those jurisdictions, this will continue to be the case, with a possible resultant risk to the practitioner's health and wellbeing, as well as to patients they provide services or treatment to whilst impaired. An alternate view is that notifications of impaired practitioners enable National Boards to put in place the necessary supervision or support to the practitioner and prevent risk to the public.

Option 1 would also see ongoing inconsistencies in arrangements, it is unclear if there is a negative consequence as a result of these differences.

Option 2 involves adopting the exemption described above nationally. This would deliver consistency across jurisdictions. It is unclear what result this change would have on the rate of notifications, and therefore the impact this would have on the regulators' costs. Again, the Review has heard opposing views on the potential impact of these options. Introducing this exemption may result in more impaired practitioners seeking treatment therefore improving outcomes for both them and their patients.

Feedback is sought on each of the above options and their potential impact

Question

19. Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

Workforce reform and access

The objectives and guiding principles of the National Scheme include:

- facilitating access to services provided by health practitioners in accordance with the public interest
- enabling the continuous development of a flexible, responsive and sustainable Australian health workforce
- enabling innovation in the education of, and service delivery by, health practitioners
- restrictions on the practice of a health profession are to be imposed under the National Scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

The National Scheme has a very strong focus on embedding and promoting responsiveness, flexibility, innovation, sustainability and access to services as key objectives and guiding principles surrounding the regulation of health professions. This means that every agency within the National Scheme is expected to contribute to these objectives and behave in a manner consistent with the guiding principles.

The Review is required to gauge how well the National Scheme responds to these objectives and guiding principles. In doing so three key issues are under examination:

- What role do the agencies within the National Scheme believe they have in respect to workforce reform?
- How are the priorities for workforce reform, innovation and access to services determined within the National Scheme?
- How do the Accreditation Authority's ensure through their accreditation of courses of study that education and training programs are delivering the workforce that is required for the future?

Feedback is sought from stakeholders on how well the National Scheme is performing in this area, if there is an issue to be addressed, and if so what changes are required to meet the workforce objectives.

In seeking information about the extent of the challenge in this area, the Review conducted a series of discussions with National Boards, Accrediting Authorities and AHPRA. Their view of their role within the National Scheme on workforce reform is that while they are in a position to support workforce reform most agencies did not see a role in driving reform and all agencies felt that better articulation of the workforce reform agenda and priorities would assist them to better fulfil their responsibilities in this area of the National Scheme.

The following describes the perspective from AHPRA, Accrediting Authorities and National Boards on their role in workforce reform:

The National Scheme supports and enables health workforce innovation and reform in two key ways:

- the objectives and guiding principles of the National Law facilitate health workforce reform and
- the National Law is based on a title protection model and imposes very few restrictions on the practice of registered health practitioners.

AHPRA and the National Boards also recognise there are many aspects of workforce reform that do not require a regulatory response. We are aware that the National Scheme was not intended to have a role in industrial issues.

National Boards have noted the opportunities for their leadership to support and drive innovation and practice, including by supporting expanded scopes of practice, multidisciplinary teams and inter-professional learning.

Nationally consistent data produced by the National Scheme plays an important role in informing workforce policy and planning. There is potentially a very significant role for AHPRA to support workforce reform in this area, particularly in the context of the phasing out of Health Workforce Australia.

National Boards are actively examining the ways in which practitioner regulation under the National Law can play its part in workforce reform and want to be clearly focused on the priorities of governments and the roles and responsibilities of National Boards. The recent establishment of a Health Workforce Reform Committee across National Boards provides a mechanism for engagement with AHMAC on reform priorities of cross profession significance.'

While there is a clear intent on the part of those agencies involved in the National Scheme to deliver more in this area, this is constrained by a lack of clarity on what the workforce reform priorities are from the perspective of health service providers.

Until the recent formation of the Health Workforce Reform Committee, there has also been no mechanism to develop a clear approach on workforce reform, this has largely been left to the individual agencies within the National Scheme.

All agencies expressed the view that a description of these priorities and regular monitoring and reporting on progress would help to harness the effort of all regulators in a common pursuit of the health reform priorities in Australia.

There would appear to be two areas in the reform agenda in which regulators have a role to play. The first is addressing the present workforce issues surrounding poor access to services, maldistribution of the workforce and increased specialisation of the workforce.

The second is a focus on producing a future health workforce capable of responding to the increased demand for health services from an ageing population with significant growth in chronic disease. These trends will need to be addressed through new ways of working across professions and using new technologies to enhance access and quality of services.

Workforce reform is focused on initiatives that maximise the skills and flexibility of all health professionals to address the challenges of workforce shortages. This can require change to the models of care and the practises of individual practitioners, and over time, to professions as a whole.

However, decisions relating to: the approval of registration standards; accreditation standards; codes; guidelines; and endorsements, have the potential to impose restrictions on professions and can act as a barrier to workforce flexibility or access.

In line with the objectives of the National Scheme, regulatory measures should not constrain workforce reform, except when needed to ensure public safety. Therefore, an important role for regulatory bodies is to ensure they remain focused on setting standards at a minimum for public safety and ensuring that the accreditation of education and training is fully weighted to ensure access to services is increased and not diminished.

In addition, there appears to be a growing trend towards universities establishing higher levels of qualification in several of the professions, for example postgraduate entry to medicine and physiotherapy, in excess of the qualification requirements of registration. It would seem this introduces an additional cost of entry in those professions beyond minimal regulatory requirements and it is unclear what degree of assessment is needed, or what bodies are responsible, for monitoring these developments.

Identifying workforce priorities

In the early stage of the Review the question as to who is responsible for setting the road map for workforce reform was raised. The Review has considered how regulators respond to the broader health workforce reform agenda and considered ways to assist the National Scheme to respond as a whole.

It is acknowledged that it may be difficult for individual National Boards to successfully address cross professional issues regarding broadening standards that may be perceived as encroaching on another profession's domain.

The National Law provides for the constitution of an Australian Health Workforce Advisory Council (AHWAC) with very general terms of reference, to provide independent advice to Health Ministers about any matter relating to the operation of the National Scheme. AHWAC was constituted in 2010 in accordance with the provisions in the National Law that:

- AHWAC is to consist of seven members to be appointed by Ministers
- the Chairperson is required not to be a current registered health practitioner, or a practitioner that has been registered in the last five years
- at least three of the other members of AHWAC must be persons who have expertise in health, or education and training, or both.

One option that may be considered in improving the articulation of government workforce reforms to the regulators and to assess and report on the performance of the regulators in this area of work is to reconstitute AHWAC.

Increased role of Australian Health Workforce Advisory Council in workforce reform

AHWAC could provide an independent, evidence-based mechanism to advise Health Ministers on proposals for regulatory change, for example:

- independent advice regarding all proposals for changes in standards being proposed to the Ministerial Council
- articulate the workforce reform agenda and monitor and report to health ministers on the contribution to reform by the National scheme including cross professional initiatives.

To carry out such a role, the AHWAC would require a membership with sufficient independence and expertise. The use of AHWAC to perform these functions does not represent an increase in regulation from the current arrangements.

Questions

- 20. To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?**
- 21. Should a reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?**
- 22. To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?**
- 23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?**

Assessment of overseas trained practitioners

One of the objectives of the National Law is to facilitate the rigorous and responsive assessment of overseas-trained health practitioners.

The National Boards are accountable for assessing applicants who were trained overseas for registration. This is of particular importance as our health system relies heavily on internationally qualified practitioners to meet workforce shortages, particularly in rural areas.

The requirements placed on overseas trained medical practitioners were subject to an inquiry by the House of Representatives Standing Committee on Health and Ageing in 2011. The final report *Lost in the Labyrinth – Report on the inquiry into registration processes and support for overseas trained doctors* made recommendations to streamline assessment processes whilst ensuring public safety.

The Review is seeking comments on the performance of the National Boards with respect to the assessment of overseas trained practitioners and meeting this objective of the National Law. Some specific issues raised with the Review are canvassed below. Feedback is sought from stakeholders on these areas for the Review to assess how well the National Scheme is performing in this area, and if there are areas that require improvement.

Nursing and Midwifery

There are two bodies that provide assessment for internationally qualified nurses:

- the Nursing and Midwifery Board of Australia (NMBA) which is ultimately responsible for determining the registration status of all nurses in Australia
- the Australian Nursing and Midwifery Accreditation Council (ANMAC) which has the authority to assess nurses who are applying for a visa under the general skilled migration programme.

Nursing is a profession that is included on the Skilled Occupation List for migration. ANMAC continues to consider the diploma level nursing qualification as meeting the criteria for this program. The NMBA has implemented a new model of assessment that requires a Bachelor Degree or equivalent qualification. This is presenting issues for nurses who have attained permanent residency and expect to practise but are unable to gain registration. This seems incongruous with an existing nursing workforce comprising many Nurses with Diploma level qualifications safely practising in Australia.

Medical Practitioners

For internationally qualified medical practitioners the Australian Medical Council (AMC) and the Medical Board of Australia (MBA) have a collaborative system where each has a role to play in determining registration status. There are a number of pathways a medical practitioner can take to gain limited, general and specialist registration in Australia. This causes some confusion, particularly around Area of Need (AoN) and District of Workforce Shortage (DWS).

The DWS system was introduced to define the geographical areas in which the population has less access to medical services than the national average according to Medicare statistics. AoN classifications are determined by state governments and are linked to job vacancies for medical practitioners that have remained vacant, in both the hospital and community sector, despite attempts to fill the positions. The criteria used to determine AoN status varies between each State and Territory.

Costs

Concerns about the cost of applications for overseas trained professionals are also a recurring theme. For medical practitioners this is particularly around the Pre-Employment Structure Clinical Interview (PESCI). At present each time a medical practitioner applies for an AoN position/limited registration they must sit for a PESCI, despite many having already having applied for a similar position with the same scope. As an example, a doctor undertaking a PESCI with the Australian College of Rural and Remote Medicine would be required to pay \$1,895 for each PESCI, in addition to all the other costs of registration.

Question

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

Governance of the National Scheme

The National Scheme is established via State and Territory legislation, using an adoption of laws model. Under this model, each State and Territory implements legislation that applies the National Law (or a law that substantially corresponds to the National Law). This is distinct from national schemes that are established by Commonwealth legislation by States and Territories ceding power to the Commonwealth. This model is used for matters where national consistency is desired, but is generally within the States' and Territories' legislative powers, and not that of the Australian Government.

The Terms of Reference of the Review requires an examination of the governance structures and relationships established under the National Scheme, with a focus on assessing their effectiveness and any options for improvement. Details of these arrangements are provided in Part III. Table 7 provides an overview of responsibilities under the National Scheme.

Table 7: Functions and responsibilities of bodies within the National Scheme

Body	Appointed by and responsible to	For how long
Australian Health Workforce Ministerial Council (known as 'Ministerial Council')	Ministers are assigned portfolio responsibility for health as members of the relevant state, territory or federal government elected by the public	For the period for which the Minister has portfolio responsibility for health
Australian Health Workforce Advisory Council (AHWAC)	Australian Health Workforce Ministerial Council	Terms up to 3 years (eligible for reappointment)
National Boards	Australian Health Workforce Ministerial Council	Terms up to 3 years (eligible for reappointment)
State/Territory/regional boards of National Boards	Established by National Boards Appointed by relevant Health Minister	Terms up to 3 years (eligible for reappointment)
AHPRA Agency Management Committee	Australian Health Workforce Ministerial Council	Terms up to 3 years (eligible for reappointment)
Accreditation Authorities (= external accreditation body, or an accreditation committee established by National Board)	National Boards decide who will exercise accreditation function and a contract is in place between the Accreditation Authority and AHPRA on behalf of the National Board	Contractual
National Health Practitioners Privacy Commissioner National Health Practitioners Ombudsman	Australian Health Workforce Ministerial Council	Remuneration, terms and conditions decided by Ministerial Council

In summary, the current structure and governance shows accountability for the National Scheme is shared between;

- National Boards for regulatory policy, standards and decision making about health practitioners. Accrediting authorities or committees are accountable through to the relevant National Board for accreditation functions;
- accountable for the operational performance and corporate support provided by AHPRA to the National Boards.

The final accountability of these agencies is to Australian Health Ministers in their capacity as the Health Workforce Ministerial Council under the National Law.

The main accountability tools that are either contained in the National Law or in other laws that impact on the agencies include:

- annual reporting and audited financial statements
- Ministerial Council policy directions and approvals with respect to registration standards and endorsements for specialties, scheduled medicines, areas of practice and acupuncture
- review of National Board registration and disciplinary decisions by State and Territory tribunals
- freedom of information protections
- privacy protections
- review of administrative decisions by the National Health Practitioner Ombudsman
- judicial review of decisions
- human rights charter legislation and anti-corruption legislation
- Council of Australian Governments (COAG) best practice regulation requirements.

As discussed in Part I of the paper, there is a view that the National Scheme is not adequately accountable to State and Territory Health Ministers and that there is a need for the National Scheme's operation to be assessed and held accountable as a whole.

Constitution of National Boards

Under Section 33 of the National Law the Ministerial Council decides the size and composition of the Board, subject to the requirements of the National Law summarised as follows:

- members of a National Board are to be appointed as practitioner members or community members
- at least half, but not more than two-thirds, of the members of a National Board must be persons appointed as practitioner members
- the practitioner members must consist of at least one member from each from a large and small participating jurisdiction
- at least 2 of the members of a National Board must be persons appointed as community members
- at least one of the members of a National Board must live in a regional or rural area
- one of the practitioner members is to be appointed as Chairperson of the Board by the Ministerial Council.
- The requirements in relation to composition of the National Boards are intended to ensure that there is sufficient diversity of views feeding into decision making.

Appointing community members to office bearing positions

The National Law currently prevents community members from being appointed as the chair of a National Board. The Review is seeking views to determine if there should be flexibility to make merit based appointments to the position of National Board Chair, whether they are a registered health practitioner or not.

National Ombudsman and Privacy Commissioner

The National Law provides that the Commonwealth's *Privacy Act 1988*, *Freedom of Information Act 1982* and *Ombudsman Act 1976*, as modified by the *Health Practitioner Regulation National Law Regulation* operate in each participating jurisdiction for the purposes of the National Scheme.

The National Law establishes the Office of the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC). These arrangements were designed to ensure the accountability, transparency and responsiveness of the regulatory system administered by the national agencies for the National Scheme, namely:

- the Australian Health Practitioner Regulation Agency (AHPRA)
- the 14 National Boards
- AHPRA’s Agency Management Committee
- the Australian Health Workforce Advisory Council.

The NHPOPC was designed to provide an avenue to those who believed they had been treated unfairly in administrative processes by a national agency within the National Scheme, or if they believe an agency has inappropriately handled their personal information.

The ability of the NHPOPC to provide independent oversight is an important part of the National Scheme. The effective operation of the NHPOPC is required to achieve redress for individuals, but also, where they identify systemic issues, to seek changes in the work of the agencies in their jurisdiction, both individually and collectively.

Issues have been highlighted regarding the effectiveness of the office of the NHPOPC and the governance structure that is required to provide oversight of the NHPOPC and ensure that the NHPOPC can fulfil the function under the National Law without interference.

In addition, a sustainable source of funds is required to enable the NHPOPC to operate effectively. As the National Scheme was intended to be administered on a cost recovery basis, the same principle should apply to the resourcing of the NHPOPC.

Governance and accountability of Accreditation Authorities

Under the National Law, National Boards regulating health practitioners in Australia must decide whether their accreditation function is to be exercised by an external accreditation entity or a committee established by the National Board. More information on accreditation functions and authorities is provided in Part III of this paper. In summary, if the Accreditation Authority is an external council, the council works with the National Board to deliver specified accreditation functions under a formal agreement with AHPRA on the board’s behalf. If the Accreditation Authority is a committee, the committee works with the National Board according to the committee’s terms of reference.

Accreditation Authorities and National Boards have separate, but complementary functions under the National Law, which specifies these functions. These are summarised in the Table 8 below:

Table 8: Accreditation functions

Accreditation Authorities	National Board
Sets accreditation standards	Approves, refuses or requires a review the standards
Accredits programs of study May refuse to accredit programs of study if it believes the course does not meet the accreditation standards	Approves accredited programs of study, can also refuse or approve a program with conditions
Monitors accredited courses. May withdraw accreditation of a course if it believes the course no longer meets the approved accreditation standards, or impose conditions on a program.	The National Boards approval of a course is cancelled if its accreditation is revoked, it may also impose conditions on an approved course.

The National Boards are responsible for determining how accreditation functions should be exercised under the National Law, and ultimately the Accreditation Authority is accountable to the National Board for these functions.

Where an Accreditation Authority issues a notice to refuse to accredit a program of study, an education provider may apply to the Accreditation Authority within 30 days for an internal review. The internal review must not be carried out by a person who assessed the program of study for the Accreditation Authority.

In respect to the accountabilities under the National Scheme it is not clear that the National Health Practitioner Ombudsman has jurisdiction over complaints raised about processes undertaken by Accrediting Authorities or committees. These are not specified in the Ombudsman's jurisdiction specifically, but if the National Boards are accountable for this function, as described in the National Law, then there may be a role for the Ombudsman to examine the process followed in reaching a decision. If not, the question arises, Who should review decisions made by accrediting authorities where there is a dispute on the outcome or process?

International comparison

In the United Kingdom and New Zealand, regulators have a central role in the development of standards and the accreditation of education and training of health professionals.

Assessing the current arrangements

There has been significant commentary on the effectiveness of the current governance arrangements of the National Scheme. To assess the extent of any problem in this area, feedback is sought from stakeholders on the following questions.

Questions

- 25. Should the appointment of Chairperson of a National Board be on the basis of merit?**
- 26. Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?**
- 27. Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?**

Cost and sustainability of the National Scheme

In June 2014, the Professional Standards Authority, working in collaboration with the Centre for Health Services Economics and Organisation, was contracted to review the cost effectiveness and efficiency of the National Registration and Accreditation Scheme for health professions (the National Scheme) in Australia. The Review was scheduled to take place between July and October 2014 and delivered in two phases, an interim assessment to inform this Consultation Paper, and a final report incorporating a more in-depth analysis.

This review was one element of the broader review of the National Scheme, commissioned by the Australian Health Workforce Ministerial Council. It was anticipated that the findings from the cost effectiveness and efficiency review would be critical to the provision of advice and options for reform to improve the operations and governance arrangements to ensure the sustainability of the National Scheme.

The Professional Standards Authority

The PSA promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. It is an independent body, accountable to the UK Parliament and oversees the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. As part of this role it reviews the regulators' performance annually and audits and scrutinises their decisions about whether people on their registers are fit to practise.

The Centre for Health Services Economics and Organisation

The Centre for Health Services Economics and Organisation (CHSEO) is a research unit with economists, statisticians and operational researchers, focused on whole-system analysis of healthcare and local health economies.

Methodology

In undertaking the review PSA has applied a methodology developed specifically for assessing the cost-effectiveness and efficiency of professional regulatory arrangements. This was developed when the PSA, working with the CHSEO, was commissioned by the Department of Health in 2011 to conduct a cost effectiveness and efficiency review of the nine UK health and care regulators. This work involved collection and cleaning of financial data, its integration with performance data, the development of economic modelling and the publication in 2012 of an analytical report and recommendations. The methodology which was developed in that exercise has been applied to the data on operating costs for the regulatory functions in Australia. The Review is not aware of any alternative methodologies having been developed elsewhere for a cost-effectiveness and efficiency assessment of professional regulatory arrangements.

Provisions for health professional regulation: Australia and the UK

A detailed description of the arrangements for the regulation of health professionals in Australia and in the UK is provided in Part III of the paper. This context is important to the economic interpretations that follow. Table 9 provides a summary of the regulators and registrant numbers in Australia and the UK.

Table 9: Regulators and registrant numbers in Australia and the UK

Australia Regulatory body	Profession(s)	No. on register
Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA)	Aboriginal and Torres Strait Islander health practitioners	330
Chinese Medicine Board of Australia (CMBA)	Chinese medicine practitioners	4,259
Chiropractic Board of Australia (ChiroBA)	Chiropractors	4,843
Dental Board of Australia (DBA)	Dentists, dental specialists, dental therapists, dental hygienists, oral health therapists and dental prosthetists	20,692
Medical Board of Australia (MBA)	Medical Practitioners	99,209
Nursing and Midwifery Board of Australia (NMBA)	Nurses and midwives	362,008
Optometry Board of Australia (OptomBA)	Optometrists	4,790
Osteopathy Board of Australia (OsteoBA)	Osteopaths	1,864
Pharmacy Board of Australia (PharmBA)	Pharmacists	28,252
Occupational Therapy Board of Australia (OTBA)	Occupational therapists	16,174
Physiotherapy Board of Australia (Physio BA)	Physiotherapists	26,076
Podiatry Board of Australia (PodBA)	Podiatrists	4,125
Psychology Board of Australia (PsyBA)	Psychologists	31,649
Medical Radiation Practice Board of Australia (MRPBA)	Medical radiation practitioners	14,360
	Total	618,631

United Kingdom Regulatory body	Profession(s)	No. on register
General Chiropractic Council	Chiropractors	2,959
General Dental Council	Dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians, orthodontic therapists	103,765
General Medical Council	Medical Practitioners	259,826
Nursing and Midwifery Council	Nurse and midwives	680,858
General Optical Council	Optometrists, dispensing opticians, student opticians (optical businesses)	24,421
General Osteopathic Council	Osteopaths	4,810
General Pharmaceutical Council and Pharmaceutical Society of Northern Ireland	Pharmacists, pharmacy technicians (Great Britain only) Pharmacists (Northern Ireland only)	71,221 2,155
Health and Care Professions Council	Occupational therapists Physiotherapists Podiatrists Psychologists Radiographers plus 11 other health and care professions	322,037
	Total	1,472,052

Aggregate operating costs in Australia

Analysis was undertaken on 2013/14 data provided by AHPRA for each of the National Boards, broken down by regulatory function. Six basic regulatory functions have been identified: notifications, registration, compliance, accreditation, professional standards and governance. There are also other costs that cannot be directly allocated to one of these functions. These seven cost categories can be found in Table 10 below.

Table 10: AHPRA spending by function 2013–14

	'Other' costs not allocated across functions		'Other' costs allocated across functions	
	Total costs by function at national level – all professions	% of total spending by function	Total costs by function at national level – all professions	% of total spending by function
Notifications	\$40,085,829	26.4%	\$54,921,366	36.2%
Registration	\$34,771,308	22.9%	\$55,465,491	36.5%
Compliance	\$5,270,936	3.5%	\$8,072,309	5.3%
Accreditation	\$9,010,232	5.9%	\$9,341,422	6.2%
Professional Standards	\$9,459,649	6.2%	\$11,942,743	7.9%
Governance	\$7,641,634	5.0%	\$12,144,609	8.0%
Other (Enabling Functions)	\$45,648,352	30.1%	N/A	N/A
Total	\$151,887,940	100.0%	\$151,887,940	100.0%

AHPRA spends approximately \$152million regulating health professionals in Australia. A large proportion of expense is on notifications (\$40million) and registration (\$35million). In their basic accounts, AHPRA's overheads and enabling factors were grouped as 'other costs'. Upon request AHPRA spread these other costs across specific functions. AHPRA determined the allocation on an FTE basis, with costs shared across functions according to the number of staff employed in each function. AHPRA has also carried out an ad-hoc adjustment to make these figures fit with its experience of its operations, increasing the size of notification expenditure and decreasing the size of spending on registration. At this stage it has not been possible to investigate AHPRA's methods but this may merit further research in the second phase of the project.

Based on these allocations, registration is the biggest area of expense (\$54.9million or 36.5% of total spending), marginally above notifications (\$54.5million, 36.2%). The four other areas each account for between 5.3% (\$8.1million) and 8.0% (\$12.1million) of expenditure.

In addition to spending incurred centrally by AHPRA, the estimates also provide for the additional cost of investigating notifications in New South Wales (NSW). NSW operates its own notification system with funds AHPRA collects on its behalf but does not include in the figures discussed above. Due to this different notification system, NSW health professionals can pay different fees to those collected by AHPRA.

The aggregate figure for the cost of notifications provided by NSW of \$19.4million is close to the total of the estimates calculated here. The adjustment to the AHPRA figures results in an increase of 36.9% on national spending on notifications and total spending on regulation by 16.5%. This causes significant changes to the overall shares of spending, as can be seen in Table 11.

Table 11: Total Spending by AHPRA and in New South Wales 2013–14

	Total costs by function at national level – all professions	% of total spending by function
Notifications	\$75,194,462	43.7%
Registration	\$55,465,491	32.2%
Compliance	\$8,072,309	4.7%
Accreditation	\$9,341,422	5.4%
Professional Standards	\$11,942,743	6.9%
Governance	\$12,144,609	7.1%
Total	\$172,161,037	100.0%

Notifications becomes the largest area of spending, accounting for 43.7%, ahead of registration (32.2%). These two areas dwarf the other four functions which incur between 4.7% and 7.1% of total spending on regulation when NSW is included.

The interim analysis has not incorporated the additional costs incurred by those cases which are managed by the Health Complaints Commissioner; therefore an estimation of the total cost of notifications handling in Australia is not yet available.

Further, the full cost of delivering accreditation by the accreditation councils, as is the case for 11 out of the 14 professions covered by the National Scheme has not been collated. This, when added to accreditation costs incurred by AHPRA, could make accreditation a more significant element of the cost of delivering the National Scheme as a whole. The costs associated with the HCCC and the accreditation councils will be considered in the second phase of the project.

Operating costs by board

There are 14 health profession boards in the National Scheme, ranging in size from Aboriginal and Torres Strait Islander Health Practice Board of Australia with 330 registrants up to Nursing and Midwifery Board of Australia which had 362,008 registrants in May 2014. Table 12 shows each board's aggregate spending by function, using the data provided by AHPRA and adjusted to account for the additional cost of the NSW notifications process.

Table 13 shows how the proportion of a National Board's spending on the various functions varies across the professions.

A second way to compare different sized boards is to look at the unit cost, or cost per registrant, for each function at board level, i.e., the total amount spent by each board on the individual functions of registration divided by the number of registrants in each profession. The rest of the analysis presented here concentrates on measures of this nature. Table 14 presents this information for the 14 National Boards, as well as an average for all registered professionals, in aggregate and for each of the six individual functions.

On average, regulating a health professional in Australia cost \$278 in 2013/14. There was wide variation across the different boards though, with Aboriginal and Torres Strait Islander Health Practitioners costing \$1,792 per registrant while a nursing or midwifery registrant cost about \$149. Aboriginal and Torres Strait Islander Health Practice Board of Australia was the most expensive National Board for all six functions as well as on an aggregate level. This unit cost analysis suggests that the size of the National Board has some role in explaining the relative expense of regulation, with larger boards appearing less costly.

Table 12: Total spending by board and function 2013-14

	All professions	ATSIHPBA	CMBA	ChiroBA	DBA	MBA	MRPBA
Registrants	618,631	330	4,259	4,843	20,692	99,209	14,360
Notifications	\$75,194,462	\$162,746	\$1,283,765	\$1,372,335	\$4,926,819	\$34,442,898	\$1,093,750
Registration	\$55,465,491	\$189,225	\$648,030	\$812,300	\$3,497,100	\$15,716,387	\$943,593
Compliance	\$8,072,309	\$21,290	\$77,427	\$109,499	\$475,310	\$2,847,794	\$115,995
Accreditation	\$9,341,422	\$26,537	\$61,927	\$150,467	\$377,436	\$3,273,807	\$152,289
Professional Standards	\$11,942,743	\$155,323	\$195,738	\$298,228	\$784,116	\$3,271,168	\$414,954
Governance	\$12,144,609	\$36,328	\$129,425	\$168,370	\$738,341	\$4,278,590	\$183,075
Total	\$172,161,037	\$591,449	\$2,396,312	\$2,911,200	\$10,799,122	\$63,830,644	\$2,903,655

Table 13: Proportion of total board spending by function 2013-14

	All professions	ATSIHPBA	CMBA	ChiroBA	DBA	MBA	MRPBA
Notifications	43.7%	27.5%	53.6%	47.1%	45.6%	54.0%	37.7%
Registration	32.2%	32.0%	27.0%	27.9%	32.4%	24.6%	32.5%
Compliance	4.7%	3.6%	3.2%	3.8%	4.4%	4.5%	4.0%
Accreditation	5.4%	4.5%	2.6%	5.2%	3.5%	5.1%	5.2%
Professional Standards	6.9%	26.3%	8.2%	10.2%	7.3%	5.1%	14.3%
Governance	7.1%	6.1%	5.4%	5.8%	6.8%	6.7%	6.3%

Table 14: Unit costs by function at board level 2013-14

	All	ATSIHPBA	CMBA	ChiroBA	DBA	MBA	MRPBA
Notifications	\$121.55	\$493.17	\$301.42	\$283.36	\$238.10	\$347.18	\$76.17
Registration	\$89.66	\$573.41	\$152.16	\$167.73	\$169.01	\$158.42	\$65.71
Compliance	\$13.05	\$64.51	\$18.18	\$22.61	\$22.97	\$28.71	\$8.08
Accreditation	\$15.10	\$80.42	\$14.54	\$31.07	\$18.24	\$33.00	\$10.61
Professional Standards	\$19.31	\$470.68	\$45.96	\$61.58	\$37.89	\$32.97	\$28.90
Governance	\$19.63	\$110.09	\$30.39	\$34.77	\$35.68	\$43.13	\$12.75
Total	\$278.29	\$1,792.27	\$562.65	\$601.11	\$521.90	\$643.40	\$202.20

NMBA	OTBA	OptomBA	OsteoBA	PharmBA	PhysioBA	PodBA	PsyBA
362,008	16,174	4,790	1,864	28,252	26,076	4,125	31,649
\$17,957,269	\$1,162,245	\$755,090	\$481,841	\$3,906,555	\$1,519,229	\$507,011	\$5,622,910
\$22,298,326	\$1,134,033	\$471,745	\$292,490	\$3,276,903	\$1,379,628	\$404,653	\$4,401,078
\$2,849,536	\$155,434	\$74,484	\$46,380	\$450,234	\$190,147	\$54,501	\$604,278
\$3,468,797	\$175,111	\$235,408	\$150,685	\$347,047	\$261,138	\$108,470	\$552,305
\$3,255,616	\$384,024	\$309,471	\$175,881	\$865,811	\$493,311	\$186,619	\$1,152,485
\$4,244,858	\$243,841	\$88,752	\$57,781	\$695,706	\$281,284	\$80,353	\$917,905
\$54,074,402	\$3,254,688	\$1,934,949	\$1,205,058	\$9,542,256	\$4,124,736	\$1,341,607	\$13,250,961

NMBA	OTBA	OptomBA	OsteoBA	PharmBA	PhysioBA	PodBA	PsyBA
33.2%	35.7%	39.0%	40.0%	40.9%	36.8%	37.8%	42.4%
41.2%	34.8%	24.4%	24.3%	34.3%	33.4%	30.2%	33.2%
5.3%	4.8%	3.8%	3.8%	4.7%	4.6%	4.1%	4.6%
6.4%	5.4%	12.2%	12.5%	3.6%	6.3%	8.1%	4.2%
6.0%	11.8%	16.0%	14.6%	9.1%	12.0%	13.9%	8.7%
7.9%	7.5%	4.6%	4.8%	7.3%	6.8%	6.0%	6.9%

NMBA	OTBA	OptomBA	OsteoBA	PharmBA	PhysioBA	PodBA	PsyBA
\$49.60	\$71.86	\$157.64	\$258.50	\$138.28	\$58.26	\$122.91	\$177.66
\$61.60	\$70.11	\$98.49	\$156.92	\$115.99	\$52.91	\$98.10	\$139.06
\$7.87	\$9.61	\$15.55	\$24.88	\$15.94	\$7.29	\$13.21	\$19.09
\$9.58	\$10.83	\$49.15	\$80.84	\$12.28	\$10.01	\$26.30	\$17.45
\$8.99	\$23.74	\$64.61	\$94.36	\$30.65	\$18.92	\$45.24	\$36.41
\$11.73	\$15.08	\$18.53	\$31.00	\$24.63	\$10.79	\$19.48	\$29.00
\$149.37	\$201.23	\$403.96	\$646.49	\$337.76	\$158.18	\$325.24	\$418.68

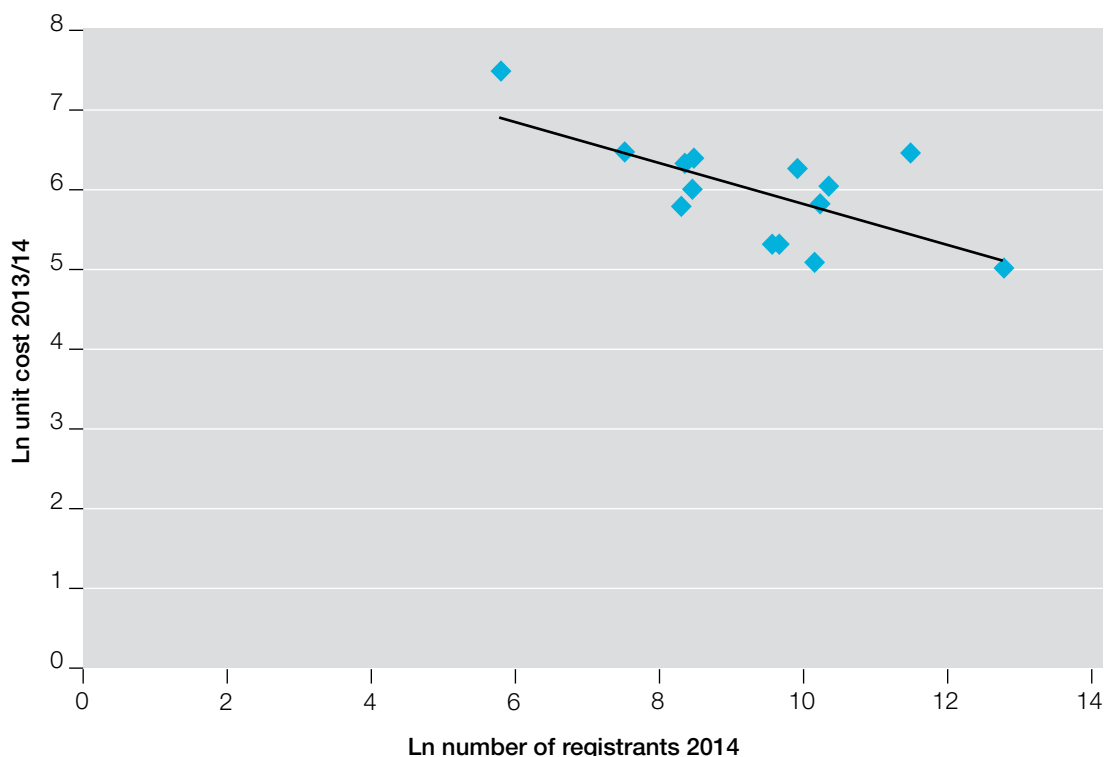
The relationship between scale and regulator unit cost

PSA's analysis explores the relationship between the scale of the regulator/National Board and the regulator's unit cost (Figure 1). The relationship is expressed in logarithms because a percentage relationship is expected between the two variables; a one percent increase in scale is associated with an x-percent decrease in unit cost.

Figure 1 gives the natural log of total unit cost on the y-axis against the natural log of the number of registrants on the x-axis. The fitted line shows the percentage increase (or decrease) if the number of registrants was 1% higher (or lower). In Figure 1, the slope of -0.26 implies that regulators that are 10% larger in size are 2.6% lower in the unit cost of regulation. Across the regulatory functions, an increase in size of 10% results in a unit cost reduction of between 2 and 3%.

The same relationship was observed between size and each function of the National Boards. It is recognised that the significant correlation between scale and cost does not in itself demonstrate a causal link.

Figure 1: Unit cost plotted against the number of registrants



Adjusting for complexity

Depending on the nature of the profession, some National Boards can be expected to incur greater costs than others. This is because the task of regulating is related both to the complexity of the tasks being undertaken by registrants, and the complexity of the risks that arise from registrants' practice. Different levels of risk complexity will require different levels of regulatory force on the part of the regulator to manage the risk. The regulator of medical practitioners who are operating in complex, high-risk areas of practice and making life and death decisions will need to apply greater regulatory force than the regulator of, for example, occupational therapists.

PSA's previous policy work in this area has shown a positive correlation between complexity and regulatory force, which appears to be borne out by the preliminary analysis in the interim report, which suggests that the complexity measure is positively related to the ratio of actual to predicted unit cost in aggregate and for each function.

Further work in this area would be informative, and will be taken forward in the second phase of the project.

A comparison of the costs of Australian National Boards and UK councils

The work PSA has undertaken for this Review has paralleled a similar review carried out by the PSA (then the Council for Healthcare Regulatory Excellence), which examined cost effectiveness and efficiency of the regulatory bodies that the Authority supervises in the UK. As such, it is possible to see how Australia's National Boards compare with their counterparts in the different regulatory framework that exists in the UK.

There are fewer regulators in the UK (nine) than there are National Boards in Australia, and they cover a slightly different mix of professions. While they are all overseen by the PSA, the regulators operate independently of each other and were formed under different acts of Parliament over the course of many years. Therefore, they do not necessarily act consistently because they have different legal standing and may interpret the relevant laws in different ways.

When examining aggregate unit costs, it appears that the unit cost of regulation is quite similar in the two jurisdictions, at \$278 per registrant in Australia and \$301 in the UK. However, there are several other factors to consider with result:

- Australian figures do not include costs incurred by the Accreditation Authorities; in the UK, the comparable function is referred to as quality assurance of higher education and is undertaken by the regulatory bodies rather than by an external organisation
- the number of UK health professionals is much larger than that in Australia – approximately 1.3million at the time the UK review was undertaken. As shown earlier, there are scale effects that show the unit cost of regulation falls as the size of the registers increase, so the UK system could be expected to be cheaper
- the aggregate similarities disguise significant difference across the functions. Governance and accreditation appear to cost regulators roughly the same per registrant in the two countries, but notifications (complaints) are much more costly in the UK and account for more than 60% of the total cost. Registration appears to be a lot more expensive in Australia, at 32% compared to 18% in the UK, as is compliance but this last is the least costly function of regulation. The reason for these differences needs to be explored in more detail.

There are six professions regulated by a National Board in Australia and a council in the UK which can be directly compared. Pharmacists have two independent regulators in the UK, one for Northern Ireland and one for the rest of the UK. There are five Australian National Boards covering professions that are among the 16 regulated by the HCPC in the UK. This means that there are eight groups that can be compared, in addition to the aggregate unit cost of regulation in the two countries. This information is presented in Table 15.

The analysis indicates that the unit cost per registrant is comparable in the UK and Australia for medicine, nursing and midwifery, pharmacy and dentistry. There are greater differences in the unit cost per registrant for chiropractor, osteopathy, optometry and for the professions regulated under the HCPC.

Nurses and midwives

Regulating each nurse and midwife costs about \$149 in Australia and \$135 in the UK. Notifications account for more than 60% of this cost in the UK and only 33% in Australia. Registration though, is three times more expensive in Australia. The other three functions account for less than 25% of the total cost in both jurisdictions.

Medical Practitioners

Medical practitioners cost slightly more to regulate in the UK than Australia, at \$742 compared to \$643. This is due to notifications being about \$145 per registrant more expensive in the UK. As with nurses and midwives, registration is considerably more expensive in Australia, both in terms of actual costs and the proportion of total regulator spend.

Dentists

The distribution of costs for dentists follows a similar pattern to that of medical practitioners – more expensive in the UK, in aggregate and notifications cost are much more in the UK, while registrations are more costly in Australia.

Chiropractors

Chiropractors are one of the few examples where UK regulation appears much more expensive than Australia. Despite having zero accreditation costs, regulating UK chiropractors cost more than twice as much as Australian ones. It is notable that the Chiropractic Board of Australia spends 28% of its aggregate spend on registration compared to 14% in the UK. The unit costs for notifications are \$283.36 in Australia and \$825.13 in the UK, representing 47% and 57% of total expenditure respectively.

Osteopaths

UK osteopaths are also about twice as costly per registrant as those in Australia. Every function costs more per registrant in the UK, although the scale of this varies from just 19% in accreditation to more than 600% in governance.

Optometrists/Opticians

Regulating optometrists is slightly more expensive in Australia than regulating opticians in the UK. Notifications take up roughly the same proportion of total spend in UK and Australia (38%-39%) as does accreditation (13%-12%) but costs for the other functions vary quite significantly, with Australia spending a bigger proportion on registration and professional standards while the UK spending on governance is much greater.

Pharmacists

In the UK the General Pharmaceutical Council registers premises as well as individual professionals. However, data about monitoring premises was omitted from the UK review so these regulators can be compared directly. The Pharmacy Board of Australia's expenditure is close to the General Pharmaceutical Council, but as is noted across most professions, the cost of registration is quite a lot higher¹.

Professions covered by HCPC in UK

These five professions (physiotherapy, podiatry, radiography, psychology, occupational therapy) are remarkably similar in Australia, spending between \$158 and \$419 per registrant in similar proportions across the functions. They are all more expensive than the HCPC costs (\$151.80), but HCPC spend on compliance is minimal, while it also has low costs of professional standards. This comparison is less perfect than the other professions though, as the HCPC also covers several other professions not regulated in Australia, and given its size, is also likely to exploit scale efficiencies unobtainable by their Australian counterparts as they are operating as separate Boards.

¹ Pharmacists in Northern Ireland are regulated by the Pharmaceutical Society of Northern Ireland. Its unit costs are higher than the GPhC, and it spends in different ways, with less on notifications and significantly more on compliance.

Table 15: Australia (2013–14) and UK (2010–11) costs (Indexed to 2013–14) compared - unit costs per registrant and % of total expenditure by function

	Total (Aus)	Total (UK) ¹	Nurses (Aus)	Nurses (UK)	Doctors (Aus)	Doctors (UK)	Dentists (Aus)	Dentists (UK)	Chiropractor (Aus)	Chiropractor (UK)
Notifications	\$121.55	\$186.89	\$49.60	\$84.01	\$347.18	\$492.10	\$238.10	\$360.66	\$283.36	\$825.13
	44%	62%	33%	62%	54%	66%	46%	64%	47%	57%
Registration	\$89.66	\$55.44	\$61.60	\$22.45	\$158.42	\$129.85	\$169.01	\$126.99	\$167.73	\$209.57
	32%	18%	41%	17%	25%	18%	32%	23%	28%	14%
Compliance	\$13.05	\$8.06	\$7.87	\$1.08	\$28.71	\$23.16	\$22.97	\$5.86	\$22.61	\$148.27
	5%	3%	5%	1%	4%	3%	4%	1%	4%	10%
Accreditation	\$15.10	\$17.67	\$9.58	\$5.34	\$33.00	\$40.84	\$18.24	\$25.37	\$31.07	\$0.00
	5%	6%	6%	4%	5%	6%	3%	5%	5%	0%
Professional Standards	\$19.31	\$11.42	\$8.99	\$10.64	\$32.97	\$11.72	\$37.89	\$12.26	\$61.58	\$50.71
	7%	4%	6%	8%	5%	2%	7%	2%	10%	3%
Governance	\$19.63	\$22.01	\$11.73	\$12.03	\$43.13	\$44.16	\$35.68	\$29.42	\$34.77	\$218.23
	7%	7%	8%	9%	7%	6%	7%	5%	6%	15%
Total	\$278.29	\$301.50	\$149.37	\$135.57	\$643.40	\$741.84	\$521.90	\$560.55	\$601.11	\$1,451.91

	Total (Aus)	Total (UK)	Osteopaths (Aus)	Osteopaths (UK)	Optometrists (Aus)	Opticians (UK)	Pharmacists (Aus)	Pharmacists (UK) ²	Pharmacists (NI)
Notifications	\$121.55	\$186.89	\$258.50	\$412.80	\$157.64	\$147.22	\$138.28	\$147.48	\$132.01
	44%	62%	40%	29%	39%	38%	41%	45%	19%
Registration	\$89.66	\$55.44	\$156.92	\$284.40	\$98.49	\$63.89	\$115.99	\$67.38	\$94.47
	32%	18%	24%	20%	24%	17%	34%	20%	14%
Compliance	\$13.05	\$8.06	\$24.88	\$150.92	\$15.55	\$38.88	\$15.94	\$20.49	\$207.90
	5%	3%	4%	11%	4%	10%	5%	6%	31%
Accreditation	\$15.10	\$17.67	\$80.84	\$105.49	\$49.15	\$48.42	\$12.28	\$43.24	\$113.38
	5%	6%	13%	7%	12%	13%	4%	13%	17%
Professional Standards	\$19.31	\$11.42	\$94.36	\$264.42	\$64.61	\$19.62	\$30.65	\$12.83	\$47.06
	7%	4%	15%	19%	16%	5%	9%	4%	7%
Governance	\$19.63	\$22.01	\$31.00	\$210.55	\$18.53	\$68.03	\$24.63	\$39.21	\$86.44
	7%	7%	5%	15%	5%	18%	7%	12%	13%
Total	\$278.29	\$301.50	\$646.49	\$1,428.60	\$403.96	\$386.07	\$337.76	\$330.64	\$681.25

	Total (Aus)	Total (UK)	Medical radiation (Aus)	Occupational therapy (Aus)	Physiotherapists (Aus)	Podiatrists (Aus)	Psychologists (Aus)	HCPC (UK)
Notifications	\$121.55	\$186.89	\$76.17	\$71.86	\$58.26	\$122.91	\$177.66	\$90.88
	44%	62%	38%	36%	37%	38%	42%	60%
Registration	\$89.66	\$55.44	\$65.71	\$70.11	\$52.91	\$98.10	\$139.06	\$31.49
	32%	18%	32%	35%	33%	30%	33%	21%
Compliance	\$13.05	\$8.06	\$8.08	\$9.61	\$7.29	\$13.21	\$19.09	\$0.82
	5%	3%	4%	5%	5%	4%	5%	1%
Accreditation	\$15.10	\$17.67	\$10.61	\$10.83	\$10.01	\$26.30	\$17.45	\$13.80
	5%	6%	5%	5%	6%	8%	4%	9%
Professional Standards	\$19.31	\$11.42	\$28.90	\$23.74	\$18.92	\$45.24	\$36.41	\$5.90
	7%	4%	14%	12%	12%	14%	9%	4%
Governance	\$19.63	\$22.01	\$12.75	\$15.08	\$10.79	\$19.48	\$29.00	\$8.90
	7%	7%	6%	7%	7%	6%	7%	6%
Total	\$278.29	\$301.50	\$202.21	\$201.23	\$158.18	\$325.24	\$418.68	\$151.80

For each UK regulator, costs were adjusted for inflation to allow for a more appropriate comparison with the Australian data. This was done by comparing the CPI² from the month at the midpoint of each UK council's reporting period³ with the CPI at the midpoint of the Australian reporting period – December 2013, and multiplying UK costs by this ratio. This resulted in an uplift of UK figures by approximately 11% from the data published in the PSA review.

The potential for cost saving by merging a number of National Boards

The existence of potential scale effects raises the possibility of realising savings by merging National Boards into fewer organisations. One possible option canvassed in this Consultation Paper is to establish a board to manage the regulatory functions of the nine low regulatory workload professions. A precedent for this exists in the UK, where the Health and Care Professions Council (HCPC) runs the register for 16 different professional groups, including several who have their own National Board in Australia.

In order to estimate the potential savings, the PSA used equations showing the relationship between scale and unit cost. By inputting the number of registrants for each Board, a measure of expected cost for the individual boards is produced which is then summed to show the aggregate expected cost of the individual boards. This calculation was then repeated using the total number of registrants if those boards were merged into one organisation. The hypothetical potential savings are the difference between the two values.

2 <http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Consumer+Price+Indices#tab-data-tables>, Table 6a – CPI All Items.

3 For GMC, GDC and GCC midpoint was June 2010; NMC, HPC, GPhC, GOC and GOsC midpoint was September 2010 and for PSNI midpoint was October 2010.

Table 16 presents two possible scenarios. Firstly, merging nine of the Boards into one. In this situation, a new Board containing 76,821 registrants would be created. Depending on whether the aggregate equation is used or a sum of the function specific equations, the individual Boards should hypothetically cost \$30.4m (function specific equations \$29.7m); the proposed Board containing all 76,821 registrants should cost \$18.7m (\$18.6m) and this may realise annual savings of \$11.7m (\$11.1m).

Secondly, there may be significant annual savings if any of the functions under the National Scheme could be fully centralised. For example, combining the registration function into one super-regulator could save \$14.1m per annum, while a central accrediting body could be hoped to save about \$2.9m per annum.

Table 16: The potential for cost saving by merging boards

	Number of registrants	Boards expected cost (using aggregate function)	Notifications	Registration	Compliance	Accreditation	Professional standards	Governance	Boards expected cost (using function specific)
ATSIHPBA*	330	\$331,554	\$121,442	\$87,491	\$11,140	\$20,907	\$74,021	\$16,650	\$331,652
CMBA*	4,259	\$2,199,619	\$861,192	\$644,270	\$86,560	\$125,720	\$290,009	\$129,593	\$2,137,344
ChiroBA*	4,843	\$2,418,994	\$950,257	\$712,249	\$95,952	\$137,578	\$310,604	\$143,666	\$2,350,305
DBA	20,692	\$7,083,269	\$2,889,817	\$2,212,873	\$307,342	\$380,994	\$674,425	\$460,613	\$6,926,064
MBA	99,209	\$22,587,535	\$9,599,306	\$7,522,450	\$1,079,741	\$1,143,933	\$1,557,355	\$1,619,874	\$22,522,660
MRPBA*	14,360	\$5,405,824	\$2,184,567	\$1,663,847	\$229,323	\$294,877	\$554,920	\$343,603	\$5,271,139
NMBA	362,008	\$58,853,776	\$25,869,652	\$20,663,103	\$3,047,616	\$2,836,017	\$3,108,357	\$4,576,064	\$60,100,809
OTBA*	16,174	\$5,903,146	\$2,392,946	\$1,825,755	\$252,268	\$320,537	\$591,308	\$378,011	\$5,760,825
OptomBA*	4,790	\$2,399,381	\$942,282	\$706,157	\$95,109	\$136,520	\$308,784	\$142,403	\$2,331,256
OsteoBA*	1,864	\$1,193,582	\$457,358	\$338,014	\$44,632	\$70,420	\$186,558	\$66,785	\$1,163,767
PharmBA	28,252	\$8,918,518	\$3,668,197	\$2,821,839	\$394,492	\$474,003	\$796,420	\$591,344	\$8,746,295
PhysioBA*	26,076	\$8,405,058	\$3,449,799	\$2,650,699	\$369,943	\$448,091	\$763,059	\$554,517	\$8,236,109
PodBA*	4,125	\$2,148,206	\$840,362	\$628,392	\$84,370	\$122,933	\$285,101	\$126,311	\$2,087,469
PsyBA	31,649	\$9,700,053	\$4,001,461	\$3,083,365	\$432,082	\$513,297	\$846,193	\$647,741	\$9,524,139
Total of the 9 professions remaining independent (indicated as * above)	76,821	\$30,405,364	\$12,200,205	\$9,256,875	\$1,269,300	\$1,677,584	\$3,364,364	\$1,901,539	\$29,669,866
Merging 9 professions	76,821	\$18,693,715	\$7,891,745	\$6,161,061	\$879,597	\$956,081	\$1,358,584	\$1,319,387	\$18,566,454
Hypothetical Potential savings		\$11,711,649	\$4,308,460	\$3,095,814	\$389,703	\$721,504	\$2,005,780	\$582,152	\$11,103,412
Total expected costs of independent regulators	618,631	\$137,548,514	\$58,228,638	\$45,560,506	\$6,530,573	\$7,025,829	\$10,347,114	\$9,797,175	\$137,489,833
1 super regulator	618,631	\$87,486,630	\$38,996,036	\$31,394,621	\$4,682,809	\$4,129,865	\$4,137,876	\$7,033,825	\$90,375,034
Hypothetical Potential savings		\$50,061,884	\$19,232,601	\$14,165,884	\$1,847,764	\$2,895,963	\$6,209,237	\$2,763,350	\$47,114,799

Discussion of economic analysis

Economies of scale

Further analysis is needed to look at how the different regulatory functions are currently being delivered, whether economies of scale are being realised currently, and what different measures would need to be applied for each in order that any further such economies might be realised. For example, at present the registration function already involves staff in AHPRA offices working across professions, and that in most offices there are three teams – those processing applications from medical practitioners, those processing applications from nurses, and those processing applications from other professions. Therefore, significant further economies here may only be achievable through major structural change, for example, by centralising all registration staff into a national registration team rather than retaining registration staff in each State and Territory AHPRA office.

It may be that the main savings through any amalgamation of smaller National Boards would be through the altered governance arrangements and the need to manage and serve a smaller number of Boards, rather than through economies of scale achieved in the delivery of regulatory functions.

There are also obvious areas for potential cost savings in the ways that Boards do business, for example, using video and teleconferencing rather than meeting in person, which is already being adopted or piloted by some National Boards. Currently the National Boards operate under a principle of no cross-subsidisation; consideration of closer working arrangements might allow for analysis of how the relaxation of that principle in some way might reduce costs.

Irrespective of whether National Boards are merged or not, a review of the purposes and effectiveness of the 62 committees of the National Boards and the 101 committees of the State/Territory and Regional Boards is required. For example, it is likely that that it might no longer be adding value for each National Board to have its own finance committee, given that AHPRA is now well established and financially secure, with established reserves and risk management processes.

Notifications and registrations – costs relative to the UK

The analysis found an interesting relationship in the costs of the two regulatory functions of registration and notifications between Australia and the UK.

The registration function in the UK is cheaper, and the notification function in the UK is more expensive. This area will be examined further as part of the second phase of the project.

The relative expense of the registrations function is particularly interesting given that one of the major achievements of the National Scheme is the establishment of a single national register, given the economies of scale this might be expected to yield. This contrasts with the UK where each of the nine regulatory bodies holds its own register. It is noted that given the larger scale of operations overall (roughly twice the number of registrants) there may well be inherent economies of scale benefitting the UK when compared to Australia.

A possible explanation of the relative expense of registration in Australia is that costs may accrue in managing the relationship between State/Territory registration staff and the registration committees, be they at national or State/Territory level. An application for registration or renewal is first made through the AHPRA website. The application is forwarded to the relevant registration team in the State/Territory from which the applicant applied. As described to the PSA there are generally three registration teams in each AHPRA office – one for medical practitioners, one for nurses, and one for all other professions. In some areas of specialised registration there are national registration teams. If the application is complete and satisfactory, the staff in the State/Territory office can either register or renew it on the national register. If however the application is complex or questionable it is referred either

to (i) the State/Territory registration committee for that profession, where such exist, or (ii) to the national registration committee where that profession does not have State/Territory Boards.

One possibility is that the processing of cases between State/Territory and national level may be causing delays and incurring expense. This could be examined further by looking at data on the numbers of cases that are being referred to registration committees, the amount of time these cases remain in the system because of the necessity for examination by a committee and an assessment of the costs that are thus accrued.

The second phase of the cost effectiveness and efficiency analysis will consider what benefits might be gained were the entire registration function to be centralised, either for all or for the nine smaller Boards, rather than maintaining teams in State/Territory offices.

Unlike in the UK, when a complaint is received (other than in NSW), the Board must confer with the local Health Complaints Entity to decide on the correct course of action for any particular complaint at the outset, including whether the complaint is a regulatory matter for the relevant Board or not. If it is referred to the Board, there is an initial risk assessment which can result in immediate action if necessary. There is then a preliminary assessment after which the case will go to the notifications committee of the National Board for the State/Territory notifications committee for those professions which have State/Territory Boards. The committee can decide that no further action is required, or can instigate an investigation. Investigations can be lengthy, possibly due to the scope not being well articulated at the outset.

After investigation, the committee can either refer to another entity, caution the practitioner, seek an undertaking or impose conditions; or it may refer the case to a panel for consideration of unsatisfactory professional conduct. The panel can determine all the same actions as the committee; the only additional sanction that can be imposed is a reprimand. Any further action can only be achieved by the referral of the matter to a tribunal, which is comparable to an employment tribunal in the UK; it is external to the Board, and cases can take a long time to be resolved and at considerable cost. PSA was advised that the cost to AHPRA of a panel hearing is estimated as being circa \$10,000 and that a tribunal could be from \$20-30,000 up to \$300,000 in extreme cases.

A further area for closer analysis is the arrangements in New South Wales, undertaking further comparison of costs both within Australia and with the UK, including an assessment of the cost of the contribution of the Health Care Complaints Commissioner.

Accreditation authorities

Assessment of the total cost of accreditation of courses of higher education in the National Scheme has not yet been undertaken. The Review has received data from Accreditation Authorities which will be analysed in detail in the next phase of the project. Accreditation of higher education courses is carried out for 11 of the 14 professions by an external accreditation council under contract to the National Board/AHPRA. For three of the professions, the responsibility for accreditation is vested in a committee of the National Board: Aboriginal and Torres Strait Islander health practitioners, Chinese Medicine, and Medical Radiation Practitioners.

The accreditation councils have a number of sources of income, including a contribution from AHPRA, fees charged to education providers, and income from fees charged to overseas applicants for assessment of their qualification (this last function would be part of the registration function within a UK regulator; the costs of the registration function in the economic analysis have not included this). This contrasts with the UK arrangements, where the quality assurance of higher education courses is undertaken by the regulator and is funded from the registration fee like the other regulatory functions. There is no direct charge to the institution whose course is being quality assured, although there are associated compliance costs.

For the three professions which have not contracted with an accreditation council, AHPRA has recently established a unit to provide support. It has established accreditation standards, put in place operational arrangements, appointed assessors, and established an application process for education providers. There are 16 programmes identified for review across the three professions. The unit provides the opportunity to explore innovative approaches including, for example, joint assessments – inspections. This activity is funded from two sources – funding from AHPRA, and a fee charged to the education providers.

The cost of accreditation will be considered in the second phase of the project. On the face of it, the existence of an external accreditation council looks inherently more expensive; these are separate entities, each of which has its own Board, premises, staff and so forth. Anecdotal information provided by the higher education sector has reported considerable increased costs in accreditation fees and compliance from the commencement of the national scheme. Accrediting Authorities advise that the contribution of pro bono assistance from within the profession has kept cost low.

Further work will be undertaken in which the total cost for accreditation will be calculated in the National Scheme, compared with costs in the UK, and compared to the costs of accreditation where there is an external accreditation council as opposed to the internal to AHPRA arrangements for the three professions as described.

Preliminary findings of interim analysis

- the unit cost per registrant is comparable in the UK and Australia for medicine, nursing/ midwifery, pharmacy and dentistry
- there are additional unit costs being incurred for the five professions in Australia (Physiotherapy, Podiatry, Radiotherapy, Psychology and Occupational Therapy) compared to the same five professions in the UK that are regulated under the HCPC, where there is a single Board shared amongst a number of professions
- there is potential for cost savings by consolidating nine professions under a single Board in Australia with expected added benefit through the application of a single fee across professions and further potential benefit in consolidating administrative arrangements or functional roles
- higher percentage spend and aggregate cost of registration was observed for Australia compared to the UK and a lower percentage spend for notifications in Australia compared to the UK. These will be further assessed to establish the reasons for the differences
- significant differences in accreditation arrangements are in place between the UK and Australia and these will be further assessed in the next phase
- aggregate proportion of total National Board spending by function in 2013 – 14 indicates: 43.7% on notifications; 32.2% Registration; 4.7% Compliance; Accreditation 5.4%; 6.9% Professional Standards; and 7.1% Governance
- there is a relationship observed between scale and regulator unit cost
- there is a relationship observed between costliness of a board and the complexity of the work it undertakes
- there are greater differences in the unit cost per registrant for chiropractic, osteopathy, optometry.

Proposed changes to the National Law

The Review has received a series of proposed amendments to the National Law, the majority of which are technical or administrative in nature. The following pages provide the details of those amendments

- endorsed by the Australian Health Workforce Ministerial Council and referred to the Review for consultation
- proposed by AHPRA and the National Boards.

Question

28. The Review seeks comment on the proposed amendments to the National Law.

As approved by Ministers – amendments to the Health Practitioner Regulation National Law

Overview

The Australian Health Workforce Ministerial Council has approved amendments to the Health Practitioner Regulation National Law and the Health Practitioner Regulation National Law (Western Australia) Act 2010.

The matters that have been identified for amendment are:

- the incorporation into National Scheme of the Commonwealth reforms to freedom of information legislation
- the adoption of the requirements that apply in each jurisdiction for the notification, publication, tabling and disallowance of regulations made under the National Law
- the provision of protection for registered health practitioners who report serious offences to police
- the replacement of the Australian Health Workforce Ministerial Council with the COAG Standing Council on Health as the responsible Ministerial Council for National Scheme, and
- other amendments to clarify and improve the operation of the legislation.

1. Commonwealth Reforms to Freedom of Information Legislation

The National Law and the Western Australian Law apply the following Commonwealth Acts for the purpose of the National Scheme:

- the *Privacy Act 1988* (applied by section 213)
- the *Freedom of Information Act 1982* (applied by section 215), and
- the *Ombudsman Act 1976* (applied by section 235).

Subsequent to the commencement of National Scheme, the Commonwealth enacted legislation to reform the Commonwealth freedom of information arrangements. The legislative amendments commenced on 1 November 2010. The legislation includes the enactment of the *Australian Information Commissioner Act 2010* which, among other things, establishes the positions of Information Commissioner and Freedom of Information Commissioner.

The National Law is to be amended to adopt the reformed Commonwealth legislation under the National Scheme. This would require an amendment to the existing provisions in relation to the Privacy Act by removing reference to the Office of the Privacy Commissioner and the Privacy Commissioner, which are no longer established under that Act. An equivalent provision to those currently in place in relation to the Privacy Act, FOI Act and Ombudsman Act will need to be included in the National Law for the Australian Information Commissioner Act.

Similar amendments to the above would also be required in the Western Australian Law.

2. Tabling of Regulations

The National Law (section 245) provides that the Ministerial Council is to make regulations under the National Law. The National Law provides that the regulations are to be published by the Victorian Government Printer. However, this provision does not apply under the Western Australian Law. Instead, the publication provisions under Western Australia's *Interpretation Act 1984* apply.

The National Law (sections 246 and 247) provides that a regulation made under the National Law may be disallowed by a House of Parliament in a participating jurisdiction in the same way that other regulations in that jurisdiction may be disallowed. The provisions also state that the disallowance applies as if the regulation had been tabled in the relevant Parliament on the first sitting day after the regulation is published by the Victorian Government Printer. This provision is relevant in terms of establishing the number of days within which a regulation may be disallowed. However, a regulation that is disallowed in a Parliament is of no effect unless it is disallowed in a majority of the participating jurisdictions.

In Western Australia, the National Law was modified so that sections 246 and 247 do not apply. Instead the provisions under the *Interpretation Act 1984* in relation to tabling and disallowance apply. Importantly, the Western Australian Law does not provide for the majority disallowance of regulations.

The following amendments to the National Law are to be made:

- the provision dealing with the publication of regulations by the Victorian Government Printer (section 245 (3)) be repealed
- section 246(1) of the National Law be replaced with a provision which states that:
 - a regulation must be published or notified in the same way that other regulations in the relevant jurisdiction are published or notified, and
 - a regulation must be tabled in a House of Parliament in the same way that other regulations in the relevant jurisdiction are tabled, and
 - a regulation may be disallowed in the same way that other regulations in the relevant jurisdiction may be disallowed.

The provisions dealing with majority disallowance (section 246(2) and (3)) are to be retained. However, the Western Australian Law will not be amended to provide for majority disallowances.

As regulations are made by the Standing Council on Health, rather than the Governor-in-Council (in the respective State), Parliamentary Counsel's advice is sought on whether modifications to the application of any State law is required.

3. Statutory protection for health practitioners reporting serious offences to police

Queensland's now repealed *Medical Practitioners Registration Act 2001* (s.176) dealt with circumstances where a medical practitioner obtains information that the practitioner honestly and reasonably believes indicates an indictable offence has taken place.

Under the Act, a medical practitioner who provided such information to a police officer was not liable, civilly, criminally or under an administrative process, for giving the information about the indictable offence or the circumstances of the indictable offence.

This provision was applied, for example, when persons presented to emergency departments with gunshot or stabbing wounds, or apparent victims of domestic violence. This provision was not replaced in Queensland legislation and practitioners are of the view that an important statutory protection is no longer available.

The National Law and the Western Australian Law are to be amended to include an equivalent provision, but the provision is to apply to all registered health practitioners.

In addition, feedback on this proposal indicated that the reference to 'indictable office' may not capture all violent crimes. As such, it is proposed that the legislation refer to a 'serious offence' and that advice from Parliamentary Counsel be sought on the best way to define this in the legislation.

4. COAG Standing Council on Health

COAG has agreed on a new Ministerial Council system. In relation to the health portfolio, COAG has established a Standing Council on Health which will assume the role of the Australian Health Ministers' Conference and the Australian Health Workforce Ministerial Council.

Under the Health Practitioner Regulation National Law, the 'Ministerial Council' means the Australian Health Workforce Ministerial Council comprising Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health. All States and Territories are 'participating jurisdictions' for the purposes of the National Law.

Legislative amendments are to be made to the National Law and the Western Australian Law to recognise the COAG Standing Council on Health to be the Ministerial Council for the purposes of the legislation. An issue with these amendments is that the New Zealand Health Minister is proposed to be a member of the COAG Standing Council on Health, but does not have a role in administering the National Law, as New Zealand is not part of National Scheme. The proposed approach is to state in the National Law that decisions relating to National Scheme under the National Law can only be made by the members of the Council from participating jurisdictions and the Commonwealth.

5. Other Amendments

Section 149 (Preliminary assessment)

Section 149 of the National Law deals with the preliminary assessment by the National Boards of notifications made to the boards. Section 149(1)(c) is to be amended to clarify that a National Board must, in all instances, decide whether or not a notification received by a board could be made to a health complaints entity.

The section is also to be clarified to state that, as a result of the assessment, the National Board must decide whether to:

- take no further action in relation to the matter
- refer the matter to another entity
- deal with the matter under section 150 (which requires a National Board to consult with a health complaints entity on matters that could be addressed by either the board or a health complaints entity), or
- deal with the matter under another division of the Act, for example, by undertaking an investigation.

Section 151 (When a National Board may decide to take no further action)

This section is to be amended to clarify that this section only applies to decisions made under Division 5 (Preliminary assessment).

Section 151 is also to be amended by explicitly stating that a board may decide to take no further action on the preliminary assessment of a notification if the notification:

- relates to a person who is not a health practitioner or registered student
- relates to a matter that is not a ground for notification under the Act, or
- the matter has been referred to another entity.

Section 167 (Decision by National Board), 177 (Decision by National Board) and section 180 (Notice to be given to health practitioner or student and notifier)

It is important that notifiers and health practitioners are advised, where appropriate, at key milestones during the consideration of health, performance and conduct issues.

To achieve this, the following amendments are to be made:

Section 167 (Decision by National Board):

- if an investigation resulted from a notification, the board must give a written notice to the notifier of the board's decision under this section; where no further action is proposed, the board is to provide reasons for taking no further action on the matter
- if the board has previously advised the practitioner or student of the investigation under section 161 (Registered health practitioner or student to be given notice of investigation), the board must give a written notice to the practitioner or student of the board's decision under this section.

Section 177 (Decision by National Board):

- if a health assessment or performance assessment resulted from a notification, the board must give a written notice to the notifier of the board's decision under this section; where no further action is proposed, the board is to provide reasons for taking no further action on the matter
- the board must give a written notice to the practitioner or student of the board's decision under this section.

Section 180 (Notice to be given to health practitioner or student and notifier) is to apply to all decisions made under Division 10 (Action by National Board), which requires a notice to be given to the practitioner or student or, if the decision resulted from a notification, the notifier.

Time-frames for taking proceedings for offences

The National Law does not provide for standardised time-frames within which alleged offences under the Act may be proceeded summarily to a court. This creates operational complexities for AHPRA in administering the legislation. A concern raised by AHPRA is that alleged offences may only come to light at the time of renewal of registration, by which time up to 12 months may have elapsed since the alleged offence occurred. For this reason, it is proposed that the time-frame set under the National Law be 24 months.

Table 17: Proposed further legislative amendments made by AHPRA and the National Boards

Issue	Legislative amendment proposal
Commencement of registration	At this time, registration commences on the date of the decision by the Board or the delegate (e.g. s 56(2)(a) however, the point is relevant for all registration types). There are a number of instances when it would be of value for the Board to commence registration on a date to be determined. Such an amendment would be of particular value in the event that further professions were registerable under the National Law.
Multiple registration subtypes including limited registration	At this stage, it is not possible to obtain limited registration in a different sub-type within the same profession (s. 65 (1). This has a negative effect on individuals who are registered, for example, as a dental hygienist but who then want to undertake limited registration, for example, for the purpose of undertaking examinations to progress to become eligible for registration as a dentist.
Contravention of undertakings	s.112(2)(b) makes the failure to comply with conditions on registration a basis on which the Board may refuse to renew an applicant's registration. We consider that undertakings should have similar weight and suggest Section 112(2)(b) - and 'or undertaking' to ... 'any condition or undertaking to which ...'
Actions following suspension	<p>There is no avenue for ending a suspension imposed under section 156 (immediate action). This is problematic as a National Board may want to end a suspension or revoke an undertaking not to practice; and impose conditions. In addition, if a health panel suspends a practitioner under section 191 (3)(b), there is no requirement under the National Law for the panel to set a review period. We think that this would be of benefit.</p> <p>When a renewal date arrives during a period of suspension of the practitioner, the National Law does not currently import a clear process for management of practitioner's registration and the subsequent application for registration/reinstatement after the conclusion of a period of suspension.</p> <p>Under the National Law practitioners who are suspended over a renewal period are not eligible for renewal - section 207 provides that during a period of suspension a practitioner is taken not to be registered and section 107 provides that renewal is only available to registered practitioners. As a consequence, the practitioner will cease to appear on the register and needs to make a new application for registration.</p>

Information on the Register	<p>Section 226 of the National Law sets out when the National Board may decide to exclude certain information from publication on the National Register. The section contemplates that conditions or undertakings entered into by impaired practitioners may be excluded for privacy reasons (s226(1)). The section also contemplates practitioners requesting information not be published where the inclusion of the information in the register would present a serious risk to the practitioner's health or safety s226(2)).The section does not provide for the National Board to consider the exclusion of information where a third party may be adversely affected nor does it allow for the National Board to consider such applications other than on the application of the practitioner.</p> <p>This concern could be addressed by the inclusion of 'or any other affected person' after 'the practitioner' in both s226(2)(a) and (b).</p>
Conditions on registration	<p>Under Part 7 of the National Law, the Board is able to impose conditions when registration is first granted, when someone is reapplying for registration and when it is renewed.</p> <p>Consideration could be given to giving a Board the power to accept an undertaking from a registrant to achieve the same purpose, rather than achieving this only by imposing conditions. This would align with the provisions of Part 8 that provide for either conditions or undertakings on registration.</p> <p>Where conditions are amended under sections 125 and 126, there is no requirement for a review period to be set and we think that this would be of benefit to practitioners.</p> <p>Co-regulatory issues – under sections 125(2)(b), 126(3)(b) and 127(3)(b), there is no equivalent section in the National Law (NSW) to allow a co-regulatory jurisdiction to change a condition imposed by an adjudication body in a National Board jurisdiction (Part 8) if the adjudication body decided, when imposing the condition, that the subdivision applied. An equivalent section be added to the legislation in all co-regulatory jurisdictions (including NSW and QLD).</p>
Abrogation of right against self-incrimination	<p>The Health Practitioner Regulation National Law (ACT) has a variant to Clause 2 of Schedule 5 that abrogates the right against self-incrimination. It provides that any information, answer or document required to be given, answered or provided is not admissible in evidence against the individual in a criminal proceeding. The same provision applies in NSW under section</p> <p>The Medical Defence Organisations have advised that they consider such an approach as desirable, as their members wish to cooperate with the Boards without fear that any information provided could be used against them in criminal proceedings.</p> <p>From a practical perspective, an amendment with application across the scheme would notifications timeframes where there are extant criminal processes. Further, it may enable practitioners to better defend immediate action proposals as they will be able to freely give their version of events.</p>
Notice requirement at section 180	<p>Section 179 of the National law sets out the requirements for a show cause process to be applied, if a Board proposes to rely on its powers to caution, accept an undertaking or impose conditions under section 178 of the National Law. Section 179(3) provides that a show cause process is not required when a Board has investigated the practitioner under Division 8 of Part 8, or conducted a health or performance assessment under Division 9 of Part 8.</p> <p>Section 180(1) provides that a National Board must give written notice of a decision made under section 179(2). If the Board is not required, because of section 179(3), to use a show cause process, then the effect of section 180(1) is that a notice of the decision to take action is not required.</p> <p>Section 180(1) could be amended to read, 'As soon as practicable after making a decision under this Division, the National Board must give written notice of the decision to ...'</p> <p>It should be noted that an equivalent provision to section 180.</p>

Appellable decisions	<p>Division 13 of Part 8 of the National Law (sections 199 to 203) sets out provisions dealing with appeals against certain decisions made under the National Law. Appeals made under the National Law are made to the responsible tribunal in each of the participating jurisdictions.</p> <p>There are no consistent provisions about the length of time that a person affected by a Board decision has to make an appeal to each responsible Tribunal. While some jurisdictions have time limits in place because of their respective tribunal legislation, it is submitted that single, nationally consistent time limit ought to be included in the legislation.</p> <p>A new subsection (3) could be inserted at section 199, so that an appeal made under this section is to be made within 28 days from the date that the person making the appeal receives notice of the reasons for the Board's or Panel's decision, unless the appropriate responsible tribunal otherwise orders.</p>
Obtaining information from other government agencies	<p>Consideration should be given to the addition of a section in Part 8 that mirrors Part 4 section 27, to remove any doubt about the ability of investigators to obtain information from other government agencies.</p>
Notice of a decision to take action	<p>s.206 requires that notice of a decision to take action against a registered health practitioner is communicated to the practitioner's employer. This definition might be expanded to require notice to all places of practice – making it clear that s.206 applies equally to contractual arrangements.</p>

Consolidated list of questions

1. **Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?**
2. **Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross professional issues are addressed?**
3. **Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? Estimated cost saving \$11m per annum**
4. **Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? Estimated cost saving \$7.4m pa.**
5. **Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?**
6. **Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?**
7. **Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?**
8. **Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?**
9. **What changes are required to improve the existing complaints and notifications system under the National Scheme?**
10. **Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?**

11. Should there be a single entry point for complaints and notifications in each State and Territory?
12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?
13. Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?
14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?
15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?
16. Are the legislative provisions on advertising working effectively or do they require change?
17. How should the National Scheme respond to differences in States and Territories in protected practices?
18. In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?
19. Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?
20. To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?
21. Should the proposed reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?
22. To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?
23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?
24. Should the appointment of Chairperson of a National Board be on the basis of merit?
25. Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?
26. Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?
27. The Review seeks comment on the proposed amendments to the National Law.

Part III: Background paper

Policy context

The National Scheme was established in the context of the need for efficient and effective delivery of health services in an environment of demographic change, technological advances and rising health costs.

The purpose of the National Scheme is to protect the health and safety of those who use health services. It was designed to ensure that health professionals receive high-quality education and training and that, once qualified, their qualifications are recognised across Australia. It was intended that this national approach would improve the consistency of regulatory oversight of health professionals while also promoting access to health services.

The National Scheme is intended to assist with the ongoing development of an Australian health workforce so that it is responsive to advancing technologies and practice and has enough professionals to meet the nation's needs, both now and into the future. This includes the assessment and monitoring of overseas-trained health practitioners.

The National Scheme seeks to achieve balance between protecting patients, delivering proportionate and fair regulation and facilitating access to health services. In circumstances where a concern about a professional is raised, a member of the public wishes to make a complaint or notify authorities of a potential safety issue, public safety is always the first priority. When an issue is deemed to be in need of investigation there is a tension between transparency, the public's right to be informed, fairness and the right to privacy of individual health professionals. The National Scheme seeks to strike the right balance between all of these competing requirements but, in such circumstances, always keeps public safety as its primary concern.

How the National Scheme came to be

The National Scheme began on 1 July, 2010, and 18 October in Western Australia. Before then each State and Territory had its own system for registering health professionals, meaning there were 97 different health practitioner boards across the eight States and Territories.

In 2005 the Australian Government asked the Productivity Commission to investigate the issues impacting on the supply of, and demand for, health workforce professionals and to propose methods to ensure a quality health workforce would be provided into the future. The Productivity Commission found there were shortages in the health workforce, especially in rural and remote areas; and increasing community demand for health services. Its report identified many difficulties with a system in which different laws and regulations overseeing

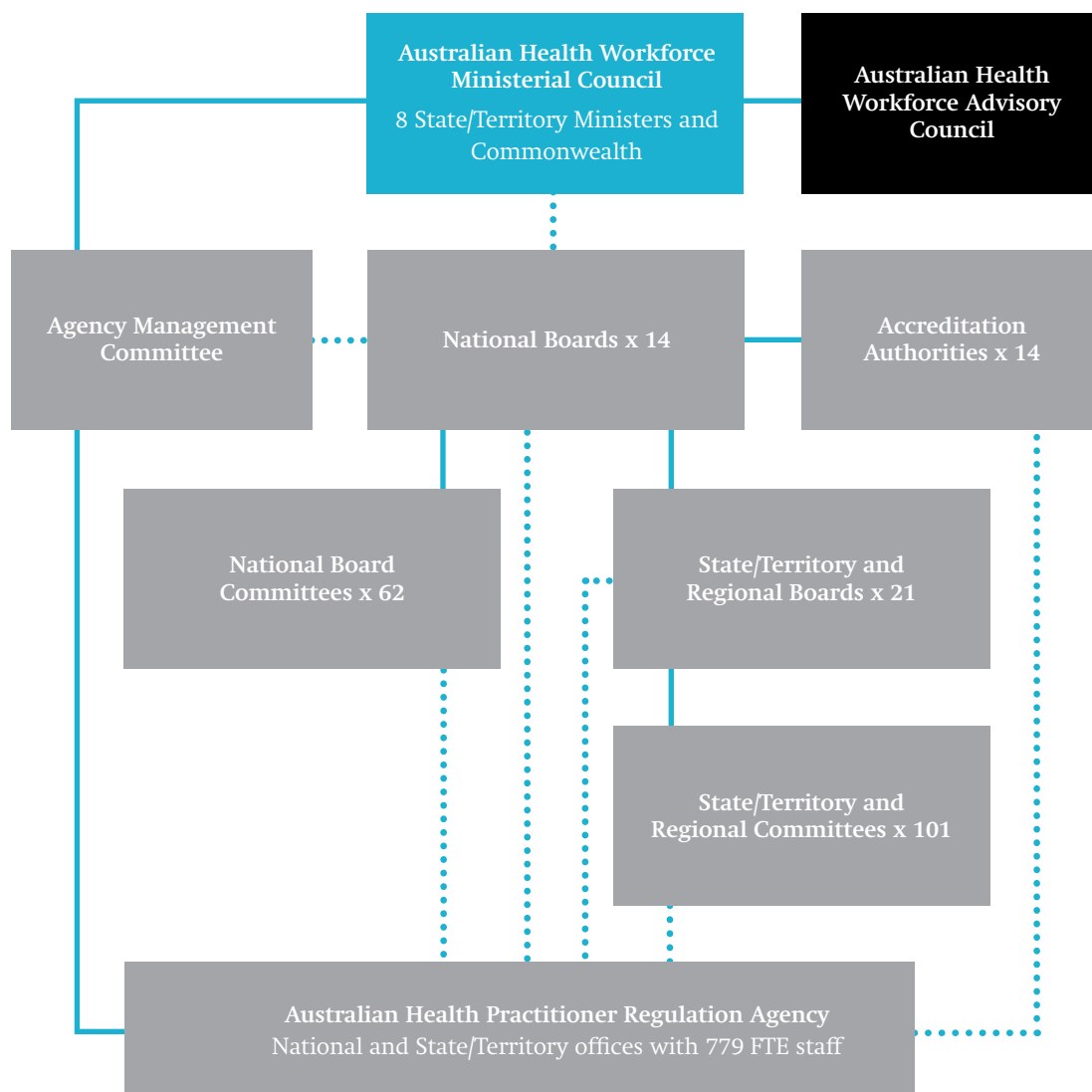
the work of a variety of health professions were operating in each State and Territory. To develop a more responsive and sustainable workforce that has a commitment to patient safety and a high quality of care as its core value, the Commission recommended there should be one national body to oversee the registration and accreditation of the health professions.

In response, the Council of Australian Governments (COAG) decided via an Intergovernmental Agreement to establish a single National Registration and Accreditation Scheme for health professionals. To achieve this, various bodies were set up to achieve regulatory accountability and responsibility:

- Australian Health Workforce Ministerial Council: comprised of Health Ministers from Commonwealth and each state and territory government. Determines policy, appoints members of the National Boards, oversees registration standards, decides on whether additional professions ought to be included in the Scheme.
- Australian Health Workforce Advisory Council: a seven-member group that provides independent advice to the Ministerial Council about the national registration and accreditation of health professions.
- National Boards: one for each profession, their role is to protect the public and oversee the registration of relevant health practitioners and students.
- Initially 10 Boards were established for: chiropractors; dentists; medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists; and psychologists. Four other professions were added in 2012: Aboriginal and Torres Strait Islander health practice; Chinese medicine; medical radiation practice and occupational therapy.
- The Boards set the standards for their profession, appoint Accreditation Authorities and deal with notifications about the potential misconduct or impairment of registered practitioners and students.
- Australian Health Practitioner Regulation Agency (AHPRA): provides administrative assistance to the National Boards; operates registration applications and ongoing registration of healthcare practitioners and students; maintains a list of approved courses of study for health professions; handles notifications or complaints about individual practitioners, referring them to Health Complaints Entities, where relevant.
- The Agency Management Committee is the governing board of AHPRA and responsible for overseeing AHPRA policy and ensuring it functions properly, effectively and efficiently. The Committee consists of eight members appointed by the Ministerial Council in accordance with the requirements of the National Law to ensure a mix of members with expertise in health and/or education and training, business or administration. The Committee Chair cannot be a registered health practitioner. The National Law specifies that a member of the Committee is to put the public interest before the interests of particular health practitioners or organisation that represents health practitioners.
- Accreditation Authorities are appointed by the National Boards to recommend education and professional standards and to ensure that the education bodies that teach the courses meet the minimum requirements of those standards. The standards are intended to ensure that students are equipped with the knowledge, skills and professional attributes required to practice their chosen health profession.
- National Health Practitioner Ombudsman and Privacy Commissioner: receives complaints and helps people who feel they have been treated unfairly by the administrative processes of the National Scheme.

On a daily basis the National Scheme is run by AHPRA in conjunction with the National Boards while the Ministerial Council has high-level oversight. The relationships between these entities are illustrated by Flowchart 1.

Flowchart 1: The National Scheme



Creation and design of the National Scheme

Objectives and guiding principles

The National Scheme was implemented through the enactment of the *Health Practitioner Regulation National Law Act 2009* (the National Law) in each State and Territory to ensure the health and safety of those who use health services. The National Scheme is designed to achieve this by ensuring that health practitioners are competent and ethical in the delivery of their profession.

The National Scheme operates according to six objectives set out in 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
- to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction
- to facilitate the provision of high quality education and training of health practitioners
- to facilitate the rigorous and responsive assessment of overseas-trained health practitioners
- to facilitate access to services provided by health practitioners in accordance with the public interest, and

- 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.

The National Scheme also has three guiding principles that underpin its operation and inform all decision-making processes:

- the scheme is to operate in a transparent, accountable, efficient, effective and fair way
- fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme
- restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

Implementation

Establishing the National Scheme was a sweeping reform that saw the States and Territories working together to ensure the regulation of health professionals is as effective and efficient as possible, providing maximum protection to the public's health and safety.

The National Scheme oversees the registration of more than 618,000 health practitioners from 14 different professions across Australia. The registration details of each practitioner is publicly accessible at the AHPRA website.

There is little doubt that public safety has been enhanced by the National Scheme as a result of:

- National register of health practitioners and specialists. This is publicly available on <http://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx>
- Mandatory identity check
- Mandatory criminal history check
- Mandatory reporting of 'notifiable conduct' (such as working while impaired by drugs or alcohol or sexual misconduct committed under the cloak of the practitioner's profession) by health practitioners
- Mandatory professional indemnity insurance arrangements
- Student registration
- A national notifications scheme for consumers to report concerns about misconduct by individual practitioners

Initial implementation challenges

Within two years of Australian governments agreeing to establish a National Scheme in 2008, new laws supporting it were in place in every State and Territory to create a national approach to regulating health professionals in Australia.

On 1 July 2010 more than 500,000 health professionals had their registrations transferred to the National Scheme and more than 400 State and Territory staff transferred to AHPRA. Assets, funds and liabilities were simultaneously transferred from State and Territory boards to the new National Boards. It was a huge and ambitious endeavour.

Not surprisingly such swift implementation brought with it initial problems relating to registration, communication, inability to contact AHPRA staff and complaint resolution. These issues impacted on practitioners and the public. Much work has already been done to rectify these and many of the initial administrative problems associated with the National Scheme have been overcome.

This Review is an avenue for those who believe there are issues relating to the implementation of the National Scheme that have not yet been addressed to voice those concerns and have them heard.

Impact of the National Scheme

While some residual issues and challenges persist from the commencement of the National Scheme, its overall achievements in a relatively short period are important to recognise, as are the efforts of those who have staffed it through such a difficult beginning.

Some of the National Scheme's key achievements include:

- moving from eight different State and Territory based regulation systems to a single National Scheme
- replacement of 97 health profession Boards with 14 National health profession Boards
- replacement of 75 Acts of Parliament with a predominantly consistent law in each Parliament
- replacement of 38 regulatory organisations with one national agency
- self-funded scheme without cross subsidisation
- more than 618,000 health practitioners are registered with the National Scheme
- consistent national standards, codes and guidelines for each of the 14 health professions
- consistent national standards for continuing professional development
- practitioners register once annually and can practice anywhere in Australia
- national workforce planning informed by an accurate practitioner database
- practitioners who have had restrictions placed on their registration, or been struck off the register, can be traced Australia wide
- overseas recruitment simplified via single support agency
- duplication of administrative functions by practitioner boards has been reduced
- health professions have begun working together on common regulatory issues.

The National Boards and AHPRA

National Boards

Each of the 14 health professions included in the National Scheme has its own National Board. The primary task of each Board is to deliver the objectives and guiding principles of the National Law and to fulfil the functions established by it. Each Board does this for its particular profession by: setting the standards for the profession; developing and approving codes and guidelines; appointing Accreditation Authorities to oversee the training and education of students; approving national accreditation standards; registering suitably qualified and competent persons; overseeing the assessment of the knowledge and clinical skill of overseas-trained health professionals; dealing with notifications about the health, conduct or performance of registrants (and, in some professions, students); and setting national registration fees.

Board members are appointed by the Australian Health Workforce Ministerial Council (AHWMC) for three-year terms. The size of individual boards varies from nine to 12 members, specifications are that: at least half but no more than two thirds of Board members must be practitioners; the remaining members will be community members; at least one Board member must live in a regional or rural area. The Ministerial Council also appoints the Chair of each Board. Under the National Law the Chair must be a practitioner. Different boards have different structures in place for dealing with their statutory responsibilities. These include a mix of delegated decision-making to national committees, state/territory/regional boards or committees in States and Territories.

More information about the individual Boards follows in Table 18. More specific information about each Board can be found [via the AHPRA website](#).

Table 18: National Boards

	Board members	Registrants	Fees 2014-15	Protected Titles and (Divisions of the register)
Aboriginal and Torres Strait Islander (ATSI) Practice	9	300	\$100	ATSI health practitioner; Aboriginal health practitioner; Torres Strait Islander health practitioner
Chinese Medicine	9	4,070	\$579	Chinese medicine practitioner; Chinese herbal dispenser; Chinese herbal practitioner; Oriental medicine practitioner; Acupuncturist (Acupuncturist; Chinese herbal medical practitioner; Chinese herbal dispenser)
Chiropractic	9	4,657	\$545	Chiropractor
Dental Board	12	19,912	\$603	Dentist, Dental therapist, Dental hygienist, Dental prosthetist, Oral health therapist (General registration: Dentists; Dental hygienists; Dental prosthetists; Dental therapists; Oral health therapists. Specialist registration: Dentists only) 13 approved specialty titles for Dentists
Medical	11	95,690	\$715	Medical practitioner; Specialist medical practitioner (23 approved specialities, with 74 approved associated specialist titles); Acupuncturist
Medical Radiation Practice	12	13,905	\$250	Diagnostic radiographer (medical radiation practitioner, diagnostic radiographer, medical imaging technologist, radiographer); Nuclear medicine (nuclear medicine scientist, nuclear medicine technologist); Radiation therapy (radiation therapist)
Nursing and Midwifery	12	345,955	\$150	Nurse; Registered nurse; Nurse practitioner; Enrolled nurse; Midwife; Midwife practitioner (Registered nurse (division 1), Enrolled nurse (division 2), Midwife)
Occupational Therapy	9	15,101	\$160	Occupational therapist
Optometry	9	4,635	\$365	Optometrist, Optician
Osteopathy	9	1,769	\$416	Osteopath
Pharmacy	12	27,339	\$317	Pharmacist, Pharmaceutical chemist
Physiotherapy	12	24,703	\$159	Physiotherapist; Physical therapist
Podiatry	9	3,873	\$388	Podiatrist, Podiatric Surgeon
Psychology	12	30,561	\$431	Psychologist

Standard setting, guidance and registration functions

Under the National Law individuals are eligible for general registration in a health profession if they: hold an approved qualification (or equivalent) for the health profession; are a 'suitable person' to hold registration; and they meet any other requirements in approved registration standard for the health profession.

The National Boards have a responsibility to: develop national registration standards for their professions; develop and approve codes and guidelines; and register suitably qualified and competent persons.

Registration standards are developed by National Boards, and approved by the Ministerial Council (AHWMC). National Boards develop and approve codes and guidelines for the profession they are charged with regulating. The Boards are required under the National Law to undertake wide-ranging consultation on all standards, codes and guidelines prior to their approval.

An approved registration standard, code or guideline is admissible in proceedings against a health practitioner registered by the Board, as evidence of what constitutes appropriate professional conduct or practice for the health profession.

All approved registration standards are available from the relevant National Boards' website.

Registration standards

There are two types of registration standards: required (under National Law as decided by Ministerial Council) & discretionary (need determined by National Boards). These are described in Table 19 over page.

Table 19: Registration standards

	Required (All Boards)	Discretionary (some Boards)
Registration standards:	<ul style="list-style-type: none"> • Continuing professional development (CPD) • Criminal history checks • English language skills • Professional indemnity insurance arrangements (PII) • Recency of practice (RoP) 	<ul style="list-style-type: none"> • About the physical and mental health of applicants and registrants and students • Scope of practice of registered health practitioners • Any other issue relevant to eligibility of individuals for registration or suitability of individuals to competently and safely practice the profession (includes registration types, eg. a limited registration standard)
Developed by	National Board – if it is a required (common) standard then National Boards will jointly consult, where practicable	
Recommended by	National Board for the relevant profession	
Approved by	Ministerial Council	
Reviewed by	National Board/s (on a regular basis, commonly every 3–5 years) Ministerial Council may request a review	

The National Scheme has enabled common standards across professions when this is appropriate. There are mandatory registration standards (English language skills, professional indemnity insurance, criminal history, recency of practice and continuing professional development).

All National Boards have adopted the same criminal history registration standard, which describes the factors a Board will take into account when considering an applicant or registrant’s criminal history. There is significant commonality across the English language skills registration standards for all National Boards, except the Aboriginal and Torres Strait Islander Health Practice Board of Australia, which has unique considerations.

In addition to general registration under the National Law, there is a range of other registration types. These are described in Table 20 on the following page.

Table 20: Registration types

	Description
Limited registration	<p>The intent of limited registration under the National Law is that an individual will be eligible for limited registration so long as they are not qualified for general registration. There are four types of limited registration:</p> <p>Postgraduate training or supervised practice</p> <p>Typically, this type of registration is for practitioners who are undertaking supervised training in Australian hospitals or other health care facilities.</p> <p>Area of Need</p> <p>Practitioners with this type of registration are usually working under supervision in an area of workforce shortage. Usually, they are registered to practice in a rural or remote location. These practitioners have been assessed by the Board as having the necessary skills, training and experience to undertake this practice safely. The State or Territory Minister for Health (or their delegate) must declare that the area in which the applicant will work is an ‘area of need’.</p> <p>Public interest</p> <p>Limited registration in the public interest is intended to be short-term, with a limited scope of practice. It applies to circumstances in which the Board deems there is a ‘public interest’ in registering a practitioner. Examples of when it might be in the public interest to register a practitioner who is not eligible for general or specialist registration might include: natural disasters, pandemics or for an expert to demonstrate a new procedure.</p> <p>Teaching or research</p> <p>Practitioners with this type of registration will likely be working in a position that involves clinical teaching or research, for example, a university appointment. These practitioners can undertake a limited clinical practice that is relevant to their teaching or research role</p>
Specialist registration	<p>Specialist registration may be granted if a practitioner meet the eligibility and qualifications requirements set out in the National Law, as well as any registration standards issued by the relevant National Board. The Ministerial Council approved the recognised specialties and specialist titles for each recognised specialty, and may be granted to practitioners in dentistry, medicine and podiatry. Details of the list of specialties and specialist titles are available here.</p>
Non-practising registration	<p>Non-practising registration is available to individuals who hold or have held general registration as a health professional. This allows a person to remain on the register and to continue to use the protected title. It may be suitable for practitioners who:</p> <ul style="list-style-type: none"> • have retired completely from practice, • are having a temporary absence from practise (for example, on maternity or paternity leave) or • who are not practising in Australia but are practising overseas. <p>Practitioners with non-practising registration must not practise the profession. It allows individuals with qualifications to be registered if they are using their skills and knowledge as a health practitioner, regardless of whether they are providing direct patient care.</p>
Provisional registration	<p>Provisional registration is available to persons required to complete a period of approved supervised practice to become eligible for general registration</p>
Student registration	<p>Students enrolled in an approved program of study leading to registration as a practitioner must be registered.</p> <p>Students enrolled in an approved program of study do not need to apply for registration. Education providers pass on student details to the Board for registration and no fees are required.</p>

Endorsement provisions

For some professions, the National Law authorises a National Board to endorse the registration of suitably qualified practitioners (such as for nurse practitioners or for acupuncture), or enables the Ministerial Council (AHWMC) to agree that the relevant National Board can endorse a practitioner’s registration (for example, for an approved ‘area of practice’). These are described in Table 21 below.

Table 21: Types of endorsements

<p>Endorsement for scheduled medicines</p>	<p>Authorises the respective National Board to endorse the registration of suitably qualified professionals as follows:</p> <p>Podiatrist or podiatric surgeon as being qualified to administer, obtain, possess, prescribe, sell, supply or use Schedule 2, 3, 4 or 8 medicines for the treatment of podiatric conditions from the list of scheduled medicines approved by the Board.</p> <p>Registered nurse (rural and isolated practice) as being qualified to obtain, supply and administer limited schedule 2, 3, 4 or 8 medicines appropriate to the registered nurse’s scope of practice within the meaning of the current poisons standard under the Therapeutic Goods Act 1989 (Cwlth), s. 52D, to the extent necessary to practice nursing in a particular area and described and listed under the relevant drug therapy protocol, Chief Health Officer standing order or health services permit that must be compliant with relevant State and Territory legislation</p> <p>Eligible midwives as being qualified to prescribe schedule 2, 3, 4 and 8 medicines required for midwifery practice across pregnancy, labour, birth and post natal care, in accordance with relevant State and Territory legislation.</p> <p>Optometrist as being qualified to prescribe or supply schedule 2, 3, or 4 medicines to patients for the treatment of conditions of the eye, from a list approved by the Board.</p>
<p>Endorsement as nurse practitioner Endorsement as midwife practitioner</p>	<p>Authorises the Nursing and Midwifery Board of Australia (NMBA) to endorse a registered nurse as a nurse practitioner who has satisfied the requirements of the NMBA under the National Law. Endorsement allows the nurse practitioner to initiate diagnostic investigations, prescribe medications and make referrals.</p> <p>While there is provision for this endorsement as a midwife practitioner under the National Law, The NMBA does not have a registration standard against which individuals can this endorsement. The NMBA recognises midwives that meet the requirements of the ‘Eligible Midwife’ registration standard with a notation on their registration.</p>
<p>Endorsement in relation to Acupuncture</p>	<p>A National Board may endorse the registration of a registered health practitioner registered by the Board as being qualified to practice as an acupuncturist. The following professions have registrants with endorsements for acupuncture: chiropractic, medical, osteopathy and physiotherapy. (Note that Acupuncture is a division of the Chinese medicine practitioner registration)</p>
<p>Endorsement for approved area of practice</p>	<p>A National Board established for a health profession may, in accordance with an approval given by the Ministerial Council under section 15, endorse the registration of a registered health practitioner registered by the Board as being qualified to practise in an approved area of practice.</p> <p>Dental Board of Australia has a registration standard for endorsement in relation to conscious sedation areas of practice.</p> <p>The Psychology Board of Australia has nine endorsements for approved area of: clinical neuropsychology; clinical psychology; community psychology; counselling psychology; educational and developmental psychology; forensic psychology; health psychology; organisational psychology; sport and exercise psychology.</p>

Consultation processes

National Boards are required under the National Law to undertake wide-ranging consultations on proposals that affect the community and registered health practitioners. If a National Board proposes to recommend a matter to the Ministerial Council (AHWMC) that another National Board may reasonably be expected to have an interest in, then consultation must occur between the Boards, and any contrary views expressed must be provided with the recommendation to Ministers.

AHPRA and the National Boards have developed publications to describe their consultation processes and are available here www.ahpra.gov.au/Publications/Procedures.aspx

Broadly speaking, National Boards release consultation papers, asking a wide range of stakeholders to provide input that will help shape registration standards, codes and guidelines, and policies.

The Office of Best Practice Regulation (OBPR) provides an assessment of the potential regulatory impact of draft new or revised registration standards, codes or guidelines and whether it is necessary for the National Board to develop a regulatory impact statement (RIS). The RIS requirements are to ensure that proposals involving regulatory options are subject to sound analysis on the potential costs and benefits to determine if it is in the public interest to use a regulatory solution.

Ministerial approval

As provided for under the National Law, and following the required consultation processes of National Boards, new and revised registration standards are submitted by National Boards to the Ministerial Council for consideration of approval.

Following current government processes for matters of national interest, the Australian Health Ministers Advisory Council (AHMAC) considers the proposal and makes recommendations to the Ministerial Council (AHWMC). Health department representatives from each jurisdiction (including the Commonwealth) brief AHMAC.

The Ministerial Council may approve a registration standard only if its approval is recommended by the National Board established for the health profession, and it does not provide for a matter about which an accreditation standard may provide.

Australian Health Practitioner Regulation Agency

The role of AHPRA is to provide administrative and operational support to the 14 National Boards. Coordinating this work through a single agency is intended to deliver efficiencies, cost effectiveness and to reduce duplication. It is intended that AHPRA works with the National Boards to effectively and efficiently implement and administer the National Scheme in accordance with the National Law and any policy directions issued by the Ministerial Council.

While the National Boards determine registration standards, AHPRA is responsible for the day to day work in managing the registration and renewal processes for health practitioners and students. It provides support to the National Boards in developing registration standards, codes and guidelines.

AHPRA is also responsible for processing notifications regarding the performance of health practitioners. This involves liaising with State Health Complaints Entities, assessing notifications, investigating where appropriate and then passing the information to the Boards for a decision regarding the appropriate course of action. (The system is different in New South Wales and Queensland, this is described further later in the paper).

AHPRA and each Board negotiates a Health Profession Agreement to outline the services AHPRA will provide each year to assist the Board in meeting its regulatory responsibilities. These agreements are published [online](#).

AHPRA also maintains the online, [publicly-available register](#) that publishes current information about the registration status of every registered health professional in Australia. This is intended to ensure that healthcare consumers have a single source that provides up-to-date registration information about more than 618,000 health practitioners across 14 professions.

Accreditation

Accreditation is the process that confirms the quality and standards of education programs. It is usually carried out by an independent party who reviews a particular program against established standards or outcomes. Accreditation plays an important role in quality assurance and quality improvement.

The National Law sets out the functions of the Accrediting Authorities, these are:

- developing accreditation standards for approval by a National Board
- assessing programs of study, and the education providers that provide the programs of study, to determine whether the programs meet approved accreditation standards
- assessing authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study relevant to registration in a health profession, to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by the authorities have the knowledge, clinical skills and professional attributes necessary to practice the profession in Australia
- overseeing the assessment of the knowledge, clinical skills and professional attributes of overseas qualified health practitioners who are seeking registration in a health profession under this Law and whose qualifications are not approved qualifications for the health profession
- making recommendations and giving advice to the National Board about any matter referred to above.

These functions may be carried out by either an external Accrediting Authority or by a committee of the relevant National Board. Currently there are eleven external Accrediting Authorities and three committees of National Boards.

Many of these Accrediting Authorities existed prior to the introduction of the National Law but some, such as the Australian Nursing and Midwifery Council and the Australian and New Zealand Podiatry Accreditation Council were new entities. Hence, the Authorities are at different stages of maturity.

APHRA enters into a formal agreement with each of the external Accrediting Authorities to undertake its work on behalf of the National Boards. This agreement details the accreditation functions, reporting, funding and work program for the Accrediting Authority.

The relationships between the AHPRA, National Boards and the Accrediting Authorities are important and have been maturing since the inception of the scheme. A [quality framework](#) has been established as a reference document for the National Boards to assess the work of the Accrediting Authorities.

Table 22 provides a summary of the role and function of the Accrediting Authority, National Boards and education provider.

Table 22: Accreditation functions

Accrediting Authority	National Board	Education Provider
Sets accreditation standards	Approves, refuses or reviews the standards	Is consulted about the standards
Accredits programs of study May refuse to accredit programs of study if it believes the course does not meet the accreditation standards	Approves accredited programs of study, can also refuse or approve a program with conditions	Develops courses, often provides accreditation experts for site visits May ask for a review of a decision to refuse to accredit a program of study within 30 days of receiving advice
Monitors accredited courses. May withdraw accreditation of a course if it believes the course no longer meets the approved accreditation standards, or impose conditions on a program	Cancels approval of a course if its accreditation is revoked, a Board may also impose conditions on an approved course.	

Complaints and notifications

The identification of health practitioners whose work, or conduct, is unsafe is a critical role of the National Scheme. Receiving notifications of poor conduct or performance through complaints made by consumers, colleagues, or other health professionals is one of the principle means by which professional conduct can be monitored, investigated and, where appropriate, addressed. The key objective of this aspect of the National Scheme is protection of public health and safety.

The management of complaints and notifications of health professionals is an area of focus of the Review and explored in more detail in sections I and II of this paper.

Under the National Scheme, complaints and notifications are managed by AHPRA and the National Boards in conjunction with State and Territory Health Complaints Offices. New South Wales and, as of July 1 2014, Queensland, have different systems for managing this process.

To provide the necessary background for these discussions the Review team requested information from AHPRA, the New South Wales Health Professions Councils and the Queensland Department of Health, that described the current arrangements in each context.

The following pages set out in detail the current arrangements under the National Scheme and the different arrangements in New South Wales and Queensland, as described by those involved in managing and/or establishing the respective systems.

The National Scheme

If a consumer believes they, or someone they are close to (such as a family member), had a negative experience with a registered health provider and decides to bring this to the attention of an authority they can either: contact their State- or Territory-based Health Complaints Entity (HCE) or contact AHPRA, these agencies then work together to determine which should act on the issues that have been raised.

The Health Complaints Entities are:

- ACT: Health Services Commissioner
- Northern Territory: Health and Community Services Complaints Commission
- South Australia: Health and Community Services Complaints Commissioner
- Tasmania: Health Complaints Commissioner and Ombudsman

- Victoria: Health Services Commissioner
- Western Australia: Health and Disability Services Complaints Office

The roles of the Health Complaints Entities and the National Boards together with AHPRA are different.

The Health Complaints Entities deal with issues relating to: health systems (such as hospitals or community health centres) and fees and charges. They can arrange conciliation (dispute resolution) sessions and for reimbursement and/or compensation to be paid, where appropriate. Under this system matters are referred to as ‘complaints’ and those who raise concerns are complainants.

AHPRA and the National Boards work together to manage concerns about individual practitioners, the guiding principle is to keep the public safe. These concerns often relate to the practitioner’s health (the practitioner is believed to have an illness, mental impairment, addiction or substance abuse problem that impacts on their ability to do their job); conduct (inappropriate behaviour); performance (poor knowledge, skill or care); or advertising.

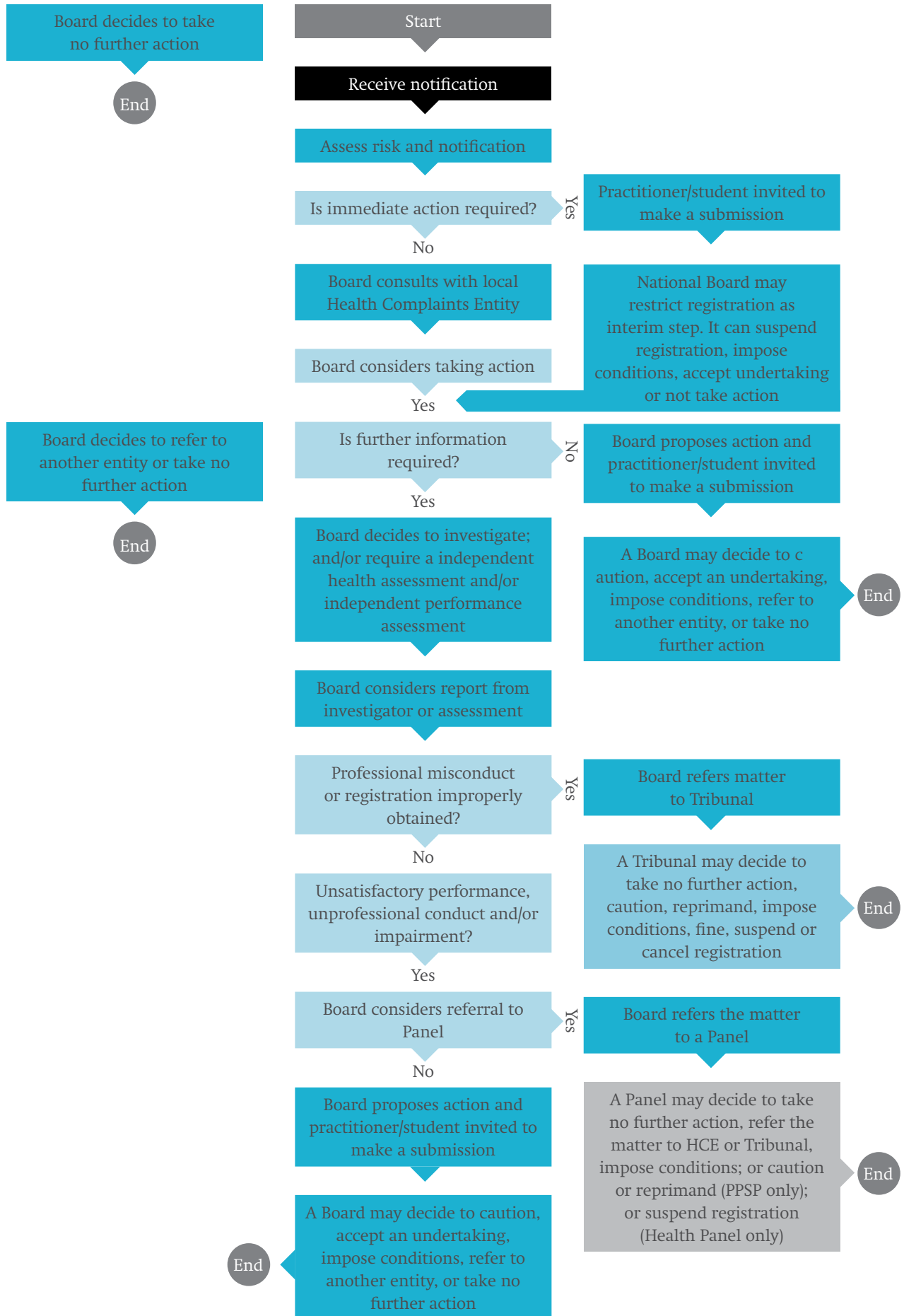
Under the National Scheme, matters are referred to as ‘notifications’ and the person who made the complaint is a ‘notifier’ and is regarded as a witness. The term notification is intended to show that a Board is not a dispute resolution agency. Its role is to protect the public from risks posed by health professionals. A Board may decide after reviewing a case that no further action is necessary as the health practitioner does not pose a risk to the public. It may alert the practitioner that a notification has been made about them and advise them on how to alter their practise so that other consumers do not experience the same issue. Or it may refer the matter to a Tribunal for consideration as to whether the practitioner’s registration should be restricted or suspended.

There is some overlap between the State/Territory complaints system and the National notification system. If a person raises their concern with one it may be referred to the other. The test for deciding whether the matter will be considered by the state or territory complaints agency or by AHPRA and the relevant National Board is that whichever system proposes the most serious action will take on the matter – ‘the most serious action proposed by either must be taken’. In practise the State/Territory agencies and AHPRA regularly work together to decide which system should take on the matter.

If a restriction is imposed on a practitioner’s registration, details are included on AHPRA’s practitioner database and made publicly available on the AHPRA website.

More information on the management of notifications is provided in Flowchart 2 on the following page and Attachment 1 on page 94. These materials were provided by AHPRA at the request of the Review.

Flowchart 2: Notification flowchart (as provided by AHPRA)



Co-regulatory complaints and notifications management

There are different processes for managing complaints about registered health practitioners in New South Wales and Queensland. In New South Wales, the health, performance and conduct processes provided for in the National Law do not apply, and in Queensland they have been modified. The regulation of this aspect of health professionals is managed under state complaints legislation. As a result of the shared regulatory role between state legislation and the National Law the arrangements in New South Wales and Queensland are often referred to as 'co-regulatory'.

New South Wales

NSW is a co-regulatory jurisdiction under the National Scheme. All complaints about NSW health practitioners and providers are handled by the NSW Health Care Complaints Commission together with the NSW Health Professional Councils Authority, which provides administrative support to 14 NSW Health Professional Councils.

Irrespective of which NSW agency hears the complaint, as soon as one is received AHPRA is informed, this is because AHPRA handles the administration of practitioner registrations. Final outcomes of the NSW process are sent to AHPRA so that its records can be kept up to date.

The 14 Health Professional Councils were created on 1 July 2010 and are responsible for managing complaints about the conduct, health and performance of registered health practitioners in NSW and the conduct and health of registered students training in NSW. The Councils are also responsible for monitoring compliance with conditions and orders imposed on a NSW practitioner following a conduct, health and performance outcome. The Health Professional Councils Authority provides administrative, legal, policy, financial services and support to the Health Professional Councils.

Councils must have the protection of the health and safety of the public as their paramount consideration when exercising any of their functions under the Law.

Role of Health Care Complaints Commission

The Health Care Complaints Commission (HCCC) was established as an independent body in 1993. Its functions include:

- receiving and assessing complaints relating to health services and health service providers in NSW
- investigating and assessing whether any complaint is serious and if so, whether it should be prosecuted
- prosecuting serious complaints; and
- resolving or overseeing the resolution of complaints.

In exercising its functions, the HCCC must also have as its primary objective, the protection of the health and safety of the public.

The current system in NSW has established a system of co-regulation with professional bodies while preserving the independence of the HCCC complaints body. The HCCC must consult with the Councils at critical points in the complaints handling process. These include:

- following initial receipt of any complaint
- before making a decision in relation to the assessment of a complaint
- prior to changing the assessment of a complaint or when adding a respondent to the complaint or adding additional allegations to an investigation
- prior to referring a complaint to a Council, so that it may take action including a performance or health assessment
- at the conclusion of an investigation; and
- prior to determining whether or not a complaint should be prosecuted before a disciplinary body.

Upon receipt of a written complaint, the HCCC and Councils will assess the complaint in consultation. Following this assessment, the HCCC and Councils can either:

- investigate the complaint
- refer the complaint to the Council to consider taking health or performance action or to counsel the practitioner
- refer the complaint to conciliation or resolution
- refer the complaint to the Secretary of the Ministry for Health
- refer the complaint to another person or body; or
- decline to deal with the complaint.

Either the Council or HCCC can insist that a complaint be investigated or referred to a Council for its management. Either the Council or HCCC can also insist that a complaint be reopened or investigated if it has previously been discontinued or terminated.

The HCCC must complete its assessment of the complaint within 60 days and both the HCCC and Councils can consider associated or previous complaints when assessing a complaint.

Complaints in NSW are investigated by the HCCC if the complaint raises a significant issue of public health or safety or if substantiated would provide grounds for disciplinary action against the health practitioner.

In the event that the HCCC decides to investigate a complaint, it will proceed to gather evidence concerning the allegations made in the complaint. This includes obtaining relevant records and statements from the complainant and any other witness of fact. The HCCC will commission a report from an expert (peer reviewer) concerning the alleged conduct. The peer reviewer provides an opinion as to whether there has been a departure from acceptable standards, and if so, whether criticism of the practitioner is warranted.

At the conclusion of its investigation, the HCCC can refer the matter to the Director of Proceedings (DP) in order to determine whether a complaint should be prosecuted before a disciplinary body. The HCCC may also refer the complaint to Councils for action under the Law, make comments to the practitioner, terminate the matter or refer the matter to the Director of Public Prosecutions. Prior to taking any action, the HCCC must consult with the relevant Council. The HCCC must also provide the practitioner with an opportunity to make submissions in relation to its proposed action.

The DP is not subject to the direction or control of the HCCC Commissioner and independently determines whether a complaint should be prosecuted before a disciplinary body. The DP must also consult with the relevant Council prior to determining whether or not a complaint should be prosecuted.

Role of Health Professional Councils

Following assessment, a complaint can be referred to a Council for its management.

Councils in NSW have urgent interim powers to suspend or to impose conditions on a registered practitioners' registration if it is appropriate to do so for the protection of the health or safety of any person or persons or if satisfied the action is otherwise in the public interest.

An immediate action inquiry enables a Council to undertake a more detailed risk assessment into the issues of concern. It also enables Councils to explore other issues that may be impacting on the practitioner's ability to practise safely, such as their health or professional performance.

Councils in NSW have adopted the former NSW Medical Board's Health Program, which was established in 1993. The primary objective of the Health Program is to protect the public whilst maintaining impaired practitioners in practice, but only if it is safe to do so.

In NSW, there is a clear process for initial assessment and ongoing management of practitioners with possible impairment. When a complaint or self-notification indicates that a practitioner may be impaired, the practitioner is assessed by a Council-appointed (independent) practitioner, often a psychiatrist, who will prepare a report for the Council. If the complaint or self-notification indicates that interim immediate action is necessary in order to protect the public, then the Council will take that action and if necessary, will either suspend or impose conditions on the practitioner's practice. Councils review the report prepared by the Council-appointed practitioner and decide whether to convene an Impaired Registrants Panel Inquiry. Again, interim immediate action can be taken if the report concludes that this is necessary.

In NSW, treatment is undertaken by the practitioner's own clinician, with no Council involvement, other than gaining the practitioner's authorisation for the treating clinician to notify the Council if the practitioner is non-compliant, terminates treatment or fails to attend for treatment. The Council relies on information and reports from the Council appointed practitioner, and does not seek information from the treating clinicians, thereby avoiding any conflict of interest or potential to compromise or harm the therapeutic relationship.

Queensland

From 1 July 2014, Queensland became a co-regulatory jurisdiction under the National Law. The Health Ombudsman is the single point of entry for all health complaints in Queensland in relation to individual health service providers (both registered and non-registered) and health service provider organisations across the public, private and not for profit sectors.

The Health Ombudsman replaces the Health Quality and Complaints Commission (HQCC), which closed on 30 June 2014, and will undertake some of the complaints handling functions previously performed by AHPRA and the National Boards.

The purpose of the Health Ombudsman is to protect the health and safety of the public. The office is also intended to: promote professional, safe and competent practice by health practitioners; promote high standards of service delivery by health service organisations, and maintain public confidence in the management of complaints and other matters relating to the provision of health services.

The Queensland complaints management system is intended to be transparent and accountable, and to effectively and expeditiously deal with health service complaints.

Queensland established a Health Ombudsman in response to three major Queensland inquiries into health-complaints' handling in that State.

The functions of the Health Ombudsman are:

- receive health service complaints and take action to deal with them
- identify and deal with health service matters, whether raised through complaints or otherwise
- deal with systemic health service issues, including matters related to the quality of health services
- oversee the performance of the National Boards and AHPRA in their health, conduct and performance roles
- provide information to the public and health service providers about minimising and resolving complaints.
- report on the performance of the Health Ombudsman's functions and the performance of the National Boards and AHPRA in their health, conduct and performance roles.

On acceptance of a complaint, or on receipt of other relevant information, the Health Ombudsman may take one or more of the following actions:

- assess a complaint to decide the most appropriate action to take
- facilitate early resolution of a complaint between the complainant and the health service provider
- take immediate action to deal with a matter by suspending or imposing conditions on a registered health practitioner's registration, or by prohibiting or imposing restrictions on the practice of another health practitioner
- investigate a matter
- refer a matter to the Director of Proceedings for the director to decide whether proceedings should be taken against a health practitioner before the Queensland Civil and Administrative Tribunal (QCAT)
- refer a matter concerning a registered health practitioner to AHPRA to be dealt with under the National Law
- conciliate a complaint, which may lead to the parties entering a confidential, legally-binding settlement
- conduct an inquiry into a matter
- refer a matter to another State or Commonwealth entity, or
- take no further action on a matter.

The Health Ombudsman may refer a health service complaint or other matters concerning a registered health practitioner to AHPRA unless a practitioner may have behaved in a way that constitutes professional misconduct or where a ground may exist for the suspension or cancellation of a registrant's registration. Under these provisions, the Health Ombudsman must deal with the above serious matters, however, the referral of any other matter to AHPRA is discretionary and may occur at any stage. The Health Ombudsman may determine that other matters will be retained for assessment/investigation/prosecution.

It is anticipated that the National Boards will continue to deal with other health and performance matters under the National Law.

Where the Director of Proceedings refers a matter to the Queensland Civil and Administrative Tribunal (QCAT) about a registered health practitioner, QCAT has the same decision-making powers as under the National Law. Under the National Law, the National Boards are required to implement QCAT decisions.

The Health Ombudsman also has immediate action powers to suspend or impose a condition on a registered health practitioner's registration and to issue interim prohibition orders or impose restrictions on practice for unregistered health service providers. In comparison to the National Law, while a show cause process is required, the Health Ombudsman may take immediate action without complying with this provision if it is judged necessary such action is required to ensure the health and safety of an individual or the public.

A key difference is that all complaints and notifications (voluntary and mandatory) are made to the Health Ombudsman, rather than being split between the Health Complaint Entity and AHPRA, as was the case before 1 July 2014.

The Health Ombudsman must keep complainants and health service providers informed when the Health Ombudsman takes action (for example, a decision to conciliate a complaint or commence an investigation). In addition, the Health Ombudsman is to provide 3-monthly progress reports on investigations to a complainant and health service provider. This information, and the reports, need not be provided to a health service provider if it may place someone at risk or compromise an investigation.

Reports can be made public. Where an investigation report is to be made publicly available, a health service provider must be given the opportunity to comment on any adverse findings.

Employers are to be advised of serious allegations in relation to their employees.

The requirement for registered health practitioners to make mandatory notifications to the Health Ombudsman under the National Law has been modified. The provided exception will apply if a matter, about which a treating health practitioner is made aware, relates to an impairment, does not relate to professional misconduct (as defined in the National Law), and the treating practitioner forms the reasonable view that the other practitioner does not pose a serious threat to the public.

International approaches to health practitioner regulation

As a part of the review, the National Scheme was compared to four international jurisdictions, the United Kingdom, New Zealand, and British Columbia and Ontario in Canada. Although expressed in different ways, each jurisdiction has an overarching obligation contained in their regulation to protect the health and safety of the public.

United Kingdom

The principle purpose of the United Kingdom system is to protect, promote and maintain the health and safety of the public and to safeguard the health and well-being of persons using or needing the services of registrants⁴ – referred to as the ‘public protection duty’. A new occupational group or profession will only be regulated in the United Kingdom where there is a compelling case based on public safety, risk and where assured voluntary registers are not considered sufficient to manage this risk – that is, where there are significant risks to persons using services which cannot be mitigated in other ways⁵. Health professions in the United Kingdom are regulated by nine regulatory bodies or Councils that operate in a complex legal framework, which has evolved over 150 years. There are currently seven separate pieces of legislation and three Orders (statutory instruments) containing a range of regulatory powers, duties and responsibilities for each regulator. There is also legislation governing the Professional Standards Authority for Health and Social Care (PSA), an independent statutory body responsible for overseeing and scrutinising the work of regulators. A recent review of the UK system has recommended these Acts and Orders be replaced by a single Act of Parliament that provides a consistent and transparent legal framework⁶. In addition, the United Kingdom has expressed a commitment to ‘right touch’ regulation that is⁷:

- proportionate to the risk that it seeks to mitigate
- accountable to ensure that all those with an interest are able to influence it
- consistent, so that it does not unreasonably place a heavier burden on any particular sector
- transparent so that its activities can be scrutinised effectively
- targeted to avoid blanket approaches which impose regulatory burdens unnecessarily

Multiple governing Acts in the United Kingdom have resulted in inconsistencies in regulator powers, duties and responsibilities. Despite this, the rules and procedures adopted by regulators tend to use similar mechanisms to perform their functions, including establishing minimum standards for safe and effective practice, title protection, registration, and accreditation of education, training and professional development. There are also a number of bodies with varying degrees of responsibility for the development of standards for the

4 Respectively, section 1(1A) Medical Act 1983(UK); Article 3(4) Nurses and Midwifery Order 2001 (UK); Article 3(4) Health and Social Work Professions Order 2001 (UK)

5 Secretary of State for Health 2011 command paper to the UK Parliament at ‘[Enabling Excellence – Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers](#)’ at page 18

6 Law Commission for England and Wales, Scottish Law Commission, Northern Ireland Law Commission, 2014 (April) [Regulation of health care professionals regulation of social care professionals in England](#). Presented to Parliament by the Lord Chancellor and Secretary of State for Justice by Command of Her Majesty. Laid before the Scottish Parliament by the Scottish Ministers. Laid before the Northern Ireland Assembly by the Department of Justice

7 United Kingdom, Professional Standards Authority for Health and Social Care 2010 [Right-touch regulation](#). August 2010

accreditation of education and training of health professionals. These include Royal Colleges, local (health) authorities, Skills Sector Councils (for example, Skills for Health), Medical Education England and educational institutions. There is often overlap in the function of regulators in setting standards, and the role of the internal and external quality assurance activities such as continuing competence and revalidation. This means that while regulators are able to prescribe professional standards they are, to varying degrees, dependent on others to monitor and deliver those standards.

The Secretary of State has ultimate responsibility for ensuring there is an effective system for the planning and delivery of education and training of current and future health professionals⁸.

The United Kingdom examples in this paper will focus on the Health and Care Professions Council (HCPC), a multi-profession regulator responsible for sixteen professions. The remaining professions in the United Kingdom are regulated by eight other regulators.

There are three key aspects of the United Kingdom system that are of particular interest to the Review:

- oversight of regulators by the Professional Standards Authority for Health and Social Care (PSA)
- multi-profession regulators (Boards) illustrated by the Health and Care Professions Council (HCPC)
- central role of regulators in the development of standards and the accreditation of education and training of health professionals

In the United Kingdom, the Secretary of State and Professional Standards Authority for Health and Social Care (PSA) have a fundamental role in the governance and accountability of regulators of health professions. The PSA's role is to promote and safeguard the health, safety and well-being of users of health care and other members of the public, and promote best practice, cooperation and good professional self-regulation of regulatory bodies. The PSA has broad powers to do anything necessary or expedient in the performance of its functions. It undertakes an annual performance review of each regulator that includes assessing regulator performance against twenty-four established standards for good regulation. The PSA reports annually to the Parliament of England and the Scottish, Wales and Northern Ireland counterparts⁹. The United Kingdom Secretary of State can request the PSA provide advice on any matter connected with a profession, and may require the PSA to investigate and report on any matter within the PSA's powers. The Secretary of State's powers are also exercisable by Welsh and Scottish Ministers and Northern Island Department of Health, Social Services and Public Safety¹⁰.

The operation of a multi-profession regulator is illustrated by the Health and Care Professions Council (HCPC) in the United Kingdom. The HCPC undertakes its functions through four statutory committees and any other committees it considers appropriate. One of the statutory committees is responsible for education and training, which includes the accreditation of courses, programs and institutions delivering all or part of a program inside or outside the United Kingdom. The other three statutory committees are responsible for the investigating allegations and adjudicating over matters involving allegations related to the fitness to practice of a registrant¹¹.

8 Section 1F National Health Services Act 2006(UK), inserted by section 7 UK Health and Social Care Act 2012 (UK)

9 Section 25(2A) National Health Services Reform and Health Care Professions Act 2002(UK) (NHSRHCP Act 2002(UK)), as amended by section 113(3) Health and Social Care Act 2008(UK); Section 26(2) NHSRHCP Act 2002(UK) , as amended by Schedule 15 Item 62(b) Health and Social Care Act 2012(UK); Schedule 7 Item 16 UK NHSRHCP Act 2002, as amended by section 114(6) Health and Social Care Act 2008(UK).

10 Section 26A National Health Services Reform and Health Care Professions Act 2002(UK), inserted by section 116(1) Health and Social Care Act 2008(UK)

11 Articles 3(9), 14, 26–28 Health and Social Work Professions Order 2001(UK)

The HCPC is responsible for the development of standards and the accreditation of education and training of health professionals. It is focused on quality assuring education and training programmes to protect the public whilst other parties are more focused on developing or promoting the profession or academic credentials of the education provider¹². The HCPC Education and Training Committee is made up of three registrant members and three lay members. The committee's main function is to establish and advise the HCPC on standards of proficiency necessary for the safe and effective practice of the different professions on the HCPC register, and the education and training necessary to achieve standards of proficiency, including continuing professional development and supervision and performance expected of registrants¹³. The Education and Training Committee may also approve, or arrange with others to approve, courses of education or training and the qualifications granted on the successful completion of an approved course that delivers necessary standards of proficiency, tests of competence or knowledge of English, institutions to deliver all or part of an approved course or training, including institutions delivering an approved course of education or training outside the United Kingdom. The HCPC has a central role in the development of standards and the accreditation of education and training of health professionals including, establishing procedures to assess whether international qualifications are a comparable standard to approved qualifications in the United Kingdom, or training and professional experience acquired outside the United Kingdom compares to the standard of proficiency in the United Kingdom¹⁴.

New Zealand

New Zealand has a single regulatory framework that aims to establish a consistent approach to the accreditation and registration of health professions. The principle purpose of the New Zealand system is to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions¹⁵. A new occupational group or profession will only be regulated in New Zealand if it poses a risk of harm to the public, or it is otherwise in the public interest that the provision of those health services be regulated¹⁶. Sixteen regulators, known in New Zealand as Responsible Authorities, regulate 22 health professions, with ultimate responsibility vesting in the Minister for Health¹⁷.

Most notable in New Zealand is the central role of the Health Disability Commissioner in the promotion and protection of the rights of health consumers under the Code of Health and Disability Support Services Consumers, including the assessment and investigation of complaints directly concerning the conduct of a health practitioner. All complaints in New Zealand are referred to the HDC for initial assessment and, where appropriate, referral to a regulator for disciplinary action. The use of alternative dispute resolution (ADR) processes (mediation/conciliation) in the management of complaints against registrants in New Zealand¹⁸ is also a key point of difference with the National Scheme.

12 Article 15(5)(a)-(c) HSWP Order 2001(UK); http://www.hcpc-uk.org/assets/documents/10003663An_introduction_to_our_education_processes.pdf at p.12

13 Article 5, 14, 21(2) Health and Social Work Professions Order 2001(UK); Rule 4 The Health Care Professions Council (Education and Training Committee) (Constitution) Rules 2013(UK)

14 Articles 12-15 Health and Social Work Professions Order Order 2001(UK)

15 Section 3(1) *Health Practitioners Competence Assurance Act 2003* (NZ)

16 Sections 115(1), 116 *Health Practitioners Competence Assurance Act 2003* (NZ)

17 Sections 5, 114, 123-125 *Health Practitioners Competence Assurance Act 2003* (NZ)

18 Sections 64(1), 80(2)(3), 82(1)-(3) *Health Practitioners Competence Assurance Act 2003* (NZ); Sections 34(1)(a), 45(2)(f)(iii), *Health and Disability Commissioner Act 1994* (NZ)

Regulators in New Zealand also have a key role in the accreditation of qualifications. They must prescribe qualifications for every scope of practice, described broadly to include specific courses or courses of a particular kind, specified exams or assessments, equivalent or satisfactory overseas qualifications, registration with an overseas organisation, or experience in specified health services. When prescribing qualifications, regulators are guided by three principles¹⁹. The qualification:

- must be necessary to protect members of the public
- may not unnecessarily restrict the registration of persons as health practitioners
- may not impose undue costs on health practitioners or on the public.

This means when accrediting qualifications New Zealand regulators are required to balance the costs and benefits of regulation or the qualifications prescribed. Regulators in New Zealand must also monitor every New Zealand educational institution it has accredited to deliver prescribed qualifications, and may monitor international institutions it has accredited²⁰.

New Zealand has also adopted a range of mechanisms to broaden scope of practice and manage disputes where scopes of practice overlap. Whilst the National Scheme does not define scope of practice by describing the contents of each profession or any health service that forms part of the profession, there are aspects of the New Zealand system that should be considered in the Review. Scope of practice in New Zealand generally occurs within professional boundaries, however it can be broadened and overlap with the scope of practice of another profession. This increases the flexibility and responsiveness of the profession to the needs of the health sector. If there is a dispute over a scope of practice the Minister may direct regulators to resolve the dispute in any way the Minister sees fit, including advising them of desirable options. The Minister may also direct regulators to implement the recommendation(s) of a panel of experts appointed by the Minister, including amending or replacing a scope of practice. The responsible authorities must comply with the directions from the Minister, and the Minister must present any direction given to the House of Representatives²¹.

Canada

The health care system in Canada is decentralised with health services, and the regulation of health professions, largely organised, managed and delivered by provincial and territory governments. The Federal Government does however play a key role in establishing and administering national criteria and conditions for provincial/territory provision of government insured health services and extended health care services. The Federal Government's primary objective is to protect, promote and restore physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barrier²². A new occupational group or profession will only be designated and regulated in British Columbia where there is a degree of risk to the health or safety of the public from incompetent, unethical or impaired practice of the health profession²³. In Ontario, the Health Professions Regulatory Advisory Council (HPRAC), an independent body created by statute advises the Minister as to whether an unregulated profession should be regulated or a regulated profession should no longer be regulated. The HPRAC has established primary and secondary criterion, a process for attributing weight to determine the extent to which criterion is met, and the types of evidence needed to support an application for statutory regulation²⁴.

19 Sections 12(1)(2), 13 *Health and Disability Commissioner Act 2003* (NZ)

20 Section 12(4) *Health and Disability Commissioner Act 2003* (NZ)

21 Sections 127(1)-(3), 128, 129 *Health and Disability Commissioner Act 2003* (NZ)

22 Preamble & Section 3 *Canada Health Act 1985* (Canada)

23 Regulation 6 *Health Professions Designation Regulation 2008* (British Columbia)

24 Sections 7, 11 *Regulated Health Professions Act 1991* (Ontario); Health Professions Regulatory Advisory Council, Regulation of a New Health Profession under the *Regulated Health Professions Act 1991*

The regulation of health professionals in Canada is also supported by national associations that develop perspectives and exchange information on matters likely to interest provincial and territory regulators²⁵. National certifying colleges²⁶ also contribute by setting standards for training, accrediting training programs, and examinations and assessment used by regulatory colleges as a requirement for registration and revalidation. National education and accreditation standards create a form of mutual recognition that is linked to scopes of practice established by regulators – also known as regulatory colleges – that support workforce mobility in Canada and internationally.

In Ontario and British Columbia provincial legislation²⁷ establishes minimum requirements for the self-regulation of regulatory colleges in each province. The governing legislation and regulations (procedural codes) in each province establish a range of provincial-wide mechanisms that regulatory colleges may/must adopt under their profession specific Acts of Parliament. These governing laws create a legislative framework that provides a degree of consistency whilst delegating the power to create regulations and by-laws that set out how each regulatory college will perform its functions.

In British Columbia and Ontario regulators also have a central role in the development of standards and the accreditation of education and training of health professionals. In British Columbia regulators may make bylaws setting out conditions or requirements related to the competencies, qualifications or standards of academic or technical achievement necessary for registration. They may also specify academic and technical programs that are recognised by the regulator as meeting established standards and the examinations required for registration, including any procedures regarding the conduct of examinations and requirements for eligibility to take examinations²⁸. Like British Columbia, regulators in Ontario are responsible for establishing and maintaining standards of practice, qualifications and the knowledge, skills and programs for registration, and to enable registrants to respond to changes in practice environments, advances in technology and other emerging issues²⁹.

The other key area of interest in the two Canadian jurisdictions is the use of independent advisory councils to advise the Minister. Like the United Kingdom, British Columbia and Ontario have adopted mechanisms that provide varying degrees of independent oversight of regulators. In British Columbia, Advisory Panel(s) appointed by the Minister provide an alternative to the broad statutory powers given to the Professional Standards Authority for Health and Social Care (PSA) in the United Kingdom. Advisory Panels provide advice and recommendations on any matter related to the functions performed by a regulator, including scope of practice, cross-jurisdictional and multidisciplinary or collaborative practice, education, training, competencies and credentials for registration, disclosure of information, quality assurance and patient relations programs, workforce planning and management, as well as the duties, objects and powers of regulators, and the operation or administration of the legislation or regulations. The independence of Advisory Panels is preserved through the appointment of a non-registrant Chair and ensuring a majority of members are not certified non-registrant, registrants of a regulatory college in British Columbia or equivalent body in another province or overseas jurisdiction, or employee or agent of the government in British Columbia or another province or overseas jurisdiction. In addition, where a regulator makes a submission to an Advisory Panel it must be open to the public, except where the panel determines it would detrimentally affect any person³⁰.

25 For example, [Federation of Medical Regulatory Authorities of Canada](#)

26 For example, [College of Family Physicians of Canada](#); [Royal College of Physicians and Surgeons of Canada](#); [Medical Council of Canada](#); [Canadian Nurses Association](#)

27 *British Columbia Health Professions Act 1996, Ontario Regulated Health Professions Act 1991*

28 Section 19(1)(m)(m.1)-(m.3) *Health Professions Act 1996* (British Columbia)

29 Section 3 *Health Professions Procedural Code*(Ontario)

30 Sections 6.2–6.4 *Health Professions Act 1996* (British Columbia)

In Ontario, the Minister and the Health Professions Regulatory Advisory Council (HPRAC) and Fairness Commissioner have a fundamental role in the governance and accountability of regulators of health professions. The Minister must ensure regulators are accountable and the legislation achieves its objectives. The Minister can require a regulator to do anything that, in the opinion of the Minister, is necessary or advisable, including requiring the regulator to inquire into the state of practice of a health profession in a locality or institution. The Minister may also review a regulator's activities, require them to provide reports and information, or to make, amend or revoke a regulation under Ontario's governing Act, a health profession Act, or other relevant legislation³¹.

The HPRAC is an independent statutory body established to advise the Minister as to whether unregulated professions should be regulated, and regulated professions should cease to be regulated. The HPRAC may recommend changes to the Ontario governing Act, a health profession Act or a regulation under one of those Acts, as well as quality assurance programs, patient relations programs, and any other matter the Minister considers desirable to refer to HPRAC. The HPRAC is made up of five to seven persons appointed for two years, with one member designated as Chair and one vice-Chair. A person cannot be appointed to HPRAC if they are an employee of a Ministry (government department), public Commission or Crown agency, or are/have been a registrant or member of the Council (board) of a regulator. The HPRAC must report annually to the Minister on its activities and financial affairs. Unlike and the advisory councils in British Columbia, the HPRAC is permanent body created by statute³².

In Ontario independent oversight of regulators also occurs through the office of the Fairness Commissioner. The Fairness Commissioner reports to the Minister and has a fundamental role in assessing the registration practices of regulators, including specifying audit standards, the scope of audits, times when fair registration practices reports and auditors reports shall be filed, the form of all required reports and certificates and the information that they must contain. The Fairness Commissioner may establish eligibility requirements for persons to conduct audits and monitor third parties relied on by a regulator to assess the qualifications of individuals applying for registration. These functions are undertaken to ensure assessments and qualifications are based on regulatory requirements. The Fairness Commissioner also provides advice and recommendations to the Minister regarding the actions a regulator is to take where the regulator has failed to comply with any requirement related to fair registration practices³³.

31 Section 5 *Regulated Health Professions Act 1991*(Ontario)

32 Sections 6-8, 11, 12 *Regulated Health Professions Act 1991*(Ontario)

33 Section 22.5, 22.8 *Health Professions Procedures Code* (Ontario)

Attachment 1

Information provided by AHPRA

Making a notification in the National Scheme

If you have a concern about a registered health practitioner, you can make a notification to a National Board, through the Australian Health Practitioner Regulation Agency (AHPRA).

In the National Scheme, we call a complaint about a registered health practitioner a 'notification', because we are 'notified' about concerns or complaints, which AHPRA and the National Boards then manage.

The National Boards are focused on public safety and managing risk to patients. When a National Board takes action, it uses the minimum regulatory force needed to keep the public safe and manage the risk to patients.

This table outlines what happens when you make a notification to a National Board, and what you can expect. The National Boards and AHPRA strive to ensure that the management of each notification best suits the issues raised. The process is not linear so your notification may not move through every step outlined here or move strictly in this order.

There is [more information published about how we manage notifications on our website here](#).

Step	Stage	Action	You can expect
	Making a notification	<p>You can make a notification by mail or by telephone:</p> <ul style="list-style-type: none">• By calling 1300 419 495• By filling in the notifications form and submitting it to AHPRA by post or in person at an AHPRA office <p>You can also lodge your complaint with your local Health Complaints Entity (HCE), which works with us to decide who will follow-up the issues you have raised.</p>	<p>Help from AHPRA staff if you need it to make your notification.</p> <p>We will write to you within 10 days confirming we have received your notification.</p> <p>If we refer your concern to an HCE we will let you know.</p>
	Risk evaluation	<p>We review your notification to make sure we have the information we need to proceed. This can include making sure we know the name of the practitioner you are concerned about and can confirm that they are registered.</p> <p>We assess your notification to see if there is a serious, immediate risk to the health and safety of the public that needs to be managed.</p> <p>If there is a serious risk, we act on it immediately. See step three below.</p>	<p>We conduct the 'risk evaluation' within three calendar days of receiving your notification.</p> <p>We contact you by phone or in writing within 14 days if we need more information.</p>

Step	Stage	Action	You can expect
	Preliminary assessment	<p>Serious risk: National Boards can limit a practitioner’s registration to keep the public safe, as an interim step while other inquiries continue. This is called taking ‘Immediate action’ and can include suspending the practitioner. More here on immediate action.</p> <p>Next steps:</p> <ul style="list-style-type: none"> • We assess your notification in more detail and contact you if we need more information. • We talk to your local HCE to decide which agency should follow-up your concerns. • We write to the practitioner to tell them about your concerns and give them the opportunity to respond. <p>AHPRA works with HCE in each state and territory to decide which organisation should manage the matter.</p> <p>If after the Board’s decision we think there are issues the HCE might be able to deal with, we tell the HCE.</p> <p>Further information can be found on our Working with health complaints entities fact sheet.</p>	<p>Serious risk: A National Board can take action within hours if needed, or within a few days to keep the public safe.</p> <p>If a National Board restricts the practitioner’s registration in some way at this stage, we will publish the change on the register of practitioners.</p> <p>Next steps: We will contact you if we need more information. If we have enough information we will contact you after the Board has made a decision about what to do next. If we refer your concerns to an HCE, we will tell you.</p>
	Board review	<p>A National Board assesses your notification and decides: to act now, by:</p> <ul style="list-style-type: none"> • Issuing a caution • Accepting an undertaking from the practitioner • Imposing conditions on their registration • Referring the matter to another organisation • Taking immediate action to limit the practitioner’s registration • Referring the matter to a panel hearing • Referring the matter to a tribunal hearing • to seek more information by: <ul style="list-style-type: none"> • investigating • requiring a health assessment • requiring a performance assessment • to take no further action, because it has enough information to decide there is no risk to the public that Boards need to act on to keep the public safe. <p>In the ACT, AHPRA gives the HCE the board’s decision, the reasons for it, and the material considered by the board.</p> <p>More information about Board assessments is published here.</p>	<p>A National Board assesses your notification within 60 days and decides what to do.</p> <p>We will tell you what the National Board has decided to do.</p>

Step	Stage	Action	You can expect
6	Investigations	<p>AHPRA investigates concerns on behalf of the National Board. After an investigation a National Board can decide to:</p> <ul style="list-style-type: none"> • take no further action • refer the practitioner for a health assessment • refer the practitioner for a performance assessment • refer the matter to a health panel • refer the matter to a performance and professional standards panel • impose conditions on/accept an undertaking from the practitioner • caution the practitioner • refer the matter to a tribunal, or • refer the matter to another entity. <p><u>More information on investigations is published here.</u></p>	<p>We will contact you if we need more information for our investigation.</p> <p>We will write to you every three months to update you on the investigation.</p> <p>At the end of the investigation, we tell you about the National Board's decision. Sometimes the law limits what we can tell you about this.</p>
7	Panel hearing	<p>National Boards can refer the practitioner to a health or a performance and professional standards panel.</p> <p><u>More information about panel hearings is published here.</u></p>	<p>We will tell you if a National Board has referred the practitioner to a panel hearing.</p> <p>We may ask you to give a statement or evidence to the panel.</p> <p>After the panel hearing, we will tell you what the panel has decided. Sometimes the law limits what we can tell you about this.</p>
8	Tribunal hearing	<p>A National Board refers a matter to a tribunal when the allegations involve the most serious unprofessional conduct (professional misconduct), and a National Board believes suspension or cancellation of the practitioner's registration may be warranted.</p> <p>There are health practitioner tribunals in each state or territory.</p>	<p>We will tell you if a National Board has referred the practitioner to a tribunal hearing.</p> <p>You may be asked to give a statement or evidence to the tribunal.</p> <p>We will tell you what the tribunal decides. The tribunal publishes its decision and the reasons for it.</p>

Footnotes

- 1 The UK data is reported in Australian dollars with an exchange rate of \$1.81 to £1 assumed.
- 2 Unlike in Australia, the UK pharmacist councils are responsible for the inspection and registration of pharmacy premises. Costs relating to these responsibilities were removed from the UK analysis so the figures can be directly compared with the Australian pharmacist board.

