Independent Review of the National Registration and Accreditation Scheme for health professions

Final report
December 2014

This final report has been prepared by the 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.

December, 2014

Australian Health Ministers' Advisory Council

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The Independent Reviewer

The Australian Health Workforce Ministerial Council (the Ministerial Council) appointed Mr Kim Snowball, Director of Healthfix Consulting, in April 2014 to undertake the Independent Review of the National Registration and Accreditation Scheme (the National Scheme) as required under the Intergovernmental Agreement signed by the Council of Australian Governments (COAG) in March, 2008.

Mr Snowball is an experienced senior public servant, formerly the Director General, WA Health and also former Chair of the Australian Health Ministers' Advisory Council (AHMAC). He has worked in both the public and private health sectors. He has considerable experience with the National Law, through its introduction in Western Australia and his chairmanship of AHMAC.

The Review has been conducted in accordance with the Terms of Reference approved by the Ministerial Council (*Appendix 1*) and the associated project plan (*Appendix 2*).

Due to the size and scale of the Review a support team was appointed in April 2014 to assist with the delivery of the project. This team was based in Melbourne and hosted by the Victorian Health Department, with Ms Louise Robinson appointed Project Manager and reporting to the Independent Reviewer.

Governance of the Review process has been provided by an AHMAC Chief Executive governance group comprised of: Dr Pradeep Philip, Secretary, Department of Health, Victoria (Chair); Dr Mary Foley, Director-General, New South Wales Health; and Australian Department of Health Secretaries Professor Jane Halton, Mr David Learmonth and Mr Martin Bowles. Support was also provided by Dr Peggy Brown, Director-General, Health Directorate, Australian Capital Territory and Chair of AHMAC, and Ms Kerry Flanagan, Deputy Secretary, Australian Department of Health.

The Review has been conducted on time and within the budget established by AHMAC.

Foreword

The oversight of Australia's health workforce is a vital, though often unsung, task within our health system. Four years ago, with the agreement of all Health Ministers, an ambitious new scheme was established to regulate the safe practice of many of the nation's health professions and build an innovative and accessible health workforce to meet future needs.

In April 2014 I was appointed to review this new National Registration and Accreditation Scheme (the National Scheme) for the health professions to assess the extent to which it is meeting the objectives and guiding principles Health Ministers and State and Territory Parliaments had in mind when it began in 2010. The National Scheme has 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 these objectives 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.

In essence, 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.

My task has been to identify the National Scheme's achievements and recommend improvements.

From the outset of the Review the National Scheme's achievements have been clear. Throughout my wide and varied consultation process there was overwhelming support for its introduction as a positive step forward in the regulation of the nation's more than 619,500 health professionals now listed on the national register.

The National Scheme, by way of legislation through each State and Territory Parliament, is a unique and substantial achievement that consolidated 75 Acts of Parliament and 97 separate health profession boards. The work involved in establishing the National Scheme and, most particularly, its administrative arm the Australian Health Practitioner Regulation Agency (AHPRA), has been enormous. Four years down the track this success can be overlooked and the benefits taken for granted.

The Review undertook broad-ranging consultations that were guided by the Consultation Paper released in August 2014. I was pleased by the high level of engagement by so many different stakeholders. The forums conducted in each capital city were well attended and more than 230 written submissions were received. I am grateful to all of those who took the time to provide thoughtful feedback and commentary.

Submissions encompassed the range of areas canvassed for Review in the Consultation Paper and, while opinions were diverse, strong themes emerged about the importance of striving to improve the ease with which practitioners, consumers and institutional stakeholders interact with the aspects of the National Scheme that most concern them. Uppermost was the desire to enhance understanding of the National Scheme and its functions and processes.

My recommendations are borne of an understanding of where the pressure points lie within the National Scheme as it currently exists, and are targeted at addressing these so that it can more expressly fulfil the tasks Health Ministers and State and Territory Parliaments set out for it in the National Law.

Taken together I believe the recommendations provide the means to increase efficiencies and deliver on the reform objectives the Australian health workforce requires. If adopted they will contribute to the improvement of a National Scheme that is already an international standard bearer.

In completing the Review I am grateful for the high degree of cooperation and responsiveness of Health Departments across Australia, those at the Australian Health Practitioner Regulation Agency, the National Boards, Accreditation Authorities and Health Complaints Entities. The Review was also assisted by the input of many professional organisations, education institutions, consumer representatives and individual members of the public. I would also like to acknowledge the support of the AHMAC governance group and members of the Review team.

Kim Snowball
Independent Reviewer

List of recommendations

1. The Australian Health Workforce Ministerial Council (the Ministerial Council) to establish the Professional Standards Advisory Council (PSAC) for a period of three years to:
   a. facilitate the implementation of accepted recommendations of the Review
   b. establish key performance standards, including financial standards to be reported to the Ministerial Council and individual Health Ministers by National Boards, the Agency Committee, Accrediting Authorities and the Australian Health Practitioner Regulation Agency (AHPRA) in delivering the objectives of the *Health Practitioner Regulation National Law 2009* (the National Law)
   c. inform National Boards, AHPRA and Accreditation Authorities on key health workforce reform priorities and health service access gaps, as identified by Australian Health Minister Advisory Council (AHMAC) standing committee structure and processes, and requiring action by the regulators
   d. examine evidence on contested cross-profession issues that arise from time to time within or between professions.
   e. undertake reviews or audits at the direction of Ministerial Council where safety issues or concerns are raised.

2. The National Law to be amended to provide the Australian Health Workforce Ministerial Council (the Ministerial Council) with the power to consolidate National Boards. This will enable the establishment of the Health Professions Australia Board.

3. The Australian Health Practitioner Regulation Agency, in conjunction with the National Boards of Aboriginal and Torres Strait Islander health practice; Chinese medicine; chiropractic; medical radiation practice; occupational therapy; optometry; osteopathy; podiatry; and physiotherapy, to develop an implementation plan for the merger of these nine low-regulatory-workload professions into the Health Professions Australia Board and submit to the Australian Health Workforce Ministerial Council for approval.

4. Once approved by the Australian Health Workforce Ministerial Council, the Health Professions Australia Board will be required to plan the consolidation of functions including formation of a consolidated fee structure, registration processes, consolidated accreditation and notification management within the first 12 months.

5. Each of the nine health professions to be represented on the Health Professions Australia Board, together with four community members.

6. The consolidation of the regulatory functions to be completed in a manner that ensures effective and ongoing professional input from the nine professions into standard setting, accreditation and notification management activities.

7. Any savings generated by the consolidation of the nine boards and their associated functions to be returned to registrants in the form of reduced fees, to the effect that no professional group will be financially worse off from the consolidation.

8. The Australian Health Workforce Ministerial Council to ensure that health professionals not included in the National Scheme should not be excluded or disadvantaged professionally by either:
   a. issuing a communique stating that the National Registration and Accreditation Scheme (the National Scheme) is for the purpose of additional regulation of specified professions only and is not to be used for any other purpose
   b. making amendments to the *Health Practitioner Regulation National Law 2009* (the National Law) to state that the National Scheme is for the purpose of additional regulation of specified professions only and is not to be used for any other purpose
   c. establish a system of quality assurance for voluntary registers of self-regulated professions.

9. Measures to be taken within the National Registration and Accreditation Scheme (the National Scheme) to ensure the following principles are met within the design and operation of the complaints and notifications process, in particular:
   a. establish a process where complaints and notifications involve a shared assessment of the appropriate means of investigating and addressing the issues between the Australian Health Practitioner Regulation Agency (AHPRA) and Health Complaints Entities (HCEs). Complainants whose issue is referred to a National Board as a notification are to be interviewed to determine their expectation and be advised of the relevant processes
   b. investigations and reports to be shared between National Boards, AHPRA and HCEs as required
   c. establish benchmark timeframes for completion of key aspects of notification management
   d. rationale for deliberations and progress reports to be routinely and quarterly conveyed to notifiers and health practitioners in plain language
   e. National Boards to be authorised to refer matters for Alternative Dispute Resolution to HCEs
   f. any adverse findings and disciplinary decisions to include the timeframe for inclusion of the decision or finding on the registrants' record. These decisions should be supported by strengthened monitoring of practitioner compliance with restrictions on registration, including adequacy of supervision
   g. the *Health Practitioner Regulation National Law 2009* (the National Law) to be amended so that notifiers personally impacted by practitioner conduct can be informed in confidence by the National Board about the process, decision and rationale for the decision regarding their case. This complements the amendments to the National Law approved by Ministerial Council in 2011 as detailed in *Appendix 11*
   h. National Boards and AHPRA to review correspondence standards with notifiers to ensure improved clarity and sensitivity in communication
   i. HCEs to file complaints so practitioners can be searched according to their AHPRA registration number to allow authorised persons to access data for research into the predictability of professional misconduct.

10. The *Health Practitioner Regulation National Law 2009* (the National Law) to be amended to reflect the same mandatory notification exemptions for treating practitioners established in the Western Australian law.

11. Make amendments to the *Health Practitioner Regulation National Law 2009* provision preventing the use of testimonials on platforms and sites that are managed or controlled by the practitioner or business.

12. The protection of the practice of birthing services to be adopted nationally, consistent with the South Australian amendment.

13. That the Australian Health Workforce Ministerial Council charge the Australian Health Ministers' Advisory Council, its Health Workforce Principal Committee and the Commonwealth Department of Health (where it carries previous functions of Health Workforce Australia) with articulating the health workforce priorities and health service access gaps to the Professional Standards Advisory Council for action by the National Registration and Accreditation Scheme. (See Recommendation 1)

14. Through the contractual arrangements between the Australian Health Practitioner Regulation Agency and the Accreditation Authorities, no fee increases levied on either National Boards or higher education institutions beyond the Consumer Price Index rate will be allowed without the express approval of the relevant National Board.

15. Through contractual arrangements between the Australian Health Practitioner Regulation Agency and Accreditation Authorities, standardised accreditation protocols and fee structures must be established within 12 months so that common accreditation processes can be adopted between all regulated health professions. These should be focused on education outcomes relevant to the outcomes of the National Registration and Accreditation Scheme not prescriptive education inputs.

16. The standardised accreditation protocols should be the subject of consultation with higher education policy makers and providers to streamline accreditation processes and avoid duplication with existing university accreditation processes. This consultation should be sponsored by the Australian Health Practitioner Regulation Agency.

17. Amend the *Health Practitioner Regulation National Law 2009* to provide that the National Health Practitioner Ombudsman has jurisdiction over accreditation functions within the National Registration and Accreditation Scheme.

18. A standing committee is needed within the National Registration and Accreditation Scheme involving the education sector, National Boards, Accreditation Authorities and representation from employers and jurisdictions to:

- **a.** discuss the means by which health workforce reform and health service access gaps can be best addressed in the education and training of health professionals
- b. consider the evidence and value of alternative innovations in the delivery of health education and training. (An example is that simulated learning is accepted by some but not all accreditors)
- c. share an understanding of workforce distribution and projected workforce needs
- d. ensure that education opportunities exist for students to meet the minimum standard of entry.

19. The fee structures for the accreditation functions associated with standard setting and assessment of overseas-trained health professionals and the accreditation of university programs of study should be clear and transparent as to which functions are funded by the National Boards from registrant fees and which are being met by the higher education sector.

20. The UK approach to accreditation should be explored to examine whether the significant cost difference between the UK and Australia results in better education outcomes in Australia. If this is not the case, then the UK approach to accreditation should be considered for application.

21. The National Boards and the Australian Health Practitioner Regulation Agency (AHPRA) to complete a review within 12 months of the 60 Committees supporting the National Boards, the 20 State and Territory or Regional Boards, and their 78 supporting committees to: consolidate committee functions; remove committees that duplicate the AHPRA corporate support role (for example, finance committees); review and revise delegation instruments to remove double handling of operational matters; and report to the Australian Health Workforce Ministerial Council on the outcomes.

22. Amend the *Health Practitioner Regulation National Law 2009* to require National Boards to seek Australian Health Workforce Ministerial Council approval for changes to qualification standards for registration purposes if the proposed standard could have a substantive and adverse impact on the recruitment or supply of health practitioners to the workforce.

23. Amend the *Health Practitioner Regulation National Law 2009* to require National Boards to seek Australian Health Workforce Ministerial Council approval for any codes or guidelines that might impose new competition restrictions or regulatory burdens, to ensure that these are in the broader public interest.

24. The performance of the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, in the implementation of changes to the International Medical Graduate assessment process arising out of the *Lost in the Labyrinth* report, form part of the key performance standards to report to the Australian Health Workforce Ministerial Council.

25. The Medical Board of Australia to evaluate and report on the performance of specialist colleges in applying standard assessments of International Medical Graduate applications and apply benchmarks for timeframes for completion of assessments.

26. That the *Health Practitioner Regulation National Law 2009* be amended to enable the Australian Health Workforce Ministerial Council to appoint either a practitioner member or a community member of a National Board as Chairperson.

27. That the *Health Practitioner Regulation National Law 2009* be amended to reflect and recognise that nursing and midwifery are two professions regulated by one National Board.

28. That the Australian Health Practitioner Regulation Agency conduct specific education and training programs for investigators. These should be designed in consultation with National Boards, Tribunals and Panel members to develop more consistent and appropriate investigative standards and approaches, consistent with the requirements of the *Health Practitioner Regulation National Law 2009*, including the primacy of public safety over other considerations within the matters.

29. That the Health Practitioner Regulation National Law 2009 prohibition order powers be amended to provide the means for Tribunals to prohibit the person from providing any type of health service, to establish an offence for breaching a prohibition order and to provide for mutual recognition of prohibition orders issued by jurisdictions.

30. That the regulation of Aboriginal and Torres Strait Islander Health Practitioners be continued by a merger into the Health Professions Australia Board, with continued involvement of Aboriginal and Torres Strait Islander Health Practitioners on issues covering that profession.

31. The Health Professions Australia Board establish a committee involving Aboriginal and Torres Strait Islander health leaders to assist the National Scheme to better respond to Aboriginal and Torres Strait Islander health and cultural issues.

32. That the *Health Practitioner Regulation National Law 2009* be amended to reflect provisions endorsed by the Australian Health Workforce Ministerial Council in 2011.

33. That the amendments proposed by the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA) be further considered by the formation of a small working group with representatives from AHPRA and jurisdictions with suitable legal and policy expertise to review the list of proposed amendments to the *Health Practitioner Regulation National Law 2009* and make recommendations to the Australian Health Workforce Ministerial Council.

Glossary

Aboriginal and Torres Strait Islander Health Practitioner Board (ATSIHPB)

Australian Health Ministers' Advisory Council (AHMAC)

Australian Health Practitioner Regulation Agency (AHPRA)

Australian Health Workforce Ministerial Council (the Ministerial Council)

Australian Medical Council (AMC)

Australian Nursing and Midwifery Accreditation Council (ANMAC)

Health and Care Professions Council (HCPC)

Health Practitioner Regulation National Law 2009 (the National Law)

Health Professions Australia Board (HPAB)

International Medical Graduate (IMG)

Medical Board of Australia (MBA)

National Code of Conduct for health-care workers (the National Code)

National Registration and Accreditation Scheme (the National Scheme)

Nursing and Midwifery Board of Australia (NMBA)

Office of the Health Services and Commissioner (OHSC)

Professional Standards Authority (PSA)

Professional Standards Advisory Council (PSAC)

Background

The National Registration and Accreditation Scheme (the National Scheme) commenced operation on 1 July 2010, and 18 October 2010 in Western Australia. Before then each State and Territory had its own system for registering and regulating health professionals, meaning there were 97 different health practitioner boards across the eight jurisdictions.

In its early days the National Scheme was beset with operational and administrative issues that have been subjected to a number of specific inquiries. Most of these establishment issues have been resolved by administrative action, however it is important to acknowledge that the National Scheme is still maturing.

The National Scheme today oversees the registration and regulation of more than 619,500 health professionals from 14 health professions. Its importance in keeping people safe and ensuring community confidence in the health workforce cannot be understated.

The 14 professions included in the National Scheme are: Aboriginal and Torres Strait Islander health practitioners; Chinese medicine; chiropractors; dentists; medical practitioners; medical radiation practitioners; nurses and midwives; occupational therapists; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists and psychologists.

The Review process

The Review process commenced with preliminary research, together with discussions with major stakeholders to identify key issues. The Independent Reviewer and team:

- canvassed key stakeholders and those involved in delivering the National Scheme
- sought views on the National Scheme from Health Ministers and Health Departments
- consulted with individuals and specific organisations interfacing with the National Scheme
- considered previous government reviews and inquiries
- received submissions from the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA) on key aspects of the National Scheme
- met with National Board Chairs, Accreditation Authorities and senior executive staff at AHPRA.

At the conclusion of this research it was clear that the Terms of Reference successfully captured the scope and extent of the issues to be considered, including the findings of the recent Victorian Legislative Committee inquiry.

The Independent Reviewer and team validated the issues by considering data and evidence on aspects of the National Scheme and its performance. The Review team:

- conducted a tender for the provision of a cost effectiveness and efficiency review of the National Scheme. The contract was awarded to the United Kingdom Professional Standards Authority, working in collaboration with the Centre for Health Services Economics and Organisation

- undertook an analysis of international regulatory schemes in England, New Zealand and two Canadian provinces (British Columbia and Ontario)
- completed a consumer engagement strategy.

This preliminary work was designed to ensure that as well as capturing the issues detailed by the Terms of Reference, the Review would canvass every aspect of the National Scheme, from registrations, complaints and notifications through to accreditation functions. It considered the cost of the National Scheme, made international comparisons and assessed relationships, performance, accountability and governance.

The preliminary work culminated in the release of the Consultation Paper, which was compliant with Office of Best Practice Regulation regulatory impact statement requirements and approved for release by the Australian Health Ministers' Advisory Council (AHMAC) governance group. The Consultation Paper was published on Friday 29 August 2014 on the website of the AHMAC Secretariat. The report was launched at the AHPRA national conference, involving more than 300 delegates, on Saturday 30 August, 2014. Advertisements were placed in 11 newspapers covering all States and Territories on Saturday 6 September 2014, alerting readers to the consultation process, the availability of the Consultation Paper and calling for written submissions.

For three weeks in September and October the Independent Reviewer presented the Consultation Paper at forums in the capital city of each State and Territory, with an additional national forum held in Melbourne. The relevant host jurisdiction took responsibility for organising its own event. Forum participants attended by invitation only, and included representatives of all the key stakeholders. A total of nearly 700 people across Australia attended the forums, which were designed to ensure that forum participants shared a common level of understanding about the National Scheme before seeking their input into the Review. Attendees were fully engaged and there was a high degree of participation and discussion.

Written submissions were also invited, with a closing date of Friday 10 October 2014. Respondents were guided in their submissions by a list of 28 questions that canvassed specific options for reform as well as more open-ended questions designed to elicit comments on the effectiveness of the current arrangements. 238 written submissions were received.

There was a strong and consistent acknowledgement across forums and submissions of the achievements of the National Scheme and the major success it has delivered in reforming health regulation in Australia. Several major themes emerged from the consultation process relating to: accountability and governance; the future regulation of health professions; complaints and notifications; public protection; and workforce reform, performance of National Boards and Accreditation Authorities.

Cost analysis

In May 2014, as required by the project plan, the Review invited external applicants to tender to conduct a cost-effectiveness analysis of the National Scheme. The United Kingdom's Professional Standards Authority, working in collaboration with the Centre for Health Services Economics and Organisation, was appointed in June to conduct this work. This aspect of the Review took place between July and October and was delivered in two phases: an interim assessment to inform the Consultation Paper and a final report incorporating a more in-depth analysis.

The final report on the cost-effectiveness and efficiency study was received on October 17 2014. This analysis identified a range of issues associated with the cost of regulation in Australia when compared to the UK and made a number of observations on potential cost saving measures that could be achieved without jeopardising public safety or quality of outcomes. These findings are critical to the provision of advice and options for reform, now submitted to the Australian Health Workforce Ministerial Council (the Ministerial Council), to improve the operations and governance arrangements to ensure the sustainability of the National Scheme into the future. A full copy of the report is attached at *Appendix 3*.

Consumer engagement

In July 2014 the Review contracted the Consumer Health Forum (CHF) to assist in engaging health service consumers from across metropolitan and rural Australia to participate in the Review process. The Review team, together with CHF held a consumer engagement workshop in Melbourne in September that brought together participants from all over the nation. The workshop initially ensured that participants had a good understanding of the National Scheme and then sought their views on its operation and where it needed to be improved. Participants were highly engaged in this workshop. Once they returned to their home states and territories, the participants consulted with their local communities and then represented their views at the relevant forum.

CHF also used its social media and online platforms to inform health-care consumers about the Review and to seek their views.

Structure of this report

Based on the evidence collected, the Independent Reviewer is in a position to make a series of findings and recommendations for consideration by the Ministerial Council. These are listed from page 5. The recommendations are also presented, together with the consultative feedback and evidence related to each, throughout this report.

This paper is structured in line with the Terms of Reference and consistent with the formats of the Consultation Paper and consultation process. Some issues were identified from the outset and put out for consultation in line with Office of Best Practice Regulation requirements. This has enabled feedback and evidence to be gathered at the level required to produce some clear options for improvement.

Other issues became apparent during the Review process and consultation phase. In response, separate, targeted consultation took place with Tribunals, Aboriginal and Torres Strait Islander Health Practice stakeholders and Accreditation Authorities. This report describes the additional issues that were identified, details feedback where it was captured and makes recommendations.

1. Accountability for the National Scheme

The Independent Reviewer identified a number of key gaps in the accountability arrangements for the National Registration and Accreditation Scheme (the National Scheme):

- limited reporting to State and Territory jurisdictions
- a lack of performance measures as a whole
- no avenue for resolving cross-profession issues
- widespread misunderstanding of the threshold for entry of new entrants
- no independent mechanism for the initial assessment of, and to advise on, applicants for entry
- no mechanism or accountability for driving health workforce reform.

The National Scheme must be accountable on a national level and to individual State and Territory Health Ministers. It was the States and Territories that established the *Health Practitioner Regulation National Law 2009* (the National Law) by passing near-identical Acts through their respective Parliaments. Health Ministers and their Parliaments should be provided with jurisdiction-specific information regarding the regulation of health practitioners in their relevant State or Territory.

This approach better reflects the fact that State and Territory Health Ministers bear ultimate responsibility for the safe practice of health professionals in their jurisdictions. To its credit, when this deficiency was raised with the Australian Health Practitioner Regulation Agency (AHPRA) it commenced reporting at a jurisdictional level in mid-2014.

The Independent Reviewer observed that while each agency working within the National Scheme is accountable to the Australian Health Workforce Ministerial Council (the Ministerial Council) and reports annually on its operational activities, there is neither obligation nor accountability for the performance of the National Scheme as a whole in terms of meeting its objectives. This was particularly evident in relation to the objectives regarding workforce reform that require collaboration between groups within the National Scheme, as well as stakeholders more broadly.

The National Boards and AHPRA expressed a willingness to progress this work but noted this had been difficult in the absence of States and Territories clearly articulating workforce reform priorities.

The Independent Reviewer initially proposed reconstituting the Australian Health Workforce Advisory Council (AHWAC) to fulfill these roles. Such a body was designed by the National Law, but is no longer active.

Attachment A of the 2008 Intergovernmental Agreement (IGA) for the National Scheme described the role of the AHWAC to "provide advice to the Ministerial Council on matters relating to the scheme, as established by the legislation. It will provide independent and transparent advice to the Ministerial Council, taking into account the objects of the legislation". The IGA also noted that Advisory Council will be funded directly by governments and supported by an independent secretariat.

While the AHWAC was intended to play an independent advisory role to the Ministerial Council, its only purpose was to respond to requests and the directions of the Ministerial Council. The body did not meet regularly. The decision on whether the AHWAC should be continued or disbanded was referred to the Review by the Ministerial Council for advice.

The initial proposal put forward in the Consultation Paper was for the AHWAC to be retained in order to strengthen accountability in the National Scheme by:

- 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
- independent advice through which any unresolved cross-professional issues are addressed.

It was proposed that AHWAC would draw on information, data and reports about individual components of the National Scheme and, if required, undertake further research, analysis or consultation to advise Health Ministers on the performance of the regulators and assist in resolving complex policy issues involving multiple professions and stakeholders.

Results of the consultation

There was strong support across the consultation forums for the strengthened accountability contained in this proposal. These views were reiterated in submissions received by the Review, where there was clear support from a wide range of stakeholders for an independent body to undertake the four functions proposed in the Consultation Paper.

The majority of responses that clearly supported these options did not make additional comment, however some highlighted the following benefits of the proposal:

- it will ensure a national approach to reporting against agreed performance measures (*Midwifery Education Advisory Committee)*
- enable greater oversight of the standards of National Boards and Accrediting Authorities (*Queensland Health*)
- if the National Scheme is to be more closely measured against its key objectives, then it is important that it has independent performance monitoring (*Health Care Consumers' Association*)
- enable better progress in workforce reform objectives by drawing information from Health Departments in each jurisdiction. Gaps in access to health services is useful information (*Committee of Presidents of Medical Colleges*)
- an independent advisory service to the National Scheme does not currently exist. This would provide some confidence to registrants and other key stakeholders in terms of monitoring performance of the regulator (*Tasmania Health*).

Professional associations argued that the majority of members on this independent body should be drawn from the professions; other stakeholders, in particular consumer representative groups, said it would be important for members to be independent from the professions and government jurisdictions.

Many respondents who supported the increased role of AHWAC added caveats to their support, for example:

- subject to AHWAC having clear governance, membership and defined workload (*ACT Health*)
- AHWAC composition must have expertise/knowledge in relevant clinical area(s) and associated standards and guidelines (*Royal Australian and New Zealand College of Obstetricians and Gynaecologists*).

A smaller group of respondents did not support one or other role for AHWAC:

- AHWAC may play a role in providing independent advice to Ministers on the appropriate performance measures for the National Scheme and provide a vehicle for further review of the National Scheme in three or five years' time if that's desired. There may be merit in a reconstituted AHWAC providing independent advice to Health Ministers on complex or contentious policy issues that cannot be resolved using current processes and providing expert advice on threshold measures for entry of professions into the National Scheme (*the National Boards and AHPRA*)
- functions regarding assessing professions for entry and articulating workforce priorities are the role of Practitioner Regulation Subcommittee or Health Workforce Principal Committee (*NT Health*).

There was advice, particularly from the jurisdictions, that the previous AHWAC body that was established by the National Law did not operate effectively and was given no standing responsibility. The reformation of this body into the future would need to ensure it did not add unnecessary bureaucracy in the national scheme or duplicate the role of other agencies.

- Department of Health and Ageing is of the view that the role proposed in the consultation paper for the Australian Health Workforce Advisory Council duplicates roles of other existing governance bodies in the National Scheme, and so recommends that the Advisory Council is not retained (*Department of Health and Ageing, South Australia*).

Discussion

During the course of this Review the National Scheme's lack of accountability to individual Ministers in the respective States and Territories was raised with the National Boards and AHPRA. As has been noted, in mid-2014 AHPRA and the Agency Committee commenced reporting to each Minister on the performance of the National Scheme within the relevant jurisdiction.

It is of critical importance that reporting to both the Ministerial Council (on the performance of the National Scheme as a whole) and reporting to each individual Minister (on the performance of health regulators in each State and Territory) be maintained.

The decision on the future of the AHWAC was referred to the Review for advice.

It is apparent to the Independent Reviewer that, at this point in the development and maturing of the National Scheme, a body advising the Ministerial Council on key issues of importance to the effective functioning and full accountability of the National Scheme to the Ministerial Council is essential.

Such a body must be carefully constructed and designed to ensure it does not become an additional layer of governance or management in the National Scheme nor duplicate the role of any existing bodies.

To that end it is proposed that a new body be established for no more than three years, using the existing provisions of the National Law. This body would be known as the Professional Standards Advisory Council (PSAC) making clear that its sole function is to advise the Ministerial Council on key matters of interest to the Ministerial Council in the performance of the National Scheme. It would not have a management or directional role over National Boards or AHPRA.

A set of narrow and distinct tasks to be completed within the three year life of the PSAC are also proposed, including the responsibility to facilitate and advise the Ministerial Council on the implementation of agreed recommendations.

There is capacity within the existing National Law for such a body to be created by the direction of the Ministerial Council. This would act as an agent for the Ministerial Council with the authority under the National Law to hold the National Scheme accountable. No other bodies with such authority currently exist that can respond to matters relating to the public, private and not-for-profit health sectors.

On this basis, rather than reconstituting the former AHWAC to undertake the required functions, it is proposed that a new body should be established with very distinct tasks and a three year life.

During its three years operation the PSAC would be required to:

- facilitate the implementation of the accepted recommendations of this Review
- establish key performance standards, including financial standards, to be reported to the Ministerial Council and individual Health Ministers by National Boards, the Agency Committee, AHPRA and Accrediting Authorities in delivering the objectives of the National Law
- inform National Boards, AHPRA and Accreditation Authorities on key health workforce reform priorities and health service access gaps as identified by the AHMAC standing committee structure and processes and requiring action by the regulators
- examine evidence on contested cross-professional issues that arise from time to time within or between professions
- undertake reviews or audits at the direction of Ministerial Council where safety issues or concerns are raised.

This range of tasks would enable the PSAC to be the Ministerial Council's agent to implement the accepted recommendations of the Review and ensure that the various agencies and functions operating within the National Scheme do so in a manner that is cohesive, and responsive to all of the key objectives and guiding principles. The cost of the PSAC will be limited to its sitting fees and it would be hosted by AHPRA to minimise outlays. These costs will be well within the overall net benefits achieved by implementation of the recommendations contained in this Review.

The PSAC will not replace the current jurisdictional processes (via the AHMAC standing committee structure of the Health Workforce Principal Committee and the Practitioner Regulation Subcommittee) for assessing draft registration standards and other applications for approval from National Boards.

The National Boards and AHPRA suggested that the Agency Management Committee should continue to be accountable to the Ministerial Council for reporting on the National Scheme. This approach is agreed to, providing that the performance measures adopted for reporting will be developed by the PSAC in conjunction with the National Boards and AHPRA.

Similarly several jurisdictions commented that the assessment of threshold entry to the National Scheme was the responsibility of the Health Workforce Principal Committee (HWPC). On that basis, the responsibility to address the lack of understanding among unregistered professions seeking to enter the National Scheme rests with the HWPC Without clarity many low-risk professions will continue to advocate for entry with Ministers.

The PSAC should have membership independent of the health professions and be appointed by the Ministerial Council with membership reflecting the role to be performed. It should have at least seven members (as currently prescribed in the National Law) with at least two members having regulatory backgrounds and experience, two with health service experience, one legal, one business, and one consumer/community representative and have access to the professional expertise as required.

Recommendation

1. **The Ministerial Council to establish the Professional Standards Advisory Council (PSAC) for a period of three years to:**
   a. **facilitate the implementation of accepted recommendations of the Review**
   b. **establish key performance standards, including financial standards to be reported to the Ministerial Council and individual Health Ministers by National Boards, the Agency Committee, Accrediting Authorities and AHPRA in delivering the objectives of the National Law**
   c. **inform National Boards, AHPRA and Accreditation Authorities on key health workforce reform priorities and health service access gaps, as identified by Australian Health Minister Advisory Council (AHMAC) standing committee structure and processes, and requiring action by the regulators**
   d. **examine evidence on contested cross-profession issues that arise from time to time within or between professions**
   e. **undertake reviews or audits at the direction of Ministerial Council where safety issues or concerns are raised.**

2. Future regulation of health professionals

The Review considered improvements that could be made to the National Registration and Accreditation Scheme (the National Scheme) to address the current issues identified within it, as well as ensuring it is structured and organised to meet the challenges of the future.

Professions within the National Scheme

Under the Terms of Reference the Independent Reviewer was asked to examine and provide comment on:

- the cost effectiveness of the National Scheme (including structure and functions), including where efficiencies could be gained and the impact of the model on the small professions, and
- whether the current regulatory arrangements for the National Scheme deliver sufficiently efficient, effective, consistent and proportionate regulations in light of the National Scheme's objectives and guiding principles.

The National Law demands the same level of regulatory force and governance structure for each of the 14 professions included in the National Scheme with little, if any, reference to each profession's unique risk profile or regulatory workload.

The analysis provided in the Consultation Paper considered the number of registrants and rate of notifications as an indicator of regulatory workload. It found the professions currently in the National Scheme could be divided into two groups: high and low-regulatory demand.

The high-regulatory-workload group comprised five professions: dental, medical, nursing and midwifery, pharmacy and psychology. These accounted for 87.5 per cent of registrants and 95.5 per cent of all complaints and notifications in 2012–13.

The Review considered that the regulatory model applied to the remaining nine low-regulatory-workload professions – that account for just 12.5 per cent of registrants and less than five per cent of notifications – was neither proportionate nor efficient.

The Consultation Paper canvassed two options for more efficient, effective and proportionate regulation to these nine health professions.

The first option was to establish a Health Professions Australia Board (HPAB) to replace and manage the regulatory functions of the National Boards of the nine low-regulatory-workload professions: Aboriginal and Torres Strait Islander health practice; Chinese medicine; chiropractic; medical radiation practice; occupational therapy; optometry; osteopathy; podiatry; and physiotherapy.

The interim report of the cost effectiveness and efficiency study found this would potentially deliver cost reductions of $11 million per annum. This option also has the potential benefit of achieving economies of scale and preserves professional input into matters affecting the regulation of the impacted professions through dedicated HPAB subcommittees. Savings would be derived from sharing common regulatory functions, including the management of complaints and notifications, accreditation (with professional input) and registration. An HPAB would also deliver benefits to all of the professions it serves via the simplification of the current registration fee structures and shared decision making, resulting in the cross-pollination of ideas.

The second option was to require the National Boards of the nine professions to share regulatory functions. The cost effectiveness and efficiency study estimated this option has the potential to reduce regulatory costs by $7.4 million per annum, derived from consolidating the registrations and notifications functions. This could be achieved by further consolidation of the committees under these nine boards so they are regulatory-function specific, rather than profession specific, across registration and notifications. In addition, by further increasing the delegation of registration decision-making it may be possible to reduce Board-related expenses through reduced committee involvement.

The third option represented the status quo – no change to the current structure or model of regulation.

The Consultation Paper asked whether savings achieved by either of the first two options should be returned to registrants.

Results of the consultation

There was clear support for change in regard to the regulatory oversight of the lower-regulatory-workload professions. There was some division regarding the nature of the change.

The consultation forums were told about the multi-professions regulator that oversees 16 health professions in the UK. There was a general acceptance of the proposed model of a multi-profession Health Professions Board of Australia across the State and Territory forums, and a notable absence of strident opposition.

However, professional associations and practitioners commonly stated that any model would need to ensure adequate professional involvement in each of the regulatory functions and that it was essential that change did not result in a decrease to public safety.

Representatives from the chiropractic and podiatry professional associations were concerned the smaller professions could be overwhelmed by the larger if a single nine-profession board was adopted. Similarly, professional associations also sought reassurance that all professions would be represented on a multi-profession board.

A common view was that the proposal was supported in principle but it was essential that professional input was assured. The majority of views expressed in forums supported the notion that any savings be returned to registrants.

Respondents who supported the option to consolidate nine National Boards noted:

- it is a logical step to explore a more tailored, efficient and cost effective regulatory footprint for the low workload professions, provided the continuation of the high standards of public safety and professional practice for these professions is assured (*NSW Health*)
- Boards are not for the professions but for consumer safety. The critical issue will be that arrangements are in place to regulate the profession to ensure public safety (*Australian Council of Pro-Vice Chancellors and Deans of Health Sciences*)
- a single, more efficient regulatory body would seem to be a worthwhile opportunity to manage the nine low regulatory workload professions (*Audiology Australia*).

The most common issues submitted in writing to the Review regarding the implementation of this model came from professional groups who were concerned it would:

- undermine the ability of professions to work with their respective Board (*Australasian Podiatry Council*)
- result in a reduction in monitoring of certain professions (*Australasian College for Emergency Medicine*)
- increase the complexity of the AHPRA structure (*Royal Australasian College of Surgeons*).

The second option, to further consolidate and share the regulatory functions of notifications and registration through a single service, received stronger support in the written submissions. The majority of respondents either clearly supported, or supported the proposal in principle. Comments included:

- The option to establish a single Health Professions Australia Board is not the preferred option for National Boards and AHPRA, however, we recognise that a similar model works successfully for the Health and Care Professions Council (HCPC) in the UK, and this question seeks to understand whether it could work in Australia (*National Boards and AHPRA*)
- We would like to see the preservation of the individual boards, while standardising and reducing costs for our practitioners (*Podiatry WA*)
- (Our submission) supports that costs be minimised through shared registrations and notifications functions, provided such changes do not impact on the improved processing times and communications (*Australian Physiotherapy Association*)
- Could potentially be a transitional phase to implementing a multi-professions national board (*Tasmanian Health*).

Those respondents who did not support any change to the current regulatory model were mostly professional associations, which indicated they did not agree with the analysis that it would lead to significant savings.

The majority of respondents clearly supported any savings from the proposed models being returned to registrants. The remaining stakeholders proposed that the savings could be reinvested in the National Scheme to achieve the broader range of objectives, to further fund accreditation, or other requests. For example:

- (it could be of) benefit if some of the savings achieved through this Review process were allocated to cross-profession work, which would maximise further efficiencies, and contribute to delivery of the workforce reform objective of the National Scheme (*Australian Medical Council*)
- once the optimum level of funding for either option was determined, however, the fee structure for registrants should reflect the cost of the board's operation. However, savings from these initiatives could also be used to enhance the oversight of the Scheme (*NSW Health*)
- savings should be directed to complaints management (*HealthCare Consumers*).

Discussion

On balance, the Review has found that there is sufficient support and evidence to more efficiently regulate the nine low-regulatory-workload professions through one Health Professions Australia Board. This is reinforced by the potential economic benefits, as well as the improved quality of regulatory processes and outcomes.

An observation of the Professional Standards Authority in its findings as part of the cost efficency and effectiveness study, was that if the National Scheme were to be consolidated to a single Board and a single Accreditation Authority as originally proposed by the Productivity Commission then savings of at least $56 million per annum could be achieved.

While the original development of the National Scheme did not pursue such an approach, it remains an available option if costs were the sole factor in determining the most appropriate means of regulating health professionals in Australia.

Throughout this Review process, there was little support from any stakeholders for consolidation of the National Scheme to this extent, it was noted that many of the larger and highest-regulatory-workload professions already achieve a comparable cost base to their overseas counterparts.

The most significant and optimum benefit would be delivered via the consolidation of the regulation of the smaller and lower-regulatory-workload professions in the National Scheme. This option would achieve a cost benefit for registrants, as well as improving decision making and allowing for more extensive cross-pollination of approaches to regulation amongst these nine professions.

While the creation of a single Health Professions Australia Board was not the preferred option of the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA), their joint submission acknowledged that the option:

> *has the potential to deliver benefits to both the public and the National Scheme. Consistency in policies and standards and their application may both facilitate operational efficiencies and mirror the community's expectations of health practitioners. In practice there is more commonality between health professions than differences, and the National Boards and AHPRA have worked steadily over the past four years to develop greater consistency of standards and guidelines between professions within the current model. A single Health Professions Australia Board could enhance this process (National Boards and AHPRA).*

The implementation of the HPAB will involve short-term transition costs. The extent of these costs can be minimised by the design and implementation of the HPAB. The significant work undertaken by National Boards and AHPRA in pursuing cross-professional approaches has made them well placed to move to effectively implement this model. The recommendation of the Independent Reviewer that AHPRA, in conjunction with the National Boards of Aboriginal and Torres Strait Islander health practice; Chinese medicine; chiropractic; medical radiation practice; occupational therapy; optometry; osteopathy; podiatry: and physiotherapy, to develop an implementation plan for the merger of these nine low-regulatory-workload professions into the Health Professions Australia Board and submit to the Ministerial Council for approval.

The implementation of the HPAB will deliver significant net benefits to the public, practitioners and the National Scheme as a whole and represents the most effective and efficient way of regulating these nine registered professions.

The Health and Care Professions Council (HCPC) in the UK provides an example of an effective multi-profession regulator that is responsible for the oversight of 16 health professions and 322,000 professionals. The HCPC is a consistently strong performer in the independent annual performance review of UK regulators that is conducted by the Professional Standards Authority. The HCPC reports that being a multi-profession regulator is one of the main contributors to this strong performance:

> *being a multi-profession regulator helps. The sheer value itself of common standards and processes, a critical mass of registrants and achieving economies of scale (telephone conference with Health and Care Professions Council).*

In the Australian context, it is proposed that the HPAB has representation from each of the nine professions, and four community members. There should also be at least one member from a small participating jurisdiction and at least one member must live in a regional or rural area.

Currently there is a "no cross-subsidisation" principle between professions in the National Scheme. The establishment of a HPAB with a single fee structure will also require amendments to enable cross-subsidisation within the professions under the consolidated Board. The principle of no cross-subsidisation between National Boards would continue.

In creating the HPAB the financial reserves for each profession will be retained to the benefit of that profession.

Any savings generated by the consolidation of the nine boards and their associated functions should be returned to registrants in the form of reduced fees to the effect that no professional group will be financially worse off from the consolidation.

Recommendations

2. **The National Law to be amended to provide the Australian Health Workforce Ministerial Council (the Ministerial Council) with the power to consolidate National Boards. This will enable the establishment of the Health Professions Australia Board.**
3. **The Australian Health Practitioner Regulation Agency, in conjunction with the National Boards of Aboriginal and Torres Strait Islander health practice; Chinese medicine; chiropractic; medical radiation practice; occupational therapy; optometry; osteopathy; podiatry; and physiotherapy, to develop an implementation plan for the merger of these nine low-regulatory-workload professions into the Health Professions Australia Board and submit to the Australian Health Workforce Ministerial Council for approval.**
4. **Once approved by the Ministerial Council, the Health Professions Australia Board will be required to plan the consolidation of functions including formation of a consolidated fee structure, registration processes, consolidated accreditation and notification management within the first 12 months.**
5. **Each of the nine health professions to be represented on the HPAB, together with four community members.**
6. **The consolidation of the regulatory functions to be completed in a manner that ensures effective and ongoing professional input from the nine professions into standard setting, accreditation and notification management activities.**
7. **Any savings generated by the consolidation of the nine boards and their associated functions to be returned to registrants in the form of reduced fees, to the effect that no professional group will be financially worse off from the consolidation.**

Professions not in the National Scheme

The Terms of Reference also required the Review to consider and comment on mechanisms for new professions to enter the National Scheme.

It was identified early in the Review process that there is a widespread misunderstanding about the purpose of the National Scheme which has prompted confusion about why some professions were included in it when it began four years ago, and why some professions were – and continue to be – omitted.

The current approach for assessing potential new entrants to the National Scheme relies on the gateway criteria and guiding principles described in Attachment B of the 2008 Intergovernmental Agreement for the National Scheme. Where there is in-principle support

for the regulation of a new profession, a further extensive regulatory impact assessment is required in accordance with best practice regulation requirements, assessed by the Office of Best Practice Regulation.

The Review considered how assessments should be conducted to determine if other professions should be admitted to the National Scheme. It needs to be acknowledged that entry to the National Scheme would impose a cost burden to be borne by registrants. This could only be justified if it could be established that there would be a cost benefit to the community.

There were a number of examples presented to the Review team from unregistered professions demonstrating the unintended consequences of not being included in the National Scheme, such as denial of employment opportunities and academic scholarships.

The Consultation Paper asked what criteria should be used to assess those professions applying to enter the National Scheme, and whether the National Law needed to be amended in some way to ensure those professions not included in the National Scheme were not disadvantaged as a result.

Results of the consultation

There was significant support for the assessment of new professions entering the National Scheme to be based on a measure of risk to the public and an associated cost benefit analysis. There were mixed views on the value of amending the National Law to recognise health professions that are subject to adequate regulatory oversight and public protection mechanisms through other means.

The voices of a number of unregistered professions were heard at various forums, all advocating for entry into the National Scheme. The view was consistently put forward that further clarity on entry criteria was desirable and that a broader assessment of risk was required.

There was overwhelming support in the written submissions for the continuation of the assessment of professions to be included in the National Scheme to be based on the risk to the public and a cost benefit analysis. 90% of respondents expressed this view and commonly identified that the current criteria were appropriate and effective. The remaining respondents were largely professional groups who put forward views that:

- all health professions should be in the National Scheme with removal occurring case by case (*Speech Pathology Australia*)
- public safety and risk should outweigh cost benefit (*Cosmetic Physicians Society of Australia*).

There were also views put forward from professions seeking future registration in the National Scheme that further guidance is needed on how the Intergovernmental Agreement and Office of Best Practice Regulation requirements are interpreted and what would constitute appropriate evidence to demonstrate this, particularly in the area of risk:

- supports a threshold of risk but seeks further clarification and articulation of the definition of risk and the thresholds for determining risk (*Australian Association of Social Workers*)
- criteria for determining risk exposure requires more flexibility in its applications (*Australian Association of Massage Therapists*).

Some of this confusion appears to relate to the differing risk profile of the 14 professions currently registered. Many unregistered groups indicated that they believe if they were assessed alongside some of the currently registered professions, they would be found to have a similar risk profile.

There was strong support in the forums for the unintended consequences of the National Scheme on unregistered professions to be addressed, with some stakeholders supporting a model that involved the recognition of self-regulated professions, either in a preamble to the National Law, or by another form of communique.

The written submissions provided further evidence of these unintended consequences. There were mixed views about the best way to address this. Just over half of respondents supported recognition under the National Law. 40% did not support this approach, with the remainder noting further assessment of the issues is required. Comments included:

- support a change in the National Law to recognise professions that provide adequate public protection through other regulatory means and note the United Kingdom has a similar approach through the Assured Voluntary Registers Scheme that could potentially be adapted to the Australian context (*the National Boards and AHPRA*)
- the National Scheme needs to include a public statement that the credibility of a professional is not reliant on government regulation but on professional registration which meets industry requirements as set down by peak bodies, both those under AHPRA and those outside of AHPRA (*Australian Counselling Association*)
- it appears unnecessary to amend the National Law to recognise those professions that provide adequate public protection through other regulatory means, given Ministers have available other mechanisms to document this recognition such as through communiques and policy statements on the AHMAC website (*Health Professions Accreditation Councils' Forum*)
- no, this would give health care workers undue status and credibility (*Australian Medical Association*).

Discussion

It is reasonable that health professionals not included in the National Scheme should not be excluded or disadvantaged professionally; this includes membership of health bodies, access to research grants, or employment simply on the basis that they are not regulated through the National Scheme.

The Review is putting forward three options to achieve this outcome for consideration by Ministers.

First, a clear statement and communique from Ministers reinforcing that inclusion in the National Scheme is for the purpose of regulation to ensure public safety and that exclusion from the National Scheme simply recognises that such professions are adequately regulated through other means, including self-regulation or do not require additional regulation.

Second, clarify the purpose in the National Law so it is clear that the National Scheme is for the purpose of additional regulation of specified professions only and is not to be used for any other purpose.

Third, establish a system of quality assurance for voluntary registers so that self-regulated professions can opt for a third party independent assessment to become accredited. This would be similar to the role of the UK Professional Standards Authority, which accredits voluntary registers of people working in a variety of health and social care occupations. Organisations that hold voluntary registers would need to demonstrate that they meet a series of standards to provide assurance that: the registers are well run and that they require registrants to meet high standards of personal behaviour, technical competence and, where relevant, business practice. Professions accredited by the third party body would be badged accordingly so that the public and employers can identify people who are on the register, and have confidence that registrants have been independently assessed and approved.

Further detail on the operation of the voluntary register model in the UK is included in Appendix 4.

This option was previously canvassed as part of the regulatory impact assessment undertaken in the development of *options for regulation of unregistered health practitioners*.

The option proposed involved the establishment of a self-funded body (or extend the role of an existing body) to act as a national standard setting agency for self-regulating professional associations and accredit the voluntary practitioner registers they maintain. It was assumed that the cost to governments of establishing a new national standard setting and accreditation entity would be approximately $500,000 in the first year, or half that figure ($250,000) if an existing body were to assume the role.

This work led to AHWMC agreeing in principle to strengthen State and Territory health complaints mechanisms via a single national Code of Conduct for unregistered health practitioners that has not yet been implemented.

Chapter one of this report recommends that the Health Workforce Principal Committee needs to undertake a body of work to clarify the threshold measures for entry to the National Scheme to applicant professions as there is considerable confusion amongst the unregistered professions on the thresholds for entry. There would seem to be some benefit in providing advice to the Ministerial Council on whether applications meet the requirements in principle for entry prior to a full regulatory impact assessment. This will enable a more informed self-assessment for those organisations who believe they may require regulation to protect the public from harm.

Recommendation

8. The Ministerial Council to ensure that health professionals not included in the National Scheme should not be excluded or disadvantaged professionally by either:

- **a. issuing a communique stating that the National Scheme is for the purpose of additional regulation of specified professions only and is not to be used for any other purpose**
- **b. making amendments to the National Law to state that the National Scheme is for the purpose of additional regulation of specified professions only and is not to be used for any other purpose**
- **c. establish a system of quality assurance for voluntary registers of self-regulated professions.**

3. Complaints and notifications – including mandatory notifications

It was apparent from the outset of the Review that there is widespread concern about the manner in which notifications have been managed under the National Registration and Accreditation Scheme (the National Scheme). These views were repeatedly raised with the Independent Reviewer by members of the public, health practitioners, ombudsman, jurisdictions and professions. Key concerns included:

- poor understanding and communication about the notifications process and its intersection with State and Territory Health Complaints Entities (HCEs) complaints processes
- no single entry point for notifications and complaints means the system is hard to navigate
- delays in the preliminary assessment or investigation of concerns raised by notifiers
- delays in the finalisation of notifications
- poor communication with both notifiers and practitioners
- outcomes are not well explained to notifiers
- consumers make notifications with the intention of preventing others from experiencing harm, but commonly feel denied this by a notifications system that does not explain its actions
- HCEs are generally not informed about the investigations and outcomes of cases handled by the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA)
- perception of inconsistent investigative processes and outcomes among participating jurisdictions.

The notification process is designed to alert regulators to registrant performance, conduct or health issues that may place the public at risk. The regulatory system is designed to safeguard the community by investigating breaches of professional standards, and where appropriate, providing feedback, intervention, and in more serious cases restricting or removing the right to practise.

To function properly, the system must have the confidence of community members and health practitioners as it relies on individuals to notify authorities if they believe registered health practitioners have behaved in a manner that is unsafe, substandard or inappropriate. Consumer representatives and individuals conveyed concerns to the Review that, in their view, the failings of the current system were to the detriment of confidence in the notifications system.

One challenge of the national notifications system is that notifiers commonly see themselves as party to their case and expect to have an active and ongoing role in the resolution of it, whereas the system views them as a witness to an allegation of misconduct. Notifiers also expect to be given information about the consequences of any investigations. However, in accordance with the National Law, notifiers are sent brief letters once matters are completed that document the outcome of the case, but the detail is limited to the information that is provided on the national register. There is no explanation of the process, decision or the rationale behind it. There is no avenue for appeal.

In 2013-14 the National Boards and AHPRA referred approximately 20 per cent of notifications received to HCE while 57 per cent of the notifications the National Boards and AHPRA managed resulted in a decision of No Further Action. The seemingly high rate of No Further Action outcomes prompts questions about the effectiveness of the triage process on receipt of the notification/complaint.

The following case study is a revealing and recent example of several key deficiencies within the complaints and notifications system that were repeatedly brought to the attention of the Review from stakeholders in all jurisdictions.

Case study

Susan first saw her GP for a small growth on her lower left leg in January 2010. It took multiple visits to doctors before she was diagnosed with advanced Amelanotic Melanoma in July 2011. After many complications, Susan, aged 60, died a terrible death in October 2013. She left behind a grief-stricken family who determined that the same thing should not be allowed to occur to someone else. Susan's husband resolved to alert authorities to what he believed were crucial medical errors that had resulted in his wife's premature death.

He wrote to the Australian Health Practitioner Regulation Agency (AHPRA) in November 2013, making notifications about the GP and dermatologist who first saw Susan a little more than three years earlier. AHPRA quickly acknowledged these notifications with an official letter of reply. But it took five months before Susan's husband received further formal correspondence from AHPRA: he received an insensitive letter in May 2014 advising him that the Medical Board of Australia had decided that the manner in which the GP practised "is or may be unsatisfactory" and then provided a short list of possible outcomes of the action that might – or might not – have been taken against the GP. (Appendix 5). The notification about the dermatologist has been postponed pending the result of a coronial inquiry.

Susan's husband remains dismayed by the responses of AHPRA and the Medical Board. He is distressed that after providing extensive information about his wife's case, all he has received are what appear to be standard letters of response.

AHPRA chief executive Martin Fletcher acknowledged to the Review that the correspondence in this case fell well short of a helpful and sensitive response and said that AHPRA was working to improve the template letters it sends to notifiers. But in regard to providing more details about the investigation or the outcome, Mr Fletcher said the National Law currently constrains the disclosure of information about National Board decisions or the reasons that underpin them.

Susan's husband is unhappy about this lack of information and believes that notifiers have the right to know the outcome of their cases. He said the public is not protected against unsafe practice so long as proceedings and outcomes remain secret. "After Susan's totally preventable and unnecessary death, I believe I should be informed of the specific actions that have been taken to ensure that someone else does not have the same terrible experience," he said.

This has been published with the kind consent of Susan's family

The case study illustrates the impact of the lack of timeliness, poor communication, and a process that essentially fails to deliver transparency and confidence. Some of these issues are administrative, others relate to constraints imposed by the National Law.

Key stakeholders told the Review that change was required in this area:

> *Seems to be a reasonable argument for notifiers who are personally involved in an incident to be treated differently from those who are not. An individual personally involved in an incident that leads them to make a notification against a practitioner would reasonably expect more information in relation to the investigation and resolution than an individual making a notification in relation to an event that did not concern them personally (Australian Medical Council).*

Results of the consultation

The Consultation Paper posed a range of questions focused on the principles of an effective notifications/complaints system. These included whether there should be: a single entry point for notifications in each jurisdiction; prescribed timeframes for notifications' management; clearer and more detailed reporting of outcomes; flexible powers – such as Alternative Dispute Resolution – available to National Boards; and a definite timeline for when an adverse finding against a practitioner ought remain on the public register.

Across each of the forums and in many written submissions there was a high level of engagement and discussion on the need to improve the management of complaints and notifications for the benefit of notifiers or complainants and practitioners, regardless of which type of model was pursued.

Table 1 on page 33 lists the aspects of the notifications system that require improvement, as reported in the submissions. Timeliness, communication, transparency and consistent outcomes were the most commonly identified areas for improvement from respondents. These views were relatively consistent across all stakeholders. The exception being that some professional associations did not agree with the right of notifiers to have access to more information than is currently available under the National Law.

Table 1: Areas requiring improvement in the complaints and notifications system

Improvement	Number of times raised in submissions
Improved timeliness	26
Communication needs to be improved	23
Increased transparency in process and outcomes	19
More consistent processes and/or outcomes	12
System needs to be simplified and streamlined	8
Make notifiers more central to the process	5
Requires an oversight mechanism	5
Needs a mechanism to appeal decisions	5
Less adversarial approach	4
Prevent vexatious notifications	3
Better triage of complaints / notifications	1

Suggestions in the written submissions to improve these issues included:

- further explanation when a finding of "No Further Action" is made (*Chiropractors' Association of Australia*)

- the lack of information about the outcome can leave the consumer wondering if their complaint (notification) has truly been heard, has changed anything and whether the public is truly protected as a result *(Health Issues Centre Victoria)*
- notifiers should be regularly updated on the progress of their notification – even if the investigation and deliberations are still pending – and be properly informed of the reasons behind any decision or delays (*Consumer Health Forum*).

A small number of stakeholders expressed an alternate view, for example:

- the only information that should be available is that on the Board's register. Rejects the notion that AHPRA's role is to "appease notifiers and the public" (*MDA National*).

The Review received submissions from Health Complaints Entities (HCEs) from each State and Territory that showed support for change:

- (we have) concerns about a lack of transparency in relation to Boards' decision making, whether Boards are truly independent in making such decisions and whether there are sufficient checks and balances in the scheme for handling complaints about practitioners … Establishing a sole independent complaints handling body by giving function to HCEs or developing an equal partnership with joint consideration between Boards and HCEs (ACT model) would provide additional confidence that Boards are not making decisions without input from an independent body (*Joint submission HCE Queensland, NT, Tasmania, ACT and NSW*)
- improvements can be made to strengthen the decision making process to more effectively manage complaints and to identify the more appropriate agency to manage the matter at the earliest opportunity (*Health and Disability Services Complaints Office, Western Australia)*
- in some cases it is necessary to seek further expert opinion on a point that has already been clarified to AHPRA or the Board. Free flow of relevant information between both agencies would be essential for a dual regulatory model to work effectively (*Ombudsman and Health Complaints Commissioner Tasmania*).

The Review also confirmed that since the publication of the Consultation Paper in August 2014, the Victorian Office of the Health Services and Commissioner (OHSC) and AHPRA have resolved issues relating to their interface:

- while there was a misconception that we were prevented from dealing with complaints that had been dealt with by a National Board, this issue has been addressed via changes to internal policy, protocol and legislative interpretation (*Office of the Health Services Commissioner, Victoria*).

64% of respondents supported the option for National Boards to adopt Alternative Dispute Resolution (ADR). 15% said there should be greater access to ADR – but through HCEs not National Boards. The remaining 21% did not support, mostly stating that the Boards should only focus on public safety assessments and not complaint resolution:

- the notification system should be changed to ensure that a complainant who wants an apology or a fair hearing has access to a process that can result in that sort of outcome, whether or not the issue raised is also (being) dealt with as a notification *(Health Care Consumers' Association).*

It was established through the consultation forums and written submissions that there is broad agreement that the following principles, which were specifically canvassed in the Consultation Paper, underpin a good notifications and complaints system:

- a single point of entry for complaints and notifications in each State and Territory (93% support in submissions)
- the introduction of national performance measures and prescribed timeframes for dealing with complaints and notifications (94% support in submissions)
- greater transparency for the public and for notifiers about the process and outcomes of disciplinary processes (87% support in submissions)

- support for National Boards to have access to ADR, noting that in the main matters requiring ADR should be directed to HCEs
- need for nationally consistent outcomes for similar offences or notifications.

Other views put forward at the forums included:

- clear feedback that the current system is poorly understood, hard to navigate and has resulted in difficult experiences for both notifiers and practitioners
- need for improvement in the communication with notifiers and practitioners.

In addition to the series of principles canvassed, the Consultation Paper asked for feedback regarding at what point an adverse finding and the associated intervention recorded against a practitioner should be removed:

- 70% of respondents indicated that this is dependent upon the individual circumstances of the case and how long it remains on the record should be determined at the same time as the condition or penalty is determined
- 14% proposed that an adverse finding should only be recorded on the public register while current.

16% presented alternative views including: a range of time periods, from two to seven years, should be recorded indefinitely, that there needs to be a broader public debate and consideration of this matter.

The Consultation Paper also sought feedback on how to improve the existing system and proposed options to achieve this. The first option proposed the retention of the existing configuration of notifications handling but to improve the process via a range of administrative and legislative changes.

The second option was for States and Territories to move towards a co-regulatory approach to managing complaints and notifications, along the lines of the Queensland Health Ombudsman model. A third option, representing the status quo was also included.

The weight of opinion heavily leant toward repairing the current system via administrative and legislative change. Participants at the forums put forward a range of views in response to the options proposed in the Consultation Paper. Some stakeholders expressed the view that a Queensland-type approach would provide greater clarity and confidence to notifiers. Other stakeholders expressed concern about the fragmentation of the National Scheme from further co-regulatory approaches. It was also noted that the Queensland model was very new and difficult to assess at this point.

From the analysis of written submissions in this area, there was minimal support for a move towards a Queensland type co-regulatory approach, with 34% reporting that the model was too new to assess or consider for broader application, and 49% clearly not supporting a co-regulatory approach. Comments included:

- concerned about the erosion of a nationally consistent approach. Queensland [model] hasn't operated long enough to demonstrate effectiveness/efficiency (*Australian & New Zealand College of Anaesthetists*)
- no. There should be national uniformity and consistency (*Optometry Australia*).

It is noted that New South Wales has had a successful co-regulatory scheme from the outset of the National Law. The submission from NSW stated that:

- NSW Health supports the current co-regulatory system in this jurisdiction. The NSW Minister for Health is currently reviewing the adoption of the National Law to ensure the objectives of the Act are being met in NSW. It is anticipated that features of the NSW co-regulatory framework will be contemplated as part of this review. NSW will consider the findings of the review of the National Scheme in this context (*NSW Health*).

The cost analysis undertaken by the Professional Standards Authority included an assessment of the different cost between the New South Wales co-regulatory complaints and notifications scheme with the National Scheme. This identified that notifications cost on average $166 per registrant in NSW and $125 per registrant in the rest of Australia (Refer Appendix 3). This marked difference in unit cost should be the subject of further analysis.

Professor Merrilyn Walton from the University of Sydney is currently conducting research that will be completed by the end of 2015, which will provide comparison and contrasts in the performance of the complaints and notifications systems between NSW and the rest of Australia.

Discussion

It needs to be emphasised that this component of the National Scheme requires much attention and effort to bring it up to the standard envisaged when it was established four years ago. The national notification system has its merits, it should be kept, but it must be improved if it is to gain the confidence of the public and practitioners.

There is a need to improve the current system to become an effective national complaints and notifications model that achieves more consistent outcomes and has the capacity to track unsafe registrants across State and Territory borders.

It should also be noted that an important feature of the current system is that it was designed to err on the side of caution when it comes to public safety even though this approach may be perceived as being at the expense of a practitioner's right to natural justice.

There is also a tension between a notifier's right to be informed and a practitioner's right to privacy. Notifiers who have made the effort to raise matters with the National Boards and AHPRA, should be informed about the process that has led to the resolution of their case. A notifier should also be given details about what the outcome of their case and the rationale behind the decision. This should not extend to a right to appeal the decision. This information should be disclosed to the notifier in confidence.

In the context of complaints and notifications, the relationship between AHPRA and the State and Territory HCEs is vital. This relationship must be robust and collaborative to ensure the smooth transfer of information between agencies. Each must have a clear understanding of the roles and powers of the other and, where possible, these interpretations should be shared by all participating jurisdictions. Consistent outcomes are unlikely to be achieved across the jurisdictions if the States and Territories have differing views of the roles of HCEs and AHPRA in the management and resolution of complaints and notifications.

While amendments to the National Law in Queensland, NSW and the Australian Capital Territory have meant that Commissioners or Ombudsmen have a central role in determining how a notification/complaint will be handled and by which agency, the Review has found that more could be done to ensure that Commissioners in all jurisdictions are engaged from the outset of a case being lodged.

There currently appears to be a reluctance to share information, leading to the time-consuming duplication of inquiries. A joint submission to the Review by Health Complaints Commissioners noted:

- Once a matter has been referred to a National Board for action, the Commissioners have no right under the National Law to reports or any other evidence obtained as part of any further action, or to be informed about outcomes of the process. Commissioners are generally not consulted on any action or sanction arising from AHPRA investigations (*joint submission from the Queensland, Northern Territory, Tasmania, ACT and NSW Health Complaints Commissioners*).

In summary, more needs to be done to ensure the smooth and efficient flow of information between AHPRA and HCEs. This would reduce duplication and improve the timeliness of the management of complaints and notifications.

The Review was also told that in many cases notifiers and complainants are motivated by the desire for an apology and to ensure that what happened to them will not be repeated upon others. It was put that Alternative Dispute Resolution processes such as conciliation and mediation can be effective means of achieving both of these outcomes and that such services are offered by HCEs.

Many practitioners and notifiers expressed frustration at the lengthy delays associated with complaints and notifications. One aspect of the new Queensland co-regulatory approach that was acknowledged by observers was the specification of Key Performance Indicators (KPIs) within the complaints framework. While there was some concern that the establishment of benchmark timeframes for the handling of notifications might lead to matters being rushed or inadequately investigated, this risk could be mitigated by requiring escalated approval for extended timeframes.

It became clear during the course of the Review that AHPRA and HCEs use different methods to file and locate complaints and notifications. While AHPRA files notifications under the practitioner's AHPRA registration number, HCE databases file complaints according to the practitioner's name.

The notifications system should strive to have the capacity to shift from being purely responsive to events to being more predictive. A consistent and linked record of registrants would assist researchers who are seeking to develop a tool to enable a more proactive approach to identifying practitioners who may need early intervention and assistance, rather than a reactive response after the public has been exposed to harm.

Recommendation

9. **Measures to be taken within the National Scheme to ensure the following principles are met within the design and operation of the complaints and notifications process, in particular:**
   a. **establish a process where complaints and notifications involve a shared assessment of the appropriate means of investigating and addressing the issues between the AHPRA and HCEs. Complainants whose issue is referred to a National Board as a notification are to be interviewed to determine their expectation and be advised of the relevant processes**
   b. **investigations and reports to be shared between National Boards, AHPRA and HCEs as required**
   c. **establish benchmark timeframes for completion of key aspects of notification management**
   d. **rationale for deliberations and progress reports to be routinely and quarterly conveyed to notifiers and health practitioners in plain language**
   e. **National Boards to be authorised to refer matters for Alternative Dispute Resolution to HCEs**
   f. **any adverse findings and disciplinary decisions to include the timeframe for inclusion of the decision or finding on the registrants' record. These decisions should be supported by strengthened monitoring of practitioner compliance with restrictions on registration, including adequacy of supervision**
   g. **the National Law to be amended so that notifiers personally impacted by practitioner conduct can be informed in confidence by the National Board about the process, decision and rationale for the decision regarding their case. This complements the amendments to the National Law approved by Ministerial Council in 2011 as detailed in *Appendix 11***
   h. **National Boards and AHPRA to review correspondence standards with notifiers to ensure improved clarity and sensitivity in communication**
   i. **HCEs to file complaints so practitioners can be searched according to their AHPRA registration number to allow authorised persons to access data for research into the predictability of professional misconduct.**

Mandatory notifications

The National Law requires practitioners to advise a National Board or AHPRA of "notifiable conduct" by another practitioner (or student) if the practitioner is: practising while intoxicated by alcohol or drugs; commits sexual misconduct in the practice of the profession; or places the public at risk of harm because of an impairment or because of a significant departure from accepted professional standards.

The National Law for mandatory notifications is applied differently in Western Australia and Queensland, see *Box 1* on the following page.

Box 1

Application of the National Law in Western Australia

Part 2, Section 4(7) *Health Practitioner Regulation National Law (WA) Act 2010*

In this Schedule after section 141(4)(c) insert—

141(4)(d) the first health practitioner forms the reasonable belief in the course of providing health services to the second health practitioner or student; or

Application of the National Law in Queensland

section 25 *Health Ombudsman Act 2013* (3) National Law provisions, section 141— insert—

(5) Subsection (2) does not apply in relation to the second health practitioner's notifiable conduct if the first health practitioner—

(a) forms the reasonable belief as a result of providing a health service to the second health practitioner; and

(b) reasonably believes that the notifiable conduct—

(i) relates to an impairment which will not place the public at substantial risk of harm; and

(ii) is not professional misconduct.

The effect of the Western Australian exemption is to remove the mandatory nature of the notification from the treating practitioner, while the Queensland law exempts the treating practitioner from making a mandatory notification where they believe the public is not at risk.

The Consultation Paper asked whether the mandatory notifications exemptions should be replicated nationally. There was a lot of discussion about this proposal at the consultation forums with a variety of positions taken:

- some attendees wanted consistency across jurisdictions on these provisions regardless of which approach was adopted
- some views that the treating practitioner only receives subjective information from the patient and therefore should be required to report
- some views that the existing mandatory reporting provisions that apply to colleagues and employers are sufficient, and there is no evidence that requiring this of treating practitioners enhances public safety.

During the consultation forums it was noted that there was confusion among stakeholders about the current arrangement. Some professionals, not from WA or Queenland, believed there was already an exemption for treating practitioners if they believed the public was not at risk.

Written submissions expressed strong support (74% of respondents) for the option of a national exemption for treating practitioners to make mandatory notifications:

- mandatory reporting is an important public protection mechanism in the National Scheme. We support the goal of nationally consistent mandatory reporting provisions, whatever Ministers decide about future exemptions for treating practitioners. Findings from early research indicate there are several feasible "intermediate" options warranting examination. They may all be mechanisms to reduce the risk of practitioners not seeking treatment, while maintaining a requirement to report practitioners who pose a substantial risk to the public (*National Boards and AHPRA*).

Discussion

There was strong advocacy from those working within the National Scheme, and also from external stakeholders, that national consistency is important in regard to this critical aspect of the National Law. It is clear that leadership is needed to achieve agreement in this area.

While the current data is inconclusive, it should be noted that a deeper research-based analysis of the subset of mandatory notifications by treating practitioners is being conducted by Dr Marie Bismark at the University of Melbourne, in partnership with National Boards and AHPRA. This research has potential benefits in the ability to closely monitor the outcome of any change to the National Law on mandatory notification provisions.

With the feedback to the Review falling squarely on the side of providing exemptions to treating practitioners, and with no evidence that the exemptions have significantly altered mandatory notification rates then it would be sensible to extend the exemptions to treating practitioners to all jurisdictions.

Two different approaches were considered in the Consultation Paper to achieve this outcome.

In Western Australia there is no legal requirement for a treating practitioner 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 this approach is to not impinge on the treating practitioner – patient relationship.

In Queensland, treating practitioners are also exempt from making mandatory notifications about impaired health practitioners or students, but this exemption only stands so long as the treating practitioner believes there is not a future risk to the public. This means treating practitioners must make a judgement about the risk posed by the individual they are treating.

The Review has found that the Western Australian exemption for treating practitioners received the strongest stakeholder support. Given there is no evidence that this approach has impacted on mandatory notification rates, and in pursuit of national consistency, it is recommended that the Western Australian exemption from mandatory reporting for treating practitioners be adopted by all jurisidictions.

Recommendation

10. The National Law to be amended to reflect the same mandatory notification exemptions for treating practitioners established in the Western Australian law.

4. Public protection mechanisms

One objective of the National Registration and Accreditation Scheme (the National Scheme) is to provide for the protection of the public.

The National Law contains a number of provisions designed to meet this objective and provide for the public's safety by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered.

The Review considered a range of matters brought to the Independent's Reviewer's attention, and sought views from stakeholders about what, if any, additional mechanisms or provisions in the National Law were required to more effectively protect the public from demonstrable harm.

The Review found that the current tools available to National Boards have been successful in delivering public safety. These include:

- a national online register to provide information about registrants to the public and employers
- setting qualification standards for the profession
- mandatory identity checking
- mandatory criminal history checking
- student registration for all regulated health professions
- consistent and approved national standards about practitioners' safety to practise
- the model of title protection and protected practices under the National Law.

In addition, the work commissioned by the Australian Health Ministers' Advisory Council (AHMAC), to develop and consult on the terms of a proposed National Code of Conduct for health-care workers (the National Code) is expected to enhance public protection for health-care workers not regulated under the National Scheme.

The National Code would protect the public by enforcing under regulation in each State and Territory, minimum acceptable professional standards applicable to all health-care workers. This proposal provides a tool for jurisdictions to respond to any unregistered health-care workers whose conduct is placing the public at serious risk by issuing a prohibition order, without the need for full registration.

From the information provided to the Review via the consultation process, stakeholders expressed broad support and confidence in the range of public protections. About half of respondents did not support any further changes to the National Law, indicating the National Code offered sufficient protection. The Review also received a number of general comments supporting the implementation of the National Code.

However, the Review received specific feedback in two areas where there is scope for improvement: advertising provisions and protected practices.

Advertising provisions

The Consultation Paper canvassed specific issues on the restriction on testimonials in the National Law and how this relates to the contemporary use of social media. Currently, practitioners are not allowed to have testimonials on any platform over which they have control that advertises their services. This has been challenging for practitioners at a practical level and at times misunderstood. The erroneous belief that comment should not be permitted on any online platform has resulted in unnecessary notifications to the Australian Health Practitioner Regulation Agency (AHPRA). Consumer representative groups have advocated that feedback – positive or negative – should be permissible and the current provision overly restricts the rights of consumers to share their experiences publicly. (See the advertising provisions in *Appendix 6*).

Three options were proposed to the advertising provisions in the Consultation Paper:

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.

Results of the consultation

The most common view put forward during the consultation forums on this question was that practitioners must be responsible for what is on their own website, and that the reality of the uncontrollable nature of social media needed to be acknowledged. There were mixed views in the written submissions in response to the options proposed in the Consultation Paper:

- 19% supported option one; to maintain the existing provisions in the National Law
- 31% supported option two: amend the National Law provision preventing the use of testimonials and to clarify when comment is permissible
- 14% supported option three; to remove the ban on the use of testimonials about a health profession service or business.

Consumer representatives were clear that consumers use social media as a means of gathering health information.

> *Social media is constantly evolving and there need to be regular reviews on how this plays out in a regulatory setting. The current wording of the testimonials ban might stop consumers discussing health issues openly, this is a problem from a consumer perspective (Health Care Consumers' Association).*

The remaining 36% of respondents made a range of comments, including: agreement that some change is required but unclear as to the preferred option; further consultation is required; and expressing the need for the current provisions to be better enforced by the National Boards and AHPRA.

Discussion

It was apparent from the consultation that further work is required to make it clear when consumer feedback or comment does not represent testimonials. However, there is little appetite to remove the ban on testimonials altogether. Legitimate concerns remain that without this protection some consumers may be misled into believing they require unnecessary treatment. On this basis the Independent Reviewer found that advertising in the form of testimonials should continue to an offence when allowed to occur on social media sites or other communication vehicles owned or managed by the respective health practitioner.

Recommendation

11. Make amendments to the National Law provision preventing the use of testimonials on platforms and sites that are managed or controlled by the practitioner or business.

Protected practices

It is a guiding principle under the National Scheme that restrictions on the practice of a health profession are to be imposed only if it is necessary to ensure health services are provided safely. The use of a title protection model in the National Law enables registered health practitioners to practice to the full scope available and consistent with their education and competence. However, there are currently three practices that are restricted to particular practitioners under the National Law:

- 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. As a result there are currently inconsistencies in protected practices across Australia.

There has also been some debate about whether to extend the practice protections to include cosmetic medicine and surgery, while recognising the complexity of defining the scope and who could perform this scope of practice. The Medical Board of Australia (MBA) has undertaken work at the request of the Ministerial Council to develop supplementary guidelines on cosmetic medical and surgical procedures. On this basis the Review did not pursue this issue further as it represents a work in progress and a final outcome is not yet clear.

Results of the consultation

The Review sought stakeholders' views regarding the circumstances in which a national response should be considered when a State or Territory increased regulatory measures. The common view put to the Review in both the consultation forums and written submissions was that there should be national consistency in protected practices. States and Territories put forward the view that while consistency was preferable, each jurisdiction needed to consider these matters within their local context.

In the South Australian forum, where birthing services are a protected practice, there were views put forward that this should be extended nationally, and confusion as to why this had not occurred. This position was supported in written submissions from some professional midwifery groups, practitioners and jurisdictions.

The Review received two submissions from groups recommending a further extension of protected practices. The Australian Acupuncture and Chinese Medicine Association (AACMA) raised concerns about the increasing number of unregistered practitioners offering services such as dry needling or point injection therapy. AACMA recommended that, in the interests

of public safety, invasive therapeutic procedures such as procedures that involved piercing the skin, should be restricted to registered health practitioners (with a series of exemptions for paramedics, administration of epi-pens and others). The Cosmetic Physicians Society of Australasia put forward the view that practice protections should include cosmetic medicine and surgery.

Discussion

In some circumstances, actions are required locally to deal with key issues affecting the community, and this should continue. However, jurisdictional differences have the potential to adversely impact on the objectives of the National Scheme, including protection of public safety.

In June 2012, the South Australian Deputy State Coroner completed an inquest into the deaths of three babies, all delivered by way of a planned homebirth, and recommended legislation that would render it an offence for any person to engage in midwifery practice without being a midwife or a medical practitioner registered under the National Law.

The purpose of the recommendation was to restrict midwifery practice to a defined group of health practitioners that are suitably trained and qualified and to protect the public from the risk of harm that may arise if midwifery practice was performed by an unqualified or unregistered practitioner.

Prior to the introduction of the National Law, New South Wales restricted birthing practices under its *Public Health Act 1991*. Restricted birthing practices were defined as the care of a pregnant woman involving the management of the three stages of labour. This restriction was repealed upon commencement of the National Law.

In 2013, South Australia legislated to restrict birthing practices (related to the intrapartum period) to midwives and medical practitioners registered under the National Law.

This approach met the Coroner's recommendation by restricting the practice to registered midwives and medical practitioners registered under the *Health Practitioner Regulation National Law* while still allowing other persons to provide antenatal and postnatal services and support to the woman and baby.

There are pending coronial inquiries into deaths resulting from homebirths in New South Wales and Victoria. While the circumstances of these deaths differ to those investigated in South Australia and Western Australia, it does reveal that a national approach to the restriction of birthing services should be considered to ensure the safety of the mother and baby, particularly where planned homebirths are being considered.

In June 2013, the Ministerial Council agreed on the need to expedite work to strengthen regulations relating to unregistered maternity care providers, including considering the option to amend the National Law to protect midwifery practice. This work was led by the Commonwealth Department of Health and referred to the Health Workforce Principal Committee. There have been no further developments since June 2013.

Recommendation

12. The protection of the practice of birthing services to be adopted nationally, consistent with the South Australian amendment.

5. Workforce reform

The objectives and guiding principles of the National Registration and Accreditation Scheme (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
- to facilitate the rigorous and responsive assessment of overseas-trained health practitioners
- enabling innovation in the education of, and service delivery by, health practitioners
- restrictions on the practice of a health profession only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

Recent health workforce analyses have reinforced that reform and flexibility are needed for the provision of a secure health workforce into the future that has the capacity to meet the community's health service needs.

A further key aim of the National Scheme is ensuring that access to services is enhanced. Limited or poor access to services is a recognised issue for many Australians. For those living in rural, regional or remote areas of Australia, the tyranny of distance and poor economies of scale – with relatively small communities unable to sustain the full range and mix of health professionals – have long posed challenges within the Australian health system.

Workforce reform is focused on initiatives that maximise the skills and flexibility of all health professionals to address the challenges of workforce shortages and increasing community demand for services. This can require change to the scope of practice of individual practitioners, and over time, to professions as a whole.

The National Scheme was designed using the protection of title model in preference to defining scopes of practice for professions. The intent was to provide maximum flexibility and to enable ongoing workforce reform.

However, decisions relating to the approval of registration standards, accreditation standards, codes, guidelines and endorsements, have the potential to impose restrictions on professions that 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 the minimum required 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.

There is a strong focus in the National Scheme on the role that education and training plays in workforce reform, to equip the future health workforce with the capacity, skills mix and expertise to meet future demand. The challenge for regulators, especially in regard to accreditation, is to ensure that innovation and future workforce distribution and educational needs are factored into undergraduate and postgraduate programs.

The National Scheme now provides the framework to achieve the integration of regulatory functions across professions and to allow approaches such as:

- multidisciplinary education and training environments with coordinated accreditation processes
- consideration of future health practitioner skills and competencies to address changes in technology, models of care and changing health needs.

Results of the consultation

The Review considered the role agencies operating within the National Scheme play in relation to pursuing workforce reform and innovation and asked to what extent National Boards and Accreditation Authorities are fulfilling this requirement. The key messages arising from the consultation process noted that:

- some efforts have been made but there is significant further work required for National Boards and Accrediting Authorities to meet the full range of statutory objectives and guiding principles of the National Law
- further effort is required for Accrediting Authorities to facilitate the development of the future workforce.

Health departments provided comments about the need for greater collaboration between stakeholders in order to achieve these objectives:

- AHPRA and the Boards, as regulators, have an important role in facilitating workforce reform, including considering interdisciplinary practice, and greater linkages with governments. Care also needs to be taken that the Boards do not present barriers to workforce reform (*Commonwealth Department of Health*)
- there is a disconnection between the National Boards and Accreditation Bodies regarding objectives and provisions for workforce reform (*ACT Health*)
- a disconnect exists between the number of accredited programs and the relevant workforce need (*Tasmania Healt*h)
- mechanisms (should be considered) whereby accreditation authorities and boards are encouraged to work together with jurisdictions to identify and develop standards that could address specific workforce needs (*NSW Health*).

Tertiary education providers expressed the view that in some areas the National Scheme was not facilitating innovation or contemporary approaches, noting:

- the current system does not encourage innovation in education and service
- that individual professions dictate standards, and assessment of these standards, limits workforce reform
- there is no flexibility to allow points of difference between universities, and encourage modern curricula and learning methods – reflecting changing community needs and health care provision, as well as educational developments and student expectations.

The joint submission by the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA) noted:

> *The National Scheme is not the main driver of workforce reform, but should be responsive to government priorities. We have established mechanisms to engage with governments on these issues across Boards and intend to work closely with the Australian Health Ministers' Advisory Council (AHMAC) and the Health Workforce Principal Committee (HWPC) to ensure we have a clear understanding of government priorities. This will help make sure our regulatory processes are appropriately responsive (National Boards and AHPRA).*

The submission from the coalition of the accreditation councils of the regulated professions, the Health Professions Accreditation Councils' Forum put forward the view:

> *The core role of the Accreditation Authorities is to ensure that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. The Accreditation Authorities contribute to this in two ways: by setting standards for education and training that are contemporary, robust, nationally and internationally benchmarked, and are responsive to the needs of the community, and by ensuring that these standards are applied to Australian programs. When applied, the standards ensure that educational programs have appropriate didactic and experiential education, have professional input, and employ assessment processes that are valid, reliable and fair (Health Professions Accreditation Councils' Forum).*

Discussion

This Review found that little attention has been directed towards understanding and designing the regulators' response to health workforce reform in the early stages of the National Scheme. Its importance is being increasingly recognised with the formation of cross-profession forums and the involvement of the Australian Health Ministers' Advisory Council (AHMAC) as a means of improving mutual understanding about the future agenda in workforce reform. While this recent development is encouraging, the National Scheme needs to have very specific and measurable targets to deliver on the health workforce reform agenda.

The Review proposes that health workforce reform responsibilities under the National Scheme be given heightened importance and clear accountability for achievement. Three steps are needed to achieve this outcome:

First, those delivering on the objectives of the National Scheme need to be clear about the health workforce reform agenda and where health access gaps exist. This needs to be communicated from government in particular. That role rests most sensibly with AHMAC and its Health Workforce Principal Committee, which has representation from all jurisdictions.

Second, the workforce reform agenda and addressing health service access gaps will have at least some potential impacts for regulators. A vehicle to ensure the regulators are aware of the priorities and their role in achieving them is needed. This needs to be supported by a clear process of accountability back to the Australian Health Workforce Ministerial Council (the Ministerial Council) to ensure the National Scheme delivers on this important objective. See Recommendation 1.

Third, the accreditation function is a critical means of ensuring the future health workforce is sufficiently equipped to meet the predicted health service needs of an ageing population. This demands innovation and a close working relationship between National Boards, Accreditation Authorities and educational institutions to harness their combined efforts into the reform agenda. See Recommendation 18.

In addition, there should be a mechanism in place to ensure that qualifications for registration purposes, or any guideline or code, approved by National Boards do not impose restrictions on professions that can act as a barrier to workforce flexibility or access. See Recommendations 22 and 23.

Recommendation

13. That the Ministerial Council charge AHMAC, its Health Workforce Principal Committee and the Commonwealth Department of Health (where it carries previous functions of Health Workforce Australia) with articulating the health workforce priorities and health service access gaps to the Professional Standards Advisory Council for action by the National Scheme (See Recommendation 1).

6. Accreditation

The Terms of Reference for the Review required particular comment on "the adequacy and transparency of the accreditation functions under the National Scheme".

This was an area of considerable interest to jurisdictions and education providers. Several structural and operational concerns were identified by the Review process about accreditation functions within the National Scheme.

At the time of releasing the Consultation Paper 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, was not possible. As such, specific options regarding legislative or structural changes to accreditation were not included in the Consultation Paper. The Review instead posed a series of questions on the performance of Accreditation Authorities in meeting the objectives of the National Law.

An assessment of the total cost of accreditation of programs of study of higher education in the National Scheme has since been completed by the Professional Standards Authority (PSA) in the second phase of its project.

The PSA found that accreditation is almost three times more expensive when compared on a per-registrant basis, than the quality assurance of higher education programs of study by regulators in the UK. While PSA recognised that there are different organisational arrangements, and that there may be differences in scope and approach, they recommended that this striking cost difference warranted further investigation.

The Review also gathered information on the accreditation fee increases over the past five years, and associated fee structures for each of the professions.

In its assessment of the fees and fee structures of Accreditation Authorities, PSA noted some evidence of accreditation fees rising in recent years. The PSA made the further observation that for most regulatory functions the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA) can exercise financial discipline by virtue of their direct control of delivery. The fact that accreditation functions are delivered by separate organisations, means that accountability structures and arrangements appear to be less clear.

PSA assessment of accreditation functions under the National Scheme

In examining this area of regulation the PSA sought to ensure that its study was comparing like with like. At least one task that is included in accreditation in Australia does not fall within quality assurance of higher education in the UK: the assessment of qualifications of overseas applicants for registration. The PSA also looked at descriptions of the function of quality assurance in the UK and accreditation in Australia in so far as it relates to higher education institutions. In Australia, AHPRA sets out up to five activities that are undertaken by the relevant Accreditation Authority. These are:

- development and review of accreditation standards
- assessing programs of study and accreditation providers against the standards

- assessing overseas-assessing authorities
- assessing overseas-qualified practitioners
- providing advice to the relevant Board on accreditation functions.

Provided in *Appendix 7* is further information on the UK approach to the accreditation of programs of study.

Under the National Scheme the 11 accreditation councils are separate organisations, external to the National Boards and AHPRA, with their own governance, staffing, premises and websites. The councils, which are listed below, are under contract to the National Boards to provide accreditation of the higher education programs of study that can lead to registration.

- Australian and New Zealand Osteopathic Council
- Australian and New Zealand Podiatry Accreditation Council
- Australian Dental Council
- Australian Pharmacy Council
- Australian Physiotherapy Council
- Australian Psychology Accreditation Council
- Council on Chiropractic Education Australasia
- Australian Medical Council
- Australian Nursing and Midwifery Accreditation Council
- Occupational Therapy Council (Australia and New Zealand)
- Optometry Council of Australia and New Zealand

These 11 accreditation councils levy fees against the higher education sector for the programs of study they assess.

For the three remaining professions in the National Scheme the responsibility for accreditation is vested in a committee of the National Board: Aboriginal and Torres Strait Islander health practice, Chinese medicine, and medical radiation practice.

The accreditation councils have three sources of income: contribution from the relevant National Board, fees charged to education providers, and income from fees charged to overseas applicants for assessment of their qualification (This process would be considered part of the registration function within a UK regulator). The National Board for each profession approves the standards against which the council is under contract to accredit.

The percentage of regulatory expenditure on this function in the two systems also differs markedly, with 19.4% being spent in Australia and 6% being spent in the UK system on the quality assurance of higher education programs of study.

The PSA report identified that the existence of 11 separate councils looks to be an inherently more expensive arrangement for the delivery of this function, because of the cost of the items listed above: staff costs, the cost of servicing the councils and holding meetings, the cost of premises and so forth. The fact that this activity is organised in a disaggregated way suggests that there might be the potential for savings were mergers possible in some form. The integration of accreditation in the UK into the core functions of the regulators, in particular standard setting, has clear benefits in terms of organisational simplicity, appropriate balancing of resources across regulatory functions, and avoidance of duplication of costs.

The PSA also found that one consequence of a system where just one body is allowed to provide accreditation for specific education programs of study is that monopoly power might be exploited to extract profit from university establishments or students. All professional regulators are by definition statutory monopolies and therefore not subject to normal external market pressures on cost. This is not unique to the Australian system – it could equally exist in the UK framework – but it provides good reason to consider the costs of this regulatory function with extra scrutiny.

The PSA identified three possible reasons for the high cost of accreditation in Australia. First, it has been noted that the accreditation cycle could lead to inconsistency across years, with some years seeing much more activity than others. This may be relevant to individual professions but unless professions are on a linked cycle is unlikely to explain the large cost difference for all professions between Australia and the UK.

A second explanation is that the process may be inefficient, with little incentive to minimise costs as the accreditation councils face no competition to their services.

A third possibility is that the higher cost of accreditation in Australia could be because the councils provide a higher quality of service than exists in the UK. A more rigorous accreditation process would lead to better programs of study and produce an improved standard of practitioner for the Australian health care system. However there is no guarantee that the higher quality of accreditation offered will be at the socially optimal level. It is beyond the scope of this project to make that judgement.

The PSA's view was that while the two systems clearly share a considerable overlap of purpose in this area, in order to draw any firm conclusions about the relative efficiency of the two a much more detailed analysis of the differences of performance, process and approach within and between them would be required, taking into account the considerations that have been set out above. This analysis would also need to examine the context in which the councils are operating and their relationship with other organisations with a quality assurance role.

The Review found that while the UK approach and costs appear attractive on the surface, further work is needed to establish the basis for this difference and, more importantly, that any fundamental change to the way in which accreditation is conducted in Australia needs to be coordinated with other reforms occurring in the higher education sector. On this basis it was not possible for the Review to undertake this assessment.

Results of the consultation

Several jurisdictions suggested that a single accreditation authority, underpinned by both common and profession specific standards, could carry out the accreditation of programs of study across disciplines. This would enhance transparency and ensure a level of consistency across professions:

- the Commonwealth is aware of complaints by the higher education sector that the accreditation processes are both costly and time intensive, especially where higher education faculties may be offering many programs of study across the 14 registered health professional groups. The accreditation standards and criteria across the 14 health professions vary greatly, which adds to the resourcing burden on the higher education sector (*Commonwealth Department of Health*).

The Health Professions Accreditation Councils' Forum (the Forum), comprised of the 11 accreditation councils, notes that it has been meeting regularly since 2007 to consider matters of common interest, principally matters concerning the accreditation of education and training programs in the health professions. In its submission the Forum noted:

> *The members of the Forum have commenced the process of workshopping common assessment processes, common policies and procedures, and joint projects where representatives from a variety of the professions are involved. This is part of the continuing quality improvement that each Council is undertaking under the Quality Framework, and also in response to concerns from education providers on timing and logistics of accreditation visits (Health Professions Accreditation Councils' Forum).*

While the Review has received reports of work being undertaken to map, consider and scope areas of commonality and opportunities to streamline, there is little evidence of this translating practically, with the exception of three professions that share a common service to their accreditation committees (Aboriginal and Torres Strait Islander health practice, Chinese medicine, and medical radiation practice).

In submissions to the Review some higher education providers raised significant issues with the processes and approach of some of the accreditation councils, including the prescriptive nature of requirements and the extensive duplication between them.

Discussion

The Review acknowledges the relationships and differences between the regulation of higher education and the health professions.

Higher education providers are assessed against the Higher Education Standards Framework. The Standards Framework comprises five domains: provider standards, qualification standards, teaching and learning standards, information standards and research standards.

The Australian Qualifications Framework is the national policy for regulated qualifications in Australian education and training. It incorporates the qualifications from each education and training sector into a single national qualifications framework.

The National Law defines accreditation standard, for a health profession, as a standard used to assess whether a program of study, and the education provider that provides the program of study, provides persons who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia.

Accreditation is significantly more expensive than the UK approach; fees are charged to both the National Boards for the accreditation role and the universities for the accreditation of programs of study. Accreditation Authorities have a uniquely privileged and monopolistic position, being mandated through the National Law as a prerequisite for universities to offer programs of study in these professions.

The Accreditation Authorities are at different stages of maturity and ability. There is currently little recourse for appeal of their decision making process in the National Scheme, seemingly even the Ombudsman lacks jurisdiction over them. They have different fee structures, different fee-setting methods and there is no standardised approach to accreditation. This means some are highly prescriptive in their requirements of universities, others focus on the education outcomes rather than process; several duplicate the already significant requirements that are imposed on universities during the accreditation processes.

This combination of issues leaves open the very real possibility that Accreditation Authorities charge rates in excess of the minimum with little or no scrutiny, and that accreditation will continue to increase in cost – in fees and compliance – over time. The different approaches to accreditation are confusing for educators and leave little capacity for streamlining accreditation processes between professions.

Addressing these issues will require short-term measures to introduce stronger accountability of the Accreditation Authorities for their processes, fee structures and charging practices. Stronger engagement between the accreditation authorities, health science higher ecuation providers and National Boards is required.

In the medium term, collaborative work with the higher education sector and National Boards is required to embed the focus on workforce reform, both in terms of numbers of students required for the future workforce demands and to consider innovative and creative approaches to education and training.

The Review encountered a number of circumstances in which universities were offering programs of study that were in excess of that required for registration, for example students at some universities can only begin studying medicine at postgraduate level. In the event that universities are only offering programs of study over and above the minimum qualification, future graduates will be disadvantaged and the cost of qualification will increase.

In conjunction with the broader reforms occurring in the higher education sector, a medium-term strategy around the future approach to accreditation with the Commonwealth Department of Education is needed. This should focus on streamlining accreditation and examine the UK approach to accreditation to consider its applicability to Australia.

This includes consideration about the source of funds. In the UK only the registrants meet the cost of accreditation, the costs are three times lower on a per-registrant basis than in Australia and accreditation is streamlined for at least 16 health professions.

Recommendations

14. **Through the contractual arrangements between AHPRA and the Accreditation Authorities, no fee increases levied on either National Boards or higher education institutions beyond the Consumer Price Index rate will be allowed without the express approval of the relevant National Board.**
15. **Through contractual arrangements between AHPRA and Accreditation Authorities, standardised accreditation protocols and fee structures must be established within 12 months so that common accreditation processes can be adopted between all regulated health professions. These should be focused on education outcomes relevant to the outcomes of the National Scheme not prescriptive education inputs.**
16. **The standardised accreditation protocols should be the subject of consultation with higher education policy makers and providers to streamline accreditation processes and avoid duplication with existing university accreditation processes. This consultation should be sponsored by AHPRA.**
17. **Amend the Health Practitioner Regulation National Law 2009 to provide that the National Health Practitioner Ombudsman has jurisdiction over accreditation functions within the National Registration and Accreditation Scheme.**
18. **A standing committee is needed within the National Scheme involving the education sector, National Boards, Accreditation Authorities and representation from employers and jurisdictions to:**
    a. **discuss the means by which health workforce reform and health service access gaps can be best addressed in the education and training of health professionals**
    b. **consider the evidence and value of alternative innovations in the delivery of health education and training. (An example is that simulated learning is accepted by some but not all accreditors)**
    c. **share an understanding of workforce distribution and projected workforce need.**
    d. **ensure that education opportunities exist for students to meet the minimum standard of entry.**

19. **The fee structures for the accreditation functions associated with standard setting and assessment of overseas-trained health professionals and the accreditation of university programs of study should be clear and transparent as to which functions are funded by the National Boards from registrant fees and which are being met by the higher education sector.**

20. **The UK approach to accreditation should be explored to examine whether the significant cost difference between the UK and Australia results in better education outcomes in Australia. If this is not the case, then the UK approach to accreditation should be considered for application.**

7. Cost analysis

The Terms of Reference for the Review asked for an examination and recommendations on:

- cost effectiveness of the National Scheme (including structure and functions), and where efficiencies might be gained and the impact of the model on the small professions
- the future sustainability of the National Scheme (particularly in relation to the addition of other professions and funding arrangements for smaller regulated professions).

To inform this work, the Australian Health Ministers' Advisory Council (AHMAC) requested a cost effectiveness and efficiency study to be undertaken by an external contractor selected through a tender process. This work was undertaken by the Professional Standards Authority (PSA), working in collaboration with the Centre for Health Services Economics and Organisation (CHSEO). The study was scheduled to take place between July and October 2014 and delivered in two phases, an interim assessment that informed the Consultation Paper, and a final report that incorporated a more in-depth analysis.

The PSA is an independent body, accountable to the United Kingdom 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. CHSEO is a research unit with economists, statisticians and operational researchers, focused on whole-system analysis of healthcare and local health economies.

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 UK Department of Health in 2011 to conduct a cost-effectiveness and efficiency review of the nine UK health and care regulators.

This work involved the 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 that was developed in that exercise has been refined to apply to the Australian context. The Review is not aware of any alternative methodologies having been developed elsewhere for a cost-effectiveness and efficiency assessment of professional regulatory arrangements.

Preliminary findings of interim analysis

The interim analysis was developed to inform the Consultation Paper and ensure that any major cost issues could be included early in the consultation process. Preliminary findings were:

- 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 five professions in Australia (occupational therapy, physiotherapy, podiatry, psychology and radiotherapy) compared to the same five professions in the UK that are regulated under the Health and Care Professions Council (HCPC), where there is a single Board overseeing a number of professions

- there is a potential for cost savings through the consolidation of nine professions under a single board in Australia, with an expected added benefit through the application of a single fee structure across professions and a further potential benefit in the consolidation of administrative arrangements or functional roles
- a 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
- significant differences in accreditation arrangements are in place between the UK and Australia
- aggregate proportion of total National Board spending by function in 2013–14 indicates: 43.7% on notifications; 32.2% registration; 4.7% compliance; 5.4% accreditation; 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 and optometry

Findings of final analysis

- the National Scheme has an annual operating cost of $214,117,803, this amount includes the expenditure of: the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA), the Accreditation Authorities, and the notifications arrangements in New South Wales
- the average unit cost for the operation of the National Boards is $346 per registrant, when analysed by profession this varies between $162 and $1,792
- the unit cost per registrant in the UK (which is estimated at $301.50) is slightly lower than in Australia, there are a number of factors that prevent a direct comparison of relative efficiency
- as a proportion of total spending, the accreditation function in Australia is markedly more expensive than the quality assurance of higher education in the UK. It costs almost three times per registrant when the full cost of accreditation is recognised. This is because a large share of the cost of accreditation is borne by the higher education sector. The cost difference in accreditation between Australia and the UK on a per registrant basis is valued at $30.2 million
- propose two options for merging boards with potential hypothetical annual savings of between $11.9 million and $58 million. There are also a number of specific recommendations relating to different functional areas (registration, notifications and accreditation) where potential areas are identified in which costs may be saved or more effectively controlled

Conclusions made by the PSA

- There is some evidence of accreditation fees rising in recent years. Whereas for other regulatory functions, the National Boards and AHPRA can exercise financial discipline by virtue of their direct control of delivery which is reinforced by a total spending constraint imposed at national level, the manner in which delivery of the accreditation function is arranged with separate organisations and accountability arrangements may be resulting in less clear arrangements.

- The accreditation function is considerably more expensive, as a proportion of total expenditure on the scheme, than the quality assurance of higher education programs of study by regulators in the UK. Recognising the different organisational arrangements, and recognising that there may be differences in scope and approach amongst other factors, this striking cost difference warrants further investigation.
- Propose a review of the remit and effectiveness of the 62 committees of the National Boards, assessing the value that each adds to decision making, and whether these decisions could be made in a more cost-effective way.
- Identified opportunities to set financial benchmarks to better control costs across the National Scheme as a whole, with accompanying reporting and oversight.
- Recommend that as well as reviewing merger options for boards and options for the further integration of functions across professions, consideration is given to reviewing the arrangements for delegation, enabling staff to take decisions wherever possible.
- Valuable to assess the costs and benefits of vesting in the National Boards the power to impose the full range of regulatory sanctions, up to and including removal from the register.

Discussion

The cost analysis conducted by the PSA has reached some interesting conclusions and provided a very useful third party assessment of the costs associated with the National Scheme, especially where further cost efficiencies may be pursued and a comparison of the relative costs of regulation between Australia and the UK.

The final report from the PSA steps through its analysis of the National Scheme and many of the conclusions align closely with the Independent Reviewer's assessment, as follows:

The PSA analysis identified similar concerns about the lack of accountability and performance management of the National Scheme as a whole by drawing attention to the absence of financial performance targets and benchmarks for National Boards and AHPRA. It is proposed that the establishment of key performance measures identified in Recommendation 1 will include key financial performance measures.

The PSA analysis identified a significant cost difference in total accreditation costs between the UK and Australia, with the Australian costs being almost three times the cost on a per-registrant basis, valuing the additional cost at $30.9 million per annum. One of the recommendations from the findings is the importance of ensuring that the additional cost of accreditation in Australia is delivering a standard of higher education that is three times better than the UK.

The PSA report also reinforced the concerns identified by the Review of the National Scheme about the apparent lack of scrutiny over the fees and fee structure applied by the Accreditation Authorities.

In this respect the PSA compared the national limits imposed by the Australian Health Workforce Ministerial Council (the Ministerial Council) on regulatory costs through registration fees imposed by the National Boards and in particular requirements that any fees beyond the Consumer Price Index (CPI) required a business case and approval from the Ministerial Council. This had led to a renewed focus on regulatory costs under the National Scheme and indeed a reduction in fee costs for a number of professions in recent years.

This approach has not been mirrored by any degree of scrutiny or benchmarking of the fee structures and fee increases imposed by Accreditation Authorities. As a result the Review is recommending that through the contractual arrangements between AHPRA and the Accreditation Authorities, no fee increases levied on either National Boards or higher education institutions beyond the CPI rate will be allowed without the express approval of the relevant National Board (See Recommendation 11).

The financial analysis spends considerable time exploring the factors influencing the cost of the National Scheme in Australia, including a cost assessment between National Boards and the influence of size, complexity and rates of notifications. Its conclusion, on both economic and quality of regulatory processes and outcomes, provides strong support for the merge and consolidation of the nine lower-regulatory-workload professions as indicated in the Consultation Paper.

While emphasising that its example was hypothetical only, the PSA report went to the extent of stating that if considered on purely financial grounds the most cost effective structure for the National Scheme would be to have a single board with a single accreditation agency for the regulation of health professionals with notional savings of $56 million to the National Scheme and ultimately registrants.

While such an approach is not recommended by the Review, it does reinforce the importance of ensuring economies of scale are pursued where it offers financial benefit and improvements in the quality of regulation.

The references to the very successful regulation of 16 health professions by the multi-profession board in the UK, which achieves consistently high ratings in regulatory performance measures applied in the UK, is an important reference for a similar approach in Australia. The HCPC has managed to ensure professional input is maintained in regulatory decisions while delivering substantial cost benefits to its member professions. As a result the Review is making the recommendation that the National Law be amended to provide for the consolidation of nine National Boards by the Ministerial Council (See Recommendation 2).

In considering the overall costs associated with the National Scheme, the PSA financial analysis raised areas for further potential cost savings including a recommended review of the 60 committees of the National Boards and the associated administrative cost burden.

Similarly, the Review considers further examination of the 18 State and Territory or two Regional Boards, and the 78 committees sitting beneath these is warranted.

A full list of the 158 committees of the National Boards, including the State and Territory or Regional Boards and committees is at *Appendix 8*.

The PSA report further raised that a commensurate review of the delegatory powers by the National Boards be considered, as the current arrangements appear to suggest that the committees simply recommend rather than make decisions under delegated powers of the National Boards. This leads to double handling and additional administrative costs.

In addition to the PSA analysis the Review has also considered the consistent growth in Full Time Equivalent (FTE) employees at AHPRA. This is provided in Box 2.

Box 2

As at 30 June 2011 – 523 FTE with 75 FTE (14%) being in National Office

As at 30 June 2012 – 570 FTE with 101 FTE (17%) being in National Office

As at 30 June 2013 – 624 FTE with 150 FTE (24%) being in National Office*

As at 30 June 2014 – 782 FTE with 177 FTE (23%) being in National Office#

* Some of the increase in staff between 2012 and 2013 relates to the introduction of the 4 new professions; introduction of the accreditation unit; and conversions of contractors to FTE to save costs

\# A majority of the increase between 2013 and 2014 is related to the notifications improvement project (which stemmed from Qld)

The National Scheme seeks to balance the benefits of a central register and processes with the need for local responsiveness and decision making. Under the Intergovernmental Agreement (IGA), AHPRA is required to have a national office and at least one local office in each State and Territory. There is a cost associated with that local representation.

Many of the AHPRA regulatory services, such as online renewals, are run out of the national office. The State, Territory and regional offices operate at a jurisdictional level on tasks relating to complaints management and investigation. Their work entails collaborating with health complaints entities, referring serious matters to local tribunals, supporting local boards and committees and communicating with notifiers.

While the cost-effectiveness analysis undertaken by the PSA concluded that the overall cost of regulation in Australia is internationally comparable (with the exception of accreditation), it is clear that the National Scheme has higher overheads to manage purely because of the requirement that AHPRA has an office in each State and Territory. This additional cost has been masked by the efficiencies driven in the National Scheme through initiatives such as the online renewal processes.

This Review has assumed that the fundamental requirement to have AHPRA offices in each State and Territory is a necessary feature of the National Scheme, despite it being a less cost-efficient method of regulating the health professions.

There has been growth in FTE across the State and Territory offices and the National Office of AHPRA. While some of this growth is required to meet the additional resources needed for the entry of four new professions into the National Scheme, and in the conversion of some external contracts with employment contracts, a greater degree of scrutiny over resource growth and some guidance on financial imperatives in the National Scheme is needed. For this reason the Review has recommended the introduction of financial benchmarks and performance indicators into the National Scheme (See Recommendation 1).

Recommendation

21. The National Boards and AHPRA to complete a review within 12 months of the 60 Committees supporting the National Boards, the 20 State and Territory or Regional Boards, and their 78 supporting committees to: consolidate committee functions; remove committees that duplicate the AHPRA corporate support role (for example, finance committees); review and revise delegation instruments to remove double handling of operational matters; and report to the Ministerial Council on the outcomes.

8. Performance and function of the National Scheme

The Review has found that the scheme has achieved its primary goal of establishing a National Registration and Accreditation Scheme (the National Scheme) on behalf of the State and Territory governments and represents a very successful reform. It struggled in the early years to quickly establish the administrative systems and processes to support national registration and this meant that many health professionals had negative intitial experiences with the Australian Health Practitioner Regulation Agency (AHPRA) and the National Scheme, and there continues to be some legacy from this. The agencies involved in the National Scheme are continuously improving and maturing as organisations.

Following the implementation of the National Scheme, the National Boards, AHPRA , the Agency Management Committee and Accrediting Authorities needed to quickly develop an understanding of each body's respective role and function and build strong working relationships.

The Review notes the effort each agency devoted to this process while simultaneously continuing to deliver registration and accreditation functions. A number of stakeholders talked about the significant "trust building" work that marked the first few years of the National Scheme's operation. It is also important to note that there was, and is, a large variation in the relative maturity of the entities involved in the National Scheme.

In general the Review finds that the National Scheme is well led at a senior level, but challenges remain in achieving a cultural shift within a section of the workforce that appears to be still transitioning from previous regulatory regimes. At times there is a disconnect between the approach of the senior leadership and the requirements of the National Scheme with the officer level day-to-day interaction with stakeholders.

The Review has identified the following areas for consideration regarding the entities in the National Scheme:

- the development of standards, codes and guidelines
- the assessment of overseas trained practitioners
- merit based appointment for Chairs of National Boards
- the role of the National Health Practitioner Ombudsman and Privacy Commissioner.

Development of standards, codes and guidelines

The National Boards have a responsibility to develop national registration standards for the professions as well as to develop and approve codes and guidelines.

While the National Law confers powers on the Australian Health Workforce Ministerial Council (the Ministerial Council) to approve registration standards, the Ministerial Council has limited powers with respect to:

- accreditation standards or the approval of qualifying programs for the purpose of registration
- approval of codes or guidelines.

While it is not considered necessary for the Ministerial Council to consider every decision made by National Boards and Accreditation Authorities, the Review has received submissions highlighting that some of these regulatory decisions can have major effects on workforce flexibility and the consultation processes appear not to have been responsive to the concerns raised by stakeholders.

Results of the consultation

Multiple submissions to the Review raised concerns regarding the Psychology Board of Australia's provisional registration standard, reflecting the impact on State Governments, health service providers and practitioners. This was highlighted by the submission from Queensland Health:

> *We are aware of examples of limited responsiveness to stakeholder feedback in consultation processes to implement or revise registration and accreditation standards. This has resulted in standards and guidelines that contribute to workforce shortages, service restrictions and limited availability of training opportunities for students. A good example is the Psychology Board of Australia's guidelines for psychology internship programs and the provisional registration standard, which include:*
>
> - *a prescriptive approach to the hours of supervision required for the '4+2' and '5+1' programs and the large number of hours of additional professional development required, and*
> - *the requirement for students undertaking the Masters Degree program to hold provisional registration.*
>
> *These requirements have been implemented despite feedback from jurisdictions as to their adverse impacts. They are complex, inconsistent with other professions and costly for employers, educators and practitioners, with little evidence of any additional benefit to public safety. It is anecdotally understood that the current standard is resulting in a reduction in the number of provisional psychologists employed within the Queensland public health sector, particularly in rural services (Queensland Health).*

The National Scheme has enabled the Psychology Board of Australia to establish a single standard for provisional registration, where there was previously eight different state and territory-based standards with considerable variation in the requirements for supervision.

The Psychology Board of Australia advised the Review that in developing the national standard they sought the 'middle-ground' option to balance regulatory risk with this unaccredited training pathway, whilst facilitating access to services.

The Review received submissions from professional associations who were also concerned that the introduction of national standards had unnecessarily increased requirements:

- the increased supervision requirements in the internship pathway to registration (primarily the 4+2 pathway) that were introduced following the implementation of the National Scheme have placed substantial constraints on the internship pathway. Although the aim of the National Scheme is to establish minimum standards to ensure public safety, the Psychology Board of Australia (PsyBA) produced guidelines for the internship pathway

that adopted the highest standards operating across the jurisdictions prior to the National Scheme. This was despite the lack of evidence to suggest that any previous State/Territory-based guidelines were inadequate or placing the safety of the public at risk (*Australian Psychological Society*)

The Psychology Board of Australia have advised the Review that they have commenced preliminary consultation on the provisional registration standard and 4+2 internship program guidelines, with public consultation, with public consultation to take place between December 2014 and February 2015.

Discussion

The May 2009 Australian Health Ministers' Advisory Council (AHMAC) communique on the design of the National Scheme notes that the accreditation function will be independent of governments, but that the Ministerial Council will have powers to act, for instance, where it believes that changes to an accreditation standard, including changes to clinical placement hours or workplace and work practice, would have a significantly negative effect.

The Review considers that these issues could be better addressed by requiring National Boards to seek prior approval of the Ministerial Council in circumstances where they are aware such changes may have negative impacts on the recruitment or supply of health professionals or where codes or guidelines might impose competitive restrictions. Such a discipline within the National Scheme would ensure that the Ministerial Council was involved where delivery of health services would potentially be adversely affected.

These provisions would provide a safeguard to ensure that any proposed changes would be in the broader public interest.

Recommendation

22. Amend the National Law to require National Boards to seek Ministerial Council approval for changes to qualification standards for registration purposes if the proposed standard could have a substantive and adverse impact on the recruitment or supply of health practitioners to the workforce.

23. Amend the National Law to require National Boards to seek Ministerial Council approval for any codes or guidelines that might impose new competition restrictions or regulatory burdens, to ensure that these are in the broader public interest.

Overseas-trained 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 on internationally qualified practitioners to meet workforce shortages, particularly in rural areas.

The requirements placed on overseas trained doctors in particular 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 while ensuring public safety.

The Review comments on the performance of the National Boards with respect to assessment of overseas trained practitioners and an update on progress with the implementation of the recommendations contained in the Standing Committee report.

Results of the consultation

The Review has heard that there is scope for greater consistency and transparency regarding how the assessment of overseas trained health professionals is undertaken by various National Boards.

Overall, there was a strong view that the current processes with respect to the assessment and supervision of overseas trained practitioners required improvement. The majority of submissions focused on international medical graduates (IMGs).

Table 2 below provides a series of examples provided in the submission process.

Table 2

Examples from submissions

English language requirements

All International Medical Graduates (IMGs) must demonstrate English language proficiency. Such graduates need to complete one of the Medical Board of Australia's (MBA) approved English language tests. Exemptions to doing the test can be granted if the IMG completed their secondary and their tertiary education in English from the list of approved countries. This list of countries is narrow and does not fully reflect where English is the official or commonly spoken language. It also does not allow a person to be able to demonstrate that they completed schooling in English in a country other than those listed.

Registration application processes

An IMG applying for registration needs to present themselves to an AHPRA office in person for their registration to be finalised. This is not the case for nursing and midwifery where applicants for registration can obtain their registration while overseas. The fact that a doctor needs to visit an AHPRA office is particularly an issue for doctors recruited to a rural or regional position. It is unclear why registration in one profession requires a personal presentation at AHPRA and one does not.

Non-removal from register after an International Medical Graduate leaves a position

IMGs with limited registration are restricted to working in the position to which they have been recruited. However if they leave that position their registration is not cancelled: they stay on the register until this registration expires or until they get another registration (if they take up a different position).

It is unclear how this system satisfies the regulatory objective of sufficiently protecting the public from unregistered professionals.

Assessment of overseas-trained specialists

The assessment of overseas-trained specialists is undertaken by the relevant specialty college which then provide advice to the Medical Board of Australia. There is a lack of transparency regarding this process, and standards and practices differ from one college to another. The Medical Board could facilitate work between the colleges to encourage transparency of requirements for applicants, and consistency in processes and times for assessment. Consideration could also be given to a competent authority pathway for specialist doctors.

There are difficulties regarding medical practitioners who are eligible for, or hold, general registration in Australia but have obtained their specialist qualifications in another country. This could include local graduates who have chosen to go to another competent authority country for their specialisation.

This group of practitioners is unable to be registered under the "limited specialist" registration category as such practitioners are only eligible for "general" registration. Failure to recognise these practitioners as specialist while they are progressing through specialist college recognition in Australia results in the health services experiencing difficulties in retaining their services and the individual practitioners being paid at a lower level. However, overseas-trained specialists that are not eligible for general registration are able to attain limited specialist registration and therefore can be paid at a higher level. This paradoxical situation disadvantages the practitioners from target recruitment markets while advantaging practitioners from less comparable health systems.

Nursing and Midwifery

Submissions received reiterated the problems experienced by internationally-qualified nurses, where there is a difference between the level of accepted qualifications by the Australian Nursing and Midwifery Accreditation Council (ANMAC) for migration, versus the Nursing and Midwifery Board (NMBA) for registration. Stakeholders expressed views that the NMBA decision to raise the required qualification level is overly restrictive and inflexible and unfair to those practitioners caught in the transition of this policy decision with inconsistent application between Australian graduate nurses and international graduate nurses.

The National Boards and AHPRA provided a response to the Review detailing their action in response to the *Lost in the Labyrinth* report. Their submission noted:

- This is a complex area and requires the Medical Board of Australia to ensure that assessment of IMGs is rigorous enough so that practitioners who are safe to practise are registered, while allowing for the registration of practitioners necessary to fill positions to meet the medical needs of the community.
- Since the report was published, the Medical Board of Australia (MBA) and AHPRA have been working with stakeholders, including the Australian Medical Council (AMC) and the specialist colleges, to streamline assessment processes for IMGs.
- Streamlining the competent authority pathway: IMGs now apply for provisional registration (rather than limited registration) and are not required to apply to the AMC for an advanced standing certificate or the AMC certificate. Rather, after 12 months satisfactory supervised practice, they are eligible for general registration. This has resulted in significantly less administrative red tape and substantially reduced costs for the IMG (reduced costs of this process from $3,770 to $2,056).

- Streamlining the specialist pathway: IMGs deal directly with specialist colleges to apply for assessment in the specialist pathway, in addition a secure portal is now used by AHPRA, colleges and AMC to communicate, reducing the need for multiple written communications, revised and consistent definitions of comparability and clearer documentation for colleges to communicate the result of their assessments.
- Changes to the standard pathway: the AMC, with the financial assistance of Health Workforce Australia and the Commonwealth, has built a world-class assessment centre that has significantly reduced waiting times for IMGs to sit the clinical examination.

In addition, other work is in progress that will further streamline processes and address concerns in the areas of: specialist IMG assessment; supervision guidelines for IMGs; guidelines for the pre-employment structured clinical interviews (PESCI); primary source verification; and English language proficiency.

Discussion

The assessment of overseas trained practitioners has been the source of considerable challenges. A number of stakeholders pointed to the degree of variability across processes and sought consistency. This needs to be balanced with the individual nature of assessments, which aims to make the process flexible and tailored. A single approach may be more efficient but would be unlikely to take into consideration the characteristics of the individual applicant and the workforce needs of the community.

The *Lost in the Labyrinth* Report came out in 2011, as noted there has been a variety of responses from National Boards and AHPRA but, based on submissions received by the Review, these responses have not yet resulted in improved experiences for overseas-trained practitioners and their employers. This must continue to be monitored.

The Review finds that immediate attention is required to the difference in accepted qualifications by ANMAC and the NMBA. This issue should never have arisen and its continuation is damaging to Australia's international reputation in the recruitment of experienced overseas nurses. This problem will be prevented in the future by the implementation of Recommendation 22.

In addition, the performance of the National Boards against this objective of the National Law should form part of the key performance standards to report to Ministerial Council (See Recommendation 1a).

Recommendations

24. The performance of the Medical Board of Australia and AHPRA, in the implementation of changes to the International Medical Graduate (IMG) assessment process arising out of the *Lost in the Labyrinth* report, form part of the key performance standards to report to Ministerial Council.

25. The Medical Board of Australia to evaluate and report on the performance of specialist colleges in applying standard assessments of IMG applications and apply benchmarks for timeframes for completion of assessments.

Merit-based appointment of a Chairperson for a National Board

The National Law currently prevents community members from being appointed as the chair of a National Board. The Review sought views to determine if there should be the flexibility to make merit-based appointments to the position of National Board Chair.

Results of the consultation

There was general support expressed at the forums that the Chair of a National Board should be the best qualified person.

The majority of submissions were supportive of merit-based appointments. The Review received 68 responses to this question, with 65% of respondents supporting the appointment of the Chairperson on merit, and available to non-practitioner members. Comments included:

- support the principle that the person assessed as being the best person for the role of Chair should be appointed (*National Boards and AHPRA*)
- no reason why the Chairperson could not be an appropriately skilled or qualified community representative if this person is the most meritorious candidate (*Queensland Health*)
- having independent chairs contributes to a culture of openness and constructive challenge and allows for a diversity of views to be considered by the Board (*Health Professions Accreditation Councils' Forum*).

There were some comments that the Chair must have the confidence of the profession and this was most likely to be achieved by a practitioner appointment.

Less than a third of respondents took this view. This group typically stated this would "engender confidence of the profession" (*Health Professional Councils Authority NSW*) and "it is crucial that the voice of the practitioner is not lost and to maintain professional trust in the Board" (*Medical Indemnity Industry Association of Australia*).

Discussion

There would appear to be reasonable grounds to provide the Australian Health Workforce Ministerial Council (the Ministerial Council) with the flexibility to appoint as Chairs of National Boards individuals who are not practitioners but who are the most meritorious candidate.

Recommendation

26. That the National Law be amended to enable the Ministerial Council to appoint either a practitioner member or a community member of a National Board as Chairperson.

National Health Practitioner Ombudsman and Privacy Commissioner

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

The NHOPOC 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; that an agency has inappropriately handled their personal information.

The ability of the NHOPOC to provide independent oversight is a critical 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.

Results of the consultation

Issues have been highlighted regarding the effectiveness of the office of the NHPOPC and these difficulties were reinforced by submissions to the Review.

At the end of 2013 the Australian Health Ministers' Advisory Council (AHMAC) was advised of concerns regarding the operation of the NHPOPC.

AHMAC commissioned a review by KPMG to examine:

- the management of the office including operating systems and processes and information systems
- the financial management, resourcing and capacity of the office
- workload and demand management including benchmarking
- staffing including the number and appropriateness, human resources protocols and practices
- the number, nature and status of the complaints that have been received within the remit of the Office and in accordance with the Commonwealth *Privacy Act 1988* and *Ombudsman Act 1976*, as applied by the National Law and the Health Practitioner National Law Regulations
- internal management protocols and practices including risk management
- governance processes including reporting and audit
- examination of the organisational relationship with the Victorian Department of Health, which is the host jurisdiction
- consideration of any alternative arrangements implemented by other contemporary national schemes to help inform future management of the office.

The KPMG report contained options for the future management of the NHPOPC office and associated budget implications and AHMAC has approved a timeline for the implementation of these recommendations.

The Consultation Paper also queried if the NHPOPC has jurisdiction over complaints raised about processes undertaken by Accrediting Authorities.

Results of the consultation

Responses to the Review indicated that there should be the opportunity for an external review process of either decisions or processes of the Accreditation Authorities. Accreditation Authorities via the Forum's submission indicated that they believe there is good oversight of the decisions made by the Accreditation Authorities through a range of mechanisms, but recognised that improvements could be made in further strengthening review, appeal and complaint mechanisms.

Discussion

The Review is satisfied with the steps taken by AHMAC to review and strengthen the capacity of the NHPOPC.

The Review has found that there is a need to strengthen the accountability arrangements with respect to the delivery of the accreditation functions under the National Scheme. See Recommendation 17.

9. Nursing and Midwifery Board of Australia

One issue raised with the Review by a number of midwifery organisations and individual midwives, was that midwifery should be recognised as a separate profession, and a Midwifery Board of Australia be created under the National Registration and Accreditation Scheme (the National Scheme).

The organisations that put this view forward were: Australian Midwives Act Lobby Group; Homebirth Australia; CRANAplus (professional body for remote and isolated health professionals); Australian College of Midwives Consumer Advisory Committee; Maternity Choices Australia; Midwives Australia; Australian College of Midwives; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; and Maternity Reform Association (South Australia).

The Independent Reviewer discussed the motivation for this proposal with a number of the midwife organisations that made submissions to the Review, as well as with the Nursing and Midwifery Board of Australia (NMBA) and the Australian Health Practitioner Regulation Agency (AHPRA).

The rationale put forward by those advocating for a separate board was the belief that the NMBA was not able to properly regulate midwifery matters due to its limited representation from midwives. Further, that the Board was not actively engaged in considering the need for alternative regulation for new midwifery service models including the role of independently practicing midwives and the development of home-birthing services. Many of the advocates for the establishment of a separate profession are also advocates for home-birthing services.

Unlike the UK and New Zealand, the significant majority of midwives in Australia hold dual registration as nurses and midwives (30,000). A further 3,000 midwives are not registered to practice as nurses.

Historically, the midwifery model in Australia has restricted midwifery qualifications to nurses, enabling them to operate flexibly across maternity and nursing services, primarily, but not exclusively, within hospital settings. This has worked well in country and regional facilities where the small number of births did not justify permanent specialist maternity staff. Nursing-midwives have successfully worked in these locations as highly-flexible generalist nurses able to attend to midwifery roles in both inpatient and outpatient settings. This matches a similar role in medicine where General Practitioners are also providing a level of obstetric services.

In more recent years the recruitment of UK midwives (not nursing qualified) to fill shortages in Australia, and the introduction of alternative maternity choices for women (mainly in metropolitan settings) including home-birthing with independently practicing midwives, has seen a growth in midwives without nursing registration. In Victoria and South Australia in 2001 legislation was introduced to allow the first direct entry midwifery programs to commence.

These emerging service models are part of the motivation to see the NMBA focus more on the regulatory measures required to keep pace with alternative birthing and maternity services.

Based on the consultation with midwives, the NMBA and AHPRA it is apparent that while concerns about the lack of involvement of midwives in aspects of the regulation by the NMBA had some justification in the past, the Board has taken active steps to ensure that midwives have increased representation on regulatory matters involving midwifery services.

The Review also found that the NMBA has increased its attention and focus on the development of alternative and innovative models of care in midwifery and birthing services. This represents an area of considerable regulatory risk and, while the pace of regulation may be seen as slow by those advocating for change, it is necessary to ensure women who are presented with alternative birthing and maternity services are offered safe and appropriately-regulated services.

It would be sensible for the Board to continue to focus increased attention on the midwifery profession to match its disproportionately high risk and the required regulatory workload.

Finally, the Review finds that a change to the National Law is required. At present it presents Nursing and Midwifery as a single profession. This represents the long-standing model of maternity services in Australia where the prevailing approach was not to separate nursing from midwifery.

Given there are now some 3000 midwives only qualified to practice in that role, it is sensible to recognise nursing and midwifery as two professions under the one Board. There is precedent for this under the National Scheme, such as the multiple professions registered with the Dental Board of Australia. It also means that single registration as a nursing midwife would still be available for the majority of registrants who hold both professional roles.

Recommendation

27. That the National Law be amended to reflect and recognise that nursing and midwifery are two professions regulated by one National Board.

10. Operation of Tribunals

The Tribunals play a key role in making decisions on serious matters raised as notifications within the National Registration and Accreditation Scheme (the National Scheme).

The National Boards have the authority to establish panels to caution a practitioner, accept an undertaking or impose conditions and, when it is necessary to protect public safety, apply Immediate Action. In addition they can suspend a practitioner's registration in relation to health impairment. If any more serious action is considered to be required on any other grounds these must be referred to the relevant Tribunal. This occurs when the allegations involve the most serious professional misconduct and a Board believes that suspension or cancellation of the practitioner's registration may be warranted

A health practitioner or student may also request that a matter be referred to a Tribunal.

During the course of the Review a number of stakeholders raised concerns that the use of jurisdictional Tribunals may result in different processes, different decisions or penalties for the same offence, leading to the possibility of increasing numbers of appeals and the application of different principles in considering cases. However, there was little evidence presented to support the assertions.

In order to more fully explore these issues the Review wrote to each of the State and Territory Tribunals and posed a series of questions, listed below (see correspondence attached at *Appendix 9*). All States and Territory Tribunals responded to the questions and this represented a reassurance and evidence that the Tribunals actively seek to ensure decisions and actions are consistent regardless of the jurisdiction in which the matter may be heard as follows:

What efforts, if any do your disciplinary hearings take in order to ensure consistency in outcomes for breaches of professional standards as described in the National Law?

The Tribunals generally referred to the publication of their determinations under the National Law including publication to Austlii (the Australasian Legal Information Institute). The Austlii was referred to as an invaluable resource when considering decisions made on the same areas of the law. The Australian Health Practitioner Regulation Agency (AHPRA) website also provides a helpful overview of Tribunal decisions made across Australia.

Does your Tribunal share your decisions and associated rationale with colleague Tribunals and are regular meetings or contact held?

The Tribunals referred to sharing of the decisions and written reasons for the decisions through publication. They also indicated that the head of the Tribunal and occasionally other members attended a national meeting of all health practitioner tribunals from across Australia. These have been held in conjunction with the annual Council of Australasian Tribunals Conference. These have been recognised as an important vehicle for discussing matters of mutual interest to members of health practitioner Tribunals. Further informal contact occurs regularly amongst the Tribunals.

Given the unique nature of the National Law and the emphasis on public safety protection as a primary principle in considering professional conduct, it would be helpful to understand what steps if any, are taken to ensure members of Tribunals are fully acquainted with these features?

The Tribunals described the innate skills, experience and qualification of their members and stated that all have a clear understanding about the primacy of public safety in considering health practitioner matters. Several Tribunals cited the conduct of in-house presentations and other approaches to maintain and enhance the experience and understanding of members.

These responses have satisfied the Independent Reviewer that the Tribunals have adequate processes in place to minimise the risk of different decisions between jurisdictions on the same or similar matters.

It became apparent during the course of the Review that the consistency of investigations, the manner of their presentation to Boards and the pace at which they are completed varies between some of the State and Territory Offices of AHPRA. These processes would appear more likely to lead to inconsistent outcomes.

AHPRA's establishment of a notifications manual and associated business rules has been helpful, however it is clear that legacy issues, especially the fact that some officers who worked under previous regulatory schemes are now performing similar jobs under the National Scheme, have resulted in some difficulties.

A similar approach to guiding the role and performance of Board panels through the establishment of a guide to panel members has been helpful in gaining consistent approaches and standards within the health disciplinary panels.

Given the essential interactions between Boards, Tribunals, AHPRA and panels, it may be helpful to invite regular discussion around improvements needed in the management of serious notifications.

The power of Tribunals to issue prohibition orders was also raised with the Review. Under the National Law, if the tribunal decides to cancel a person's registration, or the person is no longer registered, the tribunal has the power to prohibit the person from using a specified title or providing a specified health service.

These prohibition order powers have been framed to deal with circumstances where a practitioner continues to practise under another professional title when their registration has been cancelled for professional conduct, or where they have let their registration lapse in order to avoid disciplinary action. For example, a former registered nurse continuing to practise as a personal care worker.

The following concerns have been identified with the operation of the current provisions:

- the wording of 'specified health service' restricts the scope of the prohibition order, and may not give the tribunal flexibility to prohibit a practitioner from providing any type of health service, where it is found that the person is not a fit and proper person to practise
- there are no offences in the National Law for a breach of the prohibition order
- it is unclear whether prohibition orders issued under the National Law only apply in the jurisdiction in which they are issued.

The Review has found that amendments are required to the National Law to address these issues.

Recommendations

28. That AHPRA conduct specific education and training programs for investigators. These should be designed in consultation with National Boards, Tribunals and Panel members to develop more consistent and appropriate investigative standards and approaches, consistent with the requirements of the National Law, including the primacy of public safety over other considerations within the matters.

29. That the Health Practitioner Regulation National Law 2009 prohibition order powers be amended to provide the means for Tribunals to prohibit the person from providing any type of health service, to establish an offence for breaching a prohibition order and to provide for mutual recognition of prohibition orders issued by jurisdictions.

11. Aboriginal and Torres Strait Islander Health Practice Board of Australia

The Independent Reviewer chose to separately canvass the issues associated with the Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHP Board) established in 2012. These issues included:

- the number of registrants at 330 is unsustainably low and dominated by the Northern Territory, which has more than 70% of registrants. NT was the only jurisdiction regulating Aboriginal Health Workers at the introduction of the National Scheme and commenced doing so in 1985
- up until this point the common use title was Aboriginal Health Worker and this covered both clinical and non-clinical roles. The introduction of regulation and protection of the title "Aboriginal and Torres Strait Islander health practitioner" was premised on the basis that all jurisdictions and the Aboriginal Community Controlled Health Organisations would review the positions within their workforce and establish those that required regulation and retitling as Aboriginal Health Practitioner. It was unclear what progress had been made in this undertaking
- based on the ATSIHP Boards' own assessment for the current year there is an estimated 1,237 that may require registration. If correct this means about 900 unregistered employees are working in State, Territory and Aboriginal Community Controlled Organisations. There is no apparent monitoring of unregistered workers.

The low level of registrants means the Board cannot be self-sufficient as required under the National Scheme. Indeed, the level of subsidisation was masking an actual cost of $1792 per registrant, subsidised to $100 per registrant using Commonwealth and Australian Health Ministers' Advisory Council (AHMAC) cost-shared funding. This was expected to cease at June 30, 2015.

These issues were assessed in the early stages of the Review and it was identified that there was seemingly little progress and no evidence of a plan to manage them.

In early September, 2014 the Independent Reviewer wrote to the National Aboriginal Community Controlled Health Organisations (NACCHO) and State and Territory jurisdictions who employed Aboriginal and Torres Strait health practitioners seeking their specific input and advice to the Review. The Independent Reviewer also met with Northern Territory Health Minister, Hon. Robyn Lambley and key stakeholders in the Northern Territory to discuss the future of national regulation, given the unique history and leadership the NT had provided in this area since 1985.

The letter to stakeholders canvassed the issues facing the regulation of this profession and asked for advice and suggestions on the best way forward in the future regulation of the profession, particularly ways in which the number of registrants could be increased. The letter also asked for suggestions of alternative approaches to the regulation of Aboriginal and Torres Strait Islander health practitioners (correspondence attached at *Appendix 10*)

Results of the consultation

The general response to these issues was that it was too early to make a judgement about the future regulation of this profession given it only commenced in June 2012. Nonetheless it was acknowledged that action was needed to achieve a sustainable future. South Australia (currently with 12 registered Aboriginal and Torres Strait Islander health practitioners) and the NT indicated they expected growth in the number of Aboriginal and Torres Strait Island health practitioners. Both New South Wales and Queensland continued to be committed to growing their Aboriginal and Torres Strait Islander Health Workforce, but in areas that matched need rather than growing this specific profession. Queensland acknowledged that interest in conversion to these roles was not high as workers did not see a major benefit and the high cost to achieve the required standard.

All of the health departments with the exception of NT saw benefit in the inclusion of the ATSIHP Board in the proposed merger with eight other professions in the National Registration and Accreditation Scheme (the National Scheme) under the proposed Health Professions Australia Board (HPAB).

The National Aboriginal and Torres Strait Islander Health Workers Association Limited (NATSIHWA) in its submission addressed the need for a stronger focus on the whole of the Aboriginal Health Workforce and was concerned that the limited focus on regulated Aboriginal Health Practitioners was being judged too early, especially considering that it takes 12 months to two years to train new practitioners, and there are large numbers of long-term vacancies. The submission argued that to expect that the new profession could achieve a target of 1200 registrants with very little investment is unreasonable.

While NATSIHWA considered the option of inclusion within the Australian Health Professions Board it was concerned that this would diminish the voice of the regulated profession in the National Scheme especially around complaints and notifications and the cultural assessment that needed to be included.

NACCHO in its summary submission collated from a wider National Health Leadership group meeting advised that the growth to 1200 registrants would require a greater contribution from the jurisdictions to achieve within their workforces and that the scope of the coverage could be considered for social and emotional wellbeing workers and drug and alcohol workers.

Discussion

The ATSIHP Board has the lowest level of regulatory workload and the highest per registrant cost of any profession, it is heavily subsidised and the likelihood of significant further growth in registrant numbers to a more sustainable level is unlikely.

The current National Law provides no options for a lower level of regulatory effort and structure to match this low level of activity. Last year it received just four notifications regarding its registrants, yet is required under the National Law to maintain a full process and management for notifications for just 330 registrants. It has a full Board meeting regularly and, although it has sought to reduce costs, the fixed costs of operating the regulatory structure cannot be further reduced.

The cessation of the registration subsidy from the Australian Health Ministers' Advisory Council (AHMAC) cost share and Commonwealth funds will mean that the profession will no longer be financially viable.

There appears to have been little preparatory work to address these issues and no easy solutions have been offered.

The regulation of the profession was driven by the NT, which had previously subsidised the registration of Aboriginal Health Workers. One option suggested in the jurisdictional responses was that the regulation of this profession should be returned to the jurisdictions. No stakeholders suggested the profession should cease to be regulated and it is very clear that its recognition with other health professions is important to Aboriginal and Torres Strait Islander Health groups and the recognition and credibility that is associated with regulation under the National Scheme.

In the event that no further subsidisation is available from the AHMAC cost-share budget, or from jurisdictions with Aboriginal Health Practitioners, or from employers, then few options exist to maintain a financially-sustainable regulation of the profession. Asking Aboriginal and Torres Strait Islander health practitioners to pay $1792 in annual registration fees is unreasonable.

The Consultation Paper canvassed including this profession, together with eight others, under a single Health Practitioner Australia Board (HPAB). This would provide the benefit of continued regulation while benefiting from the economies of scale offered by a single Board. Aboriginal and Torres Strait Island health practitioners would be the major financial beneficiaries of such an approach.

It is clear that sustainability for regulation of the 330 Aboriginal health practitioners would be best served by inclusion within the HPAB. This would include a clear avenue for professional involvement in the regulation of this group of practitioners.

As well as being the regulator overseeing the practice of Aboriginal and Torres Strait Islander health practitioners, following consultation with NACCHO, it is proposed that the HPAB establish a national Aboriginal and Torres Strait Islander health committee to assist all health profession regulators within the National Scheme to accommodate and respond to Aboriginal and Torres Strait Islander health and cultural issues as appropriate. This national Aboriginal and Torres Strait Islander health committee working within the National Scheme will draw membership and support from the existing National Health Leadership Forum. This may include:

- assisting accreditation authorities to ensure the inclusion of Aboriginal and Torres Strait Islander health in programs of study
- advising in relation to notifications associated with Aboriginal or Torres Strait Islander health professionals
- assisting matters related to provision of health services in Aboriginal and Torres Strait Islander communities.

By drawing on the National Health Leadership Forum to improve the regulations associated with Aboriginal and Torres Strait Islander health issues there would be substantial benefits to the National Scheme as a whole.

Recommendations

30. That the regulation of Aboriginal and Torres Strait Islander Health Practitioners be continued by a merger into the Health Professions Australia Board, with continued involvement of Aboriginal and Torres Strait Islander Health Practitioners on issues covering that profession.

31. The Health Professions Australia Board establish a committee involving Aboriginal and Torres Strait Islander health leaders to assist the National Scheme to better respond to Aboriginal and Torres Strait Islander health and cultural issues.

12. Proposed amendments to the National Law

The Consultation Paper sought feedback on a series of legislative amendments to the National Law endorsed by the Australian Health Workforce Ministerial Council (AHWMC), and others proposed by the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA) (see *Appendix 11*). Less than 1% of submissions commented on these proposals.

Results of the consultation

The majority of other submissions either expressed general support for the suggested amendments and/or selectively commented on one or more of the proposals. Specific comments in response to proposals are noted the table below.

Key comments on specific aspects of proposals to amend the National Law

Freedom of Information, privacy, and the Ombudsman

It is proposed that Commonwealth legislative reforms to Freedom of Information (FOI), privacy, and the Ombudsman be reflected in the National Law (section 215). This proposal was generally supported. The Australian Medical Association noted that FOI reforms are broader than those in the consultation paper, and all the FOI reforms should be adopted, including measures to remove application fees and reduce the costs of requests, and new provisions that require proactive publication of information.

Regulations

It is proposed that the process for making regulations under the National Law be amended so that regulations are tabled in State/Territory Parliaments, disallowed and notified/published in the same way as other regulations in that jurisdiction. Under the proposed amendment jurisdiction majority disallowance provisions would be retained (sections 245-247).

Whilst the amendment was generally supported, the Australian Medical Association (AMA) expressed concern about the impact of retaining majority disallowances (except WA) on State sovereignty over the National Law. Health South Australia noted the importance of preserving the sovereignty of State/Territory Parliament, however was also concerned the National Law applied in a State/Territory may be different to that adopted in other jurisdictions (unless disallowed by a majority of Parliaments). They also were concerned that regulations may be used to make legislative changes to the National Law without opportunity for Parliamentary debate. Tasmania Health suggested that a completely new section should be inserted into National Law to limit the requirement for jurisdictions to make consequential amendments to State/Territory legislation.

Notifications

It is proposed that the National Boards and AHPRA provide information to notifiers and practitioners at key milestones. This should include reasons for a decision following an investigation, health assessment or performance assessment (sections 167, 177, 180). This proposal was supported subject to qualifications.

AVANT Mutual Group agreed so long as reasons for a decision are provided, privacy is respected, and the Boards retain the discretion to withhold sensitive information.

The AMA agreed that notifiers should be advised in very broad terms about the nature of the outcome, as per information on the public register, so long as a practitioner's personal information is not divulged. They added, a practitioner must be provided with a copy of the information given to the notifier and consideration should be given to whether different information should be given to the practitioner's employer. The AMA also noted that it is not clear how this will impact on the abrogation of right against self-incrimination as AHPRA has no control over how information provided to a notifier will be used.

Information on the Register

It is proposed that information on the public Register be limited to protect third parties who may be adversely affected (section 226). This proposal is supported. The Australian College of Nursing (ACN) noted that the National Law might also include a requirement that the public interest be considered and may override the adverse impact on one individual.

Obtaining information

It is proposed that the National Law be amended to remove any doubt about an investigator's ability to obtain information from other government agencies (section 27). AVANT Mutual Groups supports so long as registrants are also given notice and copies of documents obtained by investigators. The AMA noted that they cannot support this proposal until there is evidence that AHPRA has clear and robust procedures in place to guide and monitor the activities of its investigating officers.

Undertakings

It is proposed that a contravention of an undertaking be treated in the same way as conditions on a practitioner's registration (section 112). The proposal received some support. The AMA did not support this proposal as it allows a Board to refuse to renew a registration if a practitioner does not comply with an undertaking. They noted that a registrant should be given an opportunity to explain the circumstances of their failure to meet an undertaking, and for the Board to take that into account when deciding how to deal with the failure.

Appeals

It is proposed that a nationally consistent timeframe in which appeals to a responsible tribunal can be made is established (sections 199, 203). This proposal is supported, however the proposed timeframes varied from 28 days, 30 days to 60 days in which to lodge an appeal. It was also proposed that practitioners should be able to appeal a panel or Board decision to caution.

In their response, the National Boards and AHPRA made further suggestions for further minor technical amendments to the National Law.

Recommendations

32. That the National Law be amended to reflect provisions endorsed by the Australian Health Workforce Ministerial Council in 2011.

33. That the amendments proposed by the National Boards and AHPRA be further considered by the formation of a small working group with representatives from AHPRA and jurisdictions with suitable legal and policy expertise to review the list of proposed amendments to the National Law and make recommendations to the AHWMC.

Appendix 1

Australian Health Workforce Ministerial Council

National Registration and Accreditation Scheme for the health professions

Review terms of reference

Preamble:

The National Registration and Accreditation Scheme for the health professions (the National Scheme) is established under the *Health Practitioner Regulation National Law Act* (the National Law) as in force in each state and territory, and commenced operation on 1 July 2010, and 18 October 2010 in Western Australia.

An Intergovernmental Agreement (IGA) signed by Council of Australian Governments (COAG) members in March 2008 underpins the National Scheme and identifies its objectives as:

- protection of public safety;
- facilitation of workforce mobility and high quality education and training;
- promotion of access to health services; and
- development of a flexible responsive and sustainable workforce.

The objectives and guiding principles of the National Scheme are set out in section 3 of the National Law.

Clause 14.1 of the IGA states that for the purposes of the National Scheme, an independent review will be initiated by the Australian Health Workforce Ministerial Council (AHWMC) following three years of the National Scheme's operation.

1. Scope of the National Registration and Accreditation Scheme (NRAS) Review

The scope of the NRAS Review is to be focussed on matters relevant to:

- identifying the achievements of the National Scheme against its objectives and guiding principles;
- the future sustainability of the National Scheme, any recommended changes and the specific matters articulated below;
- the administration of the National Scheme;
- the interface between the National Scheme and jurisdictional practices; and
- an assessment of the extent to which the National Scheme meets is aims and objectives.

2. Objectives and Guiding Principles of the National Scheme

The NRAS Review will examine to the extent to which the implementation of the National Scheme and the regulation of the professions under the National Scheme is meeting the objectives and guiding principles as set out in the IGA and Section 3 of the National Law.

1. The objectives of the National Scheme are –
    - **a.** 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; and
    - b. 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; and
    - c. to facilitate the provision of high quality education and training of health practitioners; and
    - d. to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
    - e. to facilitate access to services provided by health practitioners in accordance with the public interest; and
    - f. 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.
2. The guiding principles of the National Scheme are as follows –
    - **a.** the National Scheme is to operate in a transparent, accountable, efficient, effective and fair way.
    - b. 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.
    - c. 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.

Without limiting the generality of the above, the NRAS Review should particularly comment on the benefits and costs that have been realised by the introduction of the National Scheme.

3. Operational Performance of the National Scheme

Without limiting the generality of the above, the NRAS Review should particularly comment on:

- **a.** Effectiveness of the National Scheme, including comparison with other similar international regulation authorities.
- b. Whether there are sufficient incentives built into the National Scheme to encourage continuous improvement and adoption of leaner and more efficient regulatory arrangements.
- c. 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.
- d. Whether the current regulatory arrangements for the National Scheme deliver sufficiently efficient, effective, consistent and proportionate regulations in light of the National Scheme's objectives and guiding principles.
- e. The adequacy and transparency of the accreditation functions under the National Scheme.

4. National Law

In relation to the National Law examine the:

1. Impact of mandatory notification provisions.
2. Role of the Australian Health Workforce Advisory Council (AHWAC).
3. Mechanisms for new professions to enter the scheme.
4. Key linkages to other national/jurisdictional laws (e.g. Drugs and Poisons, health complaints and tribunal legislation).
5. Requirements for amendment to the National Law to improve the effectiveness, efficiency and accountability of the National Scheme
6. Regulation and cost effectiveness of small professions.

5. Governance Effectiveness

1. Examine the governance of the National Scheme, including the roles of:
   - Australian Health Practitioner Regulation Agency (AHPRA)
   - National Boards
   - Accreditation Authorities
   - AHWAC
   - Standing Council on Health (SCoH) / Australian Health Workforce Ministerial Council (AHWMC)
   - State/Territory and Regional Boards
   - Ombudsman/Privacy Commissioner
   - Tribunals
   - State and Territory health complaints entities
2. Review the functions of these entities and the interrelationship with AHPRA and the National and State Boards.
3. Consider the administration of the scheme and the interface between NRAS and jurisdictional practices.
4. Consider the opportunities that AHPRA and the National Boards have to work effectively in partnership with other parties that influence workforce, including but not limited to state, territory and Commonwealth health departments, Health Workforce Australia, education providers.
5. 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.

6. Future sustainability of the National Scheme

In light of the above Terms of Reference, examine and make recommendations on the future sustainability of the National Scheme (particularly in relation to the addition of other professions and funding arrangements for smaller regulated professions).

Appendix 2

Australian Health Ministers' Advisory Council

Review of the National Registration and Accreditation Scheme for health professions

Project plan for the Review

1. Background

The National Registration and Accreditation Scheme for the health professions (the National Scheme) came into operation on 1 July 2010 with national registration commencing for 10 regulated health professions. On 1 July 2012, a further four professions joined the National Scheme. Prior to that date, these fourteen professions were regulated by over 90 separately constituted registration boards established under State and Territory legislation.

The establishment of the National Scheme followed publication in 2005 of the Productivity Commission report *Australia's Health Workforce*. The report highlighted difficulties with the fragmented regulatory arrangements and the need for rationalisation, not only to lift standards and provide efficiencies, but also to provide the levers to drive workforce reform and innovation.

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. The entities established under the National Law are:

- Australian Health Workforce Ministerial Council
- Australian Health Workforce Advisory Council
- Fourteen National Boards
- Australian Health Practitioner Regulation Agency and Agency Management Committee
- National Health Practitioner Ombudsman and National Health Practitioner Privacy Commissioner

The Intergovernmental Agreement (IGA) signed by COAG members in March 2008 underpins the National Scheme. The IGA identifies the National Scheme's objectives as: protection of public safety; facilitation of workforce mobility and high quality education and training; promotion of access to health services; and development of a flexible responsive and sustainable workforce. These objectives have been enacted in the National Law.

The IGA provides that an independent review of the National Scheme be initiated by the Australian Health Workforce Ministerial Council (AHWMC) following three years of the scheme's operation, that is, July 2013.

At the AHWMC meeting of 11 November 2011, AHWMC approved amendments to the *Health Practitioner Regulation National Law and the Health Practitioner Regulation National Law (Western Australia) Act 2010*, and agreed that these amendments would be included in the required three year review of the National Scheme.

2. Terms of reference

In June 2013, the AHWMC approved the terms of reference for the Review of the National Scheme.

The terms of reference address the following broad but overlapping aspects of the National Scheme:

- Achievement of legislated objectives
- Operational performance
- Cost effectiveness
- Governance effectiveness
- Future sustainability
- Amendments to National Law provisions

3. Methodology

The Review is to include the following components:

A: Preliminary research, environmental scan and cost effectiveness review

An environmental scan should be conducted to gather information and views from jurisdictions, regulators and other stakeholders on:

- how the National Scheme is operating;
- its strengths and limitations;
- key issues and concerns;
- priority areas and/or options for reform;
- specific proposals for amendment to provisions of the National Law.

The environmental scan should be supplemented with desktop research to:

- identify and compare relevant legislative frameworks in a select number of international jurisdictions and the operational performance of their regulatory bodies;
- identify suitable mechanisms for engagement of consumers and their representative bodies in the review process;

The desktop research should draw on publicly available information in statutes and parliamentary committee inquiry reports, in annual reports of regulators, on regulators' websites, and in performance review reports by oversight bodies both in Australia and internationally.

Cost effectiveness review

AHMAC has approved for the cost effectiveness/efficiency study to be undertaken by an external contractor selected through a tender process. The successful tenderer will have experience and expertise in undertaking cost effectiveness and efficiency assessments of regulatory instruments. They will work with the Review team in establishing a methodology for the cost-effectiveness and efficiency review of the scheme including:

- the standards against which performance of the regulatory regime is to be assessed;
- data collection and analysis requirements, for instance collection of data from registrants, notifiers, accredited education providers, health complaints entities, tribunals;

The methodology for the cost effectiveness/efficiency review will require the approval of the AHMAC Chief Executive Governance Group. In developing the methodology for the cost efficiency and effectiveness review, the successful tenderer and the Review Team should take account of similar studies undertake in other jurisdictions.

B: Preparation of consultation materials and strategy

Using information drawn from the preliminary research and environmental scan, a paper will be prepared for noting by AHMAC, to set the parameters for the NRAS Review.

After seeking views from key stakeholders, a Consultation Paper in the form of a COAG compliant Consultation Regulatory Impact Statement will be prepared for public release. The Consultation paper should document current arrangements, identify and discuss issues and options for reform.

The Consultation paper will identify issues and options for reform with respect to:

- the scope of the regulatory regime and its legislated principles and objectives;
- the criteria and decision making framework for entry of new professions to the scheme;
- the governance of the scheme, its structural elements and the linkages between them (the Ministerial Council, Advisory Council, Agency Management Committee, National Boards, State, Territory and Regional Boards, accreditation entities, tribunals);
- the relationship between the regulators and government;
- intergovernmental structures and processes that support decision making under the regulatory regime;
- the operation of the:
  - standard setting and guidance functions
  - registration functions
  - suitability to practice functions
  - accreditation functions
  - tribunal functions
  - prosecution for offences functions
  - accountability and performance reporting.
  - specific provisions of the National Law that may require amendment

The Consultation Paper will be prepared as a Consultation Regulatory Impact Statement, in accordance with COAG best practice regulation requirements. Advice will be sought from the Office of Best Practice Regulation on these requirements.

The Consultation Paper will seek stakeholder views on the arrangements pre and post the National Scheme, what has changed, what is working, what is not working, and how operation of the regulatory regime could be improved for the benefit of the health system, health service consumers and other stakeholders.

Consumer engagement strategy

An active strategy will be required to ensure sufficient consumer input to the Review and to strengthen the consumer voice throughout the process. A consumer engagement strategy should be prepared that incorporates strategies such as:

- provision of support for consumer advocacy organisations to assist groups and individuals to prepare their submissions;
- provision of support for consumer representatives to participate in consultation forums;
- conduct of consumer focus groups;
- research on consumer expectations and/or the experience of consumer notifiers to the Scheme
- collection and evaluation of other data on consumer complaints.

C: Conduct of national consultation

A consultation forum will be held, in each state and territory, with stakeholders being invited to participate. Jurisdictions will be responsible for the organisation of the state and territory forums. This includes:

- funding the state/territory forum;
- venue and other logistical arrangements;
- liaison with the independent reviewer and project team regarding the format ;
- invitation and RSVP arrangements;
- administrative assistance including note taking and
- the development of a final report of the forum.

The Project team will be responsible for the organisation of the national forum.

The availability of the Consultation Paper should be advertised widely. Submissions should be invited and feedback sought from individuals and groups that represent the interests of:

- health service users;
- registered practitioners and students;
- professional associations and broader professional stakeholder networks;
- employers and health service providers;
- education providers including specialist colleges;
- other bodies that share regulatory responsibilities, such as:
  - Health Complaints Entities (HCEs);
  - state and territory tribunals;
  - state and territory regulators in areas such as drugs and poisons, health facilities regulation, public health;
  - Commonwealth entities with overlapping responsibilities such as Medicare Australia, Health Workforce Australia, Veterans Affairs, Immigration, and private health insurance regulators.

D: Analysis of submissions and other data

Data gathered from the analysis of submissions, the conduct of the consultation forums and other stakeholder meetings, and any surveys conducted should be analysed and distilled into a preliminary report of the consultation for jurisdictions.

E: Preparation of final report

A final report will be prepared that draws together research data with the cost effectiveness and efficiency study and the results of the consultations. The report will include findings of the Review, any issues with the operation of the National Scheme, where improvements can be made, and whether these require legislative reform or other administrative action.

A draft of the report should be provided to AHMAC for comment prior to its formal submission to Standing Council on Health (SCoH).

4. Project deliverables:

- Project schedule with consultation plan and communications strategy;
- AHMAC paper setting the scope for the review;
- Consultation paper (COAG compliant Consultation Regulatory Impact Statement) incorporating:
  - results of environmental scan and desktop research;
  - issues identified;
  - options for reform;

- Summary report on results of consultation and stakeholder issues and views;
- Draft final report on findings of research and consultation with recommendations for reform;
- Final report for submission to Health Ministers.

5. Timetable

An indicative timetable for the Review is set out in Table 3 on the following page.

6. Costs

The costs of the Review are to be met from the allocated AHMAC Cost-shared budget. Jurisdictions will be responsible for the organisation and funding of the state/territory forums.

7. Governance arrangements

The project will be managed by an Independent Reviewer appointed by AHMAC, and supported by a Project Manager, a Senior Regulatory Policy Analyst and a Project Officer. The Independent Reviewer will report to an AHMAC Chief Executives Governance Group, made up of Chief Executives from Victoria, New South Wales and the Commonwealth.

Reporting arrangements are set out in Figure 1 below.

Figure 1: National Scheme Review governance arrangements

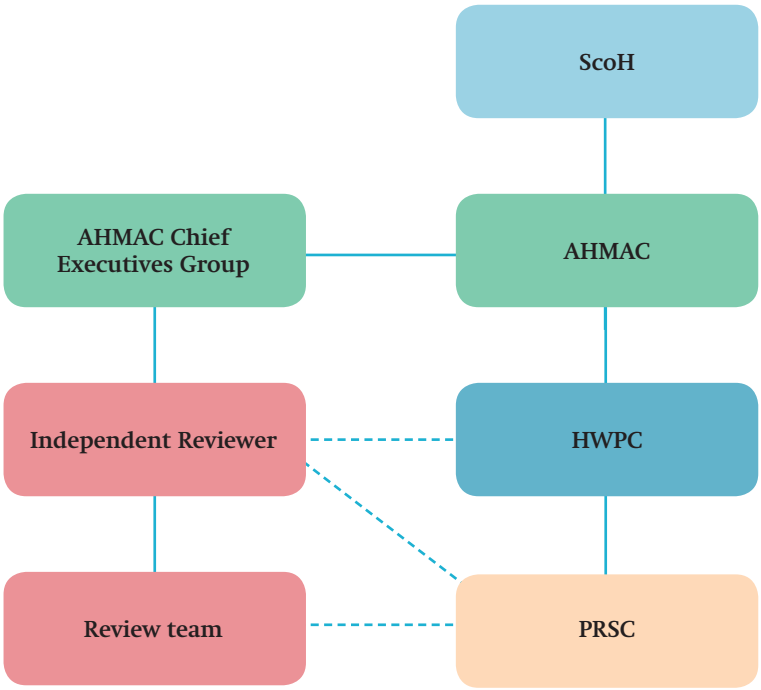


Table 3 – Indicative Review timetable

Date	Task	Outcome
	Establish governance for Review	
Nov 2013	Approve governance arrangements	AHMAC CEs Governance Group comprising of – VIC (Chair), NSW and Commonwealth Chief Executives established
	Approve budget	AHMAC confirmed funding 28 November 2013
Feb 2014	Identify suitable candidate for independent reviewer	AHMAC agreed on the preferred candidate for the role of Independent reviewer at its 14 February 2014 teleconference
	Contract independent reviewer, appoint project team and finalise tender process for cost effectiveness review.	
March 2014	Prepare contract for independent reviewer	Draft contract provided to independent reviewer
April 2014	Identify jurisdictional members for project team	jurisdictional project team established
	Sign contract for independent reviewer	Contract signed with independent reviewer
	Approve project plan	AHMAC approves project plan
	Prepare tender documentation for cost effectiveness review/economic analysis	Tender documentation finalised
May 2014	Conduct tender for cost effectiveness / economic analysis	Preferred tenderer identified
June 2014	Sign contract for cost effectiveness review	Contract signed for cost effectiveness review
	A. Preliminary research and environmental scan	
May 2014	Prepare AHMAC Paper setting the scope for the review.	AHMAC paper setting the scope for the NRAS Review
	Conduct initial meetings with key informants/ inter-governmental committees	Key informant meetings conducted with PRSC, HWPC, AHMAC CE Governance Group, AHMAC, AHPRA and National Boards
June 2014	Conduct desktop research on international regulatory regimes	Draft comparative report on international regulatory regimes
	Establish methodology and data collection requirements for cost effectiveness/efficiency study	AHMAC CE Governance Group approves methodology for cost effectiveness/efficiency review
June–Oct 2014	Conduct Cost effectiveness/efficiency study	Indicative analysis report provided to Independent Reviewer/Review team August 2014 to inform Consultation RIS. Final Report October 2014
	B. Prepare consultation materials and strategy	
May–June 2014	Prepare consultation strategy and schedule including consumer engagement strategy	AHMAC CE Governance Group approves consultation strategy
July 2014	Consult key informants on draft Consultation RIS including issues paper	Key informants including AHMAC CE Governance Group consulted on the draft Consultation RIS

Date	Task	Outcome
July–Aug 2014	Prepare COAG Compliant Consultation Regulatory Impact Statement (Consultation RIS)	AHMAC Governance Group approves Consultation RIS
	Clear Consultation RIS with Office of Best Practice Regulation (OPBR)	OBPR approves Consultation RIS for public release
	C. Conduct National Consultation	
May 2014	Settle arrangements for state and territory forums	Jurisdictions confirm arrangements for conduct of forums
Aug–Sept 2014	Advertise national consultation process	Advertisements placed
	Meet with external stakeholders (HCEs, tribunals, Medicare/PBS/Veterans Affairs)	Interviews conducted
Sept 2014	Conduct consultation forums	Forums conducted
Sept 2014	Provide assistance to consumers/consumer groups	Consumer groups assisted
	D. Analysis of submissions and other data	
Oct 2014	Final report of state/territory forums	Final reports from Jurisdictional Forum provided to the Review Team
	Analyse data from submissions and consultation forums	Submissions analysed
	Prepare summary report on consultations	AHMAC CE Governance Group considers summary report of consultations
	E. Preparation of final report	
Oct–Nov 2014	Prepare draft final report	draft final report developed
Nov 2014	Incorporate feedback from jurisdictions	AHMAC Governance Group/AHMAC considers draft final report.
Dec 2014	Finalise report and briefing papers for AHMAC and AHWMC	AHMAC approval for submission to AHWMC
Jan 2015	Submit final report to the AHWMC	AHWMC considers final report – dates to be confirmed based on AHWMC meetings for 2015
Feb–March 2015	Final report publicly released	Final report posted on AHMAC Secretariat website following AHWMC approval.

Appendix 3

Cost-effectiveness and efficiency review of the Australian National Registration and Accreditation Scheme for health professionals

Final Report October 2014

Cost-effectiveness and efficiency review of the Australian National Registration and Accreditation Scheme for health professionals

Final report
October 2014

Centre for
Health Service Economics
& Organisation

professional
standards
authority

Contents

1. Introduction

1.1 In June 2014, the Professional Standards Authority, working in collaboration with the Centre for Health Service Economics and Organisation, was contracted to review the cost-effectiveness and efficiency of the National Registration and Accreditation Scheme for health practitioners (NRAS) in Australia. The review was scheduled to take place between July and October 2014.

1.2 This review was one element of the broader review of the NRAS, commissioned by the Australian Health Workforce Ministerial Council (AHWMC), in accordance with the Intergovernmental Agreement (IGA) for a National Registration and Accreditation Scheme for the Health Professions that was signed by the Council of Australian Governments (COAG) in March 2008. The IGA provided for an independent review of the NRAS to be initiated by the AHWMC following three years of the scheme's operation; it has been in operation since July 2010. 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 NRAS.

The Professional Standards Authority

1.3 The Professional Standards Authority for Health and Social Care 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. We are an independent body, accountable to the UK Parliament. We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance annually and audit and scrutinise their decisions about whether people on their registers are fit to practise. We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

1.4 To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation[1]. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake international commissions in which we review the performance of a profession regulatory organisation, advise on regulatory arrangements, and make recommendations for regulatory improvement and development. More information on the Authority's work can be found at www.professionalstandards.org.uk

[1] *Right-touch regulation*, Council for Healthcare Regulatory Excellence, August 2010. http://www.professionalstandards.org.uk/library/document-detail?id=a3ea5638-fadf-400e-8635-47bf4b028a1f

The Centre for Health Service Economics and Organisation

1.5 The Centre for Health Service Economics and Organisation is a research unit with economists, statisticians and operational researchers, focused on whole-system analysis of healthcare and local health economies. Embedded in the Departments of Primary Care Health Services and Economics at the University of Oxford, the Centre has carried out projects commissioned by the Department of Health, the NIHR (NHS research-funding body) and various other public bodies (eg NHS London, the Health Foundation, CHRE (now the Professional Standards Authority), and Homeless Link. More information on the Centre's work can be found at www.chseo.org.uk

1.6 In undertaking the review we have applied a methodology developed specifically for assessing the cost-effectiveness and efficiency of professional regulatory arrangements. This was developed when the Authority, 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[2]. 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 that has been provided to us. We are not aware of any alternative methodologies having been developed elsewhere for a cost-effectiveness and efficiency assessment of professional regulatory arrangements and we consider this collaboration with colleagues in Australia shows the value of the model but also enables us to refine it further. We hope that this report will be of value to governmental and regulatory bodies in Australia and ultimately, through the analysis of cost and comparative data between Australia and the UK which it provides, to regulatory bodies worldwide as they consider their own cost-effectiveness and efficiency.

1.7 We are grateful to colleagues in Australia for the constructive and helpful way in which they have worked with us during this review.

2. Executive summary

2.1 In this report we have calculated an annual operating cost of the National Registration and Accreditation Scheme of $214,117,803. This equates to $346 per registered health professional.

2.2 We have shown how this total operating cost has been calculated, looking at three areas of expenditure: the Australian Health Practitioner Regulation Agency, the accreditation authorities, and the notifications arrangements in New South Wales.

[2] Final report available at http://www.professionalstandards.org.uk/library/document-detail?id=5c7ffe06-95cf-4284-8a56-f3c6a4d300e6

2.3 We have calculated the operating costs for each of the national boards, showing how much they spend on each function and how they compare to each other, including an analysis of per-registrant unit costs. We show that while the average unit cost is $346 per registrant, when analysed by profession this varies between $162 and $1,792.

2.4 We have then analysed the data in terms of the complexity of regulating different professions, and we show how effects of scale differ across the regulatory functions. We identify the aspects of the different regulatory functions which increase complexity and therefore, potentially, cost.

2.5 We compare the cost of the regulatory functions in Australia with the UK. While we find that the unit cost per registrant in the UK (which we estimate at $301.50) is slightly lower than in Australia, there are a number of factors which prevent a direct comparison of relative efficiency. We find that as a proportion of total spending the accreditation function in Australia is markedly more expensive than the quality assurance of higher education function in the UK, and we provide analysis of the possible reasons for this.

2.6 We have identified a number of potential areas for cost savings. These include two options for merging boards where we calculate hypothetical annual savings of between $11.9m and $58m. We also make a number of specific recommendations in different functional areas (registration, notifications and accreditation) where we identify potential areas where costs may be saved or more effectively controlled.

2.7 We offer a number of conclusions and recommendations, including for further areas of review and analysis.

3. Provisions for health professional regulation: Australia and the UK

3.1 In this section we outline the main provisions for the regulation of health professionals in Australia and in the UK, given the importance of comparison to this review and in order to give context to the economic interpretations that follow.

3.2 New legislation in Australia in 2010, the Health Practitioner National Law Act, established nationally consistent legislation for the regulation of ten health professions, with national boards for each of these professions. This replaced the previous state-based structures, with 85 boards and 66 acts of Parliament. The Australian Health Practitioner Regulation Agency (AHPRA) was established to support the boards in operating the National Registration and Accreditation Scheme (NRAS). From July 2012, four further groups were brought into the scheme. All 14 professional groups in the scheme are listed below, together with the relevant boards.

3.3 Registration of regulated health professionals is undertaken by AHPRA, which has established a single national register for all professions. The national boards set out standards of conduct. AHPRA and the boards work together to investigate and adjudicate where an allegation ('notification') is

made that standards have not been met. There are different arrangements in New South Wales for notifications, where this function is undertaken by the New South Wales Health Care Complaints Commission and professional councils. Also, an Ombudsman role has been established from July 2014 in Queensland[3]. Quality assurance of higher education is the responsibility of national councils for 11 of the 14 professions, and of a committee of the national board for the remaining three.

Health professional regulatory boards in Australia	**Profession(s)**	**Number on register**
Aboriginal and Torres Strait Islander Health Practice Board of Australia	Aboriginal and Torres Strait islander health practitioners	330
Chinese Medicine Board of Australia	Chinese medicine practitioners	4,259
Chiropractic Board of Australia	Chiropractors	4,843
Dental Board of Australia	Dentists, dental specialists, dental therapists, dental hygienists, oral health therapists and dental prosthetists	20,692
Medical Board of Australia	Medical practitioners	99,209
Medical Radiation Practice Board of Australia	Medical radiation practitioners	14,360
Nursing and Midwifery Board of Australia	Nurses and midwives	362,008
Occupational Therapy Board of Australia	Occupational therapists	16,174
Optometry Board of Australia	Optometrists	4,790
Osteopathy Board of Australia	Osteopaths	1,864
Pharmacy Board of Australia	Pharmacists	28,252
Physiotherapy Board of Australia	Physiotherapists	26,076
Podiatry Board of Australia	Podiatrists	4,125
Psychology Board of Australia	Psychologists	31,649
	Total	**618,631**

[3] The costs of these new arrangements in Queensland are beyond the scope of this exercise.

3.4 In the United Kingdom, the regulation of health professionals is the responsibility of nine separate statutory regulatory bodies. These are listed below. The organisations have been set up over many years under different Acts of Parliament. Their performance is overseen by the Professional Standards Authority. They are mostly UK-wide bodies with the exception of the General Pharmaceutical Council (England, Wales and Scotland) and the Pharmaceutical Society of Northern Ireland.

3.5 In addition to a wide range of health professions, the Health and Care Professions Council also regulates social workers in England only. There are separate regulators of social workers in Wales, Scotland and Northern Ireland and these are not overseen by the Professional Standards Authority.

3.6 Each of the nine bodies however has a common set of core functions. They all set and promote the standards that professionals must meet before and after they are admitted to the register; maintain the register of those professionals who meet the standards; take action where a registered professional's fitness to practise has been called into question; and quality assure the courses of higher education that lead to registration. The arrangements are set out in summary below.

Regulatory bodies of health professionals in the UK and social workers in England	Profession(s)	Number 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	Doctors	259,826
General Optical Council	Optometrists, dispensing opticians, student opticians (optical businesses)	24,421
General Osteopathic Council	Osteopaths	4,810
General Pharmaceutical Council	Pharmacists, pharmacy technicians (England, Scotland, Wales)	71,221
Health and Care Professions Council	Arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists and orthotists, radiographers, speech and language therapists, social workers (England only)	322,037
Nursing and Midwifery Council	Nurses and midwives	680,858
Pharmaceutical Society of Northern Ireland	Pharmacists (Northern Ireland only)	2,155
	Total	**1,472,052**

4. Aggregate operating costs in Australia

4.1 We calculate that the annual operating cost of the National Registration and Accreditation scheme is $214,117,803[4]. This equates to $346 per registrant in the scheme, and $9.14 per head of the Australian population. This compares to our estimate of the current operating cost of the regulatory arrangements in the UK of $392,000,000, or $301.50 per registrant, or $6.23 per head of population in the UK.

4.2 While the majority of this cost is incurred directly by AHPRA, the total also includes a calculation of the cost of the notifications process in New South Wales, and the cost of the arrangements for the accreditation of the higher education courses that lead to registration. In this chapter we take each of these elements separately below, and set out the basis for our calculations.

4.3 Table 1 gives a breakdown of the total costs, for each function giving the total cost at national level for all professions, and the percentage of total spending by function by AHPRA.

AHPRA expenditure

4.4 AHPRA has provided 2013/14 data for each of the 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 1. AHPRA spend approximately $152m regulating health professionals in Australia. About half of expense concerns notifications ($40m) and registration ($35m).

4.5 Table 1 also provides a helpful calculation by AHPRA which distributes 'other costs', a further $45m in the data that was provided to us, across specific functions. AHPRA have done this on an FTE basis, with costs shared across functions according to the number of staff employed in each function. AHPRA have also carried out an ad-hoc adjustment to make these figures fit with their experience of their operations, slightly increasing the size of notification expenditure and decreasing the size of spending on registration[5].

4.6 When the allocations and adjustments to 'other costs' have been performed, registration becomes the biggest area of expense ($54.9m or 36.5% of total spending), marginally above notifications ($54.5m, 36.2%). The four other areas each account for between 5.3% ($8.1m) and 8.0% ($12.1m) of AHPRA's expenditure.

[4] The figures that we have used to compile this estimate have been drawn from the most recently available financial data. For most of this expenditure (ie AHPRA) this has been for the financial year 2013/14 however in other cases the data has been for 2012/13.

[5] We have assessed this methodology and have concluded it is a valid way to distribute costs across functions.

Cost of New South Wales notifications arrangements

4.7 In addition to spending incurred centrally by AHPRA, our calculations also provide for the additional cost of investigating notifications in New South Wales (NSW). NSW operates its own notification system. This is funded in part by the NSW Government (the Health Care Commissioner and his office) and in part by AHPRA (the professional councils). These figures are not included in the figures discussed above. Due to this different notification system, NSW health professionals can pay different fees to AHPRA from those paid by health professionals in other states or territories.

4.8 Table 2 shows the work carried out by the Health Care Complaints Commissioner (HCCC) in 2012/13. Using figures they provided on the average cost of each stage of the notifications process, we have calculated an estimate of the total cost of this element of the notifications arrangements in Australia. The Commissioner's remit goes beyond just complaints against individual professionals, and includes complaints about health services more generally. Therefore we have not allocated the Commissioner's total expenditure of $11.7m to our estimated total operating cost. The HCCC told us that of that $11.7m, $9.9m was spent on cases involving individual professionals; the figure we have used differs slightly from this value. With assessments, resolutions and investigations, the figures relate to cases that were concluded during 2012/13, but we did not have information about the professions of those cases which went to legal resolution. As such it was decided to use those 'referred to Director of Proceedings' (of which we do know the profession) as a proxy for this measure, as this enables us to analyse expenditure by profession. There were 85 of these in 2012-13 as opposed to 88 that were resolved and this difference explains the difference between our figures and theirs.

4.9 The third element of the total costs of notifications in Australia is the costs incurred by the NSW professional councils in pursuing less serious cases. We estimate this to be an additional $20,273,096. Therefore, we calculate the total cost of notifications in NSW to be $30,029,821. Notifications cost on average $166 per registrant in NSW and $125 per registrant in the rest of Australia.

4.10 Table 3 amalgamates this with the costs incurred centrally by AHPRA to show the total cost of the notifications function in Australia. First, a per-registrant notification cost was calculated for each profession in the rest of Australia, excluding NSW (column 6). Column 4 provides the difference in registration fee for each profession. Given that AHPRA carry out all other regulatory functions (excluding accreditation), this was assumed to be the difference per registrant in the cost of notifications in the rest of Australia. Therefore, adding this figure to column 6 gives the cost per registrant for notifications in NSW (column 8). Multiplying column 8 by the number of registrants in NSW gives an estimated total cost for the work of the professional councils funded by AHPRA (column 7). The addition of this to the total cost of notifications in the rest of Australia (column 5) and the total cost of relevant HCCC activities (reproduced as column 9) gives the total cost of notifications in Australia, which we calculate to be $84,958,309.

4.11 We are not able to comment on the qualitative differences between the co-regulatory arrangements for notifications in NSW as opposed to those in place in the rest of Australia. Nevertheless, given the marked difference in unit cost set out at paragraph 4.9, we think that the relative costs and benefits of these different arrangements should be the subject of further analysis. We are aware that the notification arrangements are currently the subject of detailed analysis and research which when complete will contribute to understanding of the costs and benefits of the NSW model. We make some further observations and recommendations regarding notifications at paragraphs 8.17-8.19.

Cost of accreditation

4.12 Accreditation of higher education courses in Australia is carried out by an accreditation council for 11 of the 14 professions in the NRAS. The councils are separate organisations, external to AHPRA and the national boards, with their own governance, staffing, premises and websites. The councils, which are listed below, are under contract to provide accreditation of the higher education courses that can lead to registration.

Accreditation councils in Australia	**Websites**
Australian and New Zealand Osteopathic Council	http://www.osteopathiccouncil.org.au/
Australian and New Zealand Podiatry Accreditation Council	http://www.anzpac.org.au/
Australian Dental Council	http://www.adc.org.au/
Australian Pharmacy Council	http://pharmacycouncil.org.au/content/
Australian Physiotherapy Council	http://www.physiocouncil.com.au/
Australian Psychology Accreditation Council	https://www.psychologycouncil.org.au/
Council on Chiropractic Education Australasia	http://www.ccea.com.au/
Australian Medical Council	http://www.amc.org.au/
Australian Nursing and Midwifery Accreditation Council	http://www.anmac.org.au/
Occupational Therapy Council (Australia and New Zealand)	http://otcouncil.com.au/
Optometry Council of Australia and New Zealand	http://www.ocanz.org/

For the three remaining professions in the Scheme the responsibility for accreditation is vested in a committee of the national board: Aboriginal and Torres Strait islander health practice, Chinese medicine, and medical radiation practice.

4.13 The accreditation councils have three sources of income: contribution from the relevant national board, fees charged to education providers, and income from fees charged to overseas applicants for assessment of their

qualification[6]. The board for each profession approves the standards against which the council is under contract to accredit. There is a group which brings together the accreditation council chief executives, the boards and AHPRA which agrees a cross-professions quality framework.

4.14 For the three professions which have not contracted with an accreditation council, AHPRA has recently established a unit to deliver this function. The unit has established accreditation standards, has put in place operational arrangements, has appointed assessors, and has 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 and inspections. This activity is funded from two sources; funding from AHPRA through the registration fee, and fees charged to the institution under assessment.

4.15 At Table 4 we have set out the fees charged to education institutions, where available, for the past five years by councils.

4.16 The Australian approach contrasts markedly with UK arrangements, where the quality assurance of higher education courses is undertaken by the regulator and is funded from the registration fee like other regulatory functions. There is no direct charge to the institution whose course is being quality assured in the UK. There are of course compliance costs for course providers, in both approaches.

4.17 We have collated data on annual expenditure by the accreditation councils and have reached an estimated figure representing annual expenditure on accreditation within the scheme of $41,534,341. The method by which we have reached this figure is set out in Table 5 which attempts to capture the full direct cost of accreditation in Australia. Column (a) shows expenditure by national boards, as taken from AHPRA accounts. Column (b) shows expenditure by the accreditation councils. Column (c) shows transfers from national boards to accreditation councils to pay for their activity. To avoid double counting, this figure is removed from the total expenditure by councils and boards for each profession. Following discussion with the accreditation councils, it was decided not to try controlling for activity in New Zealand. However, three councils have provided amounts received as grants from New Zealand, so these figures have been removed from the councils' expenses so that as far as possible we are comparing like with like. The final column combines this information to provide an estimate of the total spend on accrediting courses in each profession. We note that due to accreditation cycles within Australia, and the undertaking of different projects by the councils, these figures may not necessarily represent an accurate representation of accreditation spending beyond the year under investigation. However, this data provides a general guide to the annual cost of accreditation and demonstrates the proportion of accreditation expenditure under the NRAS, since we have not seen any evidence which would suggest that cumulatively the 11 councils have had exceptional costs in this year.

[6] This process would be considered part of the registration function within a UK regulator

4.18 The total expenditure on accreditation that we have calculated now represents 19.4% of the total expenditure on the NRAS of $214,117,803. This compares to the UK arrangements where the quality assurance of higher education accounts for 6% of total regulatory expenditure. While we acknowledge that there may be differences of focus and approach between the UK and Australia, the reasons for such a marked difference in the proportion of expenditure on this function are not clear to us. We recommend that the reasons for this difference warrant further investigation. We discuss this further at paragraphs 8.20-8.34.

5. Operating costs by board

5.1 There are 14 health profession boards in the NRAS, ranging in size from ATSIHPBA with 330 registrants up to NMBA which had 362,008 registrants in May 2014. Table 6 shows each board's aggregate spending by function, using the data provided by AHPRA, adjusted to account for the additional cost of the NSW notifications process and the spending of the accreditation councils. Given the wide variation in size of the boards it is no surprise that their budgets vary significantly too, with ATSIHPBA spending $591,449 while MBA and NMBA have budgets in excess of $88m and $58m respectively. MBA spend twice as much on notifications than anyone else, and nearly 50% of the total spent on notifications nationally. Registration spending generally increases with the size of the profession, so ATSIHPBA spends the least and NMBA spends the most. ATSIHPBA spends less on every function than any other boards. MBA and NMBA are more expensive than the other boards for compliance, accreditation, professional standards and governance.

5.2 Table 7 shows how the proportion of a board's spending on the various functions differs across the professions. ATSIHPBA spend a much larger proportion than the national average on professional standards. The lowest proportion spent on this function is the MBA at 3.7%; the result of this is that most boards spend more than the mean of 5.6% on professional standards. CMBA, OsteoBA, ChiroBA and MBA spend more than would be expected on notifications; DBA, PhysioBA and OptomBA incur large costs on accreditation; NMBA, ATSIHPBA and PsyBA spend a large proportion on registration; the proportion spent on governance varies from 3.5% in OsteoBA to 7.2% in NMBA, and the proportion spent on compliance costs is relatively standard across the boards[7].

5.3 It is interesting to compare regulators of similar size. Leaving aside ATSIHPBA and OsteoBA which are significantly smaller than the third smallest regulator, and the two largest boards NMBA and MBA, the other eleven can be collected into three groups of similar size.

[7] We note that fluctuations in year on year workload may affect these figures disproportionately for the smaller professions.

4,000-5,000 registrants: CMBA, ChiroBA, OptomBA and PodBA

5.4 Of these four boards, PodBA is much the lowest cost, costing just more than half of the expense incurred by ChiroBA. They spend just $725,987 on notifications compared to $1.56m in ChiroBA, and their spend on registration, compliance and governance are all significantly lower than that of ChiroBA. The PodBA accreditation spend is comparable to that of ChiroBA, but OptomBA spend twice as much as ChiroBA on accreditation while CMBA have low accreditation costs.

14,000-16,000 registrants: MRPBA and OTBA

5.5 These two regulators are similar in most functions as well as in overall scale. The biggest difference is that OTBA spend a much larger proportion on accreditation – 11% of their total spend compared to 5.2% in MRPBA.

20,000-32,000 registrants: DBA, PharmBA, PhysioBA and PsyBA

5.6 PhysioBA is the lowest cost of these boards at $5.6m, with PsyBA and PharmBA costing approximately $13m each and DBA nearly $17m. PhysioBA are also lowest cost for all functions except accreditation, on which they spend twice as much as PsyBA. DBA, the smallest of these four regulators, are relatively expensive as a consequence of their high notification and accreditation spending.

5.7 A second way to aid comparison across different sized boards is to look at the unit cost, or cost per registrant, for each function at board level, that is, 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 8 presents this information for the 14 boards, as well as an average for all registered professionals, in aggregate and for each of the 6 individual functions.

5.8 On average, regulating a health professional in Australia cost $346 in 2013/14. There is wide variation across the different boards, with ATSIHPBA costing $1,792 per registrant while an NMBA registrant cost about $162. ATSIHPBA is the most expensive board for five of the six functions as well as on an aggregate level. The one exception is accreditation, on which DBA spend most per registrant. This unit cost analysis suggests that the size of the board has some role in explaining the relative expense of regulation, with larger boards appearing less costly, so Figures 1-8 in the next section of the report investigate this subject further.

6. Scale and complexity

6.1 Figure 1 explores the relationship between the scale of each board and its unit cost. The relationship is expressed in logarithms because it appears

reasonable to expect a 'percentage relationship'[8] between the two variables; namely, 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 -0.24 implies that regulators that are 10% larger in size are 2.4% 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%. It is important to recognise that although a significant correlation exists between scale and cost this does not in itself demonstrate a causal link.

6.2 Figure 2 looks at the relationship between size and notifications, using the same methods as adopted in Figure 1. As we discovered a significant relationship between overall unit cost and size, it is not surprising that a similar relationship is discovered in the function responsible for the largest proportion of spending. The coefficient on scale in this graph, -0.25, shows that boards with a 10% higher number of registrants have a 2.5% lower unit cost of notifications. Spend on notifications may be a function of the number of complaints received rather than the number of registrants regulated by the board. Therefore, it is important to consider the possibility that the larger boards appear more efficient because they receive fewer complaints per registrant rather than are more efficient at dealing with them. However Figure 3 plots the number of registrants against the number of complaints per registrant for the fourteen boards, and shows no evidence to support this hypothesis. Therefore, it is likely that the scale effect is due to larger boards being more efficient at dealing with notifications and not because they simply receive a smaller number per registrant.

6.3 The coefficient on scale in Figure 4, -0.22, shows that if the size of the board is 10% larger, the unit cost of registration is 2.2% lower. The coefficient on scale in Figure 5, -0.20, shows that if the size of a board is 10% larger, the unit cost of compliance is 2% lower. The coefficient on scale in Figure 6, -0.09, shows that if the size of a board is 10% larger, the unit cost of accreditation is 0.9% lower. Given that accreditation is more closely attached to the number of courses it should not be a surprise that the sensitivity of accreditation costs to registrant numbers is somewhat lower.

6.4 The coefficient on scale in Figure 7, -0.46, shows that if the size of a board is 10% larger, the unit cost of professional standards is 4.6% lower. This is the largest coefficient in all the functions. One explanation is that setting professional standards is a task not much affected by the size of the professional group, hence increasing the size of the profession means the same total cost is being distributed across a larger pool of registrants.

[8] A commonly used alternative relationship is that an absolute increase in scale would be associated with an absolute change in another variable. In some contexts, a 'percentage relationship' is more plausible than an absolute relationship. In the scale relationships here, a unit change of scale at high scale levels is unlikely to have the same influence as at low scale levels. The 'percentage relationship' fits the scale relationships here acceptably well.

6.5 The coefficient on scale in Figure 8, -0.20, shows that if the size of a board is 10% larger, the unit cost of governance is 2% lower.

6.6 Figure 9 and Table 9 provides a measure of efficiency that shows how the boards are performing relative to the costs that could be predicted by their size, for each function and in aggregate. In this Figure, a value of 1 implies that they are performing as expected given their size; a value greater than 1 that their performance is more costly relative to the levels that could be expected for an organisation of their size, and a value less than 1 shows that their performance is less costly than size would suggest.

6.7 Distance from the line analysis suggests that ATSIHPBA, DBA, MBA and PsyBA are more costly than would have been predicted purely on scale. MRPBA, OTBA, PhysioBA and PodBA generally operate at costs lower than would have been expected. The Figures are not conclusive and do not generate explanations for deviation from the line. However, they do provide an indication of areas of interest for further analysis and investigation.

Analysis of regulatory complexity by comparing ratios with UK regulators

6.8 Work to this point supposes that the only variable that would affect cost is the size of the regulated profession. This is unlikely to be the case, as professions differ in terms of complexity and therefore the regulatory force required and these factors will impact on the cost of regulation. There is no direct way of capturing complexity or its relationship to regulatory force required. However, a variety of data can be used to give an indication of the relative risk and complexity across professions and the work that follows presents data that can provide an indication of that. We suggest caution in interpreting these correlations but they may be indicative of the links between risk, complexity, regulatory force and cost.

Australia/UK comparison

6.9 We begin by looking at costs in Australia and the UK, the assumption being that each profession will face a similar risk and complexity profile in the two countries. Any systemic differences in the regulation of healthcare in the two jurisdictions should impact on all professions in a similar way; therefore, variation from this overall ratio can be interpreted as differences in the cost efficiency of regulators in the two countries.

6.10 In Table 10 it appears that chiropractors and osteopaths in Australia are regulated quite cost effectively compared to the UK system. The professions covered by HCPC in the UK appear particularly expensive in Australia. This is perhaps further evidence supporting the existence of scale effects. The HCPC regulates 16 professions in the UK and has a register of 322,037. Therefore it is significantly larger than the individual Australian boards and is able to extract efficiencies that arise from having a large number of registrants, and similar methods of undertaking each function across all professions. The annual performance reviews conducted by the Professional Standards Authority have found that the HCPC is an effective and efficient

regulator, which meets all of the Authority's *Standards of Good Regulation*[9]. The HCPC recognises the generic component of the delivery of regulatory functions across all of the professions it regulates, securing professional input into regulatory processes and policy development only when required, and maintaining wider engagement with the professions through partners' councils.

6.11 Comparing regulators in this way assumes that regulators of the same profession face similar challenges in both countries. This may not always be the case, for reasons of policy, legislation or structure. As such, further analysis is now provided using more subjective measures of complexity and regulatory force required.

Risk – using notifications to measure prevalence and severity

6.12 The notifications system is organised in a way that produces data that can measure two different features of risk – the prevalence of risk and the severity of risk when it occurs. As either of these figures increase, the role of the regulator will become greater and potentially more expensive as it is required to exert more regulatory force in mitigation of those risks, and in order to prevent harm to patients. Data is presented in Table 11 for the overall number of notifications and the rate by profession. These are measures of prevalence. The final column is the rate of mandatory notifications. Mandatory notifications[10] have been used as these are more likely to be matters which call into question a registrant's fitness to practise and result in a regulatory sanction. We recognise that other measures could be used, however we think this is a reasonable proxy for identifiable risk using available data. In Figure 10, we illustrate the combined effects of prevalence and severity of risk; the further towards the top right of Figure 10 a profession appears, the greater the regulatory force (and therefore cost) that is likely to be required to regulate it.

6.13 In other words, the boards that are near to the origin in Figure 10 are relatively low risk or 'safe' and likely to require less regulatory force than those further out, which need increasing regulatory force as prevalence and severity grow. There is some coincidence between the location of professions on Figure 10, and the identified five professions which account for 94%[11] of all notifications: medicine, nursing and midwifery, dentistry, pharmacy and psychology.

6.14 Additional features of the boards that may explain their costs relative to each other are published annually and some of these are presented below, beginning with features of registration.

Features of registration

6.15 Issues beyond scale that may affect cost in registration are presented in Table 12. The first column presents raw data on the number of registrants

[9] Performance Review Report 2013/14, Professional Standards Authority, June 2014.
[10] Mandatory notifications are those made by registered health practitioners, employers and education providers under mandatory obligations imposed by the National Law.
[11] Source: AHPRA.

and this data has been used to produce the rate of criminal history checks conducted per 10,000. Boards which perform more checks will be incurring greater expense. ATSIPHBA, CMBA, MBA and OsteoBA all carry out more than 1500 checks per 10,000 registrants per year. A larger student register is also likely to incur cost, and student registrants are not included in the full registrant numbers. MBA and NMBA have much the largest student register, with PsyBA the only board which does not have one at all. The final three columns are additional characteristics of registrants of which only some boards keep a record. MBA, DBA and PodBA record specialties, five boards approve additional qualifications which are called endorsements, and four split their professions into smaller categories or divisions. Keeping this extra information is likely to increase the cost of regulation. Every additional feature of the registration function is likely to increase cost as it will require, for example, additional staff time and more complex information management systems.

Features of accreditation

6.16 The number of accredited courses is likely to have an impact on the overall cost of accreditation; it would be no surprise if it was actually a more important determinant of cost in this function than the number of registrants. We have set out at Table 13 the total number of accredited courses in Australia, drawing on information available from the councils' websites. NMBA and PsyBA accredit in the region of eight times more courses than any other board.

6.17 A second factor to consider in accreditation is the rate of international assessments performed. Professions that experience a large flow of international applicants for registration are likely to spend proportionately more on this function[12].

Features of notifications (in addition to those discussed above)

6.18 The final function for which there is significant data to explain cost differences is notifications. The amount of notifications per registrant, the complexity of cases and the potential danger caused by offenders could all lead to increased cost within this function, set out at Table 14. DBA and MBA receive a large amount of notifications per 10,000 registrants relative to the other boards. ChiroBA and DBA have a disproportionate number of notifications that progress to a panel or tribunal hearing; i.e. the latter stages at which notifications can be resolved. Finally, immediate action cases are those in which the public have been placed at greatest danger and in which the professional needs to be immediately prevented from practising. These cases are most likely to occur in DBA, MBA or PharmBA.

[12] We were unable to obtain a complete data set on the number of international applicants from publicly available sources.

7. A comparison of the cost of Australian boards and UK councils

7.1 This research has paralleled a similar review carried out by the Professional Standards Authority (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 and indeed worthwhile to see how Australian 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 boards in Australia (14), and they cover a slightly different mix of professions. While in the UK the regulators are all overseen by the Professional Standards Authority, they 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.

7.2 Looking first at aggregate unit costs, it seems that the unit cost of regulation is quite similar in the two jurisdictions, at $346 per registrant in Australia and $301.50 in the UK. There are however caveats to this comparison. Firstly, the number of UK health professionals is much larger than that in Australia – approximately 1.3m[13] at the time the UK review was undertaken, compared to 618,631 in Australia. This larger total population of regulated health professionals in the UK would be likely to result in positive scale effects on cost, compared to Australia, all else being equal. However, spreading the regulated population across a larger number of regulators in Australia – 14 as opposed to nine in the UK - makes it harder for regulators in Australia to reach levels at which scale effects can provide benefits to the system, as on average the number of Australian health professionals covered by each board is smaller. As shown above, there is evidence regarding scale showing that the unit cost of regulation falls as the size of the registers increase, so the UK system could be expected to be proportionately cheaper than the Australian system. Secondly, the aggregate similarities disguise significant difference across the functions. Governance appears 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 and accreditation appear to be more expensive in Australia compared to the UK, as is compliance but this last is the least costly function of regulation. In the paragraphs that follow we explore some of the comparisons in more detail.

7.3 There are six professions regulated by a 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 boards covering professions which are among the

[13] The figure given at page 6 is the current figure of 1,472,052. The total number of registrants now includes social workers in England, which did not apply at the time of the UK cost-effectiveness and efficiency review.

16 regulated by the HCPC in the UK. Chinese medicine and Aboriginal and Torres Strait islander health practice medicine are not regulated in the UK. This means that we have 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 and Figures 11-28.

Nurses and midwives

7.4 Regulating each nurse and midwife costs about $162 in Australia and $136 in the UK. Notifications account for more than 60% of this cost in the UK and only 33% in Australia. Registration though, is almost three times more expensive in Australia. The other three functions account for less than 30% of the total cost in both jurisdictions.

Medical practitioners

7.5 Medical practitioners cost more to regulate in Australia, at $889 compared to $741 in the UK. This is due to accreditation being about $180 per registrant more expensive in Australia. Similarly registration for nurses and midwives, is more expensive in Australia in terms of actual costs but the proportion of total regulator spend is similar.

Dentists

7.6 The cost of dentists follows a similar pattern to that of medical practitioners – more expensive in Australia, in aggregate, for registration and accreditation, but notifications cost more in the UK.

Chiropractors

7.7 Chiropractors are one of the few examples where UK regulation appears much more expensive than Australia. Despite having zero accreditation costs, regulating UK chiropractors costs more than twice as much as regulating those in Australia. It is notable that ChiroBA spends 25% of its aggregate spend on registration compared to 14% in the UK. The unit costs for notifications are $322 in Australia and $825 in the UK, representing 48% and 57% of total expenditure respectively.

Osteopaths

7.8 UK osteopaths are also significantly more costly per registrant than those in Australia. Apart from accreditation which is more expensive in Australia, every other 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

7.9 Regulating optometrists is more expensive in Australia than regulating optometrists and dispensing opticians in the UK. Costs for the individual functions vary quite significantly, with Australia spending a bigger proportion on accreditation and professional standards, while the UK spending on governance, compliance, and notifications is much greater.

Professions covered by the HCPC in the UK

7.10 The cost of these five professions (physiotherapy, podiatry, radiography, psychology, occupational therapy) vary between $202 and $436 per registrant. Proportion of spending by function is quite similar, with the exception of accreditation on which physiotherapy spend 31% whereas medical radiation and psychology are around 5%-6%[14]. They are all more expensive than the HCPC ($152), but HCPC spend on compliance is minimal, while it also has low costs of professional standards. This comparison is less straightforward than the other professions though, as the HCPC also covers several other professions not regulated in Australia, and given its size, is also able to exploit scale efficiencies unobtainable by their Australian counterparts.

Pharmacists

7.11 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 pharmaceutical regulators can be compared directly. The Australian board's expenditure is between that of the GPhC and the PSNI, but registration costs are higher in Australia. PharmBA also spends a large proportion on accreditation relative to the UK regulators, while PSNI is notably more expensive on compliance.

8. Potential areas for cost savings

8.1 In this section, we set out some ideas on where there is potential for cost savings within the NRAS, and have set out some hypothetical scenarios which could indicate the degree of savings that might be possible in future.

Board mergers

8.2 The existence of potential scale effects raises the possibility of realising savings by merging boards into fewer organisations. One possible option would be to create a board covering several of the lower-risk professions. A precedent for multi-professional regulation exists in the UK, where as we have discussed the HCPC runs the register for 16 different professional groups, including several which have their own boards in Australia.

8.3 In order to estimate the potential savings, we use the equations showing the relationship between scale and unit cost presented in the previous section. By inputting the number of registrants for each board, we get a measure of expected cost for the individual boards which is then summed to show the aggregate expected cost of the individual boards. We then repeat the calculation 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.

[14] These figures could be affected by accreditation cycles resulting in fluctuating activity year on year.

8.4 Calculations have been performed using both the aggregate unit cost equation from Figure 1, and the function specific equations in Figures 2, 4, 5, 6, 7 and 8.

8.5 Table 16 presents two calculations. Firstly, merging nine of the lower-risk 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 $36.1m (function specific equations $33.9m); the proposed board containing all 76,821 registrants should cost $22.9 ($22.1m) and this may realise annual savings of $13.2m ($11.8m).

8.6 We have also calculated the hypothetical costs were all of the boards to be merged into one, and of full centralisation of the regulatory functions individually. This could theoretically result in significant annual savings; for example, combining the registration function into one unit could save $14.2m per annum, while a central accrediting body could be hoped to save about $3.8m per annum.

8.7 It is important to stress that these are purely hypothetical calculations. There may be aspects of the system or special circumstances within the boards that prevent the full realisation of these savings, plus other issues that these calculations are unable to account for. In particular, the data used throughout this analysis does not take into account the extra spending that occurs in accreditation at institutions not funded through AHPRA. In addition, altering the structure of NRAS will incur significant transition costs and this will undermine the benefits, at least in the short term.

8.8 An accurate projection of cost savings from the amalgamation of boards would be extremely complex to construct. For example, many of the board committees are in fact carrying out executive functions – making decisions which are core to the delivery of the scheme's regulatory purposes. Committees are not an efficient mechanism for operational decision-making and tend to generate administrative cost rather than reduce it. Further exploration of the possibility of reducing the number of boards may present opportunities to consider more cost-effective working arrangements, which might include staff making regulatory and operational decisions currently made by board committees.

8.9 It is also important to stress that we recognise that to some extent merger already occurs in the way that regulatory functions are delivered, for example in the registration function staff already work across a number of professions. In the area of standards opportunities for standards that apply to all health professional are being pursued, such as guidance on blood borne viruses.

8.10 It may therefore be the case that the main savings through any amalgamation of smaller 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 in a more multi-professional way. Even without merging boards, there are already obvious ways for achieving cost savings, for example through the use of video and teleconference rather than meeting in

person, which we understand is already being adopted or at least piloted by some boards.

8.11 Irrespective of whether boards are merged or not, a review of the remit and effectiveness of the 62 committees of the national boards would be timely. For example, it may be the case that it is no longer adding value for each of the national boards to have its own finance committee, given that AHPRA is now well established and financially secure, with established reserves and risk management processes.

8.12 Given that to some extent the delivery of functions is already merged across professions, particularly in registration, it is perhaps surprising that there remains the degree of variation in unit costs that our calculations have demonstrated. To address this, we recommend the development of more transparent cost benchmarking across the boards, supported by consistent financial management data and key performance indicators. This will enable areas of concern to be easily identified.

8.13 On the basis of the hypothetical calculations that we have set out, there is the scope for substantial savings from the merger of boards and regulatory functions. We recommend that our calculations are taken into account in the ongoing discussions of options for merger in the review.

Registration

8.14 One of the key achievements of the NRAS is the establishment of a single national register for regulated health professionals.

8.15 We understand that at present the registration function involves staff in AHPRA offices working across professions, and that in most AHPRA offices there are three teams – those processing applications from medical practitioners, those processing applications from nurses and those processing applications from other professions. In some areas of specialised registration there are national registration teams. Therefore, AHPRA staff are already working flexibly in delivering the registration function across different professions; economies of scale are probably already being realised.

8.16 Nevertheless it seems likely that costs are being accrued 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 it originated. 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 contentious it is referred either (i) to the state/territory committee for the profession where such exists, or (ii) to the national registration committee where that profession does not have state/territory boards.

8.17 AHPRA has provided us with estimated figures on the number of registration decisions (both registration and renewal) which have been decided by committee. For renewal decisions, perhaps unsurprisingly, the figure is very

low, between 0.12% and 3.51% of applications, with 11 of the 14 professions below 0.5%. For initial registration decisions, the figure is higher, with 13 of the 14 professions between 6.8% and 22.4%, and Aboriginal and Torres Strait islander health practitioners an outlier at 40%. We understand that until this year the board had not delegated decision making to AHPRA in relation to criminal history, no matter how minor, and the percentage may also have been increased by grandparenting arrangements for access to this profession in which decisions could only be taken at board level.

8.18 In Table 17 we have set out some hypothetical cost savings that might be achievable through the creation of a single registrations function, if it were possible to achieve reduction of costs in different scenarios. We acknowledge that we have not attempted to assess the costs of transition to a different structure, but hope that these calculations will contribute to further discussion and planning of future options.

8.19 We recommend that the hypothetical cost savings are taken into account in further discussion and planning for future options for the delivery of the registration functions. A particular area for further consideration whatever structure is adopted would be to review the delegation arrangements that are in place with a view to reducing where possible the number of decisions that need to be taken by a committee, rather than by AHPRA staff.

Notifications

8.20 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 what is 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 or 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. We understand that investigations can be lengthy, possibly due to the scope not being well articulated at the outset, and that the prevalence of 'no further action' decisions after investigation, in matters which could have been closed without one, is already a matter of concern. Clearly reducing the number of unnecessary investigations could save costs. This could be supported by reviewing the effectiveness of the assessment of complaints at an early stage.

8.21 In the Australian system, the committee can either refer a case to another entity, caution the practitioner, seek an undertaking or impose conditions; or it may refer the case to a panel for 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 broadly comparable to a first tier tribunal in the UK. It is external to the board, and cases can take a long time to be resolved and at considerable cost. We understand that the cost to AHPRA of a panel hearing is estimated

as being in the region of $10,000, and that a tribunal could be from $20,000-$30,000, or up to $300,000 in extreme cases. We think that an area for further work as part of this review could be to review these arrangements and explore the costs and benefits of vesting in the regulator the power to remove registrants from the register.

8.22 Another area for further consideration could be the relative costs and benefits of the different notification arrangements in NSW and Queensland[15]. At Table 3 we showed that notifications cost on average $125 per registrant outside NSW and $166 per registrant inside NSW. The aggregate cost of notifications within NSW is $30,029,821, and the aggregate cost of notifications in the rest of Australia is $54,931,584. We are not able to comment on the qualitative differences between the different arrangements. However we are aware that these processes are currently the subject of detailed analysis and research, and recommend that the data that we have provided is taken into account in future discussion about the direction of policy in this area.

Accreditation

8.23 In paragraphs 4.10-4.16 we set out how we had compiled an estimate of annual expenditure on the delivery of the accreditation function across all professions. We described how accreditation of higher education courses in Australia is carried out by an accreditation council for 11 of the 14 professions in the NRAS. The councils are separate organisations, external to AHPRA and the national boards, with their own governance arrangements, staffing, premises, websites and so forth. 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 councils have a number of different sources of income.

8.24 These arrangements differ markedly from the arrangements for the quality assurance of higher education courses in the UK. The UK regulators quality assure relevant higher education courses themselves, and the activity is funded from the income from registrant fees in the same way as the regulators' other activities are funded. There is no direct charge to the institution whose course is being quality assured, although there are of course compliance costs.

8.25 We understand that in Australia the board for each profession approves the accreditation standards, which the accreditation council is then under contract to accredit courses against; and that there is a group which brings together the accreditation council chief executives, the boards and AHPRA which agrees a cross-professions quality framework. This takes place within the statutory framework of the National Law and its guiding principles.

8.26 The percentage of regulatory expenditure on this function in the two systems also differs markedly, with 19.4% being spent in Australia and 6% being spent in the UK system on the quality assurance of higher education courses.

[15] The costs of arrangements in Queensland introduced in 2014 were beyond the scope of this exercise.

8.27 On the face of it, the existence of 11 separate councils looks an inherently more expensive arrangement for the delivery of this function, because of the cost of the items listed above: staff costs, the cost of servicing the councils and holding meetings, the cost of premises and so forth. The fact that this activity is organised in a disaggregated way suggests that there might be the potential for savings were mergers possible in some form. The integration of accreditation in the UK into the core functions of the regulators, in particular standard setting, has clear benefits in terms of organisational simplicity, appropriate balancing of resources across regulatory functions, and avoidance of duplication of costs.

8.28 One consequence of a system where just one body is allowed to provide accreditation for specific education courses is that monopoly power might be exploited to extract surplus from university establishments or students. All professional regulators are by definition statutory monopolies and therefore not subject to normal external market pressures on cost. This is not unique to the Australian system – it could equally exist in the UK framework – but it provides good reason to consider the costs of this regulatory function with extra scrutiny. In the Australian system, the accreditation councils are required to agree budgets with regulatory boards who do not fund the expenditure. In contrast, for other regulatory functions, the board will set expenditure unilaterally with their total budget for these other functions given to them. This asymmetry of budget setting may grant accreditation greater scope for increasing the cost of their part of the regulatory service.

8.29 As we have noted, accreditation in Australia is high cost in terms of total spend and proportion of spend. We have identified three possible reasons for this. Firstly, it has been noted that the accreditation cycle could lead to inconsistency across years, with some years seeing much more activity than others. This may be relevant to individual professions but unless professions are on a linked cycle is unlikely to explain the large mean difference for all professions between Australia and the UK.

8.30 A second explanation is that the process may be inefficient, with little incentive to minimise costs as the accreditation council face no competition to their services, and less budget control from the individual boards, than total board level expenditure must face from central Government to increase total spending. There is also likely to be minimal pressure from individual universities to improve efficiency as they will be able to pass on costs to students whose demand may be inelastic as they also face an imperfect market, in a large country with costly geographical immobility.

8.31 A third possibility is that the higher cost of accreditation in Australia could be because they provide a higher quality of service than exists in the UK. A more rigorous accreditation process would lead to better courses and produce an improved standard of practitioner for the Australian health care system. However there is no guarantee that the higher quality of accreditation offered will be at the socially optimal level. It is beyond the scope of this project to make that judgement.

8.32 In giving further consideration to this area of regulation we should of course seek to be sure that we are comparing like with like. We have acknowledged

that at least one task that is included in accreditation in Australia does not fall within quality assurance of higher education in the UK, the assessment of qualifications of overseas applicants for registration. We have also looked at descriptions of the function of quality assurance in the UK and accreditation in Australia in so far as it relates to higher education institutions. In Australia, AHPRA sets out[16] up to five activities that are undertaken, either by the council or board committee. These are:

- Development and review of accreditation standards
- Assessing programs of study and accreditation providers against the standards
- Assessing overseas assessing authorities
- Assessing overseas qualified practitioners
- Providing advice to board on accreditation functions.

8.33 Which committees and boards undertake which functions is set out at http://www.ahpra.gov.au/education/accreditation-authorities.aspx

8.34 In the UK, the Professional Standards Authority sets out the following standards against which regulators' performance in this regard is assessed annually, in the *Standards of Good Regulation*[17]. The standards state that "the regulator has a role in ensuring that students and trainees obtain the required skills and knowledge to be safe and effective. They also have a role in ensuring that, once registered, professionals remain up to date with evolving practices and continue to develop as practitioners. As part of this work, the regulators quality assure and where appropriate approve educational programmes which students must complete in order to be registered". The standards stress that the process for quality assuring should be "focused on ensuring that education providers can develop students and trainees so that they meet the regulator's standards for registration".

8.35 A paper[18] by the Council for Healthcare Regulatory Excellence[19] in June 2009 found that there was a range of approaches being taken in the UK to quality assurance of higher education, but stated that "the broad structure is the same, following a pattern of programme approval, monitoring and reapproval", which is consistent with the arrangements for accreditation in Australia as we understand them. However the paper also noted that "differences become clear both in the methods and frequency regulators adopt in employing these aspects of quality assurance. The rationale for different approaches in part can be explained by the different role played by undergraduate education in meeting pre-registration requirements, but also

[17] Annual Report and Accounts and Performance Review Report Volume II 2013/2014 http://www.professionalstandards.org.uk/docs/default-source/scrutiny-quality/performance-review-report-2013-2014.pdf?sfvrsn=0

[18] Quality assurance of undergraduate education by the healthcare professional regulators, Council for Healthcare Regulatory Excellence, June 2009. https://www.professionalstandards.org.uk/docs/psa-library/quality-assurance-of-education---advice.pdf?sfvrsn=0

[19] The Council for Healthcare Regulatory Excellence was the previous name of the Professional Standards Authority

reflects difference between the professions and the regulators themselves". It was noted that UK educational institutions are also audited by the Quality Assurance Agency[20] for Higher Education.

8.36 While the two systems clearly share a considerable overlap of purpose in this area, in order to draw any firm conclusions about the relative efficiency of the two a much more detailed analysis of the differences of performance, process and approach within and between them would be required, taking into account the considerations that we set out above. This analysis would also need to examine the context in which the councils are operating and their relationship with other organisations with a quality assurance role. We think this would be a valuable exercise, in order to understand more clearly the marked difference in the relative costs, and to see if there is potential for learning across the two systems.

8.37 To assist further analysis we have set out at Table 21 some calculations relating to a number of hypothetical future scenarios. The Table shows what the cost of the accreditation scheme could be if operating at the cost of the NMBA (the cheapest in Australia); if the six most expensive regulators can reduce accreditation costs to the average cost of $67.14 and the rest continue at current levels; if operating at the average unit cost of accreditation within the UK of $17.66 per head; and if operating at cost of the UK GOC ($105.49 per head). It is understood that the councils are under contract to the AHPRA for four further years and that even if there was an intention to change the arrangements this could not be achieved quickly. However we hope that setting out these figures will be a useful contribution to further analysis of the costs of this area of health professional regulation.

8.38 In conclusion, while recognising the different organisational arrangements and that there may be differences of scope and approach, we feel that this striking area of cost difference between Australia and the UK warrants further investigation. We hope that the hypothetical future cost scenarios that we have set out will be a useful contribution to further analysis of the costs of this area of professional regulation.

9. Conclusions

9.1 We have discussed at a number of places in the report the cost of the accreditation function in general terms, and have also provided data on the fees being charged to higher education institutions. There is some evidence, where historical data is available, of fees rising in recent years. It seems to us that there may be an asymmetry of financial control on AHPRA's part with respect to the way that this aspect of the Scheme is funded. Whereas for other regulatory functions, AHPRA and the boards can exercise financial discipline by virtue of their direct control of delivery, that is reinforced by a total spending constraint imposed at national level, here the way that delivery of the function is arranged with separate organisations and accountability arrangements may be resulting in less clear arrangements. It is less clear in

[20] http://www.qaa.ac.uk/en

this format that each board is content that the share of all their regulatory spend that is allocated to accreditation is what they would choose. We recommend that this would be a useful area for further consideration in the review.

9.2 The accreditation function is considerably more expensive, as a proportion of total expenditure on the scheme, than the quality assurance of higher education courses by regulators in the UK. Recognising the different organisational arrangements, and recognising that there may be differences in scope and approach amongst other factors, still we feel that this striking cost difference would warrant further investigation, of the value of this higher accreditation expenditure to the Australian patient.

9.3 We have provided hypothetical savings for two scenarios involving the merger of boards and for the merger of specific regulatory functions, indicating that some savings may be possible as a result of mergers. We recommend that these are taken into account in ongoing discussion of options for mergers within the review.

9.4 We propose that a review of the remit and effectiveness of the 62 committees of the national boards would be timely, assessing the value that each adds to decision making, and whether these decisions could be made in a more cost-effective way.

9.5 We recommend that as well as reviewing merger options for boards, and options for the further integration of functions across professions, consideration is given to reviewing the arrangements for delegation, enabling staff to take decisions wherever possible.

9.6 We note that different areas of the boards' activities seem to be subject to different levels of financial control. This asymmetry particularly applies to accreditation. We recommend the development of more transparent cost benchmarking across the boards, supported by consistent financial management data and KPIs. This will enable areas of concern to be easily identified and internal control of costs improved.

9.7 Acknowledging the work that is already being done in this area, we encourage continuing efforts to identify cost reduction in the arrangements for meetings such as teleconferencing.

9.8 We understand that the notifications process is already subject to considerable review and analysis. Given the marked difference in unit cost set out at paragraph 4.9 between New South Wales and the rest of Australia, we think that the relative costs and benefits of these different arrangements should be the subject of further analysis.

9.9 We suggest that a particular area of focus should be to ensure the quality of assessment at the outset of the process, to reduce the prevalence of cases proceeding unnecessarily to investigation.

9.10 While recognising that legislative change would be required, nevertheless we think it would be valuable to assess the costs and benefits of vesting in the national boards the power to impose the full range of regulatory sanctions, up to and including removal from the register.

9.11 We are aware that research is ongoing into the qualitative differences between the notifications arrangements in New South Wales and those in the rest of Australia. We hope that the comparative cost data that we have provided will be a useful contribution to that ongoing work and consequent policy discussions.

Cost-effectiveness and efficiency review of the Australian National Registration and Accreditation Scheme for health professionals

Final report: tables and figures
October 2014

Centre for
Health Service Economics
& Organisation

professional
standards
authority

Table 1 – 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%
Source: AHPRA accounts, as submitted to the NRAS review				

Table 2 - Cost of HCCC Process by Profession in New South Wales 2012-13

Profession	Assessments	Resolution	Investigation	Referred to Director of Proceedings	Total cost of HCCC by board
All Professions	2816	217	166	85	$9,756,725
ATSIHPBA					$0
CMBA	11				$7,123
ChiroBA	16		4	2	$186,108
DBA	466	36	21	7	$1,127,739
MBA	1599	170	91	46	$5,478,388
MRPBA	4				$2,590
NMBA	391	8	31	16	$1,661,374
OTBA	5				$3,238
OptomBA	14				$9,065
OsteoBA	3		5	5	$353,953
PharmBA	152	2	8	3	$401,909
PhysioBA	20				$12,950
PodBA	12		3	3	$218,977
PsyBA	134	1	3	3	$300,433
Average progressive cost for handling complaints at this stage	$648	$2,460	$17,472	$52,930	
Source: HCCC submission to the NRAS review					

Table 3 – Adjusting notification costs to fully account for New South Wales system

	NSW registrants	Registrants	Per-registrant rebate (surcharge) in NSW	AHPRA Notifications	Unit cost in AHPRA	Additional cost of NSW	NSW unit cost (HCPA)	Additional cost of HCCC	Total Unit cost in NSW (HCPA + HCCC)	Total cost of notification	% adjustment (notification function)
All Professions	180,700	618,631		$54,921,366	$125	$20,273,096	$112	$9,756,725	$166	$84,958,309	54.7%
ATSIHPBA	31	330	$0	$147,458	$493	$15,288	$493	$0	$493	$162,746	10.4%
CMBA	1,731	4,259	$0	$762,000	$301	$521,765	$301	$7,123	$306	$1,290,888	69.4%
ChiroBA	1,616	4,843	$85	$1,005,944	$312	$366,391	$227	$186,108	$342	$1,558,444	54.9%
DBA	6,335	20,692	$8	$3,453,603	$241	$1,473,216	$233	$1,127,739	$411	$6,054,558	75.3%
MBA	31,212	99,209	$83	$25,382,440	$373	$9,060,458	$290	$5,478,388	$466	$39,921,285	57.3%
MRPBA	4,796	14,360	$0	$728,456	$76	$365,294	$76	$2,590	$77	$1,096,340	50.5%
NMBA	100,291	362,008	$1	$13,054,878	$50	$4,902,390	$49	$1,661,374	$65	$19,618,643	50.3%
OTBA	4,575	16,174	$0	$833,491	$72	$328,754	$72	$3,238	$73	$1,165,483	39.8%
OptomBA	1,633	4,790	$61	$563,319	$178	$191,771	$117	$9,065	$123	$764,155	35.7%
OsteoBA	530	1,864	-$119	$299,700	$225	$182,141	$344	$353,953	$1,011	$835,795	178.9%
PharmBA	8,758	28,252	$4	$2,719,712	$140	$1,186,843	$136	$401,909	$181	$4,308,464	58.4%
PhysioBA	7,566	26,076	$21	$1,191,206	$64	$328,022	$43	$12,950	$45	$1,532,179	28.6%
PodBA	1,077	4,125	-$42	$341,211	$112	$165,800	$154	$218,977	$357	$725,987	112.8%
PsyBA	10,549	31,649	$98	$4,437,948	$210	$1,184,962	$112	$300,433	$141	$5,923,343	33.5%
Source: AHPRA accounts; HCCC submission to the NRAS review; HPCA submission to the NRAS review											

Table 4 – Comparative cost of accreditation fees over five years (where data available)

	2009-10/ 2010	2010-11/ 2011	2011-12/ 2012	2012-13/ 2013	2013-14/ 2014/current
ABTSI (Initial assessment)	-	-	-	-	$3,000
ABTSI (Annual fee)	-	-	-	-	$3,000
Chinese medicine One division one site (Initial assessment)	-	-	-	-	$12,000
Chinese medicine One division one site (Annual fee)	-	-	-	-	$4,000
Chinese medicine Two divisions one site (Initial assessment)	-	-	-	-	$16,000
Chinese medicine Two divisions one site (Annual fee)	-	-	-	-	$6,000
Chinese medicine Three divisions one site (Initial assessment)	-	-	-	-	$20,000
Chinese medicine Three divisions one site (Annual fee)	-	-	-	-	$8,000
Chinese medicine More than one site (Per additional site)	-	-	-	-	$6,000
Chiropractic (Macquarie)	-	--	-	-	$17,406.15
Chiropractic (Murdoch)	-	-	-	-	$21,291.35
Chiropractic (RMIT)	-	$9,545	-	-	$2,126.36
Dental degree[1] (Initial fee)	-	-	-	$40,000	$40,000
Dental degree (Annual fee)	-	-	-	$25,000	$18,000
Dental degree (programme being phased out)	-	-	-	$14,000	$11,000
Oral health (Initial fee)	$7,000	$7,000	$7,000	$30,000	$30,000
Oral health (Annual fee)	$6,000 + $2,000 per follow up visit	$6,000 + $2,000 per follow up visit	$6,000 + $2,000 per follow up visit	$14,000	$11,000
Dental hygienist (Initial fee)	-	-	-	$15,000	$15,000
Dental hygienist (Annual fee)	-	-	-	$7,500	$7,500
Dental therapist (Initial fee)	-	-	-	$15,000	$15,000
Dental therapist (Annual fee)	-	-	-	$7,500	$7,500

[1] A one off grant of $100,000 was received from the DBA to reduce fees for 2014

	2009-10/ 2010	2010-11/ 2011	2011-12/ 2012	2012-13/ 2013	2013-14/ 2014/current
Specialist[2] (Initial fee)	$5,000 per discipline	$5,000 per discipline	$5,000 per discipline	$15,000	$15,000
Specialist (Annual fee)	$3,000 per discipline to max $15,000	$3,000 per discipline to max $15,000	$3,000 per discipline to max $15,000	$7,000	$5,000
Prosthetist (Initial fee)	-	-	-	$15,000	$15,000
Prosthetist (Annual fee)	-	-	-	$6,000	$6,000
General dental programs (Initial fee)	$12,000 + $3,000 per follow up visit	$12,000 + $3,000 per follow up visit	$12,000 + $3,000 per follow up visit	-	-
General dental Programs (Annual fee)	$8,000 + $3,000 per follow up visit	$8,000 + $3,000 per follow up visit	$8,000 + $3,000 per follow up visit	-	-
Medicine [3] (26 Specialty training programs and 50 fields of specialty practice – subspecialties)	-	-	-	-	$155,274 ($60,091)
Medicine (One specialty - three training pathways)	-	-	-	-	$67,087 ($17,785)
Medicine (One specialty five fields of specialty practice)	-	-	-	$114,253 ($36,584)	-
Medicine (One specialty three training pathways)	-	-	-	$111,911 ($29,601)	-
Medicine (Training in one specialty, seven fields of specialty practice)	-	-	$7,448 ($3,396)	-	-
Medicine (Two specialist training programs)	-	-	$68,543 ($24,868)	-	-
Medicine (Two specialty training programs)	-	-	$88,202 ($33,208)	-	-
Medicine (One specialty training program)	-	$42,485 ($14,760)	-	-	

[2]In 2013 specialist programs were charged $7,000 for first specialist program and $4,000 for each subsequent specialist program for Universities with multiple specialist programs.
In 2014 specialist programs were charged $5,000 in total for all specialist programs conducted at the same University.

[3] Figures from medicine have been aggregated as described in the first column. The figure given in the cells is the total "College Fee" provided, and the figure in brackets is amount provided for "fees" as a separate item within this, the others being airfares, accommodation, taxis and incidentals.

	2009-10/ 2010	2010-11/ 2011	2011-12/ 2012	2012-13/ 2013	2013-14/ 2014/current
Medical radiation (one program one site, initial assessment)	-	-	-	-	$20,000
Medical radiation (one program one site, annual fee)	-	-	-	-	$4,000
Medical radiation (two programs one site, initial assessment)	-	-	-	-	$25,000
Medical radiation (two programs one site, annual fee)	-	-	-	-	$4,000
Medical radiation (three programs one site, Initial assessment)	-	-	-	-	$30,000
Medical radiation (three programs one site, annual fee)	-	-	-	-	$4,000
Nursing and midwifery (program length over 12 months, initial assessment)	-	-	-	-	$38,100
Nursing and midwifery (program length 6-12 months, initial assessment)	-	-	-	-	$23,700
Nursing and midwifery (program length under 6 months)	-	-	-	-	$10,600
Nursing and midwifery Dual degree (initial assessment)	-	-	-	-	$53,600
Nursing and midwifery Major modification	-	-	-	-	$10,600
Occupational therapy NO DATA	-	-	-	-	-
Optometry Entry level program (Initial fee)	-	-	$60,000	$63,000	$69,300
Optometry Entry level program (Annual fee)	-	-	$8,000	$8,400	$9,240
Optometry Post entry level program (Initial fee)	-	-	-	$8,000	$8,800
Optometry Post entry level program (Annual fee)			-	$1,000	$1,100
Osteopathy New program (Initial assessment)	-	-	-	-	$20,000[4]

[4] This figure and the $15,000 below include a $5,000 application fee

	2009-10/ 2010	2010-11/ 2011	2011-12/ 2012	2012-13/ 2013	2013-14/ 2014/current
Osteopathy Existing program (Initial assessment)	-	-	-	-	$15,000
Osteopathy (Annual fee)	-	-	-	-	$2,000
Osteopathy (Major course change)	-	-	-	-	$5,000
Pharmacy Degree program Initial assessment	-	$25,000	$25,000	$25,000	$30,000
Pharmacy Degree program annual fee per program amortised over 5 years	$15,000	$15,000	$15,000	$15,000	$17,000
Pharmacy Intern training program Initial assessment	$5,000	$5,000	$5,000	$5,000	$5,000
Pharmacy Intern training program Capitation fee	$50	$50	$50	$50	$55
Pharmacy CPD accrediting organisation Initial application	$10,000	$15,000	$15,000	$15,000	$15,000
Pharmacy CPD accrediting organisation Annual accreditation fee	-	-	-	$2,950	$2,950
Pharmacy CPD accrediting organisation Annual renewal fee	-	-	-	$3,500	$3,500
Physiotherapy Assessment	$5,000	$10,000	$10,000	-	-
Physiotherapy Provisional accreditation	$18,000	$20,000	$20,000	-	-
Physiotherapy Full accreditation	$12,500	$15,000	$15,000	-	-
Physiotherapy Maintenance of accreditation	$3,000	-	-	-	-
Physiotherapy Annual fee	-	$7,000	$7,000	-	-
Physiotherapy Application	-	-	-	$25,000	$25,000
Physiotherapy Annual fee for programs currently accredited	-	-	-	$10,000	$13,750
Physiotherapy Annual fee for programs currently accredited (conditions)	-	-	-	$13,750	$13,750
Physiotherapy Annual fee for programs under transition	-	-	-	$13,750	$13,750

	2009-10/ 2010	2010-11/ 2011	2011-12/ 2012	2012-13/ 2013	2013-14/ 2014/current
Podiatry Initial assessment requiring 1 visit	-	-	-	-	$30,000
Podiatry Major change to accredited program requiring 1 visit	-	-	-	-	$10,000
Podiatry Program requiring 1 site visit Follow up of conditions of accredited program	-	-	-	-	$10,000
Additional site visit	-	-	-	-	$5,000
Psychology Application submission fee	$1,800	$2,700	$2,795	$2,935	$3,080
Psychology Onshore education provider assessment	$3,800	$4,800	$4,970	$5,219	$5,480
Psychology Additional onshore campus site visit	$3,800	$4,800	$4,970	$5,219	$5,480
Psychology Three year undergraduate sequence assessment	$5,000	$5,000	$5,175	$5,434	$5,700
Psychology Four year undergraduate sequence assessment	$5,800	$5,800	$6,000	$6,300	$6,615
Psychology Fourth year programs of study	$5,200	$5,200	$5,380	$6,122	$6,430
Psychology Undergraduate bridging program assessment	$3,800	$5,800	$6,000	$6,337	$6,650
Psychology Graduate diploma of professional psychology (5^{th} year) assessment	-	$6,700	$6,935	$7,655	$8,035
Psychology Generalist Masters Degree professional sequence assessment	$3,800	$7,200	$7,450	$7,823	$8,251
Psychology Specialist Masters Degree professional sequence assessment	$4,000	$8,000	$8,280	$8,694	$9,130
Psychology Graduate certificate or diploma in psychology (area of specialisation) (professional level bridging program) assessment	$2,000	$4,000	$4,140	$4,374	$4,590

Psychology Follow up assessment to assess progress towards meeting condition	-	$1,000	$1,035	-	$1,575
Psychology Offshore programs assessment[5]	$4,500	$5,900	$6,106	$6,600	$6,930
Psychology Assessment of an additional degree title to an existing accredited sequence/program of study	-	$500	$518	-	$575
Psychology Assessment of an onshore fieldwork placement program	-	$1,600	-	-	$1,655
Psychology Late application fee	$1,000	$2,000	$2,000	$2,000	$2,000
Source: Accreditation councils submissions to NRAS review; search of council annual reports					

[5] Figure given is per visit in this row. Additionally, institutions are required to directly bear the full cost of document translation, business class travel, accommodation and meals for all assessment team members travelling offshore.

Table 5 – Total accreditation costs by profession

	Expenditure by national boards (a)	Expenditure by accreditation councils (b)	Transfers from boards to councils (c)	Contributions from NZ Govt (d)	Total spend on accreditation in Australia (a + b - c -d)	Number of accredited programmes	Cost per accredited programme
Total for all professions	$9,341,422	$38,007,056	$5,748,254	$65,883	$41,534,341	1276	$32,550
Aborigine and Torres Strait Islander Health Practice	$26,537				$26,537	2	$13,269
Chinese Medicine	$61,927				$61,927	12	$5,161
Chiropractic	$150,467	$354,425	$160,000	$22,211[6]	$322,681	4	$80,670
Dentistry	$377,436	$5,414,000	$400,000		$5,391,436	62	$86,959
Medicine	$3,273,807	$19,545,007	$642,740	[7]	$22,176,074	24	$924,003
Medical Radiation Practice	$152,289				$152,289	34	$4,479
Nursing and Midwifery	$3,468,797	$5,591,817	$2,738,296		$6,322,318	480	$13,171
Occupational Therapy	$175,111	$386,456	$180,862		$380,705	34	$11,197
Optometry	$235,408	$756,763	$290,000	$31,900	$670,271	11	$60,934
Osteopathy	$150,685	$251,016	$149,888		$251,813	4	$62,953
Pharmacy	$347,047	$2,899,288	$300,000	[8]	$2,946,335	24	$122,764
Physiotherapy	$261,138	$1,729,004	$250,000		$1,740,142	30	$58,005
Podiatry	$108,470	$294,037	$120,728	$11,772	$270,007	33	$8,182
Psychology	$552,305	$785,243	$515,740		$821,808	522	$1,574
Source: Accreditation council submissions to the NRAS review; Accreditation council's annual reports							

[6] Includes $16,217 for work carried out in Asia
[7] Australian Medical Council perform work on accreditation in New Zealand but did not provide any information on these activities
[8] The Australian Pharmacy Council undertake work on accreditation in New Zealand but did not provide any information on these activities

Table 6 - total costs by function and profession at national level

	All Professions	ATSIHP	CM	Chiro	Dentistry	Medicine	MRP	NM	OT	Optom	Osteo	Pharm	Physio	Pod	Psy
Notifications	$84,958,309	$162,746	$1,290,888	$1,558,444	$6,054,558	$39,921,285	$1,096,340	$19,618,643	$1,165,483	$764,155	$835,795	$4,308,464	$1,532,179	$725,987	$5,923,343
Registration	$55,465,491	$189,225	$648,030	$812,300	$3,497,100	$15,716,387	$943,593	$22,298,326	$1,134,033	$471,745	$292,490	$3,276,903	$1,379,628	$404,653	$4,401,078
Compliance	$8,072,309	$21,290	$77,427	$109,499	$475,310	$2,847,794	$115,995	$2,849,536	$155,434	$74,484	$46,380	$450,234	$190,147	$54,501	$604,278
Accreditation	$41,534,341	$26,537	$61,927	$322,681	$5,391,436	$22,176,074	$152,289	$6,322,318	$380,705	$670,271	$251,813	$2,946,335	$1,740,142	$270,007	$821,808
Professional Standards	$11,942,743	$155,323	$195,738	$298,228	$784,116	$3,271,168	$414,954	$3,255,616	$384,024	$309,471	$175,881	$865,811	$493,311	$186,619	$1,152,485
Governance	$12,144,609	$36,328	$129,425	$168,370	$738,341	$4,278,590	$183,075	$4,244,858	$243,841	$88,752	$57,781	$695,706	$281,284	$80,353	$917,905
Total	$214,117,803	$591,449	$2,403,435	$3,269,522	$16,940,861	$88,211,298	$2,906,245	$58,589,297	$3,463,519	$2,378,877	$1,660,139	$12,543,453	$5,616,690	$1,722,120	$13,820,898

Table 7 - Proportionate cost of each function by profession

	All Professions	ATSIHP	CM	Chiro	Dent	Med	MR	NM	OT	Optom	Osteo	Pharm	Physio	Pod	Psy
Notifications	39.7%	27.5%	53.7%	47.7%	35.7%	45.3%	37.7%	33.5%	33.7%	32.1%	50.3%	34.3%	27.3%	42.2%	42.9%
Registration	25.9%	32.0%	27.0%	24.8%	20.6%	17.8%	32.5%	38.1%	32.7%	19.8%	17.6%	26.1%	24.6%	23.5%	31.8%
Compliance	3.8%	3.6%	3.2%	3.3%	2.8%	3.2%	4.0%	4.9%	4.5%	3.1%	2.8%	3.6%	3.4%	3.2%	4.4%
Accreditation	19.4%	4.5%	2.6%	9.9%	31.8%	25.1%	5.2%	10.8%	11.0%	28.2%	15.2%	23.5%	31.0%	15.7%	5.9%
Professional Standards	5.6%	26.3%	8.1%	9.1%	4.6%	3.7%	14.3%	5.6%	11.1%	13.0%	10.6%	6.9%	8.8%	10.8%	8.3%
Governance	5.7%	6.1%	5.4%	5.1%	4.4%	4.9%	6.3%	7.2%	7.0%	3.7%	3.5%	5.5%	5.0%	4.7%	6.6%

Table 8 - Unit cost by function and profession at national level

	All	ATSIHP	CM	Chiro	Denti	Med	MRP	NM	OT	Optom	Osteo	Pharm	Physio	Pod	Psy
Notifications	$137.33	$493.17	$303.10	$321.79	$292.60	$402.40	$76.35	$54.19	$72.06	$159.53	$448.39	$152.50	$58.76	$176.00	$187.16
Registration	$89.66	$573.41	$152.16	$167.73	$169.01	$158.42	$65.71	$61.60	$70.11	$98.49	$156.92	$115.99	$52.91	$98.10	$139.06
Compliance	$13.05	$64.51	$18.18	$22.61	$22.97	$28.71	$8.08	$7.87	$9.61	$15.55	$24.88	$15.94	$7.29	$13.21	$19.09
Accreditation	$67.14	$80.42	$14.54	$66.63	$260.56	$223.53	$10.61	$17.46	$23.54	$139.93	$135.09	$104.29	$66.73	$65.46	$25.97
Professional Standards	$19.31	$470.68	$45.96	$61.58	$37.89	$32.97	$28.90	$8.99	$23.74	$64.61	$94.36	$30.65	$18.92	$45.24	$36.41
Governance	$19.63	$110.09	$30.39	$34.77	$35.68	$43.13	$12.75	$11.73	$15.08	$18.53	$31.00	$24.63	$10.79	$19.48	$29.00
Total	$346.12	$1,792.27	$564.32	$675.10	$818.72	$889.15	$202.38	$161.85	$214.14	$496.63	$890.63	$443.98	$215.40	$417.48	$436.69

Figure 1 – Total Unit cost plotted against the number of registrants

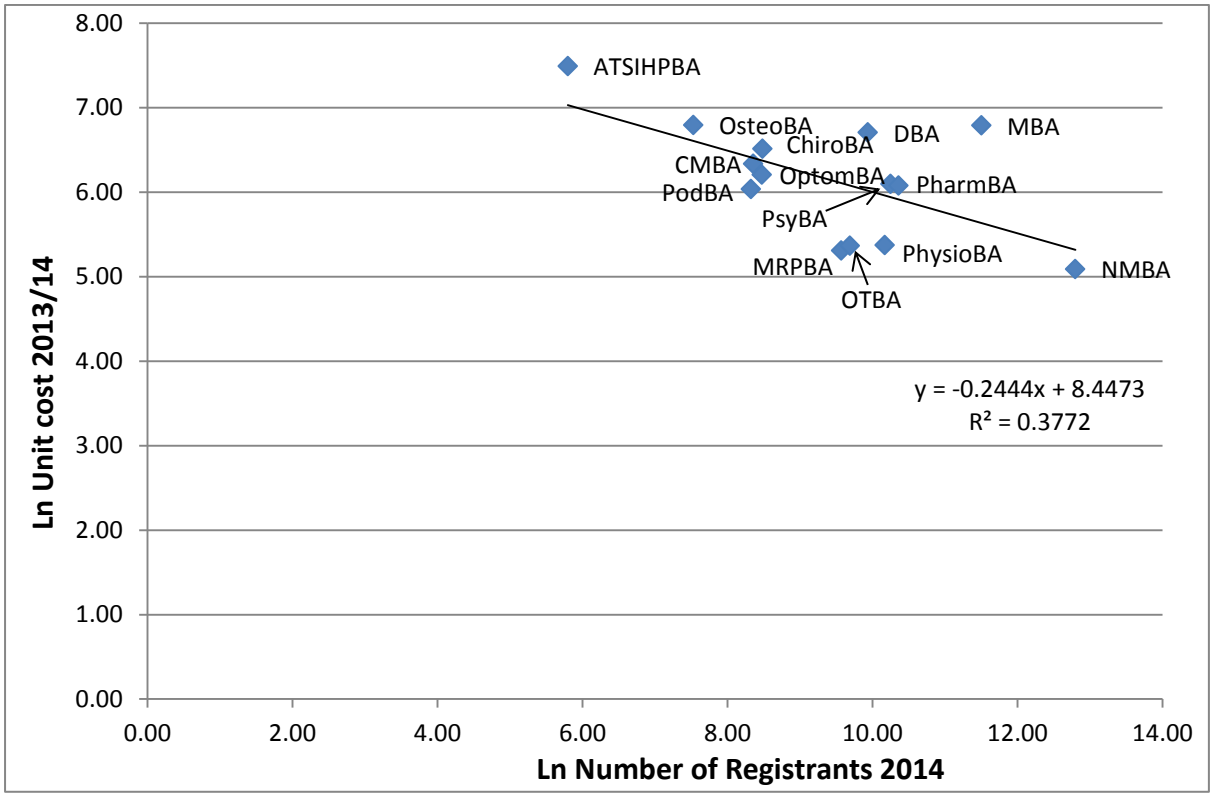


Figure 2 – Unit cost of notifications plotted against the number of registrants

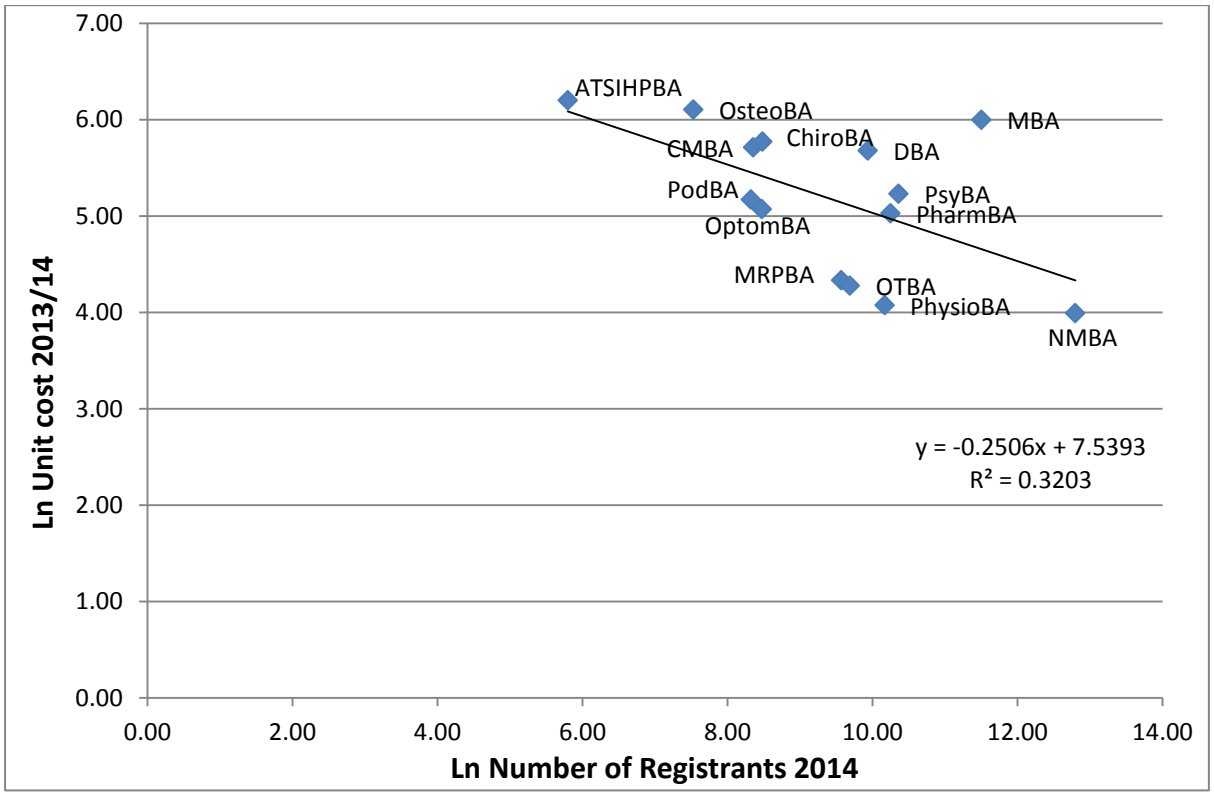


Figure 3 – Notifications per 1,000 registrants plotted against the number of registrants

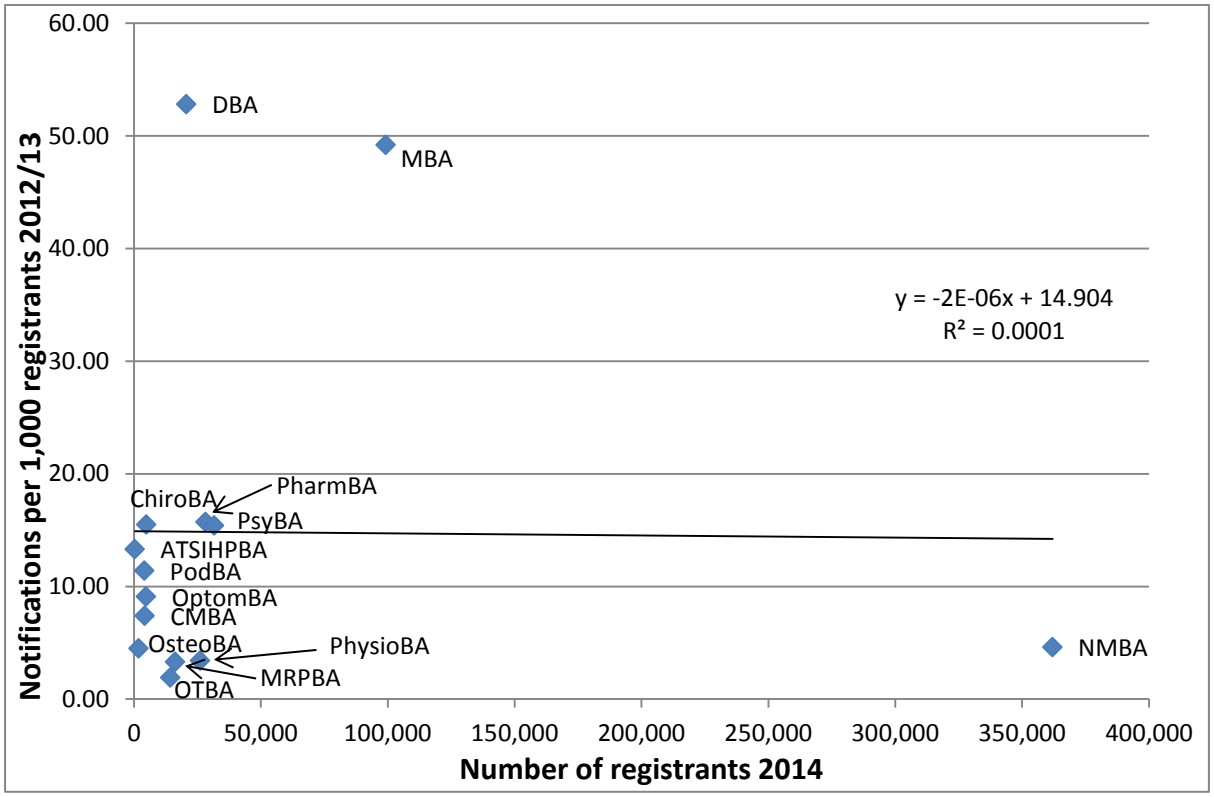


Figure 4 – Unit cost of registration plotted against the number of registrants

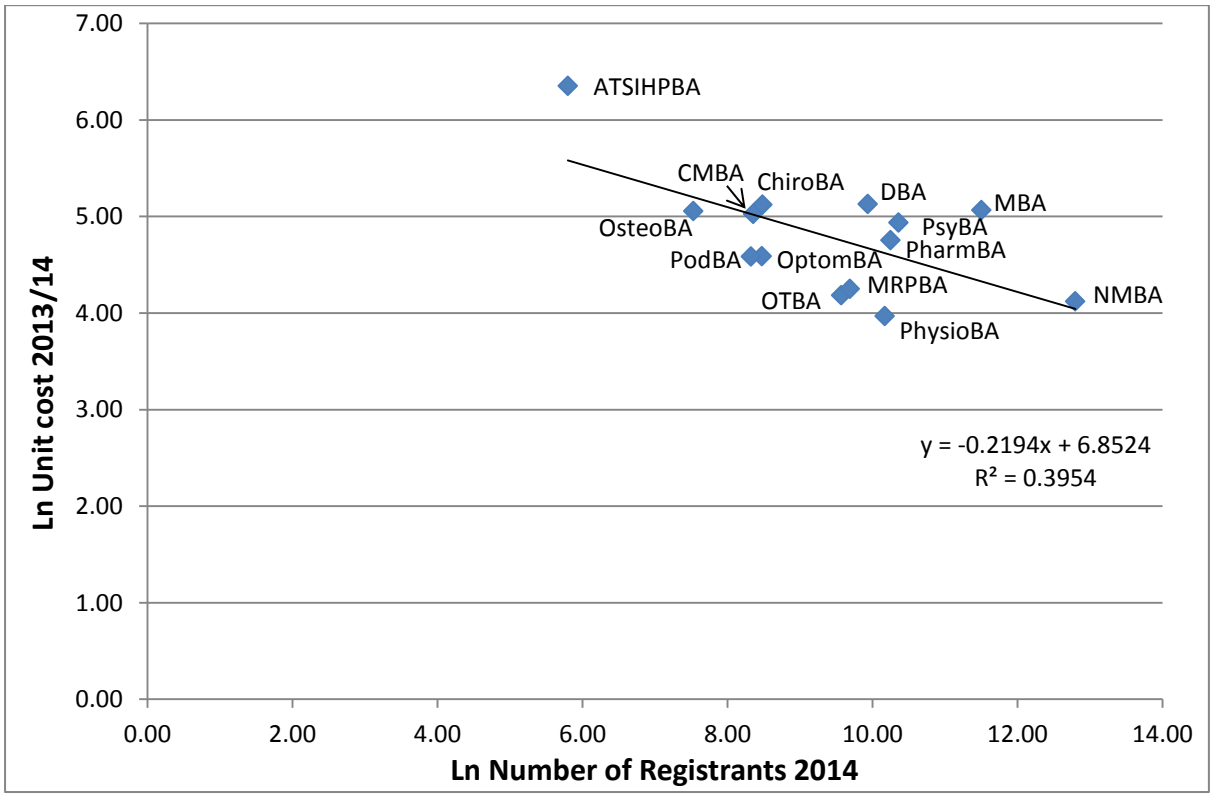


Figure 5 – Unit cost of compliance plotted against the number of registrants

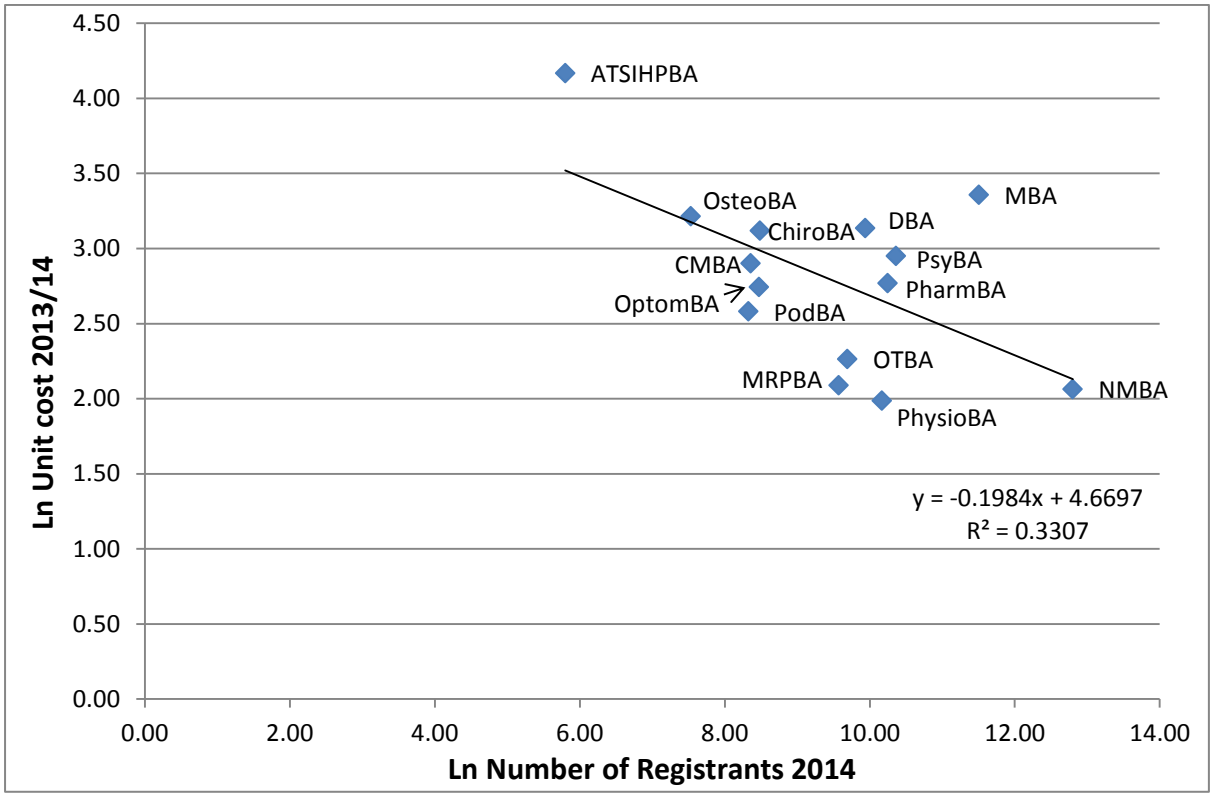


Figure 6 – Unit cost of accreditation plotted against the number of registrants

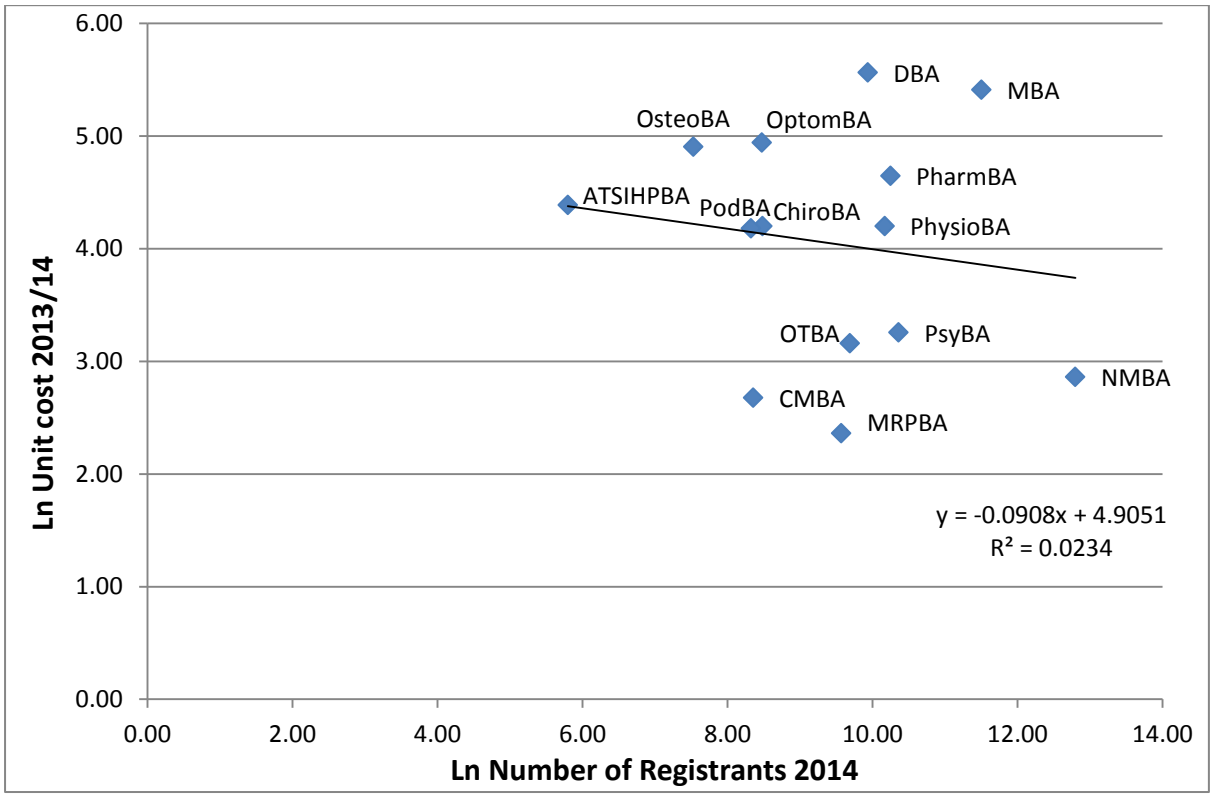


Figure 7 – Unit cost of professional standards plotted against the number of registrants

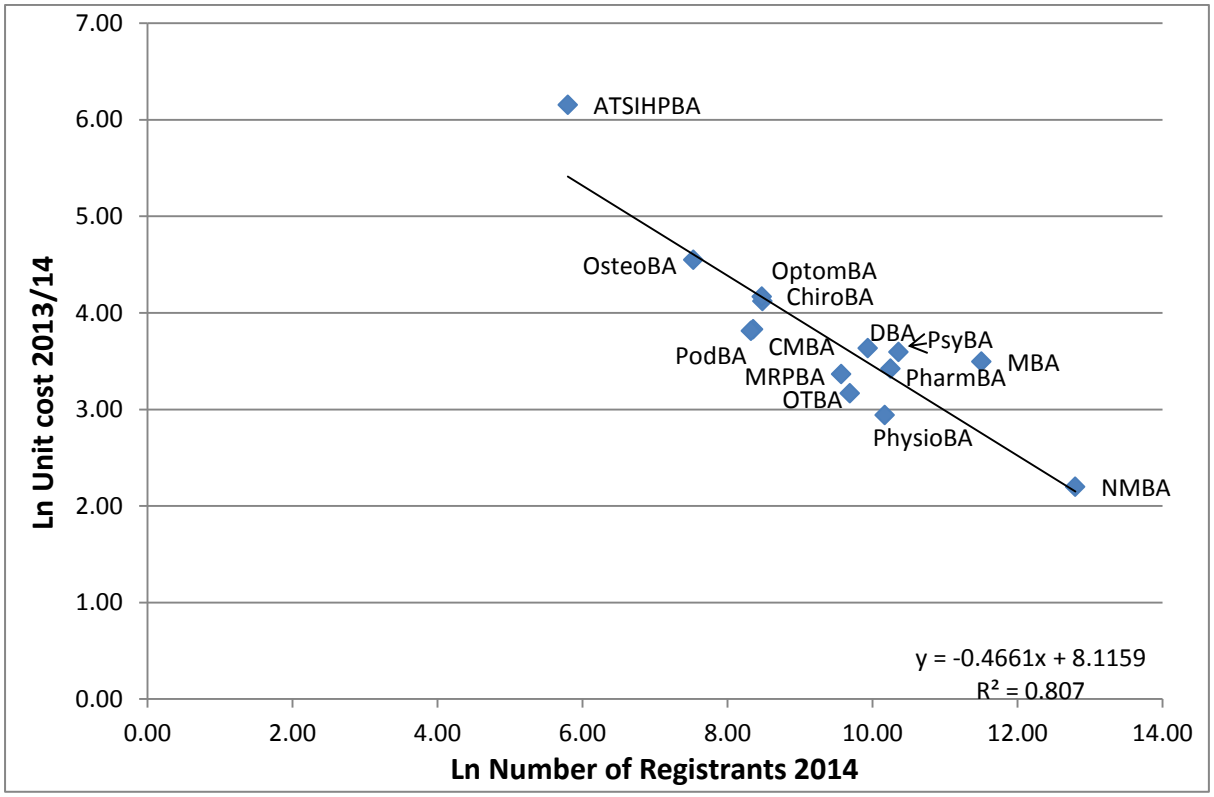


Figure 8 – Unit cost of governance plotted against the number of registrants

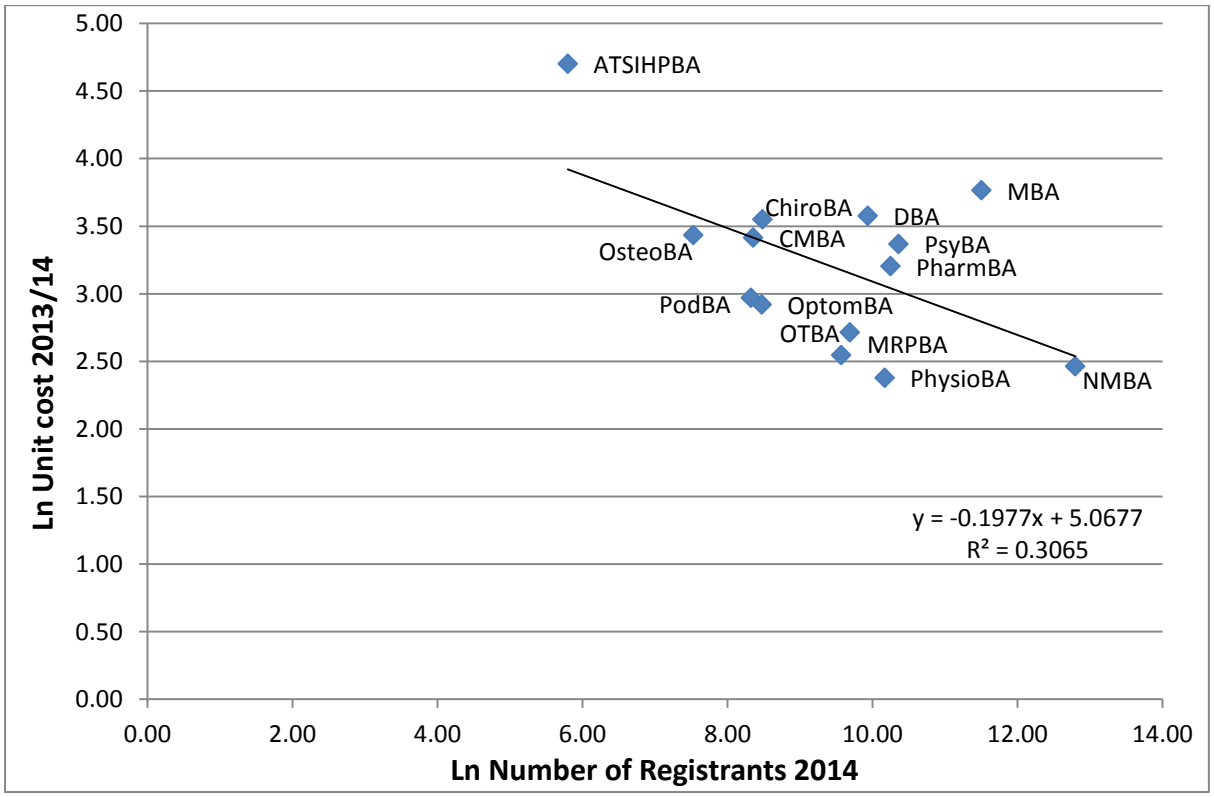


Figure 9 – Performance relative to costs predicted by size

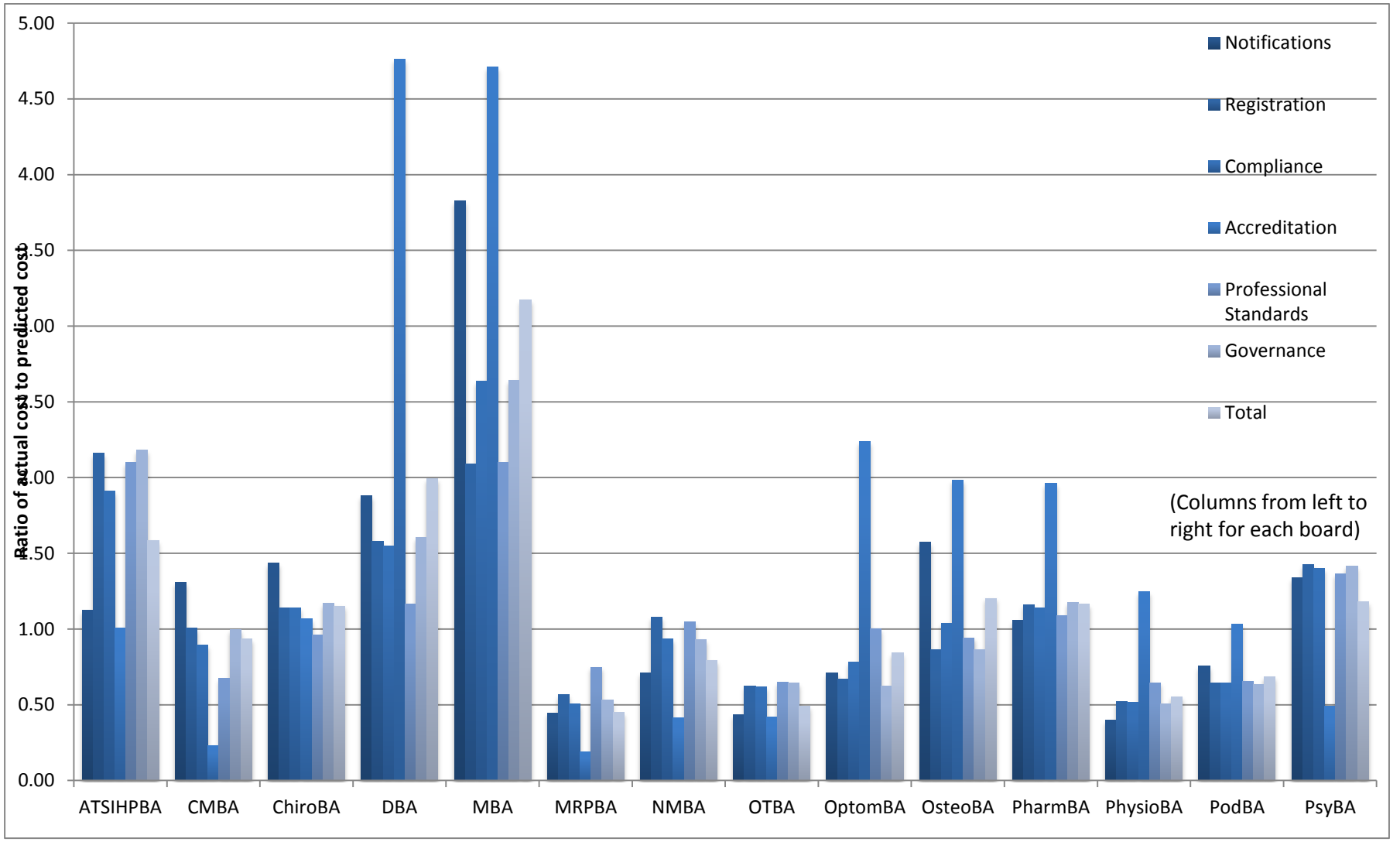


Table 9 - Ratio of actual cost to that predicted by the scale of the board

	Notifications	Registration	Compliance	Accreditation	Professional Standards	Governance	Total
ATSIHPBA	1.12	2.16	1.91	1.01	2.10	2.18	1.59
CMBA	1.31	1.01	0.89	0.23	0.67	1.00	0.93
ChiroBA	1.44	1.14	1.14	1.07	0.96	1.17	1.15
DBA	1.88	1.58	1.55	4.76	1.16	1.60	1.99
MBA	3.83	2.09	2.64	4.71	2.10	2.64	3.17
MRPBA	0.45	0.57	0.51	0.19	0.75	0.53	0.45
NMBA	0.71	1.08	0.94	0.41	1.05	0.93	0.79
OTBA	0.43	0.62	0.62	0.42	0.65	0.65	0.49
OptomBA	0.71	0.67	0.78	2.24	1.00	0.62	0.84
OsteoBA	1.57	0.87	1.04	1.98	0.94	0.87	1.20
PharmBA	1.06	1.16	1.14	1.96	1.09	1.18	1.17
PhysioBA	0.40	0.52	0.51	1.25	0.65	0.51	0.55
PodBA	0.75	0.64	0.65	1.03	0.65	0.64	0.68
PsyBA	1.34	1.43	1.40	0.49	1.36	1.42	1.18

Colour scheme – GREEN less than 0.8, AMBER between 0.8 and 1.3, RED greater than 1.3.

Table 10 - Ratio of costs in Australia to costs in UK for professions where there is a suitable comparator

	Notifications	Registration	Compliance	Accreditation	Professional Standards	Governance	Total
All Profs	0.73	1.62	1.62	3.8	1.69	0.89	1.15
Nurses	0.65	2.74	7.26	3.27	0.84	0.97	1.19
Medical Practitioners	0.82	1.22	1.24	5.47	2.81	0.98	1.2
Dentists	0.81	1.33	3.92	10.27	3.09	1.21	1.46
Chiropractor	0.39	0.8	0.15	-	1.21	0.16	0.46
Osteopathy	1.09	0.55	0.16	1.28	0.36	0.15	0.62
Opticians	1.08	1.54	0.4	2.89	3.29	0.27	1.29
English Pharmacists[9]	1.03	1.72	0.78	2.41	2.39	0.63	1.34
NI Pharmacists[10]	1.16	1.23	0.08	0.92	0.65	0.28	0.65
Medical radiation therapy[11]	0.84	2.09	9.81	0.77	4.89	1.43	1.33
Occupational therapy	0.79	2.23	11.67	1.71	4.02	1.69	1.41
Physiotherapy	0.65	1.68	8.86	4.84	3.2	1.21	1.42
Podiatry	1.94	3.11	16.04	4.74	7.66	2.19	2.75
Psychology	2.06	4.42	23.19	1.88	6.17	3.26	2.88

Colour scheme – GREEN less than 1, AMBER between 1 and 1.5, RED greater than 1.5.

[9] Values in this row are calculated by taking the ratio of costs for PharmBA with that of the GPhC in the UK.
[10] Values in this row are calculated by taking the ratio of costs for PharmBA with that of the PSNI in the UK.
[11] Values for the final five rows are calculated by taking the ratio of costs for the relevant Australian boards with those from HCPC, which regulates all five of these professions in the UK.

Table 11 - Notification Statistics that can be used to define prevalence and severity of risk

	Table 117: Notifications received in 2012/13 by profession and state or territory	Notifications Rate / 10,000 practitioners	Table 127: Registrants involved in mandatory notifications by profession rate / 10,000 practitioners
ATSIHPBA	4	133.3	0
CMBA	30	73.7	4.9
ChiroBA	72	154.6	6.4
DBA	1,052	528.3	8
MBA	4,709	492.1	28.9
MRPBA	26	18.7	5
NMBA	1,598	46.2	15.7
OTBA	50	33.1	2.6
OptomBA	42	90.6	0
OsteoBA	8	45.2	5.7
PharmBA	429	156.9	12.8
PhysioBA	83	33.6	2.8
PodBA	44	113.6	0
PsyBA	471	154.1	18.3
Source: 2012-13 Annual report: AHPRA and National Boards			

Figure 10 –Severity and prevalence of risk using mandatory notifications as a proxy for risk

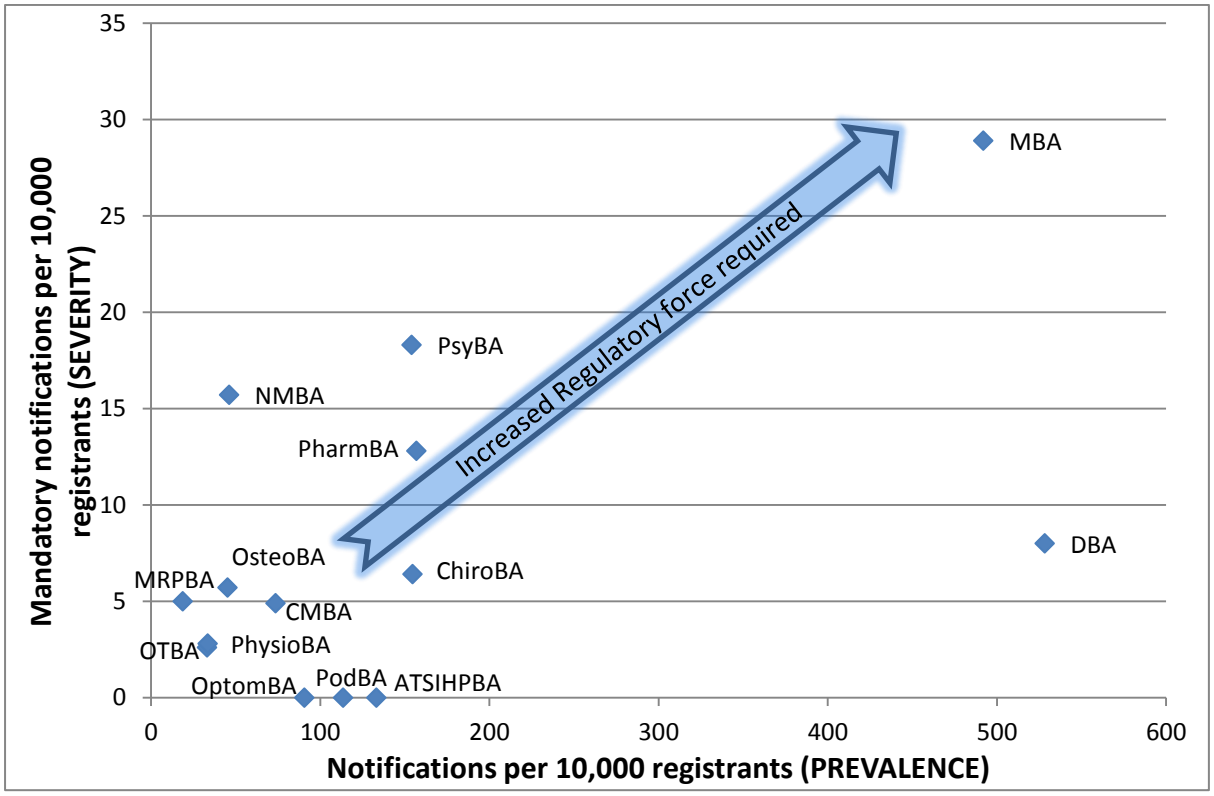


Table 12 – Features of Registration Function that may affect cost of Regulation

	Registrants	Criminal history checks conducted		Student register	Specialist register	Endorsements	Registration division
		Number	Rate per 10,000 registrants				
Aboriginal and Torres Strait Islander Health Practitioner	300	86	2,867	69		Y	
Chinese Medicine Practitioner	4070	851	2,091	1,169		Y	Y
Chiropractor	4657	618	1,327	1,398			
Dental Practitioner	19,912	1,891	950	3,823	Y		Y
Medical Practitioner	95,690	14,501	1,515	19,434	Y		
Medical Radiation Practitioner	13,905	2	1	3,573		Y	Y
Nurse/Midwife	345,955	27,717	801	65,965			Y
Occupational Therapist	15,101	709	470	5,880		Y	
Optometrist	4,635	181	391	1,279			
Osteopath	1,769	2,668	15,082	746			
Pharmacist	27,339	3,863	1,413	7,885		Y	
Physiotherapist	24,703	2,197	889	8,161			
Podiatrist	3,873	321	829	1,740	Y		
Psychologist	30,561	4,448	1,455	-			

Source: 2012-13 Annual report: AHPRA and National Boards

Table 13 – Features of Accreditation Function that may affect cost of Regulation

	Number of accredited programmes
Aborigine and Torres Strait Islander Health Practice	2
Chinese Medicine	12
Chiropractic	4
Dentistry	62
Medicine	24
Medical Radiation Practice	34
Nursing and Midwifery	480
Occupational Therapy	34
Optometry	11
Osteopathy	4
Pharmacist	24
Physiotherapy	30
Podiatry	33
Psychology	522
Source: council websites	

Table 14 - Features of Notification Function that may affect cost of Regulation

	Registrants	Notifications received in 2012/13		Notifications closed at panel or tribunal hearing		Immediate action cases	
		Number	Rate per 10,000 registrants	Number	Rate per 10,000 registrants	Number	Rate per 10,000 registrants
Aborigine and Torres Strait Islander Health Practice	300	4	133.3	0	0.0	0	0.0
Chinese Medicine	4,070	30	73.7	0	0.0	0	0.0
Chiropractic	4,657	72	154.6	11	23.6	4	8.6
Dentistry	19,912	1,052	528.3	65	32.6	24	12.1
Medicine	95,690	4,709	492.1	110	11.5	147	15.4
Medical Radiation Practice	13,905	26	18.7	2	1.4	1	0.7
Nursing and Midwifery	345,955	1,598	46.2	119	3.4	172	5.0
Occupational Therapy	15,101	50	33.1	4	2.6	0	0.0
Optometry	4,635	42	90.6	1	2.2	0	0.0
Osteopathy	1,769	8	45.2	2	11.3	0	0.0
Pharmacist	27,339	429	156.9	47	17.2	34	12.4
Physiotherapy	24,703	83	33.6	2	0.8	1	0.4
Podiatry	3,873	44	113.6	2	5.2	1	2.6
Psychology	30,561	471	154.1	27	8.8	22	7.2
Source: 2012-13 Annual report: AHPRA and National Boards							

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

	Total (Aus)	Total (UK)	Nurses (Aus)	Nurses (UK)	Medical Practitioners (Aus)	Doctors (UK)	Dentists (Aus)	Dentists (UK)	Chiropractor (Aus)	Chiropractor (UK)
Notifications	$137.33	$186.89	$54.19	$84.01	$402.40	$492.10	$292.60	$360.66	$321.79	$825.13
Registration	$89.66	$55.44	$61.60	$22.45	$158.42	$129.85	$169.01	$126.99	$167.73	$209.57
Compliance	$13.05	$8.06	$7.87	$1.08	$28.71	$23.16	$22.97	$5.86	$22.61	$148.27
Accreditation	$67.14	$17.67	$17.46	$5.34	$223.53	$40.84	$260.56	$25.37	$66.63	$0.00
Professional Standards	$19.31	$11.42	$8.99	$10.64	$32.97	$11.72	$37.89	$12.26	$61.58	$50.71
Governance	$19.63	$22.01	$11.73	$12.03	$43.13	$44.16	$35.68	$29.42	$34.77	$218.23
Total	$346.12	$301.50	$161.85	$135.57	$889.15	$741.84	$818.72	$560.55	$675.10	$1,451.91
Source: Cost effectiveness and efficiency review of the health professional regulators, CHRE 2012										

	Total (Aus)	Total (UK)	Nurses (Aus)	Nurses (UK)	Medical Practitioners (Aus)	Doctors (UK)	Dentists (Aus)	Dentists (UK)	Chiropractor (Aus)	Chiropractor (UK)
Notifications	40%	62%	33%	62%	45%	66%	36%	64%	48%	57%
Registration	26%	18%	38%	17%	18%	18%	21%	23%	25%	14%
Compliance	4%	3%	5%	1%	3%	3%	3%	1%	3%	10%
Accreditation	19%	6%	11%	4%	25%	6%	32%	5%	10%	0%
Professional Standards	6%	4%	6%	8%	4%	2%	5%	2%	9%	3%
Governance	6%	7%	7%	9%	5%	6%	4%	5%	5%	15%

Table 15 (continued)

	Total (Aus)	Total (UK)	Osteopaths (Aus)	Osteopaths (UK)	Optometrists (Aus)	Opticians (UK)	Pharmacists (Aus)	Pharmacists (UK)[12]	Pharmacists (NI)
Notifications	$137.33	$186.89	$448.39	$412.80	$159.53	$147.22	$152.50	$147.48	$132.01
Registration	$89.66	$55.44	$156.92	$284.40	$98.49	$63.89	$115.99	$67.38	$94.47
Compliance	$13.05	$8.06	$24.88	$150.92	$15.55	$38.88	$15.94	$20.49	$207.90
Accreditation	$67.14	$17.67	$135.09	$105.49	$139.93	$48.42	$104.29	$43.24	$113.38
Professional Standards	$19.31	$11.42	$94.36	$264.42	$64.61	$19.62	$30.65	$12.83	$47.06
Governance	$19.63	$22.01	$31.00	$210.55	$18.53	$68.03	$24.63	$39.21	$86.44
Total	$346.12	$301.50	$890.63	$1,428.60	$496.63	$386.07	$443.98	$330.64	$681.25

	Total (Aus)	Total (UK)	Osteopaths (Aus)	Osteopaths (UK)	Optometrists (Aus)	Opticians (UK)	Pharmacists (Aus)	Pharmacists (UK)	Pharmacists (NI)
Notifications	40%	62%	50%	29%	32%	38%	34%	45%	19%
Registration	26%	18%	18%	20%	20%	17%	26%	20%	14%
Compliance	4%	3%	3%	11%	3%	10%	4%	6%	31%
Accreditation	19%	6%	15%	7%	28%	13%	23%	13%	17%
Professional Standards	6%	4%	11%	19%	13%	5%	7%	4%	7%
Governance	6%	7%	3%	15%	4%	18%	6%	12%	13%

[12] UK regulators are also responsible for the inspection and registration of pharmacy premises, but costs relating to these issues were removed from the UK analysis so the figures can be directly compared with Australian equivalents.

Table 15 (continued)

	Total (Aus)	Total (UK)	Medical radiation (Aus)	Occupational therapy (Aus)	Physiotherapists (Aus)	Podiatrists (Aus)	Psychologists(Aus)	HPC (UK)
Notifications	$137.33	$186.89	$76.35	$72.06	$58.76	$176.00	$187.16	$90.88
Registration	$89.66	$55.44	$65.71	$70.11	$52.91	$98.10	$139.06	$31.49
Compliance	$13.05	$8.06	$8.08	$9.61	$7.29	$13.21	$19.09	$0.82
Accreditation	$67.14	$17.67	$10.61	$23.54	$66.73	$65.46	$25.97	$13.80
Professional Standards	$19.31	$11.42	$28.90	$23.74	$18.92	$45.24	$36.41	$5.90
Governance	$19.63	$22.01	$12.75	$15.08	$10.79	$19.48	$29.00	$8.90
Total	$346.12	$301.50	$202.38	$214.14	$215.40	$417.48	$436.69	$151.80

	Total (Aus)	Total (UK)	Medical radiation (Aus)	Occupational therapy (Aus)	Physiotherapists (Aus)	Podiatrists (Aus)	Psychologists(Aus)	HPC (UK)
Notifications	40%	62%	38%	34%	27%	42%	43%	60%
Registration	26%	18%	32%	33%	25%	23%	32%	21%
Compliance	4%	3%	4%	4%	3%	3%	4%	1%
Accreditation	19%	6%	5%	11%	31%	16%	6%	9%
Professional Standards	6%	4%	14%	11%	9%	11%	8%	4%
Governance	6%	7%	6%	7%	5%	5%	7%	6%

Table 6a - CPI All Items. For each regulator, costs were adjusted for inflation to bring them in line with the Australian figures. This was done by comparing the CPI from the month at the midpoint of their reporting period[13] with the CPI at the midpoint of the Australian reporting period – December 2013, and multiplying UK costs by this ratio.

[13] 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.

Figure 11 – UK/Australia Unit cost comparison – All professions [14]($)

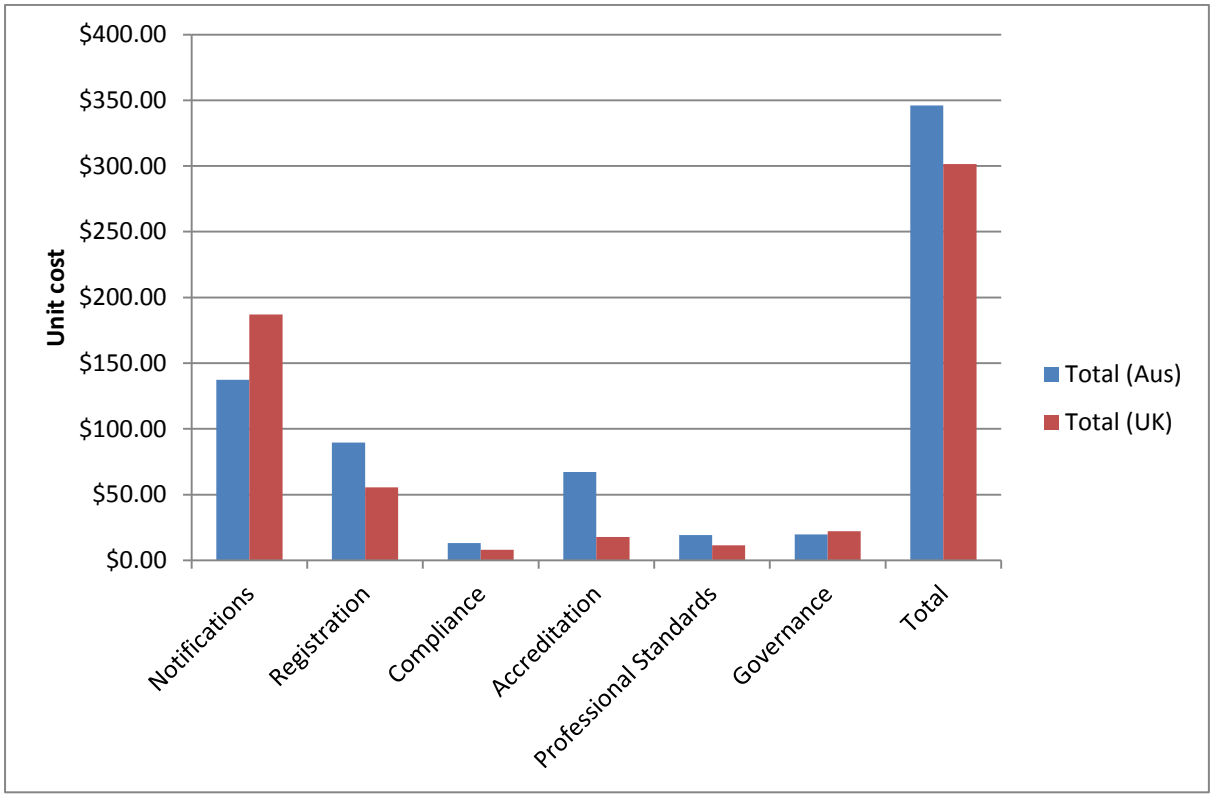
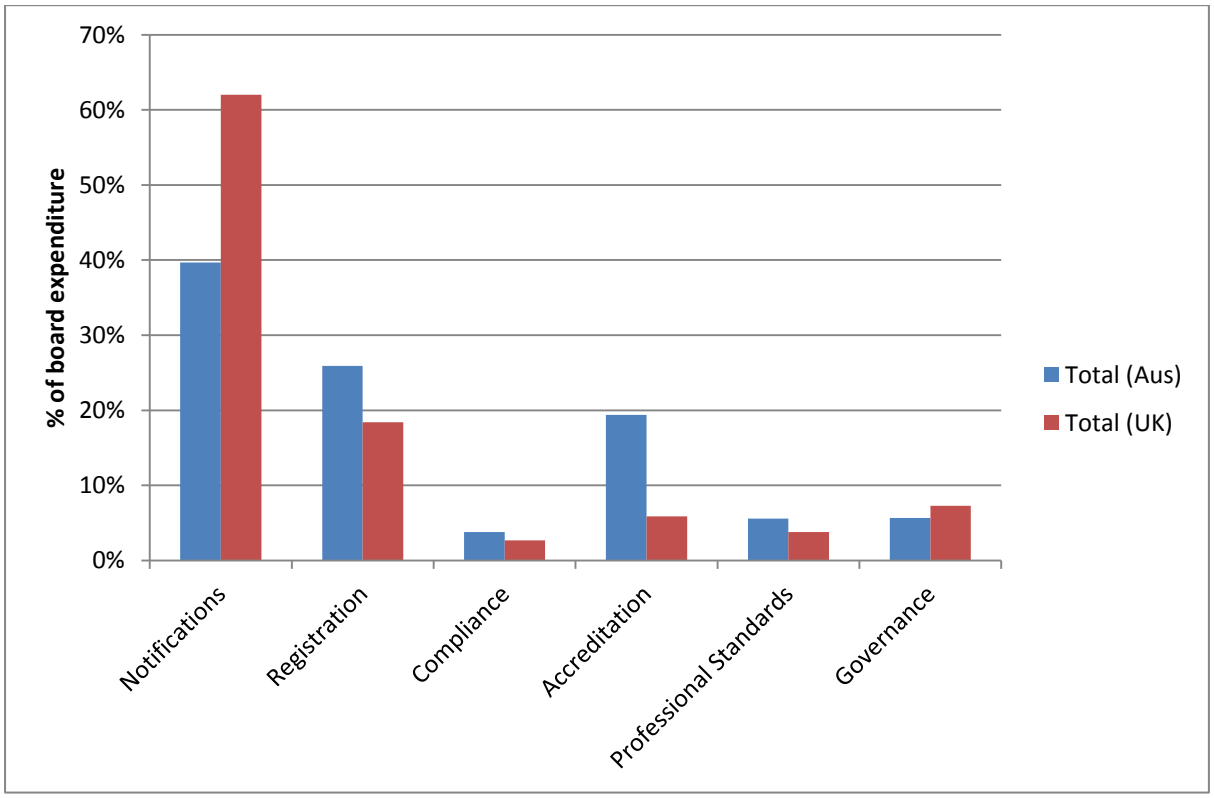


Figure 12 – UK/Australia Unit cost comparison – All professions (%)



[14] UK costs adjusted in Figures 11-28

Figure 13 – UK/Australia Unit cost comparison – Nurses and midwives ($)

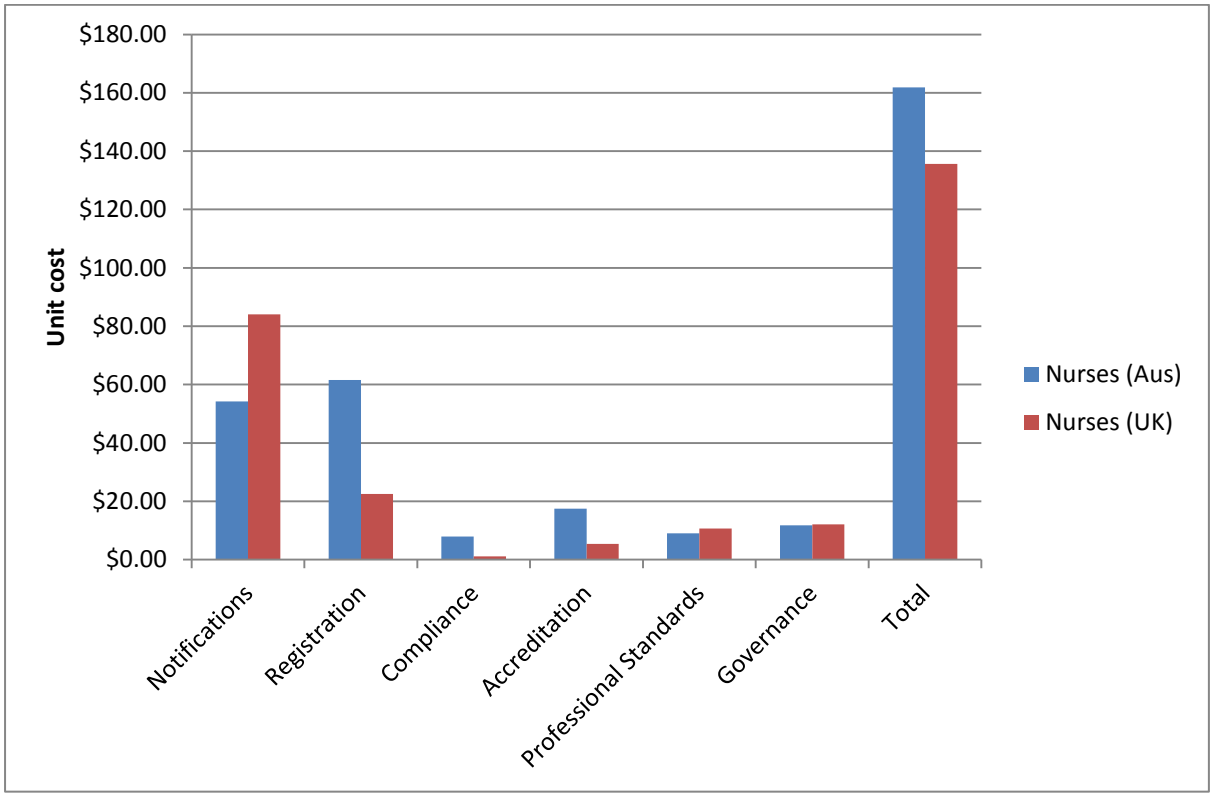


Figure 14 – UK/Australia Unit cost comparison – Nurses and midwives (%)

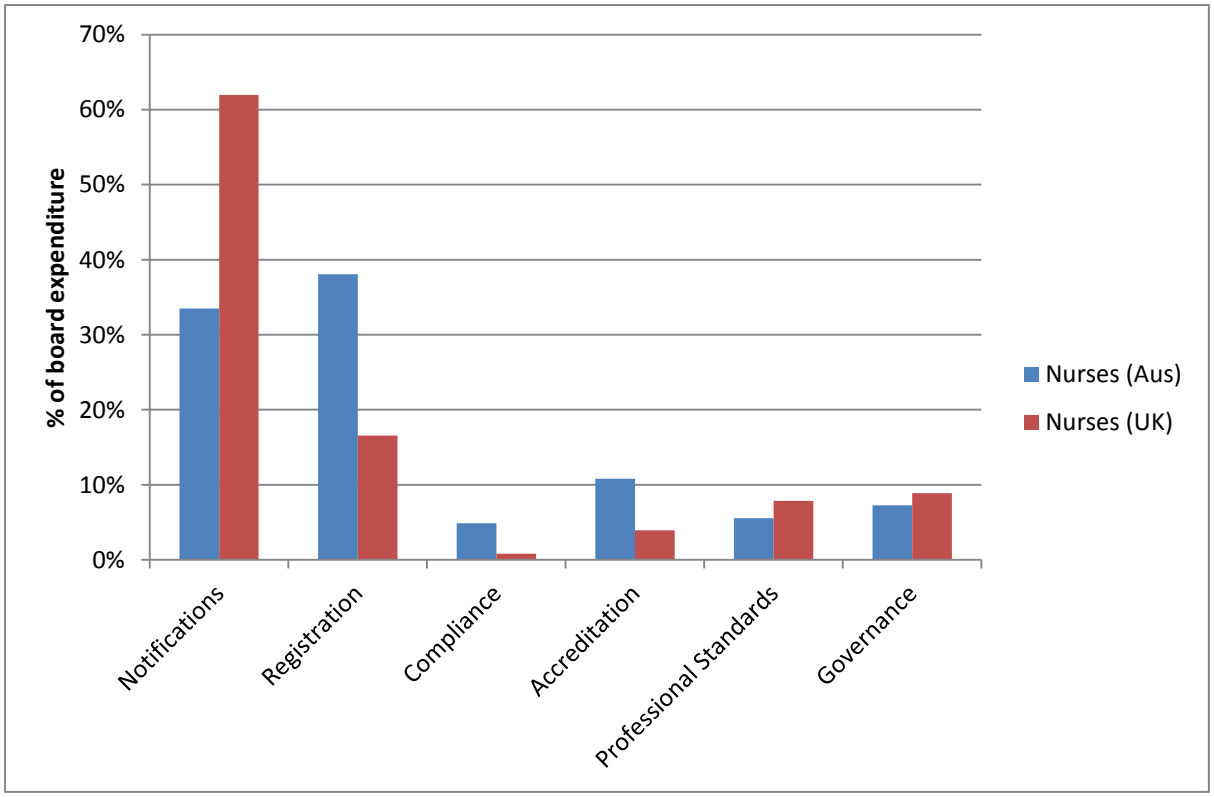


Figure 15 – UK/Australia Unit cost comparison – Medical Practitioners ($)

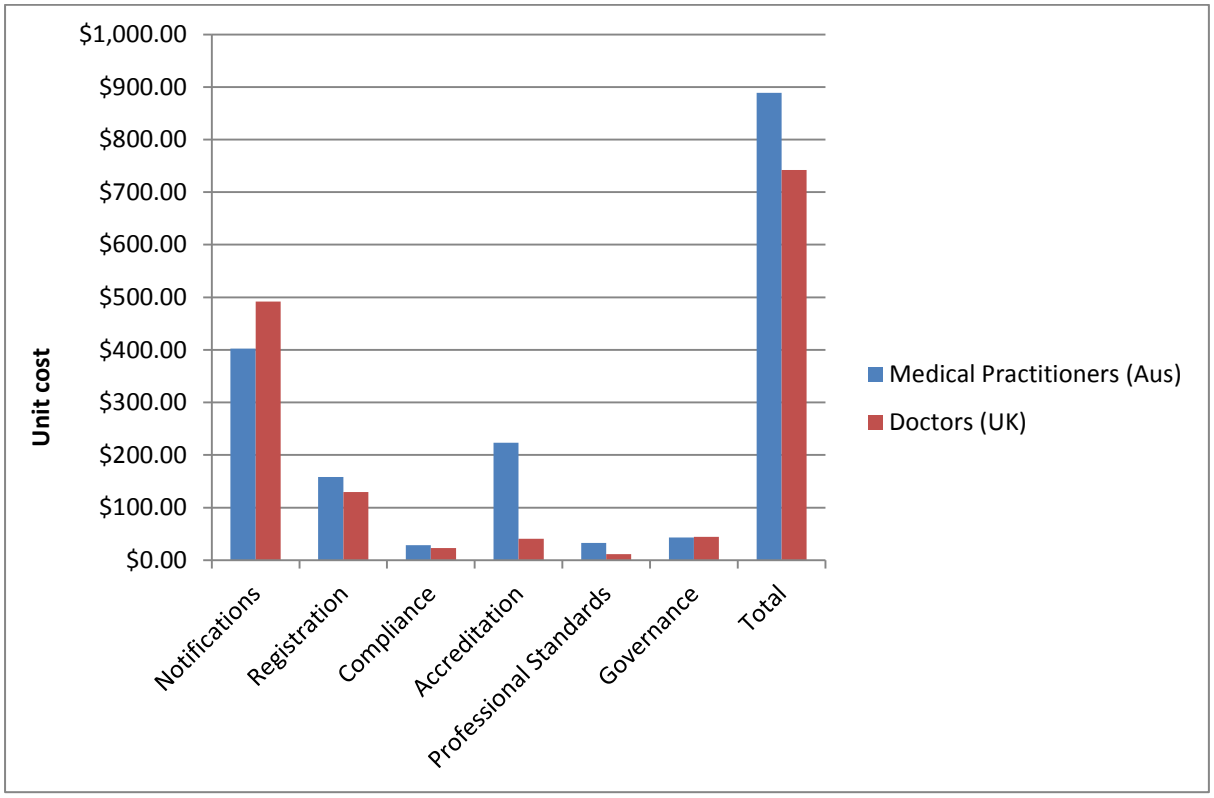


Figure 16 – UK/Australia Unit cost comparison – Medical Practitioners (%)

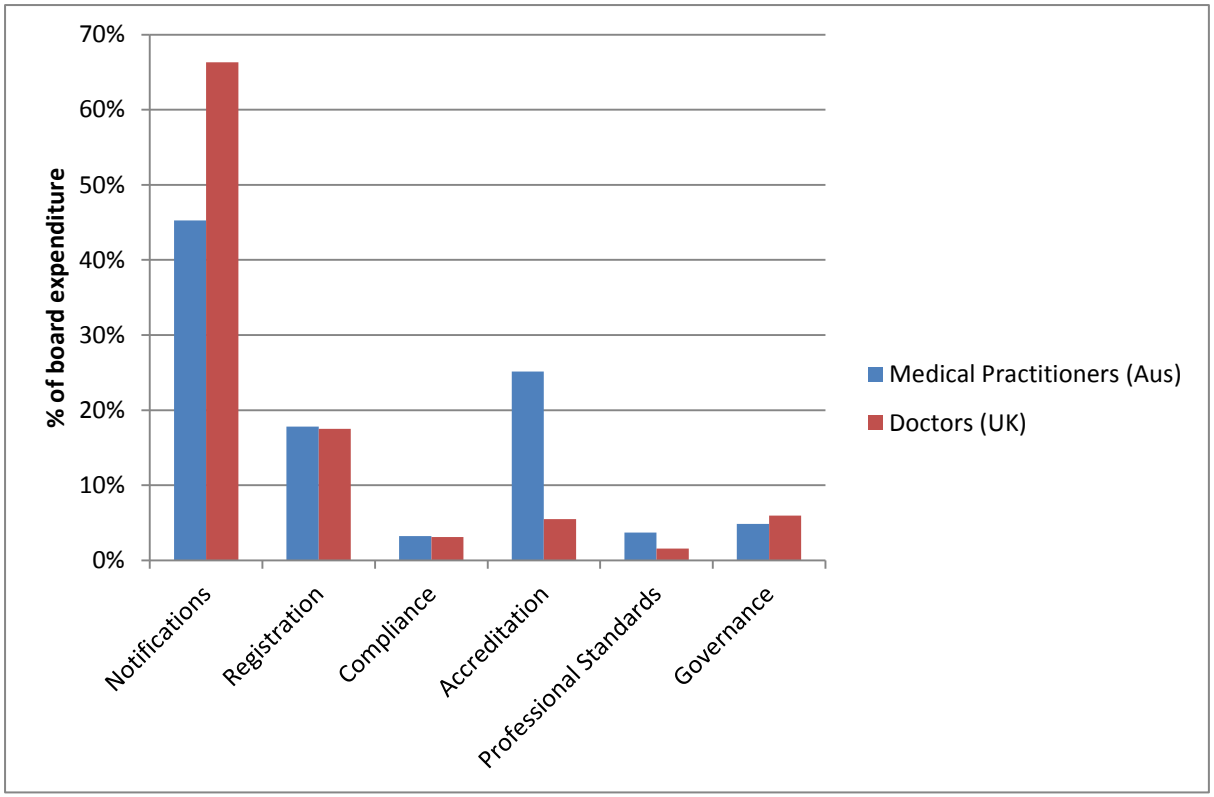


Figure 17 – UK/Australia Unit cost comparison – Dentists ($)

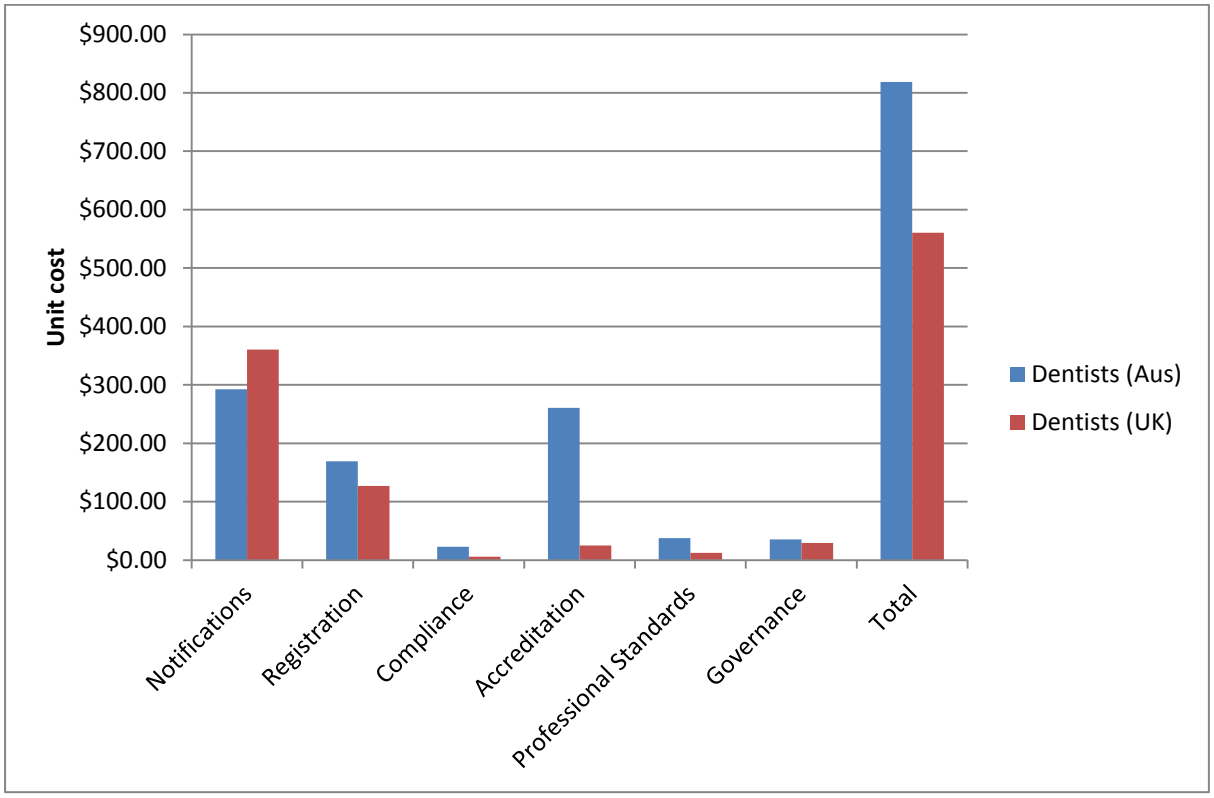


Figure 18 – UK/Australia Unit cost comparison – Dentists (%)

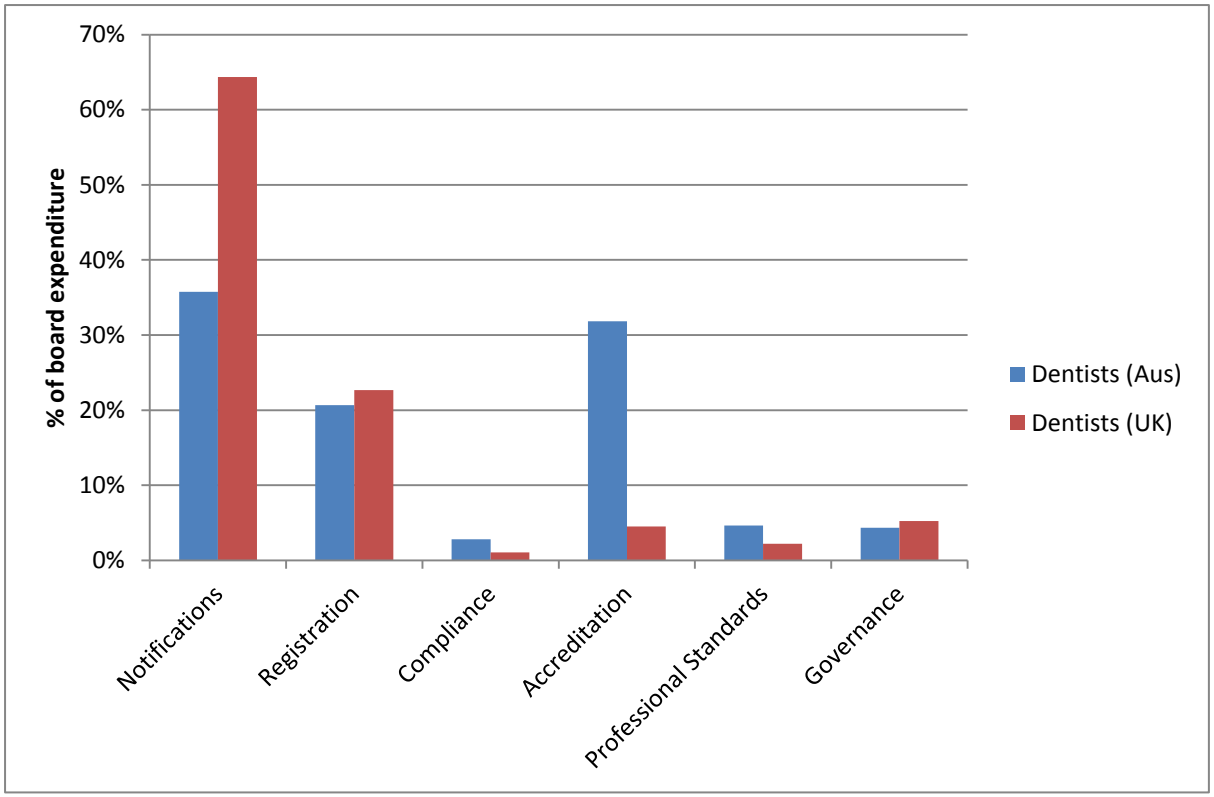


Figure 19 – UK/Australia Unit cost comparison – Chiropractors ($)

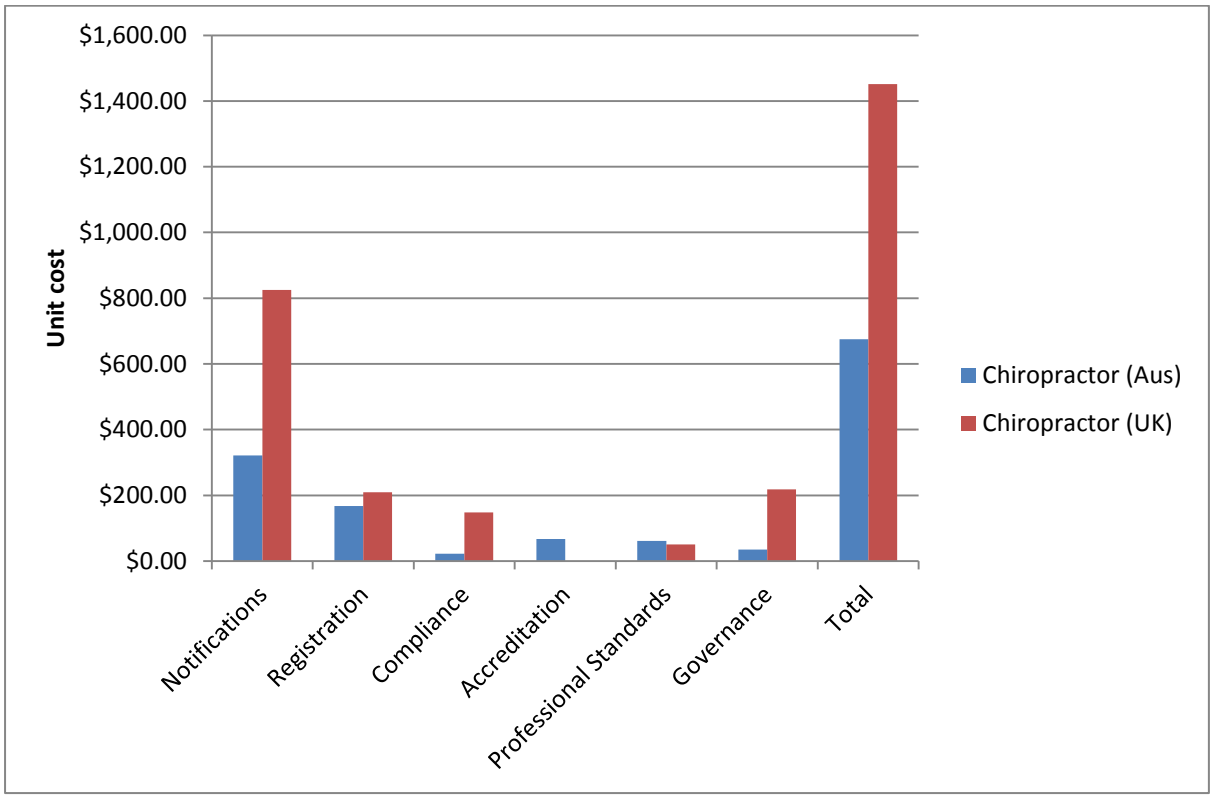


Figure 20 – UK/Australia Unit cost comparison – Chiropractors (%)

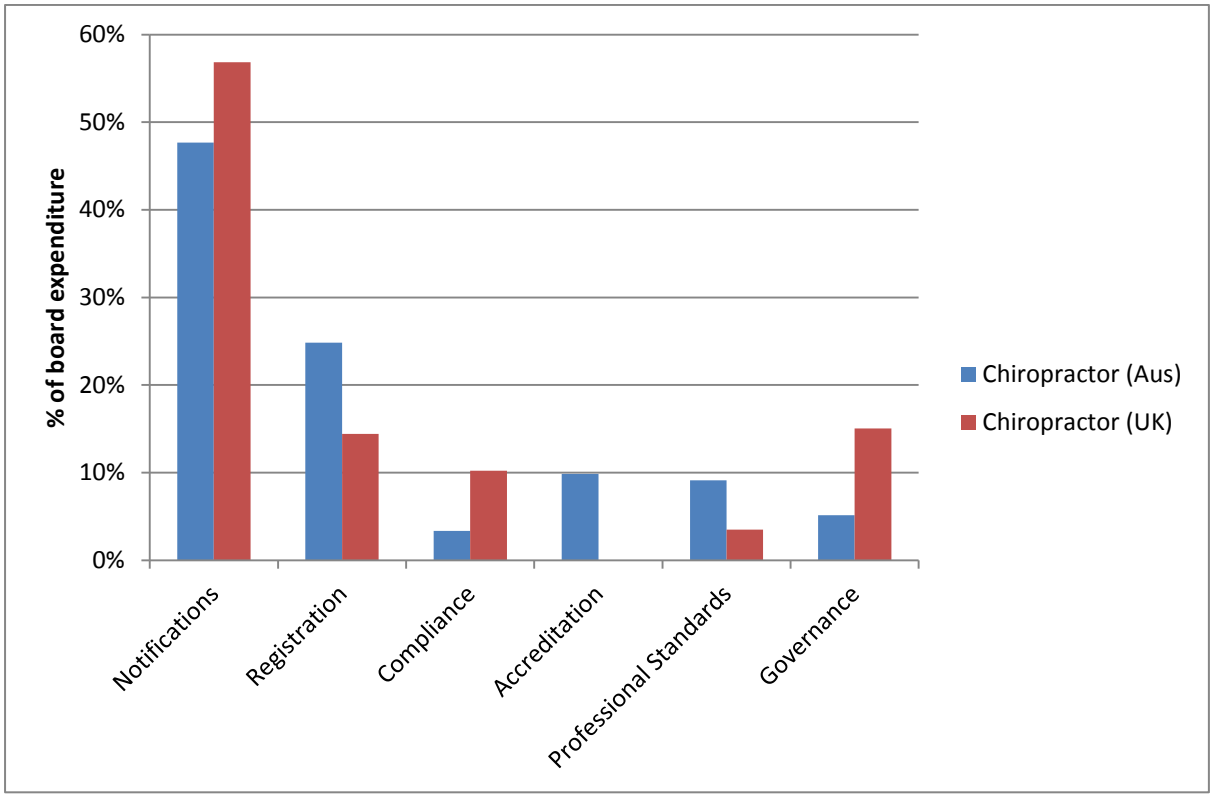


Figure 21 – UK/Australia Unit cost comparison – Osteopaths ($)

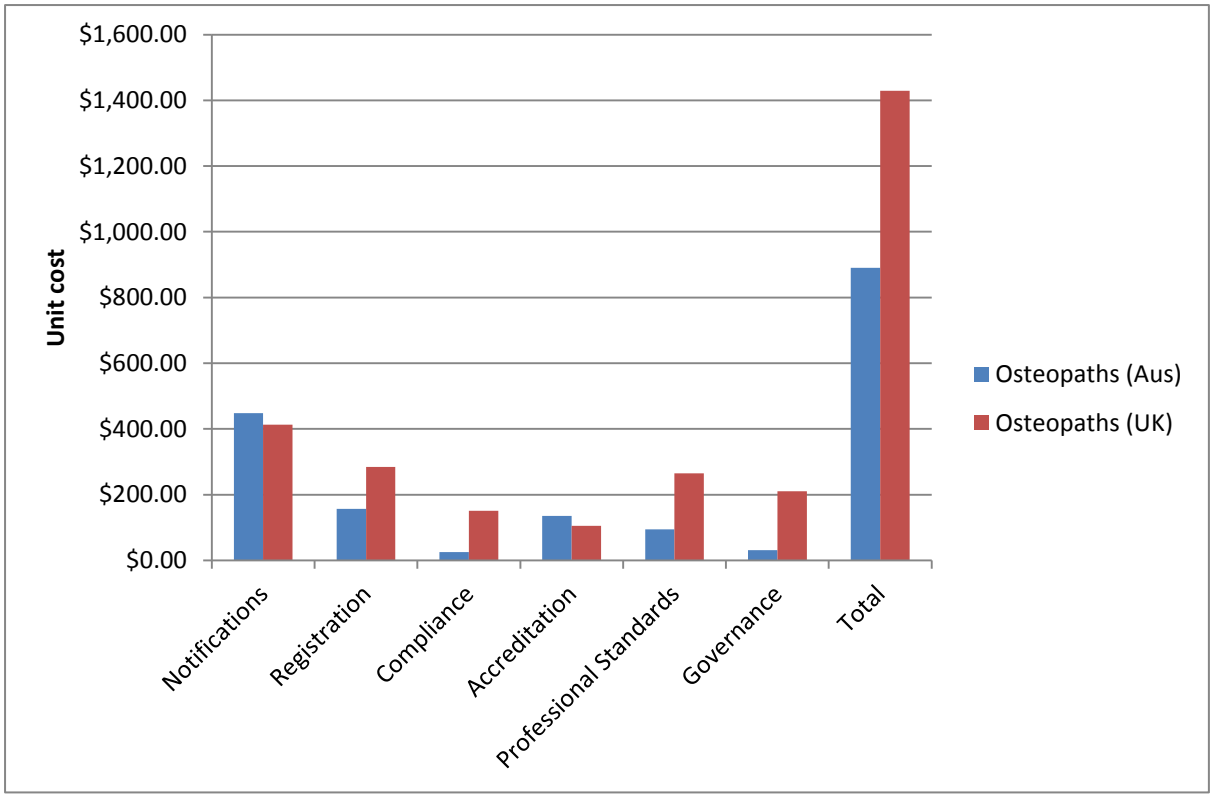


Figure 22 – UK/Australia Unit cost comparison – Osteopaths (%)

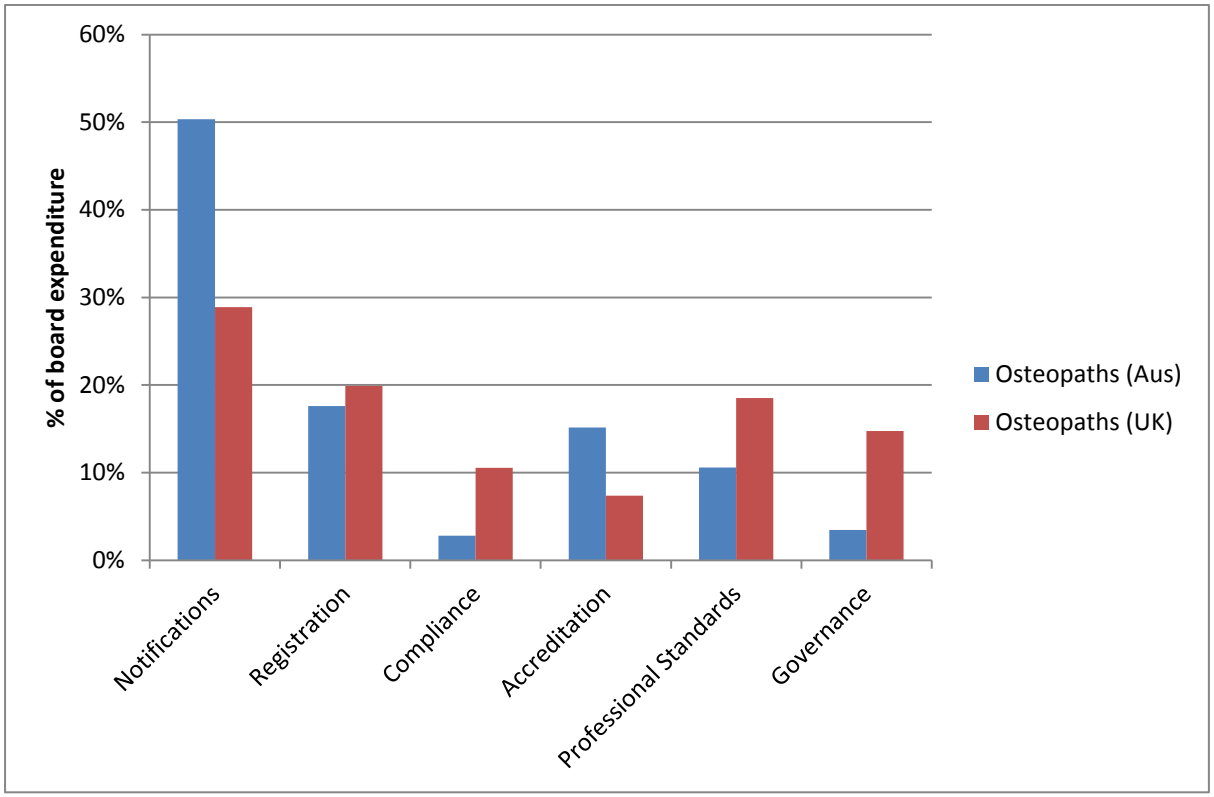


Figure 23 – UK/Australia Unit cost comparison – Opticians/Optometrists ($)

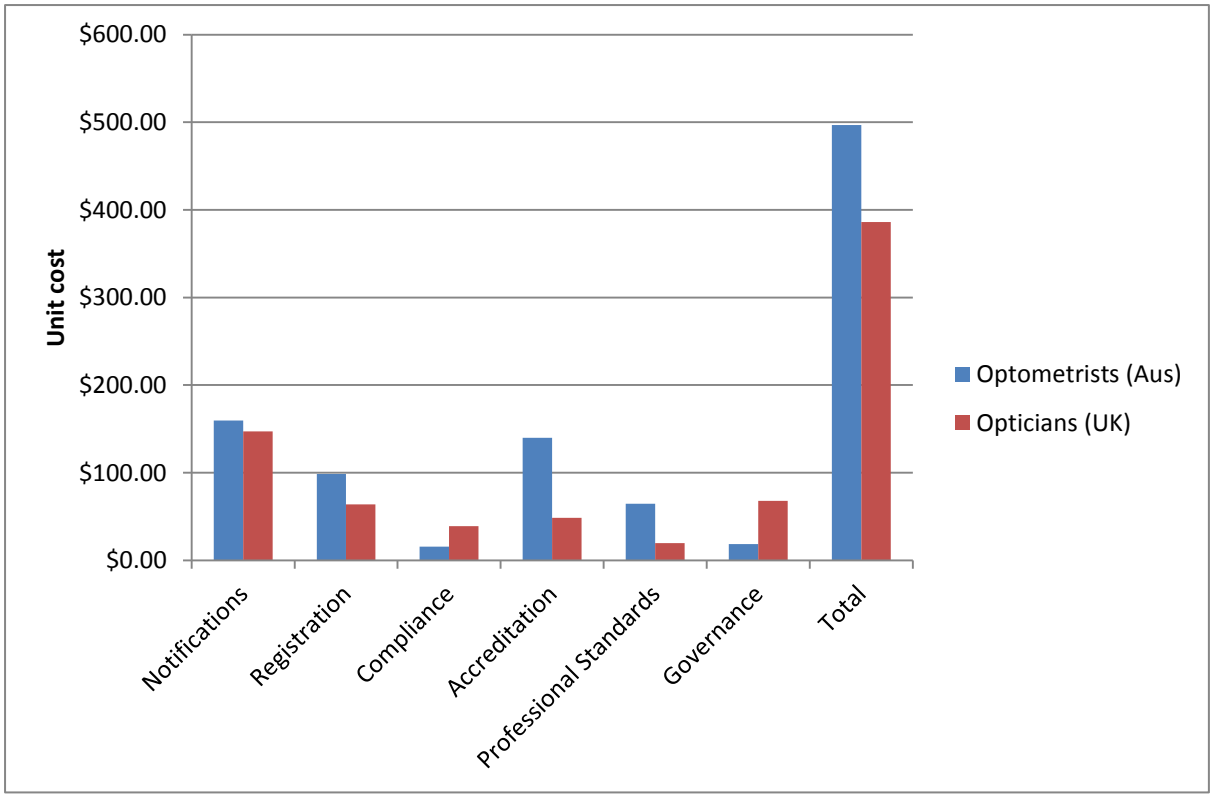


Figure 24 – UK/Australia Unit cost comparison – Opticians/Optometrists (%)

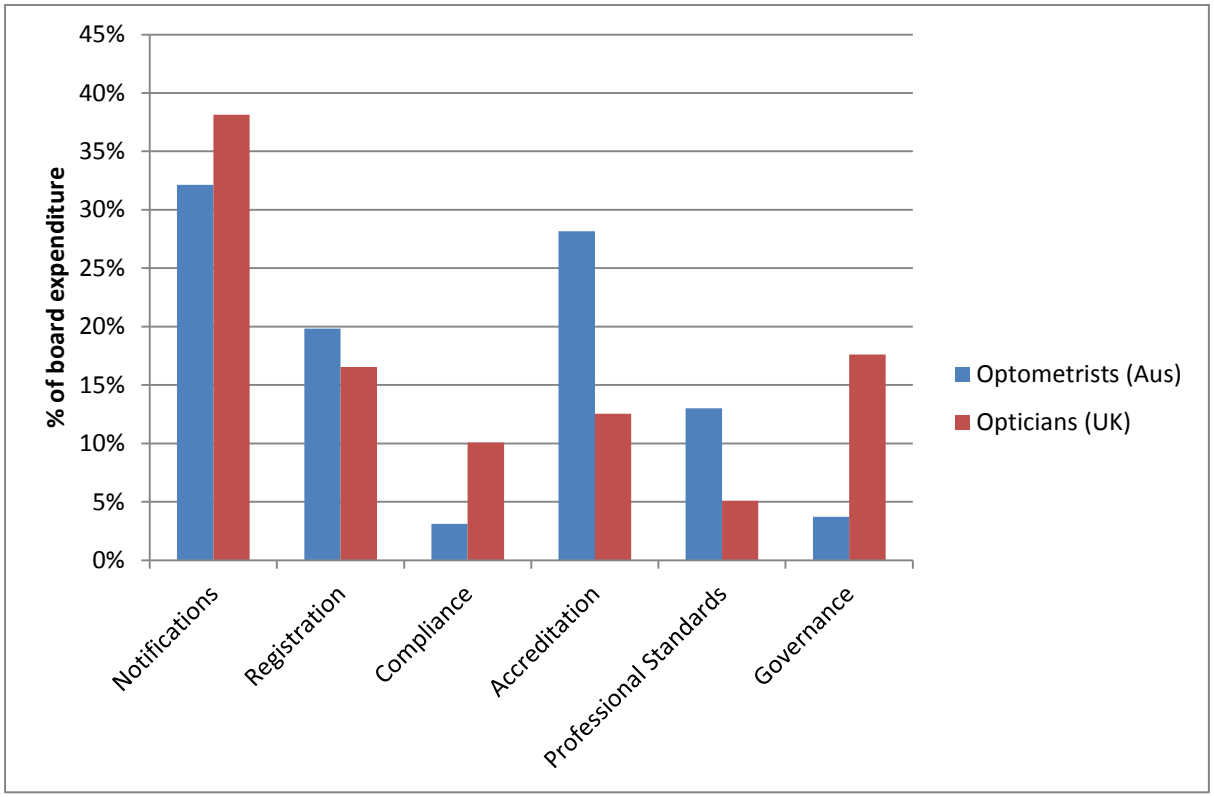


Figure 25 – UK/Australia Unit cost comparison – Professions covered by HCPC in UK ($)

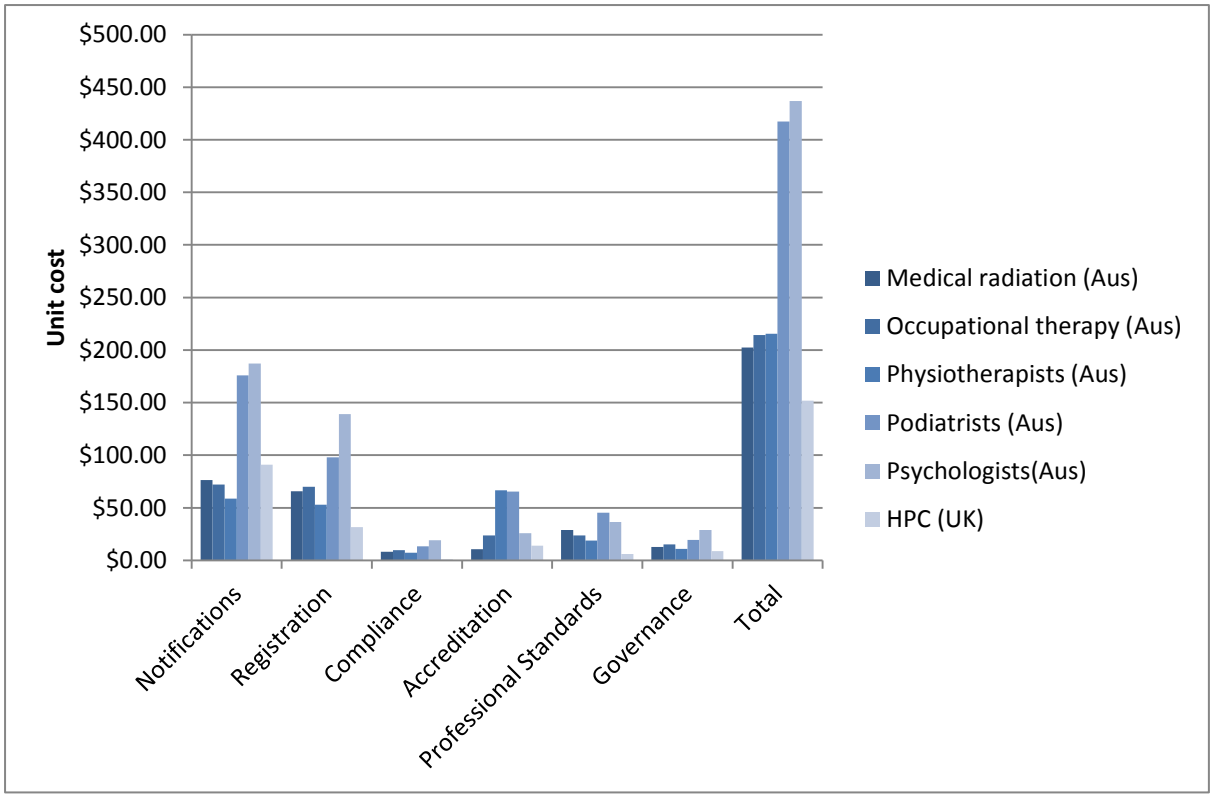


Figure 26 – UK/Australia Unit cost comparison – Professions covered by HCPC in UK (%)

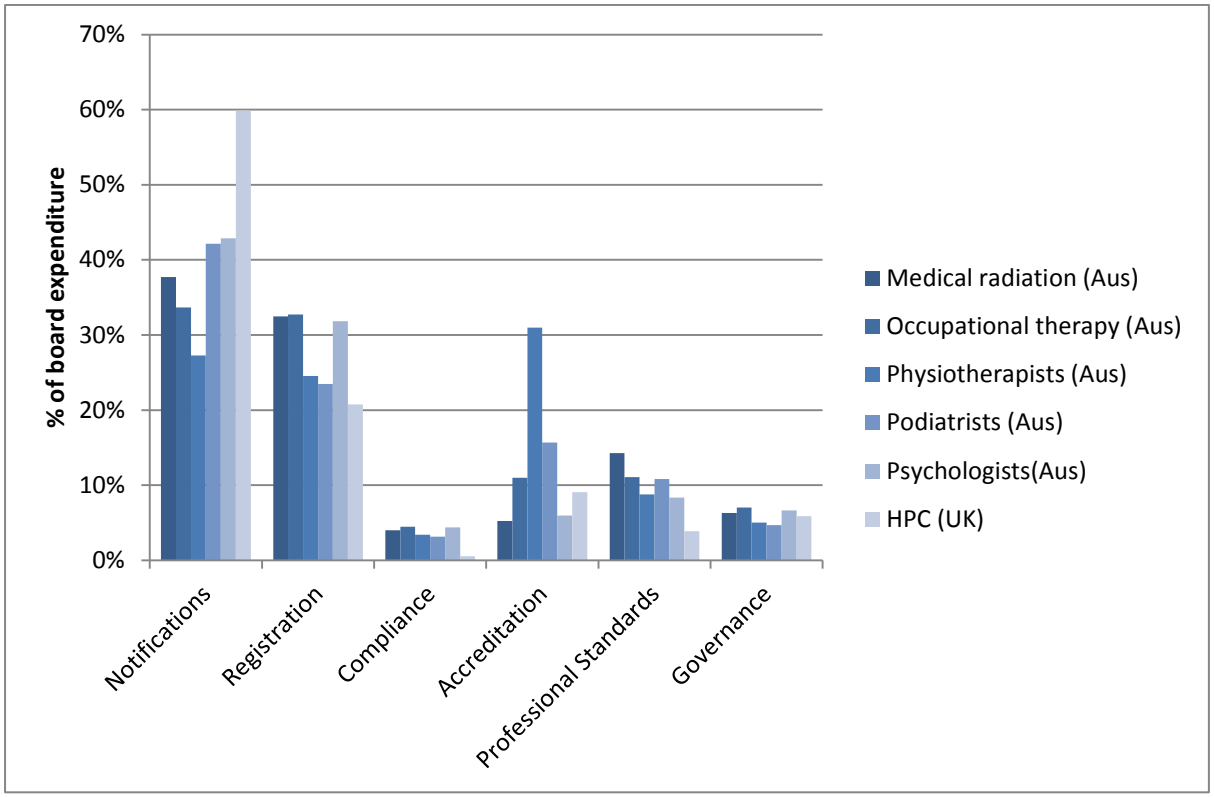


Figure 27 – UK/Australia Unit cost comparison – Pharmacists ($)

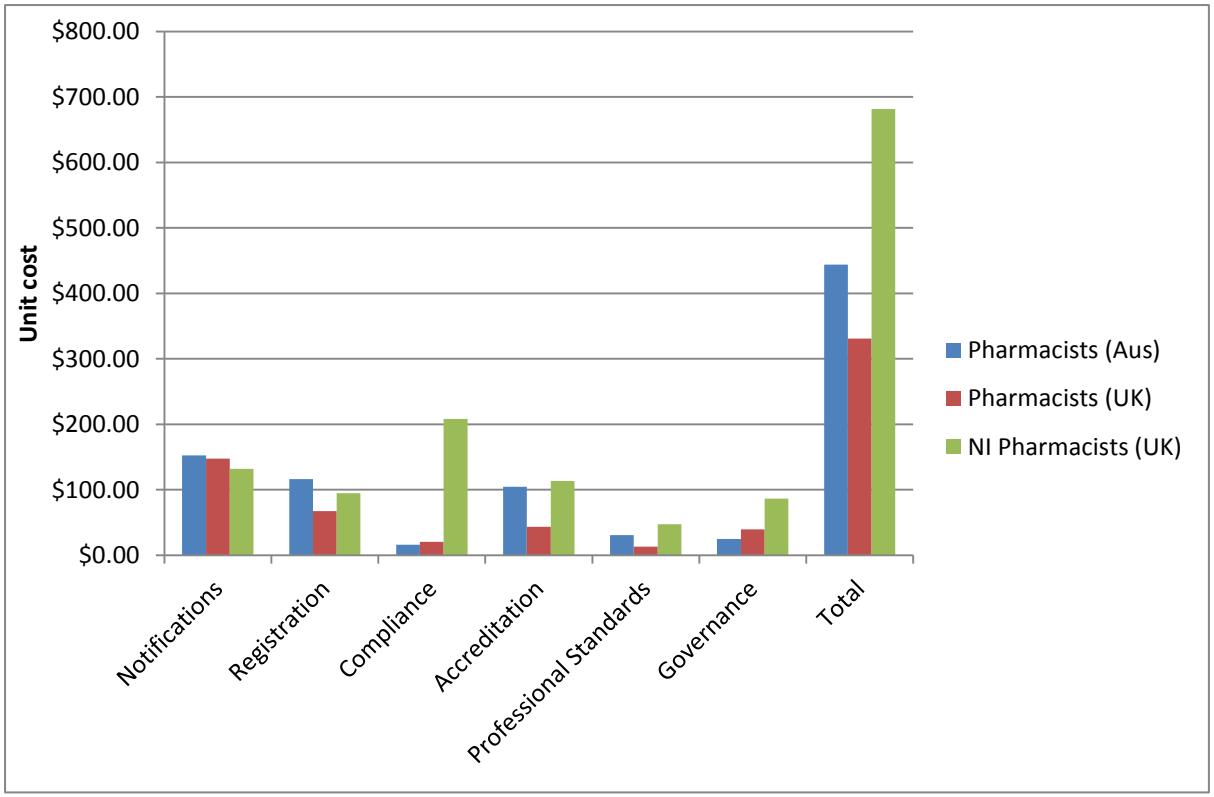


Figure 28 – UK/Australia Unit cost comparison – Pharmacists

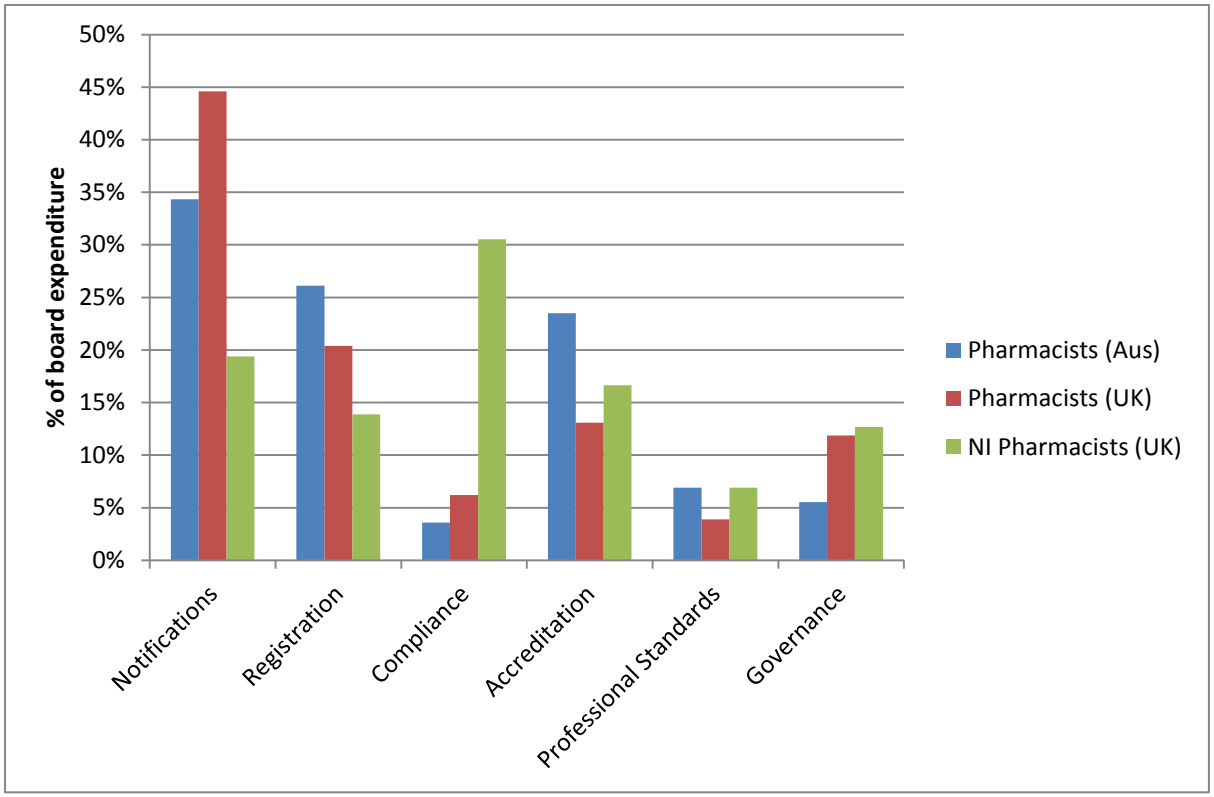


Table 16 - The hypothetical potential for cost saving by merging boards

	Number of registrants	Boards expected cost (using aggregate function)	Notifications	Registration	Compliance	Accreditation	Professional Standards	Governance	Boards expected cost (using function specific)
ATSIHPBA*	330	$372,940	$145,056	$87,491	$11,140	$26,303	$74,021	$16,650	$360,662
CMBA*	4,259	$2,576,106	$986,080	$644,270	$86,560	$269,092	$290,009	$129,593	$2,405,604
ChiroBA*	4,843	$2,838,781	$1,085,753	$712,249	$95,952	$302,440	$310,604	$143,666	$2,650,663
DBA	20,692	$8,505,211	$3,223,583	$2,212,873	$307,342	$1,132,504	$674,425	$460,613	$8,011,340
MBA	99,209	$27,801,262	$10,434,209	$7,522,450	$1,079,741	$4,709,280	$1,557,355	$1,619,874	$26,922,911
MRPBA*	14,360	$6,453,708	$2,451,633	$1,663,847	$229,323	$812,460	$554,920	$343,603	$6,055,788
NMBA	362,008	$73,933,749	$27,524,593	$20,663,103	$3,047,616	$15,277,728	$3,108,357	$4,576,064	$74,197,461
OTBA*	16,174	$7,060,677	$2,680,213	$1,825,755	$252,268	$905,258	$591,308	$378,011	$6,632,813
OptomBA*	4,790	$2,815,276	$1,076,837	$706,157	$95,109	$299,429	$308,784	$142,403	$2,628,720
OsteoBA*	1,864	$1,379,764	$530,882	$338,014	$44,632	$126,951	$186,558	$66,785	$1,293,822
PharmBA	28,252	$10,761,646	$4,070,861	$2,821,839	$394,492	$1,503,148	$796,420	$591,344	$10,178,105
PhysioBA*	26,076	$10,129,250	$3,833,564	$2,650,699	$369,943	$1,397,511	$763,059	$554,517	$9,569,293
PodBA*	4,125	$2,514,625	$962,739	$628,392	$84,370	$261,384	$285,101	$126,311	$2,348,296
PsyBA	31,649	$11,725,688	$4,432,385	$3,083,365	$432,082	$1,666,609	$846,193	$647,741	$11,108,375
Total of the 9 low risk professions remaining independent	76,821	$36,141,126	$13,752,757	$9,256,875	$1,269,300	$4,400,828	$3,364,364	$1,901,539	$33,945,662
Merging 9 low risk professions	76,821	$22,915,970	$8,614,461	$6,161,061	$879,597	$3,732,263	$1,358,584	$1,319,387	$22,065,353
Hypothetical Potential savings		**$13,225,157**	**$5,138,296**	**$3,095,814**	**$389,703**	**$668,564**	**$2,005,780**	**$582,152**	**$11,880,309**
Total expected costs of independent regulators	618,631	$168,868,682	$63,438,389	$45,560,506	$6,530,573	$28,690,097	$10,347,114	$9,797,175	$164,363,853
1 super regulator	618,631	$110,836,557	$41,124,950	$31,394,621	$4,682,809	$24,867,630	$4,137,876	$7,033,825	$113,241,712
Hypothetical Potential savings		**$58,032,126**	**$22,313,439**	**$14,165,884**	**$1,847,764**	**$3,822,467**	**$6,209,237**	**$2,763,350**	**$51,122,141**

Table 17 – Hypothetical savings for registration function

Some possible savings if the **registration** function could be performed at the cost achieved in certain situations.

	If operating at cost of PhysioBA (cheapest board in Australia) - $52.91 per head	If six most expensive regulators can reduce registration costs to the average cost of $89.66 and the rest continue at current levels	If operating at average unit cost of registration within UK - $55.44 per head
Cost for all professions	$32,731,766	$46,074,541	$34,296,903
Potential total savings if these costs could be achieved	$22,734,689	$9,391,915	$21,169,553
Cost by profession:			
Aborigine and Torres Strait Islander Health Practice	$17,460	$29,588	$18,295
Chinese Medicine	$225,344	$381,862	$236,119
Chiropractic	$256,243	$434,223	$268,496
Dentistry	$1,094,814	$1,855,245	$1,147,164
Medicine	$5,249,148	$8,895,079	$5,500,147
Medical Radiation Practice	$759,788	$943,596	$796,118
Nursing and Midwifery	$19,153,843	$22,299,693	$20,069,724
Occupational Therapy	$855,766	$1,133,959	$896,687
Optometry	$253,439	$471,767	$265,558
Osteopathy	$98,624	$167,126	$103,340
Pharmacy	$1,494,813	$3,276,949	$1,566,291
Physiotherapy	$1,379,681	$1,379,681	$1,445,653
Podiatry	$218,254	$404,663	$228,690
Psychology	$1,674,549	$4,401,110	$1,754,621

Table 18 - Total costs by function at national level (after allocating 20% of accreditation costs to notifications)

	All Professions	ATSIHPBA	CMBA	ChiroBA	DBA	MBA	MRPBA	NMBA	OTBA	OptomBA	OsteoBA	PharmBA	PhysioBA	PodBA	PsyBA
Notifications	$84,958,309	$162,746	$1,290,888	$1,558,444	$6,054,558	$39,921,285	$1,096,340	$19,618,643	$1,165,483	$764,155	$835,795	$4,308,464	$1,532,179	$725,987	$5,923,343
Registration	$63,772,359	$194,532	$660,416	$876,837	$4,575,387	$20,151,602	$974,050	$23,562,790	$1,210,174	$605,799	$342,853	$3,866,170	$1,727,656	$458,654	$4,565,439
Compliance	$8,072,309	$21,290	$77,427	$109,499	$475,310	$2,847,794	$115,995	$2,849,536	$155,434	$74,484	$46,380	$450,234	$190,147	$54,501	$604,278
Accreditation	$33,227,473	$21,230	$49,541	$258,145	$4,313,148	$17,740,859	$121,831	$5,057,854	$304,564	$536,217	$201,450	$2,357,068	$1,392,113	$216,006	$657,447
Professional Standards	$11,942,743	$155,323	$195,738	$298,228	$784,116	$3,271,168	$414,954	$3,255,616	$384,024	$309,471	$175,881	$865,811	$493,311	$186,619	$1,152,485
Governance	$12,144,609	$36,328	$129,425	$168,370	$738,341	$4,278,590	$183,075	$4,244,858	$243,841	$88,752	$57,781	$695,706	$281,284	$80,353	$917,905
Total	$214,117,803	$591,449	$2,403,435	$3,269,522	$16,940,861	$88,211,298	$2,906,245	$58,589,297	$3,463,519	$2,378,877	$1,660,139	$12,543,453	$5,616,690	$1,722,120	$13,820,898

Table 19 - Total costs by function at national level (after allocating 20% of accreditation costs to notifications)

	All Professions	ATSIHPBA	CMBA	ChiroBA	DBA	MBA	MRPBA	NMBA	OTBA	OptomBA	OsteoBA	PharmBA	PhysioBA	PodBA	PsyBA
Notifications	39.7%	27.5%	53.7%	47.7%	35.7%	45.3%	37.7%	33.5%	33.7%	32.1%	50.3%	34.3%	27.3%	42.2%	42.9%
Registration	29.8%	32.9%	27.5%	26.8%	27.0%	22.8%	33.5%	40.2%	34.9%	25.5%	20.7%	30.8%	30.8%	26.6%	33.0%
Compliance	3.8%	3.6%	3.2%	3.3%	2.8%	3.2%	4.0%	4.9%	4.5%	3.1%	2.8%	3.6%	3.4%	3.2%	4.4%
Accreditation	15.5%	3.6%	2.1%	7.9%	25.5%	20.1%	4.2%	8.6%	8.8%	22.5%	12.1%	18.8%	24.8%	12.5%	4.8%
Professional Standards	5.6%	26.3%	8.1%	9.1%	4.6%	3.7%	14.3%	5.6%	11.1%	13.0%	10.6%	6.9%	8.8%	10.8%	8.3%
Governance	5.7%	6.1%	5.4%	5.1%	4.4%	4.9%	6.3%	7.2%	7.0%	3.7%	3.5%	5.5%	5.0%	4.7%	6.6%

Table 20 – Hypothetical savings for accreditation function

Some possible savings if the **accreditation** function could be performed at the cost achieved in certain situations.

	If operating at cost of NMBA (cheapest profession with a council in Australia) - $17.46 per head	If six most expensive regulators can reduce accreditation costs to the average cost of $67.14 and the rest continue at current levels	If operating at average unit cost of accreditation within UK - $17.66 per head	If operating at cost of GOC (most expensive UK regulator) - $105.49 per head
Cost for all professions	$3,155,022	$20,487,637	3,191,162	$19,062,043
Potential total savings if these costs could be achieved	$38,379,319	$21,046,703.63	38,343,179	$22,472,298
Cost by profession:				
Aborigine and Torres Strait Islander	$541	$22,156	$547	$3,270
Chinese Medicine	$30,223	$61,927	$30,569	$182,603
Chiropractic	$28,215	$322,681	$28,539	$170,472
Dentistry	$110,609	$1,389,243	$111,876	$668,279
Medicine	$544,962	$6,660,805	$551,204	$3,292,554
Medical Radiation Practice	$83,738	$152,289	$84,697	$505,930
Nursing and Midwifery	$1,751,081	$6,322,318	$1,771,139	$10,579,698
Occupational Therapy	$79,880	$380,705	$80,795	$482,617
Optometry	$28,512	$321,596	$28,839	$172,265
Osteopathy	$9,254	$125,147	$9,360	$55,910
Pharmacy	$152,915	$1,896,814	$154,666	$923,881
Physiotherapy	$132,102	$1,740,142	$133,616	$798,137
Podiatry	$18,804	$270,007	$19,020	$113,613
Psychology	$184,186	$821,808	$186,295	$1,112,814

Centre for
Health Service Economics
& Organisation

Centre for Health Service Economics & Organisation

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Telephone: **020 7972 5219**
Email: **webenquiries@chseo.org.uk**
Web: **http://www.chseo.org.uk/**

Professional Standards Authority for Health and Social Care

157-197 Buckingham Palace Road
London SW1W 9SP

Telephone: **020 7389 8030**
Fax: **020 7389 8040**
Email: **info@professionalstandards.org.uk**
Web: **www.professionalstandards.org.uk**

Appendix 4

Assured voluntary registers in the United Kingdom

The Accredited Registers programme is run by the Professional Standard Authority (PSA). Organisations that hold a voluntary register of health and care practitioners can apply for the Accredited Registers "quality mark". The PSA states that the program "aims to enhance public protection and promote public confidence in health and social care occupations that are not statutorily regulated".

Applicant organisations holding these registers must prove that they meet the PSA's eleven standards for Accredited Registers:

Standard 1 – Register for a health of social care occupation

Standard 2 – Commitment to public protection

Standard 3 – Risks and risk management

Standard 4 – Financial sustainability

Standard 5 – Management of the register

Standard 6 – The knowledge base for the occupations on the register

Standard 7 – Governance

Standard 8 – Setting of standards for registrants

Standard 9 – Education and training

Standard 10 – The Register

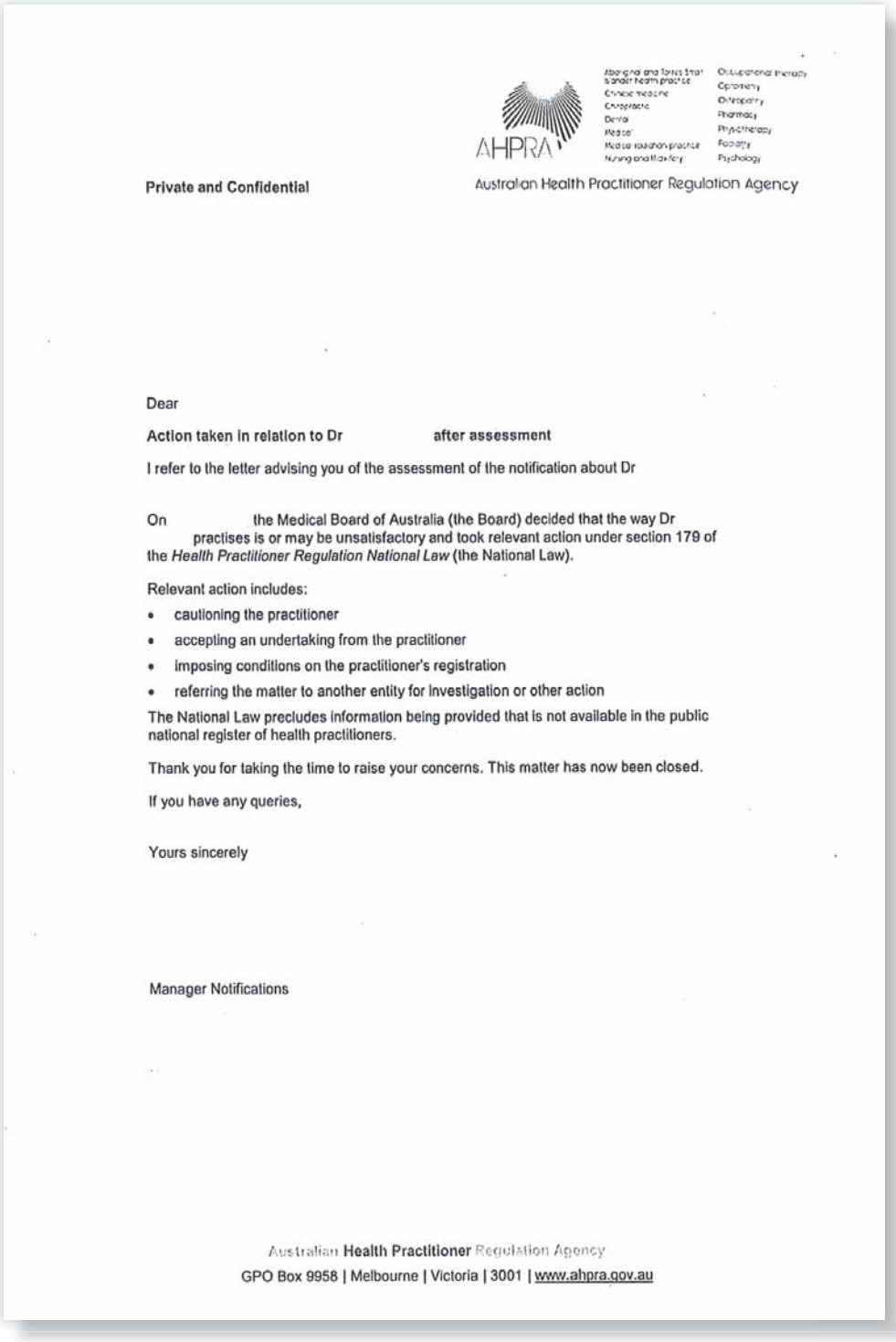
Standard 11 – Complaints.

The program is designed to provide assurance to the public that the accredited registers are well run and that the organisation requires its registrants to meet high standards of personal behaviour, technical competence and, where relevant, business practise. The PSA publishes a list of Accredited Registers on the website and allows these organisations to use the "quality mark" on their literature and their websites to show that they are accredited by the Authority.

Accreditation lasts for 12 months and is renewable annually, provided organisations demonstrate that they continue to meet the standards. Applicant organisations are charged a £12,000 fee for each new application for accreditation and a £9,000 fee for each renewal.

Appendix 5

AHPRA correspondence



AHPRA

Aboriginal and Torres Strait Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

Private and Confidential

Dear

Action taken in relation to Dr after assessment

I refer to the letter advising you of the assessment of the notification about Dr

On the Medical Board of Australia (the Board) decided that the way Dr practises is or may be unsatisfactory and took relevant action under section 179 of the *Health Practitioner Regulation National Law* (the National Law).

Relevant action includes:

- cautioning the practitioner
- accepting an undertaking from the practitioner
- imposing conditions on the practitioner's registration
- referring the matter to another entity for investigation or other action

The National Law precludes information being provided that is not available in the public national register of health practitioners.

Thank you for taking the time to raise your concerns. This matter has now been closed.

If you have any queries,

Yours sincerely

Manager Notifications

Australian **Health Practitioner** Regulation Agency
GPO Box 9958 | Melbourne | Victoria | 3001 | www.ahpra.gov.au

Appendix 6

Advertising provisions

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:

a. is false, misleading or deceptive or is likely to be misleading or deceptive; or
b. 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
c. uses testimonials or purported testimonials about the service or business; or
d. creates an unreasonable expectation of beneficial treatment; or
e. directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.'

Appendix 7

Accreditation in the United Kingdom

The accreditation arrangements in the National Scheme differ markedly from the arrangements for the quality assurance of higher education programs of study in the UK. The UK regulators quality assure relevant higher education programs of study themselves, and the activity is funded from the income from registrant fees in the same way as the regulators' other activities are funded. There is no direct charge to the institution whose course is being quality assured, although there are compliance costs.

The Professional Standards Authority sets out standards against which regulators' performance in this regard is assessed annually, in the *Standards of Good Regulation*. The standards state that "the regulator has a role in ensuring that students and trainees obtain the required skills and knowledge to be safe and effective. They also have a role in ensuring that, once registered, professionals remain up to date with evolving practices and continue to develop as practitioners. As part of this work, the regulators quality assure and where appropriate approve educational programs which students must complete in order to be registered". The standards stress that the process for quality assuring should be "focused on ensuring that education providers can develop students and trainees so that they meet the regulator's standards for registration".

A paper by the UK Council for Healthcare Regulatory Excellence in June 2009 found that there was a range of approaches being taken in the UK to the quality assurance of higher education, but stated that "the broad structure is the same, following a pattern of program approval, monitoring and reapproval", which is consistent with the arrangements for accreditation in Australia. However the paper also noted that "differences become clear both in the methods and frequency regulators adopt in employing these aspects of quality assurance".

The rationale for different approaches can in part be explained by the different role played by undergraduate education in meeting pre-registration requirements, but it was noted that UK educational institutions are also audited by the Quality Assurance Agency for Higher Education.

Health and Care Professions Council

The Health and Care Professions Council (HCPC) regulates 16 professions. Part of its brief is accreditation. It sets standards for registrants' education and training, professional skills, conduct, performance, ethics and health.

The HCPC sets the standards that are needed for safe and effective practice. These are set at a "threshold" level, which is the minimum level of safe and effective practice.

The HCPC sets "standards of proficiency" that are threshold standards for safe and effective practice that all registrants must meet. They include general elements, which all registrants must meet, and elements specific to the particular professions. They outline what an individual must know, understand and be able to do when they join the register and begin practising their profession.

The standards of education and training (SETs) are the standards that an education and training program must meet before it can be approved. These general standards ensure that anybody who completes an approved program meets the standards of proficiency for their profession and so is eligible to apply to be on the register.
The HCPC states that it has, "deliberately written the standards of education and training to reflect the fact that they are used by a number of professions in a range of settings. Our standards are general principles on which we will make judgements about the education and training provided. We deliberately use adjectives and adverbs such as 'appropriate' and 'effectively' to make sure that those making the judgements assess, in an effective way, the systems, policies and scenarios proposed by education providers.".

Appendix 8

Committee Structure of the National Boards

National Board	Committee Structure
Aboriginal and Torres Strait Islander Health Practice Board of Australia	**One national committee:** Registration and Notification Committee
Chinese Medicine Board of Australia	**Five national committees:** • Accreditation Committee • Communications Committee • Finance Committee • Registration and Notifications Committee • Policies, Standards and Guidelines Advisory Committee
Chiropractic Board of Australia	**Seven national committees:** • Accreditation, Assessment and Education Committee • Communications and Relationships Committee • Continuing Professional Development Committee • Governance, Finance and Administration Committee • Immediate Action Committee • Registration, Notification and Compliance Committee • Standards, Policies, Codes and Guidelines Committee
Dental Board of Australia	**Three national committees:** • Accreditation Committee • Administration and Finance Committee • Registration and Notification Committee **15 state and territory committees:** • 7 state and territory registration and notification committees • 1 registration committee in NSW • 7 immediate action committees across the states and territories (excluding NSW)

Medical Board of Australia	**Two national committees:** • Finance Committee • National Specialist International Medical Graduate Committee **Eight State and Territory Boards of the Medical Board of** • Australia **33 state and territory committees:** • 7 state and territory health committees; • 7 immediate action committees across the states and territories (excluding NSW); • 11 notifications committees (note four jurisdictions have two committees to deal with the volume of notifications); • 8 registration committees across the states and territories
Medical Radiation Health Practice Board of Australia	**Nine national committees:** • Communications Committee • Finance, Risk and Governance Committee • Immediate Action Committee • Notifications and Registration Committee • Overseas Qualifications • Assessment Committee • Policy, Research and Standards Committee • Professional Capabilities Working Group • Supervised Practice • Committee • Workforce Innovation and Reform Working Group
Nursing and Midwifery Board of Australia	**Three national committees:** • Accreditation Committee • Finance and Governance Committee • Policy Committee **Eight State and Territory Boards of the Nursing and Midwifery Board of Australia** **23 state and territory committees:** • 7 immediate action committees across the states and territories (excluding NSW); • 7 notifications committees (excluding NSW); • 8 registration committees across the states and territories • 1 state and territory chairs' committee
Occupational Therapy Board of Australia	**Five national committees:** • Communications Committee • Finance and Governance Committee • Immediate Action Committee • Registration and Notifications Committee • Registrations Standards, Codes and Guidelines Committee
Optometry Board of Australia	**Five national committees:** • Continuing Professional Development Accreditation Committee • Finance and Risk Committee • Policy, Standards and Guidelines Advisory Committee • Registration and Notification Committee • Scheduled Medicines Advisory Committee

Osteopathy Board of Australia	**Two national committees** • Finance Committee • Registration and Notification Committee
Pharmacy Board of Australia	**Five national committees** • Finance and Governance • Committee • Immediate Action Committee • Notifications Committee • Policies, Codes and • Guidelines Committee • Registration and • Examinations Committee
Physiotherapy Board of Australia	**Two national committees** • Continuous Improvement Committee • Registration and Notifications Committee (except Victoria) **One state and territory committees:** • (Vic) registration and notification committee
Podiatry Board of Australia	**Five national committees** • Finance Committee • Immediate Action Committee • Registration and Notification Committee • Scheduled Medicines Advisory Committee • Strategic Planning and Policy Committee
Psychology Board of Australia	**Four national committees** • Finance and Management Committee • National Examination Committee • Accreditation Advisory Committee • Notifications Audit Committee **2 state boards;** • New South Wales • Queensland **2 regional boards** • Australian Capital Territory, Tasmania and Victoria • Northern Territory, South Australia and Western Australia **6 state and territory committees** • 3 immediate action committees (excluding NSW) • 3 impaired practitioner committees (excluding NSW)
Totals	**14 National Boards** **58 National Committees** **18 State and Territory Boards** **2 Regional Boards** **78 State and Territory or Regional Committees**

Appendix 9

Correspondence to State and Territory Tribunals

Dear

I have been appointed by the Australian Health Workforce Ministerial Council, comprised of all Australian Health Ministers, to undertake an independent Review of the National Registration and Accreditation Scheme. For your information the terms of reference are attached. The scope of this Review encompasses all functions and activities under the *Health Practitioner Regulation National Law Act 2009* (the National Law) passed by each State and Territory Parliament.

During the course of this Review, issues associated with notifications, investigations and ultimately the work of tribunals has been raised. To assist in the Review process and to inform the final report to Health Ministers, I would appreciate your comments in a number of key areas.

Firstly, while professional standards have been set under the the National Law, each State and Territory has separate and sometimes different tribunal processes. I would appreciate your advice on what efforts, if any, your disciplinary hearings take to ensure consistency in outcomes for similar breaches of professional standards as described in the National Law.

Secondly, does your tribunal share your decisions and associated rationale with colleague tribunals, and are regular meetings or contact held?

Finally, given the unique nature of the National Law and the emphasis on public safety protection as a primary principle in considering professional conduct, it would be helpful to understand what steps, if any, are taken to ensure members of tribunals are fully acquainted with these features.

If you have any questions associated with the Review please don't hesitate to contact me.

Yours sincerely

Mr Kim Snowball
Independent Reviewer
Review of the National Registration and Accreditation Scheme for health professions

Appendix 10

Correspondence to stakeholders regarding regulation of Aboriginal and Torres Strait Islander Health Practitioners

Dear

I am currently undertaking an independent review of the National Registration and accreditation scheme for health professions for the Australian Health Ministers. I have attached the terms of reference for this review for your information.

A key part of the review is to examine every aspect of the scheme and advise Ministers on how well the scheme is operating and delivering against the objectives laid out in the national law enacted by all State and Territory Parliaments in 2010.

As you may be aware the introduction of the scheme included a commitment to establish national regulation of Aboriginal and Torres Strait Islander Health Practitioners under the Aboriginal and Torres Strait Islander Practice Board of Australia, this was proposed by the Northern Territory (which had already established registration for Aboriginal and Torres Strait Islander Health Workers) and was supported by all jurisdictions. The profession was included in the scheme in July 2012.

This support was premised on action by the jurisdictions to focus on reviewing their Aboriginal Health Worker positions (the common use title for these Health Practitioners) and ensuring that the occupants of these positions met the required entry qualifications and experience before they were to be regulated. This approach would avoid the potential loss of many experienced Aboriginal Health Workers who would not have met the new regulatory standard. This process was also designed to only focus on regulating those Aboriginal Health Practitioners who were providing clinical services. This recognised that in many circumstances the title of Aboriginal Health Workers was also being applied to positions that were not providing a direct clinical service.

Once completed it was expected that the relevant jurisdiction would change the title from the common use title to the protected title. This would have ensured a significant and growing number of regulated Aboriginal Health Practitioners over time. Unfortunately, the action to reassess positions and focus on a career path for the practitioners across the States and Territories has not occurred and as a consequence the number of regulated professionals is unsustainably low at just 330 registrants.

As the National Law does not allow for lower levels of regulation for professions with little risk to the public or of a small size then the regulation of the small number of registered Aboriginal and Torres Strait Islander Health Practitioners has come at an extraordinary cost. It has a separate National Board, registration processes, complaints and notification and accreditation bodies.

This extra cost has been subsidised by the Australian Health Workforce Ministerial Council in the initial establishment of the Aboriginal and Torres Strait Islander Practice Board of Australia. If subsidisation had not occurred then the registration fee of $100 would have been approximately $1,792.

The presence of the National Aboriginal and Torres Strait Islander Board has been a positive benefit in drawing attention to the importance of Aboriginal and Torres Strait Islander Health workers and practitioners in addressing the health of Aboriginal and Torres Strait Islander people. The substantial benefit of having health practitioners with understanding of cultural issues and cultural norms cannot be underestimated. However the initial intention of a steadily increasing level of registrants into the Scheme has not occurred and only 330 registrants are regulated from a possible base of approximately 1,237 (based on 2011 census of population and housing self identified occupation.). Leaving the profession unable to meet the costs of regulation from its registration fees.

This represents a major problem for sustainability and capacity to provide adequate regulation in the key functions due to the very low level of activity. The vast majority of registrants are from the Northern Territory, which reflects the fact that the NT was the only jurisdiction regulating "Aboriginal health Workers" from 1985.

While the independent review is in the consultative phase and a consultation paper has been released (see WWW.AHMAC.gov.au) I have chosen to separately canvass the issues associated with the regulation of Aboriginal and Torres Strait Islander Health Practitioners with those jurisdictions and organisations who significantly employ Aboriginal Health Workers and Health practitioners.

I am seeking your advice and suggestions about the best way forward in the future regulation of this profession, particularly ways in which the number of registrants can be increased or alternative approaches to regulation of this profession that would reduce the costs involved to a appropriate level, capable of support from the registration revenue.

If you wish to discuss this further please contact me.

Yours sincerely

Mr Kim Snowball
Independent Reviewer
Review of the National Registration and Accreditation Scheme for health professions

Appendix 11

List of proposed amendments canvassed in consultation paper

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

Proposed further legislative amendments made by AHPRA and the National Boards

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

There is no avenue for ending a suspension imposed under section 156 (immediate action). This is problematic as a National Board may want *t*o 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.

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.

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.

Information on the Register

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.

This concern could be addressed by the inclusion of 'or any other affected person' after 'the practitioner' in both s226(2)(a) and (b).

Conditions on registration

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.

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.

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.

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).

Abrogation of right against self-incrimination

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

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.

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.

Notice requirement at section 180

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.

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.

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 …'

It should be noted that an equivalent provision to section 180.

Appellable decisions

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.

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.

A new subsection (3) could to 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.

Obtaining information from other government agencies

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.

Notice of a decision to take action

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.

Definition of terms

Accreditation function – functions listed in National Law as: to develop standards, apply the standards in accrediting training programs that qualify practitioners for registration, assess equivalence of overseas qualifications, examine overseas trained practitioners, assess competent authorities.

Agency Management Committee – means the Australian Health Practitioner Regulation Agency Committee established under section 29 of the National Law.

AHPRA or 'the National Agency' – means the Australian Health Practitioner Regulation Agency established under the National Law.

AHWAC or 'Advisory Council' – means the Australian Health Workforce Advisory Council established under section 18 of the National Law.

AHWMC or 'Ministerial Council' – means the Australian Health Workforce Ministerial Council defined under the National Law as comprising Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health.

Health Complaints Entity – means an entity that is established by or under an Act of a participating jurisdiction whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system.

Health practitioner – means an individual who practices a health profession.

Health profession – means the professions listed in section 5 of the National Law (14 professions)

IGA – Intergovernmental Agreement, also defined in the National Law as 'the COAG Agreement'.

Mandatory notification – means a notification an entity is required to make to the National Agency under Division 2 of Part 8 of the National Law.

National Board – a National Board established for a health profession under section 31 of the National Law. There are 14 National Boards.

National Law – means the Health Practitioner Regulation National Law Act as in force in each State and Territory.

NRAS or 'the National Scheme' – means National Registration and Accreditation Scheme for the health professions as referred to the COAG IGA and established under the Health Practitioner Regulation National Law.

Notification – means a mandatory or a voluntary notification under Part 8 Division 2 of the National Law.

Notifier – means a person who makes a notification (complaint) to AHPRA about a registered health practitioner.

PESCI – Pre-employment structured clinical interview

Responsible tribunal – means a tribunal or court that hears disciplinary matters and appeals arising from the National Scheme in a participating jurisdiction. In Victoria the responsible tribunal is the Victorian Civil and Administrative Tribunal (VCAT).