The Australian Health Practitioner Regulation Agency and the National Boards, reporting on the National Registration and Accreditation Scheme

Annual Report 2010-11

AHPRA

Chiropractic
Dental
Medical
Nursing and Midwifery
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

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This annual report is prepared and submitted in accordance with Clause 8 to Schedule 3 of the *Health Practitioner Regulation National Law Act* (the National Law) as in force in each state and territory. All references in this report should be understood to refer to the National Law as in force in each state and territory.

Copies of this annual report are publicly available at www.ahpra.gov.au and at no cost by contacting the Australian Health Practitioner Regulation Agency (AHPRA) by telephone on 1300 419 495, in writing to GPO Box 9958, Brisbane Q 4001 or by email through the online enquiry form at the AHPRA website at www.ahpra.gov.au.

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2010-11 – At a Glance

- On 30 June 2011, there were more than 530,000 health practitioners from 10 professions registered under the National Registration and Accreditation Scheme.
- More than 46,000 health practitioners across the professions have registered, many for the first time which means new practitioners delivering health services throughout Australia.
- AHPRA renewed the registration of more than 630,000 health practitioners. Some practitioners renewed more than once in the process of aligning national renewal dates for each profession.
- The AHPRA website at www.ahpra.gov.au hosted close to six million visits.
- AHPRA responded to 310,000 phone calls to state and territory offices from January to June 2011.
- AHPRA issued more than 850,000 certificates of registration to health practitioners across Australia.
- The National Scheme received 8,139 notifications about health practitioners, 428 of them mandatory reports.
- There were almost 1,500 meetings of National Boards, state and territory boards and their committees.
- There were almost 100,000 students registered after the student register was introduced in April 2011.
- AHPRA conducted Australia's largest-ever simultaneous renewal of health practitioner registration in May and June 2011 when 320,000 practitioners renewed registration.
- Online renewal rates increased significantly over 12 months – up from an average of 60% when the National Scheme began, to more than 80% of practitioners renewing online by year's end.
- More than 91% of practitioners have provided their email address to AHPRA, improving direct communication about registration renewals and important board issues.
- One in 44 Australians – or one of every 20 working Australians - is a registered health practitioner.

The journey so far

July 2006 — Council of Australian Governments (COAG) agrees to establish a single national registration scheme for health professionals and single accreditation scheme for health education and training

March 2008 — COAG members sign Intergovernmental Agreement to establish National Scheme

November 2008 — Queensland's *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (Act A) establishes the Ministerial Council, the National Boards and AHPRA

Nov 08 – April 09 — Consultation on the National Scheme with stakeholders through National Registration and Accreditation Implementation Project (NRAIP)

March 2010 — Ministerial Council approves mandatory registration standards developed by National Boards, following widespread consultation

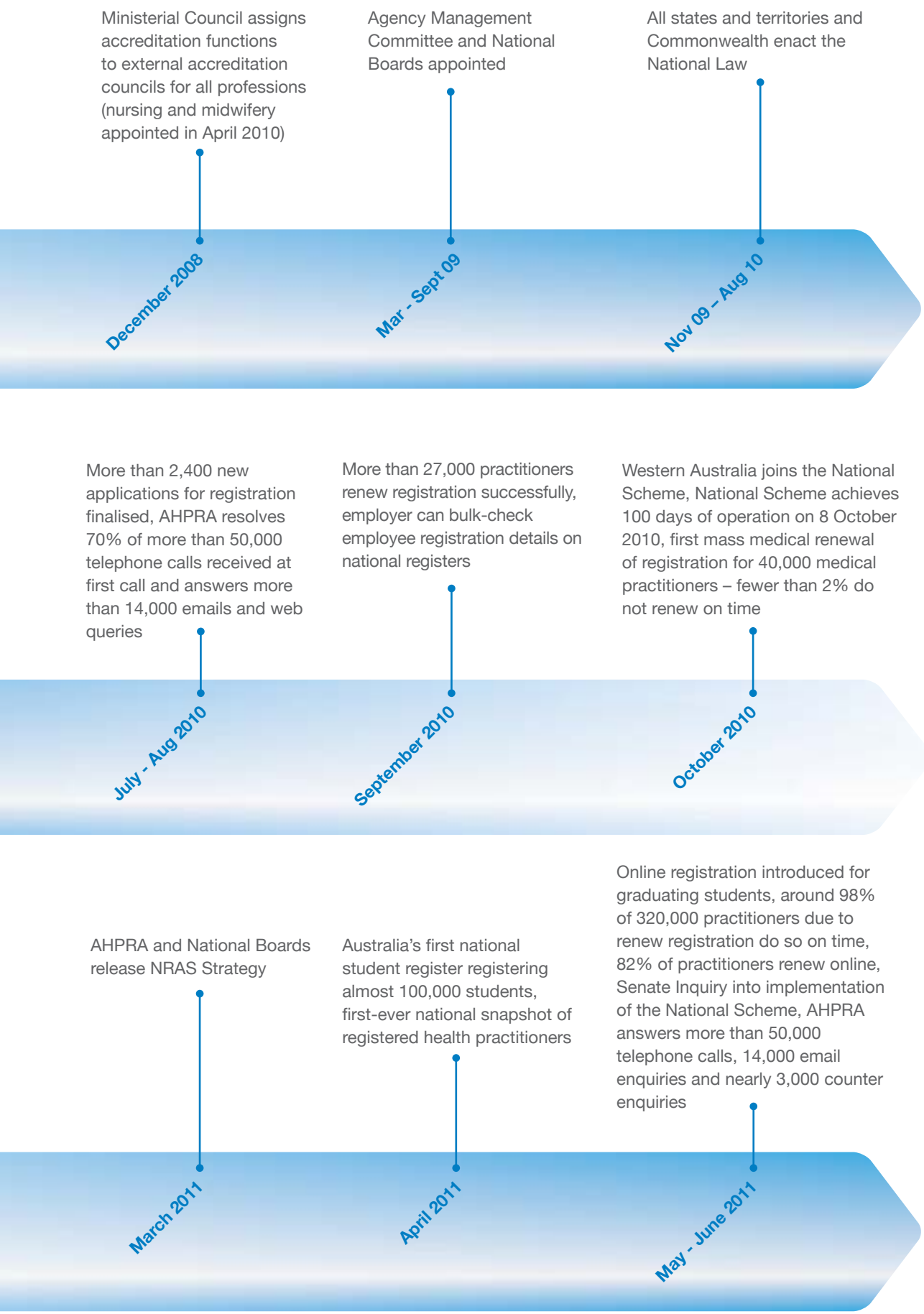
April - June 2010 — National Boards and AHPRA advise registrants on transition arrangements to National Scheme

1 July 2010 — 500,000 health practitioners transfer to national registers, the National Law and the National Scheme begin, National Boards start regulating 10 professions, AHPRA begins operations, more than 400 staff members transfer to AHPRA

November 2010 — Early application service introduced for up to 30,000 graduates, first AHPRA annual report published

January 2011 — Online service to check receipt of registration renewal introduced

February 2011 — Customer service teams start in each AHPRA state and territory office


Ministerial Council assigns accreditation functions to external accreditation councils for all professions (nursing and midwifery appointed in April 2010)
December 2008
Agency Management Committee and National Boards appointed
Mar - Sept 09
All states and territories and Commonwealth enact the National Law
Nov 09 – Aug 10
More than 2,400 new applications for registration finalised, AHPRA resolves 70% of more than 50,000 telephone calls received at first call and answers more than 14,000 emails and web queries
July - Aug 2010
More than 27,000 practitioners renew registration successfully, employer can bulk-check employee registration details on national registers
September 2010
Western Australia joins the National Scheme, National Scheme achieves 100 days of operation on 8 October 2010, first mass medical renewal of registration for 40,000 medical practitioners – fewer than 2% do not renew on time
October 2010
AHPRA and National Boards release NRAS Strategy
March 2011
Australia's first national student register registering almost 100,000 students, first-ever national snapshot of registered health practitioners
April 2011
Online registration introduced for graduating students, around 98% of 320,000 practitioners due to renew registration do so on time, 82% of practitioners renew online, Senate Inquiry into implementation of the National Scheme, AHPRA answers more than 50,000 telephone calls, 14,000 email enquiries and nearly 3,000 counter enquiries
May - June 2011

Foreword

from the Agency Management Committee Chair

On any measure, this has been a momentous first year for the National Registration and Accreditation Scheme for health professionals. The significance of the change and what has been accomplished is a world first. This past year has seen AHPRA established at breakneck speed as a new national organisation with responsibility for implementing a complex range of regulatory functions, alongside the National Boards. With more than 530,000 health practitioners in the National Registration and Accreditation Scheme, AHPRA has a span of responsibilities which directly impact on one in 44 - and indirectly on all - Australians. Because of the important public safety issues involved, every member of the Australian community has a vital interest in our work.

At the end of our first year of operations, I am pleased to report that AHPRA is functioning well, that our systems are robust, that our partnership with National Boards is strong, and that the complex network of relationships that help make the National Scheme work effectively are building progressively. To have made this much progress on so many fronts in one year is a substantial achievement.

This report profiles the first year of the National Scheme, by detailing the actions and achievements of AHPRA and the 10 National Boards. It describes and contextualises our work in our first year of service delivery. It has been a journey of significant change, challenge and opportunity. In particular, there are three milestones that I would like to highlight.

First: the realisation of vision. It has been little more than three years since the Council of Australian Governments (COAG) formalised their Intergovernmental Agreement to establish a national scheme for the registration and regulation of health professions and the accreditation of their education and training. Governments set a clear vision for a modernised national practitioner regulation system focused on patient and public safety as well as workforce sustainability. This is reflected in the ideals and objectives of the National Law which underpins our work. The focus is on public protection, fairness, openness and transparency, best practice and a recognition of the wider context of workforce requirements and needs in which all our work occurs.

Second: the work of AHPRA to develop a clear roadmap for improving the way we work to maximise the benefits of the National Scheme and support the regulatory functions of the National Boards. As we have moved beyond the early challenges of transition and implementation, AHPRA has become far more rigorous and demanding in assessing its own processes, systems and programs. This is not always easy but has distinguished an organisation that is maturing rapidly. AHPRA continues to engage actively with stakeholders, the community and boards

about achieving high standards for regulatory excellence and harnessing the benefits of a national approach.

Third: our increasing confidence in being able to anticipate and manage our responsibilities. There is a growing list of examples including the success of the 2011 nursing and midwifery registration renewal campaign (the biggest single renewal ever undertaken in Australia), our committed program of work to ensure national consistency in our approach to managing notifications, our capacity to better respond to practitioner and community queries across all of our state and territories offices, and our strengthening partnership with National Boards as we advance our shared goals of implementing best practice regulation. Taken together, these provide substantial assurance that we can continue to meet the challenges ahead.

There are, of course, many people to thank for the successful introduction of the National Scheme. In particular, the insight and leadership of Australia's health ministers, and their senior officials whose combined will and commitment saw the legislation to support the National Scheme introduced in all jurisdictions. The continued support of Ministers and their departments through this first year has been critical and valued greatly.

I thank the National Boards for their leadership and the diligence with which they exercise their responsibilities in close collaboration with AHPRA.

My colleagues on the Agency Management Committee have provided energy, insight, resilience and focus as we have guided the work of AHPRA in embedding the safe delivery of the National Scheme.

Finally I thank Martin Fletcher, senior managers and staff at AHPRA for their hard work and unstinting commitment to ensuring the National Scheme delivers on its promise for the benefit of all Australians.

Peter Allen

Chair
Agency Management Committee

Foreword

from the Chief Executive Officer

AHPRA has covered enormous ground at great pace to establish itself as a new national regulatory organisation. I would like to personally thank our many talented and dedicated staff who, in partnership with National Boards and the Agency Management Committee, have brought the National Registration and Accreditation Scheme to life with energy, commitment and sheer hard work.

Implementing the National Scheme has meant significant upheaval and no part of Australia's health system has been untouched. However, while many features of the National Scheme are new and different, the core focus of practitioner regulation on patient and public safety remains unchanged.

AHPRA exists to implement the National Scheme in partnership with 10 National Boards. This means that we administer registration standards set by these boards, which health practitioners must meet. We maintain national registers of health practitioners who meet the required registration standards, including any conditions or special requirements associated with their registration. We work with and on behalf of National Boards to take appropriate action when concerns have been raised about the conduct, health or performance of a registered health practitioner. And we work with accreditation councils and National Boards to ensure continued high standards of education for those training to be a health practitioner.

The work of the National Boards is detailed in this annual report. AHPRA is proud to have worked closely with the National Boards over the past year. There is cross-profession collaboration between the National Boards about matters of common interest and profession-specific focus on issues that require this. We look forward to working with four new National Boards for the 2012 professions as they prepare to join the National Scheme in July 2012.

AHPRA experienced some well-documented difficulties with transition and early implementation. I have been heartened by the strong support for the objectives of the National Scheme expressed by the diverse range of organisations with which we work, who see the many advantages of national registration for the public and practitioners.

For the first time, there are nationally-consistent standards that all practitioners must meet. The framework provided by the National Law sets tougher requirements designed for greater public protection. Registration and practice across geographic boundaries is no longer a barrier. Most health practitioners can register once and practise Australia-wide. And as can be seen in this annual report, national registration also means better and more consistent practitioner data across Australia which will be useful for workforce policy and planning.

The foundations of the National Scheme are solid. A major focus in the past year has been to get the basics right. AHPRA systems and processes are working well and improvements are being added all the time.

Services to the community and practitioners are more accessible and becoming more responsive. While much has been achieved, there is of course more to do to fully realise the benefits of the National Scheme.

We are continuing to develop and implement nationally-consistent work processes across AHPRA, which make the most of the National Law. We have a relentless focus on implementing standardised operational processes and procedures wherever possible, delivering staff and board education and training, and making continued improvements in our information systems. We are working hard to embed the 'national' in the National Registration and Accreditation Scheme.

We will continue to build strong partnerships. More than anything, the National Scheme is about partnership in a complex environment with new roles and responsibilities. To work well, it relies on a series of constructive and mutually respectful relationships: between AHPRA and the National Boards; between boards and their professions, in each state and territory and nationally; with accreditation councils; and with our many stakeholders in government, education providers, employers, practitioners and the community.

We want to strengthen our engagement with the health professions and the community. During the past year, AHPRA has worked to inform the professions and practitioners about the National Scheme and to respond quickly and constructively to suggestions for improvement. Open collaboration with these stakeholders has been crucial. Over the coming year, we will continue to strengthen our dialogue with stakeholders nationally and in states and territories. We also want to strengthen our links with consumers and the community.

Martin Fletcher

Chief Executive Officer
Australian Health Practitioner Regulation Agency

Changing regulation for changing times

Introduction

Over the past year, the regulation of health practitioners in Australia has undergone reform on an unprecedented scale. The outcome of this process is a national system of health practitioner regulation in which uniform standards apply in each profession, increasing public and patient safety.

Historically, the regulation of health professionals was undertaken by states and territories, without a consistent approach across Australia. In July 2006, the Council of Australian Governments (COAG) agreed to implement a National Registration and Accreditation Scheme for health professionals, beginning with those professions currently registered in all jurisdictions. In March 2008, COAG members signed the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* to implement the National Scheme by 1 July 2010.

On 1 July 2010, Australia introduced the National Registration and Accreditation Scheme (the National Scheme) to regulate health practitioners for states and territories other than Western Australia, which joined the National Scheme on 18 October 2010. The National Scheme involved the creation of a single national system for 10 health professions: chiropractic, dental, medicine, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology. The new arrangement aims to provide stronger safeguards for the public, facilitate health practitioners moving around the country more easily, reduce red tape and promote a more flexible, responsive, safe and sustainable health workforce.

The National Scheme marks the first time one country has regulated the practice of 10 health professions – made up of more than 530,000 health practitioners - using a single National Law, to protect the public and facilitate access to health services.

What are the objectives of the National Scheme?

The National Scheme has been established by states and territories through a national 'applied laws' model. It is not a Commonwealth scheme. The *Health Practitioner Regulation National Law* has been enacted in each state and territory. It established a national system of regulation for health practitioners in the 10 health professions. Queensland enacted the National Law in terms agreed by the jurisdictions and other jurisdictions proceeded to adopt the National Law, or pass corresponding legislation in the case of Western Australia. The National Law received royal assent in each state and territory parliament progressively: in November 2009 in Queensland and New South Wales, in December 2010 in Victoria, in March 2011 in the Australian Capital Territory and the Northern Territory and in June 2011 in South Australia and Tasmania. In October 2011, it was proclaimed in Western Australia.

The objectives of the National Scheme, defined in the National Law, are:

- protecting the public by ensuring that only suitably trained and qualified practitioners are registered
- facilitating workforce mobility across Australia
- facilitating the provision of high-quality education and training of health practitioners
- facilitating the rigorous and responsive assessment of overseas-trained health practitioners
- enabling the continuous development of a flexible, responsive and sustainable Australian health workforce and
- enabling innovation in the education of, and service delivery by, health practitioners.

The National Law also sets out three guiding principles for the National Scheme:

- transparent, accountable, efficient, effective and fair operation of the National Scheme
- that the 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 and
- that restrictions on the practice of a health profession are to be imposed only to the extent necessary to ensure health services are provided safely and are of an appropriate quality.

Although the intention of the National Scheme was to implement uniform legislation, several jurisdictions have made amendments. In particular, New South Wales opted out of Part 8 of the National Law and retained its own complaints system, rather than using the national system for dealing with notifications about health practitioners.

What are the roles and responsibilities within the National Scheme?

Figure 1: The architecture of the National Scheme

The National Scheme includes a number of different entities with distinct roles and responsibilities. These are outlined in *Figure 1: The architecture of the National Scheme*. Together, these entities have a shared responsibility for the regulation of health practitioners within the National Scheme.

Australian Health Workforce Ministerial Council

The Australian Health Workforce Ministerial Council (the Ministerial Council) is made up of the health ministers of each state and territory and the Commonwealth. The functions of the Ministerial Council are set out in the National Law and include:

- appointing the National Board members and the Agency Management Committee
- the capacity to give directions to the Australian Health Practitioner Regulation Agency (AHPRA) and the boards about the policy they must apply in exercising their functions
- approving registration standards, lists of specialties and specialist titles and endorsements in relation to scheduled medicines and areas of practice.

The Australian Health Workforce Advisory Council (AHWAC) can provide independent advice to the Ministerial Council about matters related to the National Scheme.

National Boards

The National Boards are established under the National Law for each of the regulated health professions with members appointed by the Ministerial Council in August 2009. Under the National Scheme, the major regulatory policy role rests with the National Boards.

Functions are set out in the National Law and include:

- responsibility for registering health practitioners who meet the requirements of the approved registration standards (English language skills, professional indemnity insurance, recency of practice, continuing professional development and criminal history)
- investigation and management of concerns (notifications) about performance, conduct or health of practitioners
- development of standards, codes and guidelines and
- setting national fees.

The National Boards can – and do - delegate functions to AHPRA and board committees (national or state and territory or regionally-based) to support the efficient and effective functioning of the National Scheme. The details of the arrangements for National Boards are outlined in the separate National Board reports.

AHPRA Agency Management Committee

The Agency Management Committee was appointed by the Ministerial Council in March 2009 in accordance with the *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008*.

The role of the Agency Management Committee is to oversee the affairs of AHPRA, to decide the policies of AHPRA, and to ensure AHPRA functions properly, effectively and efficiently working with the National Boards.

The Committee consists of at least five people:

- a Chair who is not a registered health practitioner and has not been a health practitioner in the last five years
- at least two people with expertise in health and/or education and training and
- at least two people with business or administrative expertise who are not current or previous registered health practitioners

The members of the Agency Management Committee are Peter Allen (Chairperson), Professor Con Michael AO, Professor Genevieve Gray, Michael Gorton AM and Professor Merrilyn Walton.

Biographies of the Agency Management Committee members are published in this annual report in the financial statements.

Australian Health Practitioner Regulation Agency

AHPRA administers the National Scheme and provides operational and administrative support to the National Boards in their core role of protecting the public. It performs the functions directly conferred on it by the National Law.

Accreditation authorities

Accreditation authorities recommend accreditation standards to National Boards for approval and assess programs of study and education providers to determine whether accreditation standards are being met. Accreditation standards help to ensure that education providers and programs of study provide students with the knowledge, skills and professional attributes to competently practise the profession in Australia. Accreditation authorities also assess overseas authorities and in some cases assess overseas-qualified practitioners.

The Ministerial Council appointed external accreditation authorities for the health professions in the National Scheme (with the exception of nursing and midwifery) in December 2008. The accreditation authority for nursing and midwifery was appointed in April 2010. All accreditation authorities have been assigned for a period of three years commencing 1 July 2010.

The external accreditation authority for each health profession in the National Scheme is:

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

The objectives and principles of the National Law apply to accreditation authorities in the way they carry out their accreditation functions. The National Law also allows AHPRA to enter into contracts with each accreditation authority on behalf of National Boards.

NRAS strategy

In March 2011, the Agency Management Committee and National Boards endorsed a strategy for the National Scheme for the next three years. The *National Registration and Accreditation Scheme Strategy 2011-2014* sets out the vision, mission and strategic priorities of the National Scheme. This statement was developed jointly by the National Boards and AHPRA.

Figure 2: The National Registration and Accreditation Scheme Strategy 2011-2014

AHPRA corporate plan 2011-2012

AHPRA's first corporate plan was approved by the Agency Management Committee in December 2010. The focus for this first phase of development is on designing and building an organisation capable of delivering all the potential benefits of the National Scheme. This includes investing in developing AHPRA's people, relationships, systems and processes, and the continuous improvement of information and services.

The corporate plan is available on the AHPRA website at www.ahpra.gov.au.

The National Scheme: Key features

The National Law was shaped by the 65 acts of parliament it replaced. Many features of the National Scheme are new, but there is also important continuity with previous laws. The National Law has set a new, nationally-consistent and in many cases, higher benchmark for patient safety. In developing the National Law, where one jurisdiction had an arrangement in place that protected public safety better than arrangements in other jurisdictions, ministers largely chose to incorporate the more robust approach in the National Scheme.

Significant changes accompanied the introduction of the National Law and are summarised in *Table 1: Significant features of the National Law*.

Table 1: Significant features of the National Law

Feature	New requirement under the National Law
Getting registered	
Student registration	Students in approved programs of study must be registered from the point set by the relevant National Board (except psychology).
Criminal record	Applicants for initial registration must undergo a criminal record check. National Boards may also require criminal record checks at other times.
English language skills	Practitioners must meet the English language skills required by the approved registration standard for their profession to be eligible for registration.
Identity checking	Applications for registration must be accompanied by proof of the applicant's identity.
Specialist registration	Separate registers of specialists are established under the National Law for the medical, podiatric and dental professions. The National Scheme provides for specialist registration standards, including approved lists of specialties and protected specialist titles, for medical specialists, dental specialists, and podiatric surgeons.
Endorsements for extended practice	National Boards may grant endorsements for scheduled medicines, acupuncture and approved areas of practice in specified circumstances.
Standard registration types	Before the National Scheme was introduced, registration types varied between state and territory legislation and between professions. Under the National Law, there is a range of consistent and specific registration types across professions.
Staying registered	
Continuing professional development	Practitioners must undertake continuing professional development required by the relevant registration standard for their profession.
Professional indemnity insurance	Registered practitioners must not practise their profession unless professional indemnity insurance arrangements are in place which meet the approved registration standard.
Recency of practice	Practitioners must meet the recency of practice requirements set in the approved registration standard for their profession.
Registration expiry	If practitioners do not renew their registration by the end of the late period (one month after their registration expiry date), their registration will lapse. They will need to make fresh applications to become re-registered and be able to practise.
Managing notifications	
Notifications	There is a nationally-consistent process for managing notifications about registered health practitioners and in certain circumstances, registered students and for ensuring outcomes apply nationally.
Mandatory reporting for students and practitioners	Practitioners and employers must notify AHPRA of notifiable conduct by registered practitioners that would place the public at risk of harm, such as practising while intoxicated. Education providers must notify AHPRA if they reasonably believe that a registered student has an impairment.

The National Scheme: Key benefits

The National Scheme strikes a careful balance between public safety and supply of a flexible and qualified health workforce. It brings substantial benefits to the community, individual practitioners and to the health professions, including:

- **mobility:** practitioners with general registration can register once and practise anywhere in Australia
- **uniformity:** there are now consistent national standards in relation to registration and professional standards for each profession
- **efficiency:** less red tape associated with registrations and notifications, processes are being streamlined and there will be considerable economies of scale
- **collaboration:** sharing, learning and understanding of innovation and good regulatory practice between professions and
- **transparency:** national online registers displaying all registered health practitioners, including current conditions on practice (except health-related conditions).

Table 2: The changing face of professional regulation in Australia shows direct benefits arising from the introduction of the National Scheme.

Table 2: The changing face of professional regulation in Australia

Pre-National Scheme	Post-National Scheme
Eight separate regulatory systems	One National Scheme[1]
65 different pieces of legislation	One nationally-consistent law
85 health practitioner registration boards	One National Board per profession, supported by committees at national, state and territory level
38 regulatory organisations	One National Agency
Registration required to practise in different states or territories	Australia-wide registration for all practitioners covered by the National Scheme
Fee differences across states and territories	One fee schedule per profession, with no cross-subsidisation between professions
1.2 million data items held by 85 boards	One set of national registers of practitioners, available online at www.ahpra.gov.au
Different dates to renew registration across jurisdictions	One annual renewal date for each profession from 2012
Differences in conditions and types of registration within and across professions	National consistency as registration conditions and types are standardised within and across professions
Differences in requirements to be eligible for registration	Uniform registration standards within professions and broad consistency among professions
Largely paper-based systems	Able to capitalise on the digital age and expand online services for practitioners and the community to improve accessibility
Limited national data on practitioners	Nationally-consistent data on the regulated professions

1 New South Wales operates a co-regulatory model where notifications involving registered health practitioners are managed through the NSW Health Care Complaints Commission and the health professional councils.

First year of operation

2010-11 in review

A major focus of the first year has been on transition and the early implementation of the National Scheme. Its introduction involved the largest change to the practitioner regulatory framework ever undertaken in Australia. Major priorities for AHPRA have been to ensure that all processes and systems are working according to specifications, improving service delivery to health practitioners and working with new staff across the organisation to embed national consistency within the requirements of National Boards and the framework of the National Law.

No part of the health system has been untouched by the move to national registration. It is different for the community, which can now access information about every registered practitioner online (through the national registers for each profession) and for whom there is now a 'one stop shop' to raise concerns about health practitioners. It is different for practitioners, who must now meet new professional standards for registration and engage in new ways with AHPRA which administers the National Scheme.

It is different for the stakeholders of National Boards and AHPRA, including employers and professional associations, who must establish new relationships and new ways of working together in the interest of responsible regulation at a national level. It is different for National Boards and their state, territory and regional boards, which have to regulate their professions in the public interest through a new law, in a new model of regulation and with a new partner – AHPRA – to support them. And of course it is new for AHPRA, which only completed its first full year of operation on 30 June 2011.

The initial implementation of the National Scheme proved challenging, with new systems, a new law, significant uncertainty among practitioners about the implications of national registration, significant demand for information and services and rapidly-evolving processes in place to support the impact of the change. Over several months, AHPRA rolled out a comprehensive action plan to address areas of concern identified in the early months of the National Scheme. The action plan put in place robust and strengthened systems that now work well administratively and meet National Law requirements of public protection and patient safety. A major emphasis has been to implement initiatives which support greater national consistency in processes. This is an ongoing focus.

Change of this scale always takes time to embed. It requires new understanding that only deepens with time, and new relationships that only flourish if they are built on trust. These will take longer than 12 months to develop fully. AHPRA is confident that by the end of its first year of operation, the foundations of the National Scheme are strong and will support the continued development of a world-class regulatory system into the future.

In March 2011, the Senate referred AHPRA's administration of health practitioner registration to the Senate Finance and Public Administration committees for inquiry and report. At that time, although AHPRA is not a Commonwealth agency, the Agency Management Committee welcomed the Senate's scrutiny of the early implementation of the National Scheme. When the committee report and the Government senators' minority report were published in June 2011, the Agency Management Committee was pleased that they did not identify any new issues that AHPRA had not already addressed. Throughout the Inquiry, senior AHPRA personnel listened carefully to all presentations and analysed every written submission to identify implementation issues that required action. AHPRA acknowledged that many concerns expressed by stakeholders about the early implementation period were valid and noted that most submissions from organisations confirmed support for the National Scheme.

The Ministerial Council also monitored the implementation of the National Scheme. In February 2011, responding to challenges with the early implementation, Ministers agreed to provide additional support for AHPRA in strengthening systems and making processes more robust. This additional support was greatly appreciated. AHPRA continues to feedback regularly to the Ministerial Council and provide updates on the progress of the National Scheme.

Services to practitioners

Contacting AHPRA

During 2011, AHPRA invested heavily in improving community and practitioner access to accurate and complete information about how the National Scheme works and what it means for them. As a cornerstone, this involved establishing and strengthening customer service teams within each state and territory office with direct access to the computerised registration system. This means that individual practitioner queries - by phone and email - can be dealt with far more effectively and quickly. AHPRA also increased the staffing of customer service teams in each state and territory office so they can manage up to 3,000 phone calls per day, as required.

In the first six months of 2011, AHPRA customer service teams answered 310,000 phone calls.

AHPRA closely monitors the reasons why practitioners contact it and ways in which it can improve the accessibility of information. Common queries include information about registration standards, questions from overseas-trained practitioners about registration in Australia, queries about the status of applications and advice on using online services such as logging into online renewal.

In response, AHPRA has substantially re-modelled the AHPRA and National Board websites to make them easier to navigate and find the required information. AHPRA has also established new online services. This includes a service through which practitioners can check their applications for renewal have been received by AHPRA – and can confirm they can continue to practise while their applications are being assessed and finalised.

Requirements of the National Law: lapsing registration

Under the National Scheme, individual health practitioners hold primary responsibility for renewing their registration. AHPRA and the National Boards are responsible for communicating registration and renewal requirements clearly to practitioners. The National Law also makes practitioners responsible for advising AHPRA about changes in their principal places of practice, addresses or names. This is no different from the responsibilities under many of the previous regulatory arrangements with state and territory boards before 1 July 2010.

The National Law provides for automatic expiry of registration at the end of the one-month late period after a practitioner's registration expiry date. If a practitioner does not apply to renew his or her registration before, or within one month of the registration expiry date, that registration must lapse and the practitioner is no longer registered as a health practitioner. If a practitioner wishes to practise, he or she must submit a new application for registration.

Practitioners whose registration has lapsed must apply for registration again and meet the requirements of registration if they wish to stay in practice. Under the National Law, they are not able to simply renew or restore registration once their registration has lapsed.

This provision in the National Law is significantly different from the requirements in place in some jurisdictions before 1 July 2010. An additional complication was the inconsistent and uneven quality of some of the practitioner contact data migrated to AHPRA at the start of the National Scheme. The combined effect of these issues caused significant distress to a small number of practitioners in the early days of the National Scheme who, for a range of reasons, did not renew their registration on time.

Each year, some practitioners do not renew their registration on time. Historically, between 5% and 10% of practitioners were in this group. Some practitioners who do not renew are deliberately opting out of registration: to retire, or take parental leave or for other reasons. Others forget to renew on time. While comparative performance

information is patchy, AHPRA found no evidence that there are more practitioners opting out of registration than was the case in the past.

To smooth the transition to this part of the National Law, AHPRA has worked with National Boards to:

- **establish a fast-track application process** for registrants who miss the renewal deadline and who wish to remain in practice; the fast-track process was available from September 2010 and is open for four weeks after registration expiry (3,912 applicants applied for registration via the fast-track process in 2010-11 or 0.6% of total renewals)
- **enhance renewal communication** to give practitioners more notice of the renewal timeframes and more reminders if they do not renew their registration on time; AHPRA worked closely with professional associations and employers to raise awareness of these timeframes
- **introduce a process** to allow practitioners to indicate if they intend not to renew their registration and
- **recognise when practitioner renewal issues** were a consequence of transition data quality and implement an administrative procedure to address this with affected health practitioners. During the year, 459 practitioners applied for consideration under a special administrative procedure in place to achieve continuity of registration in specified circumstances.

National registers

The integrity of the national registers is a core element of the role of AHPRA and National Boards in protecting the public. These are published online.

To create the national registers, more than one million names and addresses were consolidated to a single database from more than 85 different sources located within state and territory registration boards throughout Australia. The source databases were built in a variety of different formats and technologies, including paper-based systems. The quality and comparability of the data varied widely between boards. More than 500,000 data records were cleansed, processed and migrated as active practitioner records into the AHPRA database.

AHPRA's early focus has been on strengthening the systems and processes that support the registration process – from new applications for registration, through assessment, review and processing to the management of large-scale registration renewals. In particular, AHPRA has focused its core data improvement work on assuring the accuracy and completeness of data stored in the AHPRA database to support smooth registration renewal processes. Key projects completed during the year included:

- **Accurate practitioner contact details**: Significant work was done to structure, complete and cleanse the 'preferred addresses' that are used for correspondence with registrants. More than 91% of health practitioners have now provided an email address to AHPRA, although there is variation across professions.
- **Removing duplicates**: Given the transfer of data from previous boards, practitioners who were registered in more than one state or territory may have been listed initially more than once on the national registers. A program of 'de-duplication' was undertaken to ensure each registrant had only one record.
- **Data definition**: A comprehensive data dictionary and data model were created for the registration, application, contact and notification areas. This represented a significant step forward in system documentation, enabling more effective reporting, development and specification.
- **Medical Specialists Register:** Before the National Scheme, only four jurisdictions had a Specialist Register for the medical profession. Building a nationally-consistent and accurate Medical Specialists Register was an initial imperative for the Medical Board of Australia and AHPRA and was a significant undertaking that will continue into 2012. During 2010-11, AHPRA worked intensively with Medicare Australia and the specialist colleges to improve the quality of information held about practitioners with specialist registration. During the next year, AHPRA will be working with individual practitioners to check the accuracy of their listing on the Specialists Register and the completeness and consistency of the display of both their specialist qualifications and their primary medical degrees. AHPRA will then extend this work to the dental and podiatry professions.
- **Notifications data**: All notifications transferring to the National Scheme were reviewed and a case officer assigned. This review ensured that no open notification was overlooked in transition.

Registration renewal

The May / June registration renewal of 320,000 health practitioners was a significant test of AHPRA's systems. As a result of lessons learned from the 2010 registration renewal experience, AHPRA significantly increased direct communication with registrants and implemented an extensive stakeholder engagement campaign that aimed to support the renewal process.

AHPRA's **Renew online, on time!** campaign involved direct practitioner email (wherever possible) and hard copy mail, strong partnerships with, and support from, employers and professional associations, (including through publications and communications support) and media promotion. The campaign aimed to raise practitioner awareness of the need to renew.

As a result, close to 98% of 320,000 practitioners due to renew registration in May and June did so on time, with 82% doing so online. By 30 June 2011, AHPRA held email contact details for more than 91% of practitioners, significantly increasing the effectiveness of future practitioner information and education campaigns.

Certificates of registration

One of the significant benefits of the National Scheme is community, practitioner and employer access to up-to-date and accurate information about a practitioner's registration status through the online national registers. The registers are the 'touchstone' for registration information and provide proof to employers and others of a practitioner's registration status.

In addition, AHPRA issues hard copy certificates to practitioners each year after they have renewed their registration. AHPRA is aware that behaviour change takes time and recognises that some employers and practitioners will continue to require hard copy certificates as proof of registration status, even though this information is now available online and is always the most up-to-date source of information.

During the year, AHPRA:

- established an online process to enable registrants to print copies of their registration certificate, in addition to the hard copy certificates mailed to them by AHPRA
- provided pop-out wallet-sized registration cards with renewal certificates
- implemented a communications campaign targeted to employers about the online national registers and
- issued more than 850,000 certificates of registration to health practitioners across Australia from 1 July 2010 to 30 June 2011.

Smoothing the path from study to work

In November 2010, AHPRA put in place a targeted graduate registration process for students graduating from programs of study approved under the National Law. This allowed graduates to apply for registration before completing their program of study. Their applications were then assessed, including proof of identity and criminal history checks, before their final academic results were provided to AHPRA by the education providers. When education providers advised AHPRA that graduates had completed the approved programs of study, the graduates' registration applications could be finalised.

In a deliberate strategy to smooth entry to the workforce, AHPRA prioritised applications from new graduates with confirmed work dates.

In May 2011, AHPRA extended this early application facility and opened an online registration application capacity for new graduates from approved programs of study. AHPRA worked closely with education providers and the professions to support early – and online – registration applications. As a result, 2,322 new graduates used AHPRA's online application facility in May and June 2011. The vast majority of applicants were from the nursing and midwifery professions. AHPRA continues to work closely with stakeholders in the education sector to develop national knowledge of graduation dates for courses across professions and jurisdictions and to raise awareness of the requirements for graduate registration.

The graduate online application capability will also increase the accuracy of data entry, providing long-term benefits for future renewal processes.

Figure 3: Smoothing the path from study to work flyer

First national student registration

Student registration was introduced nationally for the first time in Australia in April 2011. Under the National Law, the National Board for each of the 10 professions has the power to register students from 2011. The Psychology Board of Australia does not register students and uses provisional registration for this purpose.

Almost 100,000 students were registered in 2011 through direct partnership between AHPRA and Australian universities and training providers. The student register has been established from data provided by education providers to allow for the registration of students who are enrolled in approved programs of study for the 2011 academic year.

The register of students is not available publicly. The role of the National Boards in relation to students is limited to student health impairment matters or when there is a criminal charge or conviction of a serious nature, either of which may affect public safety. National Boards have no role to play in the academic progress or conduct of students. This continues to be a core responsibility of educational providers.

National consistency

Embedding national consistency is one of AHPRA's key priorities and a challenge that applies across all aspects of the work of National Boards and AHPRA. The challenge is multi-dimensional and includes:

- introducing common policies, procedures and processes that underpin the operation of the National Law, and harnessing technology wherever possible to support this
- building a coherent culture and consistent way of working across AHPRA's national and state and territory offices, while encouraging constructive local differentiation and respecting the varied history and culture of previous boards
- managing the transition to national registration, during which local AHPRA offices must complete notifications underway on 1 July 2010, consistent with the wide range of laws previously in place, while managing new notifications made since 1 July 2010 under the National Law (more detail on this is included in the *Notifications* section of this report)
- supporting the National Boards which have delegated some of their powers to AHPRA or state, territory or regional boards or committees of the National Board. The delegations made by each board, which vary between professions, are applied consistently across Australia within professions. These are detailed later in this annual report and reflect both the regulatory workload of each profession and each board's view of the structure that wil be most effective in optimising the advantages of the National Scheme.

Some of the core AHPRA programs that have helped to achieve national consistency are developed nationally and delivered locally. This includes Business Improvement and Innovation; National Legal Services and National Board Services.

The results of the work of AHPRA's **Business Improvement and Innovation** team are detailed throughout this report. This team has a significant, ongoing program of work in place to support national consistency across jurisdictions and improvements in service delivery. A suite of standard operating procedures and business processes has been developed to support nationally-consistent implementation of all aspects of AHPRA's operations in each state and territory AHPRA office. State and Territory Managers, with technical advice from committees of Directors of Registration and Notifications, have provided expert advice on the development and implementation of these standard procedures.

AHPRA's **National Legal Services** team invested considerable effort on a range of fronts to promote consistency. Major projects have focused on National Board delegations, governance, statutory interpretation, steps toward consistency with tribunals, developing a guide to conducting panel hearings and a memorandum of understanding between AHPRA and the eight health complaints entities. The team also provides legal support to National Boards and works with legal officers in states and territories in providing advice to local offices, boards and committees.

Through **National Board Services,** AHPRA invests considerable effort in supporting a consistent national approach, and, wherever possible and appropriate, applying this to the regulatory functions of the National Boards. This integrated approach supports the objects and guiding principles of the National Law and enables AHPRA and the National Boards to effectively manage their legislative regulatory functions. Some important initiatives undertaken during 2011 included:

- formalising and providing policy advice to the Forum of National Board Chairs as a key opportunity for collaboration and sharing across National Boards
- establishing and supporting a joint accreditation working party between National Boards, the Forum of Australian Health Profession Councils and AHPRA to substantially progress the formal

implementation of the new accreditation arrangements under the National Scheme; the working party was co-chaired by Dr Joanna Flynn AM, Chair, Medical Board of Australia and Dr Robert Broadbent, CEO, Australian Dental Council and has achieved agreement on a number of matters including a quality framework

- reviewing key policy areas that relate to National Boards' registration standards including English language requirements, professional indemnity insurance arrangements, the approach to audit of practitioners against mandatory standards and the current broad definition of 'practice'
- making substantial progress to prepare for the registration and accreditation functions of four new National Boards from 1 July 2012: ministers have appointed four new National Boards; the small AHPRA project team has support from the Ministerial Council, particularly through the NRAS sub-committee and this work continues to be funded by governments as part of the implementation of the National Scheme and
- the second annual meeting of all National Boards and AHPRA was held in August 2010 with a keynote address from Mr Harry Cayton, CEO of the Council for Healthcare Regulatory Excellence United Kingdom. The conference program reviewed early implementation and identified future priorities for the National Scheme.

Other key partnerships and consultations that have involved all National Boards and AHPRA over the past year include:

- Health Workforce Australia in the consultation and development of the National Health Workforce Innovation and Reform Strategic Plan for Action and the Aboriginal and Torres Strait Islander Health Worker Project and
- the Health Workforce Principal Committee (HWPC) of AHMAC on the proposed approach to unregulated health practitioners and monitoring the ongoing implementation of mandatory notifications.

National consistency will not be achieved overnight, but it is being pursued actively and applies across all areas of AHPRA's operations.

Employer services

The National Scheme has significant benefits for health practitioner employers, which now have a single access point for registration information about practitioners from 10 regulated professions.

AHPRA has introduced a range of new services so employers can check the registration details of their employees online and amend employer contact details, including:

- **multiple registration checks** through an online subscription service in which an employer can request the publicly-available registration details of multiple practitioners (up to 50,000 practitioners at a time) using their new AHPRA registration numbers - this is designed for use by large-scale employers and other eligible organisations and over the past year, 743 organisations have taken advantage of this service
- **conversion of pre-AHPRA registration numbers** where the employee registration number search capacity provides a quick way for employers to obtain the new AHPRA-issued registration number of each employed health practitioner and
- **outreach to help employers** better understand the requirements of the National Scheme and work actively with applicants to increase the number of applications that are complete when they are received by AHPRA. The service included workshops with organisations that help applicants to prepare / submit applications for registration to improve awareness of new requirements and extensive work by state and territory AHPRA staff with local stakeholders to improve awareness and understanding of the National Scheme.

Information and engagement

By early 2011, the systems and processes AHPRA put in place to support the National Scheme had improved services to practitioners significantly. To support these changes, AHPRA implemented a comprehensive communications campaign, aimed at increasing practitioner awareness of new registration and renewal requirements, through engagement with professional associations, employers, education providers and students.

AHPRA is committed to creating and supporting opportunities for consultation with key stakeholders to inform and advance the National Scheme. Initiatives in 2010-11 included:

- collaboration between AHPRA, the Chairs of the 10 National Boards and the Forum of Australian Health Profession Councils to maximise the efficiency and effectiveness of health profession accreditation and promote cross–profession learning
- publication of *AHPRA Report*, an electronic newsletter reporting on the work of AHPRA and distributed directly every two months to around 1,000 health industry leaders
- preparatory work to establish reference groups for the health professions' associations, the community and practitioners from mid-2011 and

- active collaboration through AHPRA's state and territory offices with local stakeholders across professional associations, government, education providers, employers and unions. This work is complemented by collaborations with national stakeholders through AHPRA's national office and the National Boards.

Financial foundations

This section of the annual report aims to provide an overview of the financial impact of the introduction of the National Scheme, and explain both current costs and the efficiencies that are being realised over time.

The National Scheme provides for a more robust and protective regulatory environment than was in place previously. It does not replicate existing local schemes on a national level, but reformed Australia's regulatory framework substantially and included new protective mechanisms – such as new registration standards – that cost more to implement. The responsibilities and costs of the previous regulatory environment are not mirrored in those of the National Scheme. It is now more complex to administer and requires more resources per practitioner to assess applications for greater patient and public safety.

The National Law establishes a set of financial management responsibilities for AHPRA and the National Boards. These include a requirement to submit audited financial statements to the Ministerial Council annually. The Victorian Auditor-General's office has been appointed as AHPRA's external auditor with the agreement of all jurisdictions. AHPRA's audited financial statements are included in the annual report to the Ministerial Council, which is tabled in the parliament of each participating jurisdiction and the Commonwealth.

AHPRA and the National Boards are committed to transparent resource management. One of the guiding principles of the National Law is that the 'fees required to be paid ... are to be reasonable having regard to the efficient and effective operation of the scheme'. Registration fees are set according to the principles established by the National Law.

AHPRA's ongoing funding is sourced solely from the registration fees set by the National Boards and paid by health practitioners. There is no cross-subsidisation between boards in the National Scheme. Each National Board is required to build and maintain adequate reserves in its own right. This is written into the National Law and underpins the Health Profession Agreements between each National Board and AHPRA on an annual basis.

In the National Scheme, there are no ongoing government funding nor subsidies, as existed in some jurisdictions before July 2010. National Boards have had to set registration fees with no expectation of any additional or ongoing government or external funding.

Some National Board registration fees introduced at the start of the National Scheme attracted considerable comment. National Boards have acknowledged that in some cases, these fees represented a significant increase for Australian health practitioners, reflecting the full costs of professional regulation and accreditation.

How are registrant fees spent?

The major components of costs within the National Scheme are:

- *Cost of new registration standards:* The National Scheme provides for a more robust and protective regulatory environment than was in place previously. It delivers a range of new services designed to increase public protection and improve professional standards. In some areas, new registration standards have added costs to the system; for example, the costs for criminal record checks. All these requirements create new demands in the complexity of administration and the effort per practitioner to assess and process applications.
- *Legal and tribunal costs:* A key issue for the National Scheme is to manage carefully the risk associated with notifications about the health, performance or conduct of health practitioners, including those most serious cases that lead to tribunal hearings. AHPRA is working with the National Boards to build reserves and provide adequate provisioning; for example, to support the costs of legal proceedings in relation to individual practitioners. These legal costs in the National Scheme are likely to be higher than previously as National Boards must now fund the cost of matters referred to tribunals in states and territories which, in some jurisdictions, were funded previously by governments. Most boards have also inherited responsibility for open cases underway in each state and territory before 1 July 2010, while making provision for all new notifications since that date.
- *AHPRA operations*: These are the core AHPRA costs of managing registration, notification and customer service systems on behalf of National Boards. These systems are largely managed through AHPRA state and territory offices, with a number of national programs run through the national office. Each National Board pays an agreed proportion of AHPRA costs according to a set formula. This formula will be reviewed in the coming year.
- *National Board policy costs*: National Boards have an important national professional

leadership role. Improving policy support to National Boards has been a major emphasis during the last 10 months. The early months of the National Scheme made clear that this level of resourcing was not adequate and an extensive, independent review led to an increase in staff, to provide National Boards with dedicated resources and improved policy development and coordination capability to match their responsibilities under the National Scheme. There has also been an increase in the policy capacity across National Boards through formalising the role of the Executive Officer, Policy. This position is particularly aligned to support the outcome of national consistency and provide high-level advice to the Forum of Chairs of National Boards.

- *Implementation costs*: Implementation costs were higher than expected initially and not covered by initial government allocations. AHPRA expects that implementation-related costs will peak in 2011-12 and, although reducing, are expected to continue until 2013-14 as AHPRA embeds the systems and processes required to support the effective and efficient operation of the National Scheme.

States and territories and the Commonwealth funded a significant proportion of the costs associated with the implementation of the National Scheme. In addition, an agreed proportion of the reserves held by the previous state and territory boards that transferred into the National Scheme was used to support implementation, particularly accommodation and fit-out costs.

However, the reserves transferred from previous regulatory authorities were generally lower than estimated, with several boards opting to fund local education or research programs, rather than allocate reserves to National Boards. This impacted on the resources available to each National Board and therefore, the fees required to support responsible regulation in the public interest.

In addition to managing 'business as usual', AHPRA is making a significant investment in building and improving its systems and processes for registrations and notifications. There is an extensive work program to be progressed in the next 12 months designed to improve both the quality and efficiency of the way AHPRA works. A Business Improvement and Innovation Directorate has been formed to drive this work program and manage a number of national services.

- *New South Wales costs*: The National Scheme collects registrant fees from practitioners based in New South Wales and provides agreed funds for managing notifications to the NSW Health Professional Councils Authority. The registration fee for New South Wales practitioners takes account of the impact of the ongoing subsidy from the New South Wales Government for the Health Care Complaints Commission, through a rebate arrangement.
- *Board operations*: These are largely the travel and sitting fees associated with National Boards and committees, including state and territory boards. During 2010 -11, there were almost 1,500 meetings of National Boards and committees.
- *New accreditation costs*: National Boards are now meeting the agreed costs of accreditation authorities through registration fees.

Implementation

Implementation issues have affected the National Boards differently, as has each board's approach to a range of issues, including the initial registration fee levied, the complexity and number of matters investigated and referred to panels or tribunals for hearing, the individual work program being undertaken by each board and the relative costs of national accreditation. There is no cross-subsidisation between professions. For example:

- The costs of regulating the medical profession accounted for 39% of AHPRA's budget during the year, while medical practitioners account for 16% of registered practitioners. Regulatory costs are the result of increased legal fees (including tribunal costs) for matters involving medical practitioners, the complexity of notifications matters and the assessment and management of international medical graduates. The Medical Board of Australia increased registration fees substantially in the first year compared to previous fees in most jurisdictions, in recognition of the complexity of the National Scheme and the accommodation of lower than expected reserves into the National Scheme and the need to develop an adequate level of financial reserves.
- Nursing and midwifery accounts for 37% of AHPRA's budget, but makes up 63% of all registered practitioners. The Nursing and Midwifery Board of Australia did not levy a significant fee increase in the first year of the National Scheme and is reviewing its budget position currently before finalising fees for 2011-12. The board must ensure the registration fee is set at a level that enables the board to meet its responsibilities under the National Law, supports the board's regulatory work plan (for example, in relation to reviewing competency standards, developing new registration standards and codes and guidelines), enables the new nursing and midwifery accreditation authority to meet its responsibilities and ensures ongoing, responsible financial management.

- The cost of regulating practitioners in the other eight health professions accounts for the remaining 24% of AHPRA's budget with these practitioners making up 21% of all registered practitioners. These boards are expected to set registration fees for the 2011-12 year in line with CPI.

Given the marked differences between the National Scheme and previous systems based in states and territories, comparisons should be treated with caution. However an overview of expenditure suggests that the current costs of managing core AHPRA notification and registration systems (not allowing for implementation costs) approximate the cost of previous state and territory boards.

AHPRA is working with National Boards to maintain a close review of the resources required to operate the National Scheme effectively and efficiently. Ongoing vigilance in this will be critical, but was particularly so in the transition to national registration, when there were a number of one-off costs associated with decommissioning previous boards, transition and implementation. AHPRA expects to realise efficiencies over time.

AHPRA has advised that costs will be higher in the first three years, during the implementation phase, but will stabilise as systems and processes operate more effectively. Some costs will reduce as staff become familiar with new systems and processes, and others will reduce as practitioners become familiar with changes to registration requirements. For example, 60% of current applications for registration are incomplete. As registrants become more familiar with the requirements, these costs will reduce.

Early efficiency initiatives include:

Forms management was moved in-house reducing costs by 75%. AHPRA manages more than 220 forms.

Review and redesign of registration form layout increased usability and consistency of forms. Better quality of information provided by applicants will reduce staff costs over time, through increased proportions of complete applications submitted.

Introduction of PDF form mail merge technology enabled AHPRA to merge information from the national registers to support distribution of practitioner-specific communications, allowing targeted communications to be developed and delivered quickly and at very low cost.

Renewals management was introduced and embedded by building AHPRA's capacity to distribute emails in bulk, in-house. This enabled AHPRA to improve communication cycle time, reduce costs, and increase contact with health practitioners.

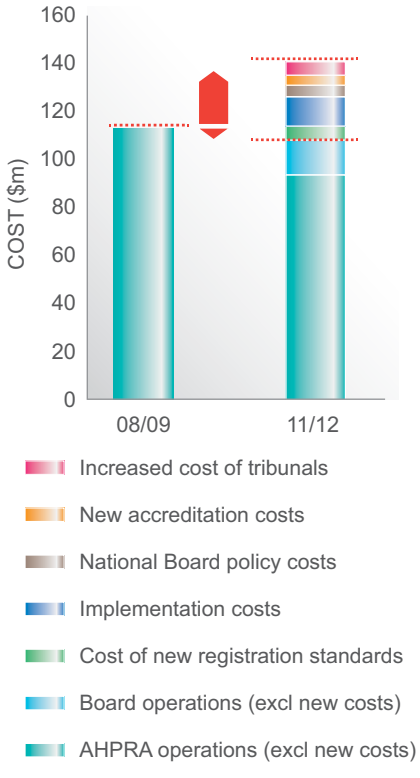
Generic registration certificate stock was introduced across health professions. Print production costs decrease with volume so AHPRA began using generic certificate base stock which decreased the cost of print production per certificate and reduced human error in production.

Promotion of online renewal of registration through an email campaign that reduced the need to mail hard copy communications (reducing postage, paper and productions costs) and encouraged online renewals, which increased from 60% to more than 80%.

Introduction of a wallet-sized registration card improved health practitioner convenience and utility.

If the National Scheme requires more resources, additional revenue can only be raised by National Boards' increasing the registration fees paid by health practitioners. In most cases, AHPRA and the boards do not expect fees to increase by more than the inflation rate on an annual basis. AHPRA and the National Boards have agreed to advise the Ministerial Council of any proposed fee increase above the inflation rate. This advice will be supported by a business case.

Figure 4: Overview of the costs associated with the National Scheme compared to previous systems



How AHPRA delivers the National Scheme

Introduction

AHPRA has an office in each state and territory and a national office in Melbourne. AHPRA's national office provides strategic and corporate leadership for the organisation and designs and delivers national projects that are implemented through AHPRA's network of state and territory offices.

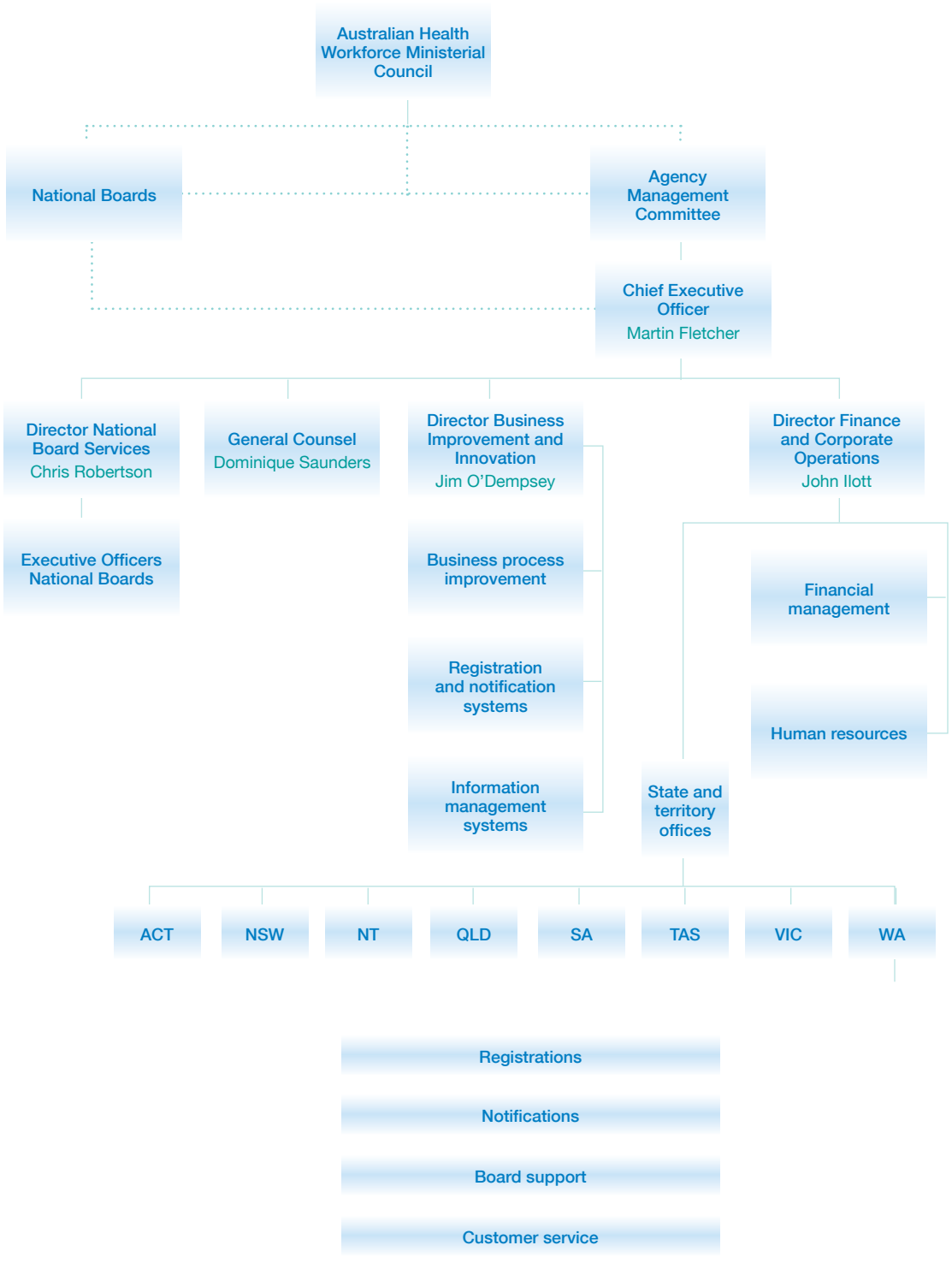
Most services to the public and health practitioners are delivered through local offices. The organisational structure allows work to be allocated between offices at times of peak demand, according to need. *Figure 5: Organisational structure of AHPRA* outlines the organisation structure nationally.

Each of the AHPRA state and territory offices is led by a State or Territory Manager, and provides services in registrations, notifications (excluding New South Wales – see more information in the AHPRA New South Wales office section), corporate services, customer service and board support. State and territory offices provide support for state, territory and regional boards and committees of the National Boards.

AHPRA has around 600 core full-time and part-time staff. With 80% of staff from previous state and territory registration boards opting to join AHPRA, staff brought substantial experience and expertise in professional regulation to the new organisation. In addition, key individuals from previous boards have been recruited to senior management roles. For example, most AHPRA State and Territory Managers were recruited from previous chief executive officer roles in state and territory boards for medicine, pharmacy, nursing and other health professions. Other managers have come from senior leadership positions in health-related areas.

AHPRA's executive management group, with executives from the national, state and territory offices provides overall guidance.

Figure 5: Organisational structure of AHPRA



States and territories

AHPRA Australian Capital Territory office

In 2010-11, the Australian Capital Territory office of AHPRA was located at Scala House, 11 Torrens Street, Braddon. It has 18 staff members providing services to health professionals and the community in the ACT, which is home to more than 8,000 health practitioners. In mid-2011, the AHPRA Australian Capital Territory office is relocated to Level 3, RSM Bird Cameron Building, 103 Northbourne Avenue, Canberra.

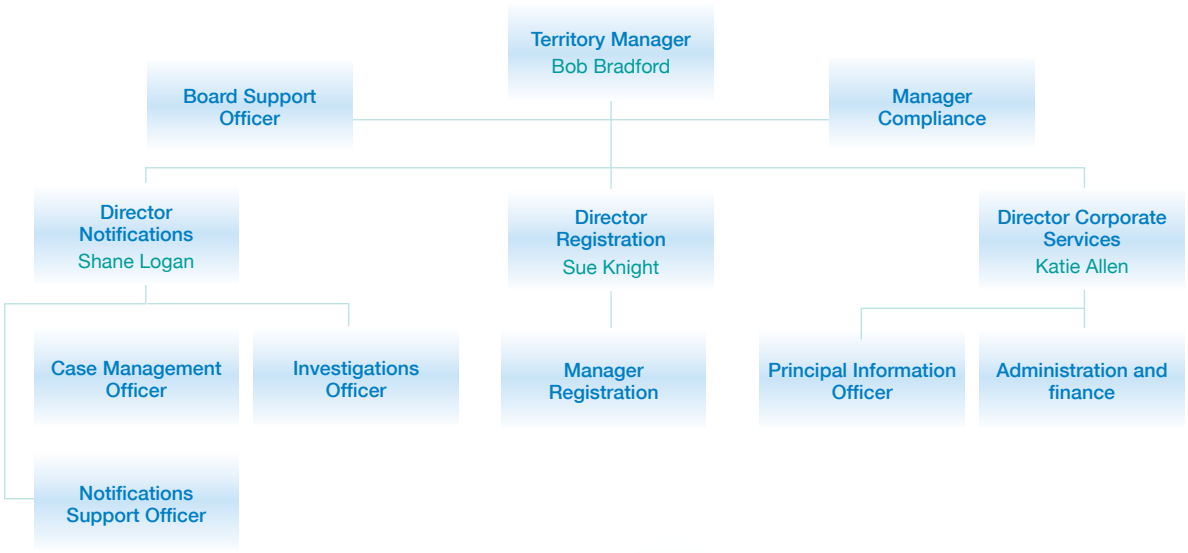
Bob Bradford, territory Manager Australian Capital Territory joined AHPRA after eight years as Chief Executive Officer of the ACT Medical Board. In his capacity as Territory Manager, Mr Bradford has been responsible for transferring the operations of the 10 health professions boards and establishing the AHPRA Australian Capital Territory office on commencement of the National Law in July 2010 including the transfer of ACT Health staff. He holds a BA (Mil) (UNSW), a MSc (Def Stud) (Madras) and a Grad Dip Strategic Studies.

Major highlights for the first year of operations included the seamless transition from the previous local regulatory scheme to the National Scheme. This was assisted by the hard work of the local AHPRA team who embraced the massive changes and overcame obstacles and issues that presented themselves. As they grew in confidence, they became involved in several national AHPRA projects; for example, liaison with Medicare in the updating of registration data. This project-type work is continuing with the involvement of this office in the project to finalise the medical Specialists Register.

The Australian Capital Territory office of AHPRA provides services for:

- the territory board of the Medical Board of Australia, and its territory committees on health, notifications, performance and professional standards and registrations
- the territory board of the Nursing and Midwifery Board of Australia and its territory Committees on immediate action, notification and registration
- the regional board of the Physiotherapy Board of Australia and
- the ACT registration and notification committees of the Dental Board of Australia.

Figure 6: Organisation structure - AHPRA Australian Capital Territory office



AHPRA New South Wales office

The New South Wales office of AHPRA is located at Level 51, 680 George Street, Sydney and has 55 staff members providing services to health professionals and the community in New South Wales, which is home to more than 156,000 health practitioners.

Kym Ayscough, State Manager New South Wales came to AHPRA in March 2010 after seven years as Chief Executive Officer and Registrar of the Pharmacy Board of New South Wales. Given that the model of national regulation is different in New South Wales, Ms Ayscough works in strong partnership with the co-regulatory agencies in that state; the Health Care Complaints Commission and the Health Professional Councils Authority. She holds Bachelor of Laws and Masters of Law and Management degrees.

Regulation of health practitioners in New South Wales varies from other states and territories. The National Law was adopted in NSW on 19 November 2009, except for:

- definitions of health assessment, performance assessment, professional misconduct, unprofessional conduct and unsatisfactory professional performance and
- mechanisms for dealing with complaints, investigations, health and performance assessments, disciplinary proceedings and mandatory notifications

On 8 June 2010, legislation was passed to establish the infrastructure to manage these matters and confirm the current co-regulatory framework in New South Wales involving:

- the government-funded Health Care Complaints Commission
- instead of existing boards, a council for each of the 10 professions registered under the National Law and
- a tribunal for each profession with a permanent chair, members appointed as required by the councils and registry support provided by the staff supporting the councils.

Until 30 June 2010, there were four separate employers of staff supporting the boards in New South Wales. Since 1 July 2010, a new single administrative authority, the Health Professional Councils Authority, has employed all of the staff supporting the councils. The Health Care Complaints Commission (HCCC) continues to provide an alternative pathway for receiving complaints and has responsibility for independent investigation and prosecution of professional misconduct matters. New South Wales legislation retains provisions which enable flexibility for the HCCC and a council to decide that matters which are not likely to give rise to professional misconduct proceedings should be referred at an early stage to the relevant council for investigation, hearing or other resolution.

As a result, AHPRA's New South Wales office deals only with registration and accreditation matters and not with notifications. The National Law provides that any notification received, in any AHPRA office, which relates to conduct occurring in New South Wales, must be referred immediately to the HCCC or the relevant New South Wales council.

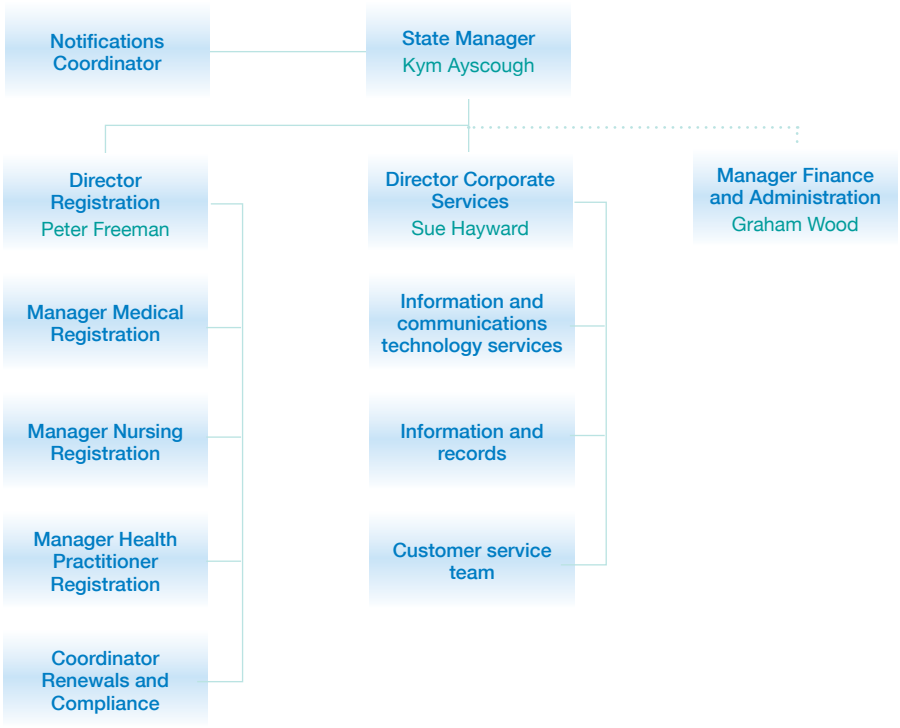
Some major highlights for the first year of operations in New South Wales are:

- successful completion of significant numbers of registration renewals aligning with national renewal dates. The former medical and nurses and midwives boards of New South Wales renewed the registration of a portion of practitioners each month (rather than renewing the entire registrant population on the same date each year). As a result in the first year of operations AHPRA's New South Wales office managed renewal of registration for large numbers of practitioners every month, starting in July 2010. New South Wales registrants will be aligned to national renewal dates by 2012.
- establishing strong working relationships with the New South Wales Health Professional Councils Authority. Efficient operation of the co-regulatory model in New South Wales relies on a strong working relationship between AHPRA, the Health Professional Councils Authority and the HCCC. Throughout the first year of operation, regular meetings and open communication have enabled all partners in the co-regulatory model to work effectively together.
- move to offsite scanning. As part of developing its national operation, AHPRA introduced processes to ensure that relevant documents are appropriately accessible to AHPRA staff across the country. Relevant documents are maintained in electronic format to enable this access and to help customer service teams respond quickly to requests from applicants and practitioners to confirm receipt of important documents. As the state with the largest practitioner base, the New South Wales office of AHPRA receives the largest number of documents relating to practitioner registration. AHPRA's New South Wales office piloted the use of an off-site contractor to scan documents on the day of receipt. This ensures the hard copy moves efficiently to the part of the business where it is required and confirmation via the electronic record is generally available on the day of receipt, significantly improving capacity to meet applicant and registrant expectations.

The New South Wales office of AHPRA provides services for:

- the state board of the Dental Board of Australia and its state committee on registrations
- the state board of the Medical Board of Australia, and its state committee on registrations
- the state board of the Nursing and Midwifery Board of Australia and its state committee on registration
- the state board of the Physiotherapy Board of Australia and
- the regional board of the Psychology Board of Australia.

Figure 7: Organisation structure - AHPRA New South Wales office



AHPRA Northern Territory office

The Northern Territory office of AHPRA was located at Level 2, Harbour View Plaza, 8 McMinn St, Darwin. In July 2011, the office moved to Level 5, 22 Harry Chan Avenue, Darwin and has 18 staff members providing services to health professionals and the community in the Northern Territory, which is home to more than 4,700 health practitioners.

Jill Huck, Manager Northern Territory came to AHPRA from the Northern Territory's Health Professions Licensing Authority where she was director for five years and the registrar of 11 health practitioner registration boards and the Health Professionals Review Tribunal. Jill continues to be the registrar for the territory boards regulating occupational therapists, Aboriginal health workers and radiographers - three professions scheduled to join the National Scheme in 2012 – as well as a community member for both the Northern Territory Mental Health Review Tribunal and the Northern Territory Parole Board. Her qualifications include a Bachelor of Social Work (Hons) from University of New South Wales and a Master of Social Policy (Class 1) from James Cook University.

Major highlights for the first year of operations of AHPRA's Northern Territory office included negotiating an agreement with the Northern Territory health department to continue to support three health professions registered in the Northern Territory.

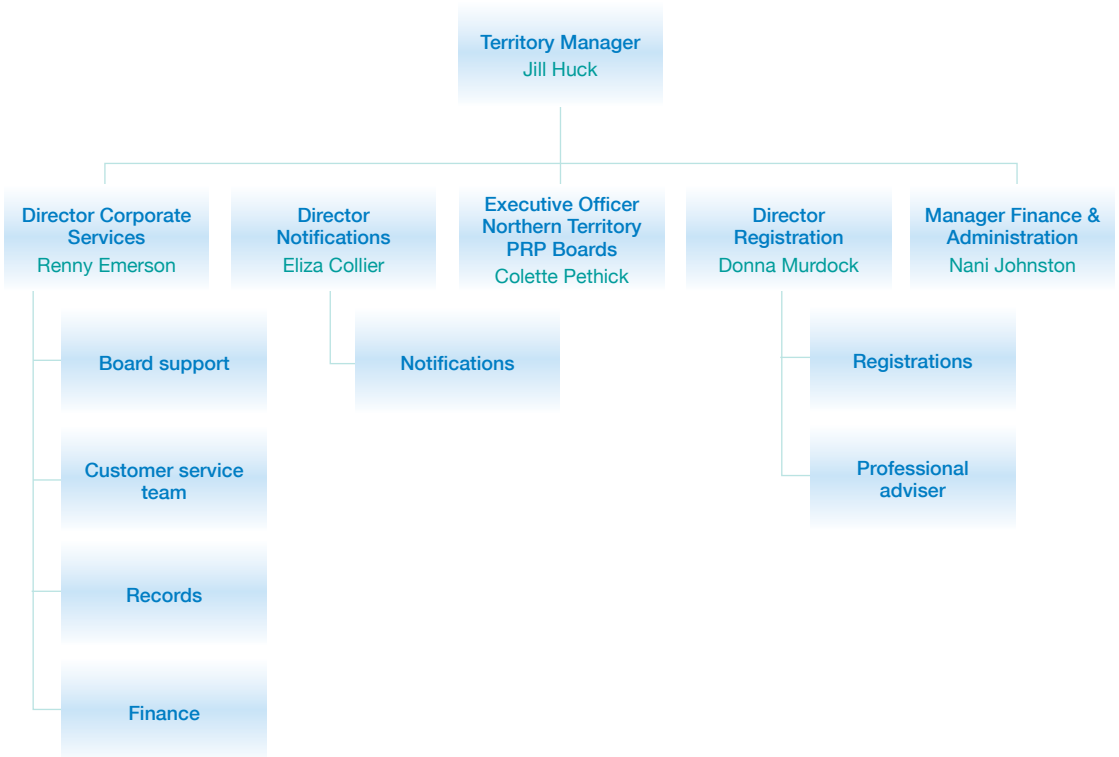
The Northern Territory office of AHPRA provides services for:

- the territory board of the Medical Board of Australia, and its territory committees on health, notifications, performance and professional standards and registrations
- the territory board of the Nursing and Midwifery Board of Australia and its territory committees on immediate action, notification and registration
- the territory board of the Physiotherapy Board of Australia
- the territory registration and conduct committee for the regional board (Queensland and Northern Territory) of the Psychology Board of Australia and
- the regional registration and notification committee for the Dental Board of Australia.

The Northern Territory office also provides services for three health professions registered in the Northern Territory, but which are not yet regulated under the National Scheme:

- Aboriginal Health Worker Board of the Northern Territory
- Radiographers Board of the Northern Territory and
- Occupational Therapists Board of the Northern Territory.

Figure 8: Organisation structure - AHPRA Northern Territory office



AHPRA Queensland office

The Queensland office of AHPRA is located at Level 18, 179 Turbot Street, Brisbane and has 107 staff members providing services to health professionals and the community in Queensland, which is home to more than 99,000 health practitioners.

Anne Morrison, State Manager Queensland has more than 20 years' experience in health regulation, beginning as a registered nurse and midwife in Scotland. Before taking on the State Manager Queensland role, Ms Morrison was Executive Officer for the Nursing and Midwifery Board of Australia, with a key role in supporting the National Board in meeting its legislative functions. She holds a Master of Business Administration (Queensland University of Technology), a Graduate Diploma in Management (QUT), a Bachelor of Educational Studies (University of Queensland) and a Bachelor of Science (with Nursing), Dundee College of Technology, Scotland.

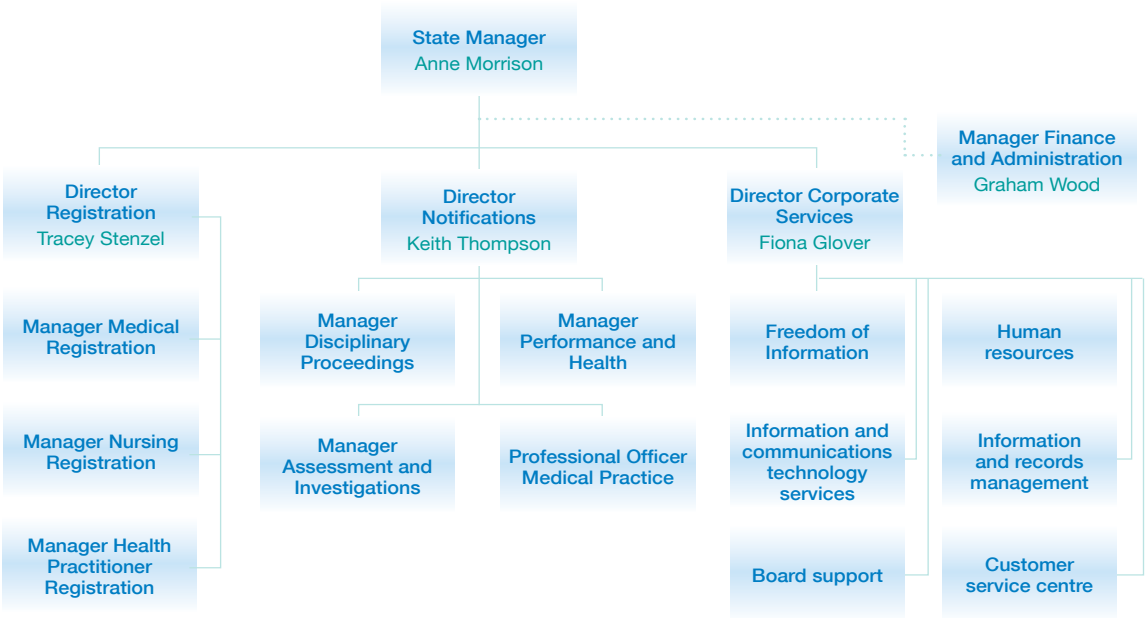
Major highlights for the first year of operations of AHPRA's Queensland office included:

- online renewal of registration in May and June 2011 by 85% of nursing and midwifery practitioners who nominated Queensland as the principal place of practice
- establishment of a dedicated renewals team to manage all renewal applications and related disclosures, enabling the office to refine its renewal processing and assess applications within a few days of receipt; this resulted in the efficient and effective renewal of Queensland-based medical practitioners and nurses and midwives during April, May and June 2011 and
- delivery of a report which analysed and evaluated the current and prospective efficiency and serviceability of work practices in AHPRA's Queensland office. The review focused on an end-to-end audit of the application workflow for a health practitioner, resulting in an auditable process which can be used as a template across all state and territory AHPRA registration teams to support best practice, efficient service to practitioners and effective public protection.

The Queensland office of AHPRA provides services for:

- the state board of the Dental Board of Australia and its state committees on registration and notification and immediate action
- the state board of the Medical Board of Australia, and its state committees on health, notifications, performance and professional standards and registration
- the state board of the Nursing and Midwifery Board of Australia and its state committees on immediate action, notification and registration
- the national registration and notifications committee of the Optometry Board of Australia
- the national registration and notifications committee of the Osteopathy Board of Australia
- the state board of the Physiotherapy Board of Australia and
- the regional board (Queensland and Northern Territory) of the Psychology Board of Australia and its Queensland registration and conduct committee.

Figure 9: Organisation structure - AHPRA Queensland office



AHPRA South Australia office

The South Australia office of AHPRA is located at Level 8, 121 King William Street, Adelaide and has 63 staff members providing services to health professionals and the community in South Australia, which is home to more than 44,000 health practitioners.

Jancy McHugh, the Acting State Manager in South Australia, came to AHPRA from the Medical Practitioners board of Victoria where she had been the interim Chief Executive Officer before the introduction of the National Scheme. Ms McHugh assumed responsibility for leading the South Australian AHPRA office in early 2011, when Alyson Smith, the former AHPRA State Manager in South Australia, was appointed to her current role as Executive Officer of the Nursing and Midwifery Board of Australia. Ms McHugh has wide-ranging experience in governance, planning, policy development and the management of strategic, policy and operational issues, gained across the regulatory, health and higher education sectors. She holds a Bachelor of Science from the Australian National University.

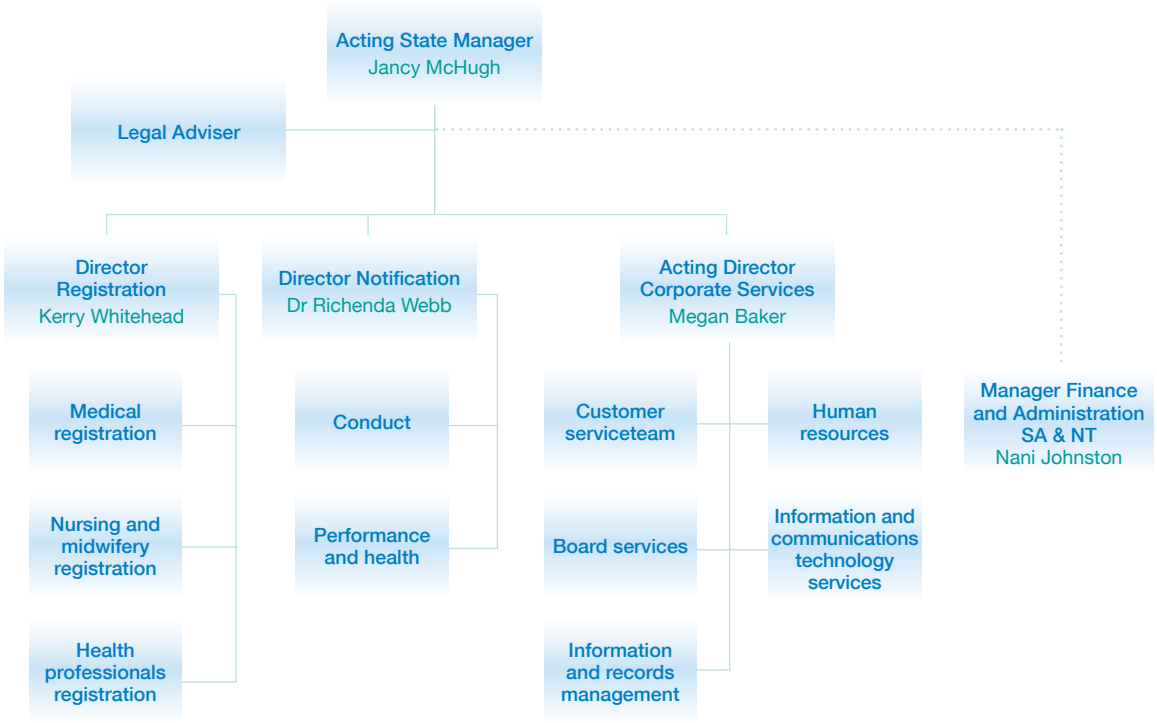
Major highlights for the first year of operations of AHPRA's South Australia office included:

- undertaking the first renewal of health practitioner registration under the National Law, with around 30,000 nurses and midwives renewing their registration in August 2010
- assessing the first midwife in Australia to hold a notation on registration as an eligible midwife and
- establishing the notification and registration compliance monitoring programs for all 10 regulated professions. This is the first time that some of the smaller professions have had formal programs in South Australia. AHPRA staff have validated and consolidated all existing health / performance / conduct undertakings and conditions and registration conditions and requirements in central databases; communicated with registrants, supervisors and treating practitioners; and provided regular compliance reports to boards and their committees. The clear communication of expectations to registrants has resulted in greater levels of compliance and facilitated many registrants' successful remediation, rehabilitation to unrestricted practice and unconditional registration.

The South Australia office of AHPRA provides services for:

- the state board of the Medical Board of Australia, and its state committees on health, notifications, performance and professional standards and registrations
- the state board of the Nursing and Midwifery Board of Australia and its state committees on immediate action, notification and registration
- the state board of the Physiotherapy Board of Australia
- the state committees on registration and conduct and immediate action of the regional board (South Australia and Western Australia) of the Psychology Board of Australia and
- the regional board (South Australia and Northern Territory) of the Dental Board of Australia and its state committee on immediate action.

Figure 10: Organisation structure - AHPRA South Australia office



AHPRA Tasmania office

The Tasmania office of AHPRA is located at Level 12, 86 Collins Street, Hobart and has 24 staff members providing services to health professionals and the community in Tasmania, which is home to more than 12,000 health practitioners.

Lisa Wardlaw-Kelly, State Manager Tasmania came to AHPRA from her role as Tasmanian regional Director with the Australian Bureau of Statistics. She was previously State Manager with the Department of Health and Ageing, which included the regulation of aged and community care providers, as well as delivery of Australian Government health programs. Ms Wardlaw-Kelly's academic qualifications include a Master of Public Health from La Trobe University, a Bachelor of Arts (honours) from Australian National University, a Graduate Certificate in Public Administration and a Certificate of Enrolled Nursing.

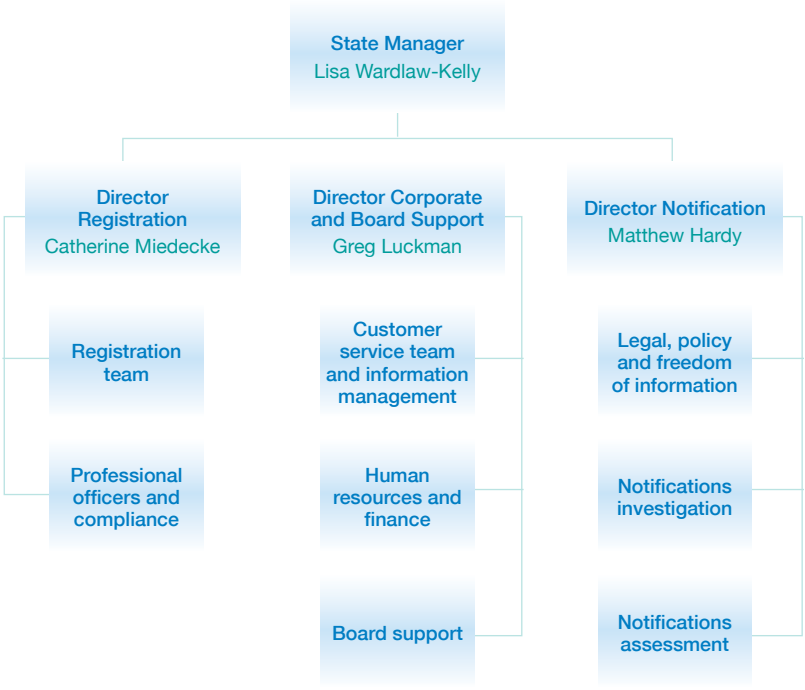
Major highlights for the first year of operations of AHPRA's Tasmania office included:

- retaining 100% of staff who transferred from former boards and welcoming new staff to create a unified and productive office that prides itself on the high standard of service delivered to boards; Tasmanian team members have made a strong contribution to AHPRA's national leadership by chairing the national directors of registration committee, coordinating the national professional officers network for psychology and leading the development of AHPRA's inaugural corporate plan and *National Registration and Accreditation Scheme Strategy 2011-2014* and
- developing and trialling a number of initiatives to reduce costs and increase the quality of service: for example, Tasmania's state board of the Medical Board of Australia and its committees were the first to adopt secure mobile technologies for board papers, which has significantly reduced collation, printing and postage costs while improving board member satisfaction and meeting efficiency. The office has also developed quality assurance procedures and guidelines for the preparation of advice to boards.

The Tasmania office of AHPRA provides services for:

- the state board of the Medical Board of Australia, and its state committees on health, notifications, performance and professional standards and registration
- the state board of the Nursing and Midwifery Board of Australia and its committees on immediate action, notification and registration and
- the state board of the Physiotherapy Board of Australia.

Figure 11: Organisation structure - AHPRA Tasmania office



AHPRA Victoria office

The Victorian office of AHPRA is located at Level 8, 111 Bourke Street, Melbourne and has 148 staff providing services to health professionals and the community in Victoria, which is home to more than 136,000 health practitioners.

Richard Mullaly, State Manager Victoria joined AHPRA in February 2010, from his role as Chief Executive Officer of the Medical Practitioners Board of Victoria. Mr Mullaly leads a team supporting the 10 National Boards in their core role of registering and regulating registered practitioners. Mr Mullaly holds an MBA from Monash University and a B.Sc (Hons), also from Monash.

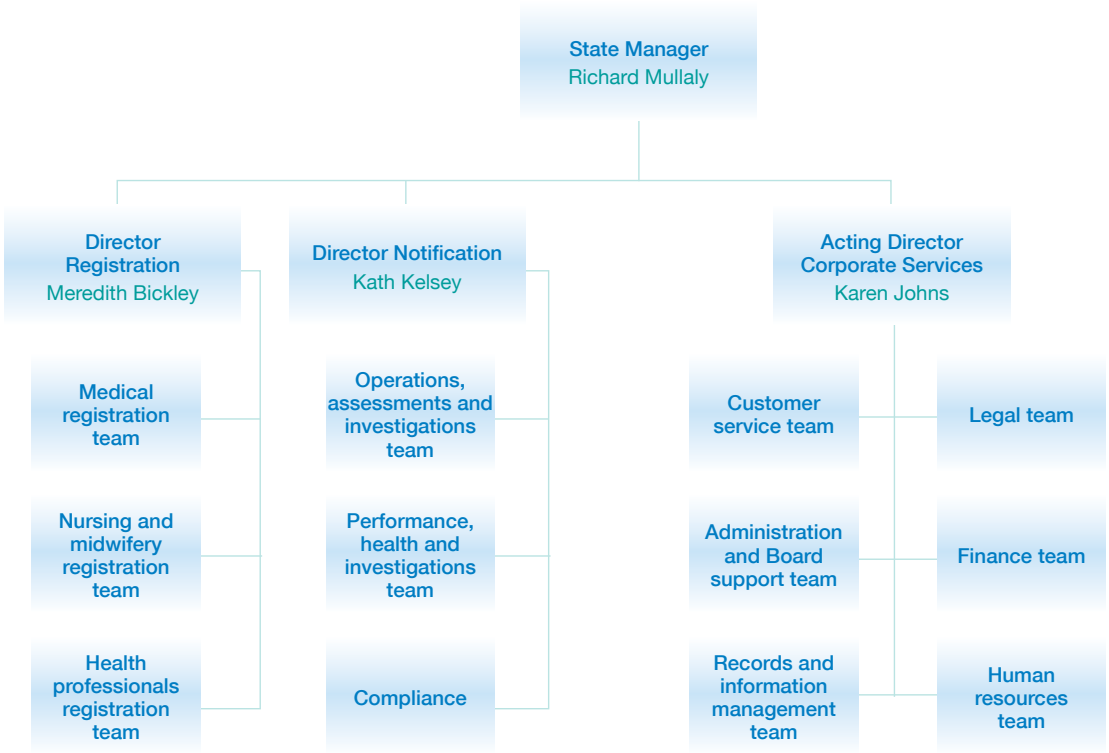
Major highlights for the first year of operations of AHPRA's Victoria office included:

- successful implementation of the in-house customer service team function which saw all calls to Victoria (and to AHPRA from international locations), all emails and front counter visits managed internally by the Victorian customer service team - the metrics for this initiative are equal to the best in the country and well ahead of international call-centre benchmarks
- successful renewal of nearly 210,000 Victorian health practitioners and
- the Victorian-based AHPRA legal team guided and managed more than 150 appealable matters under the National Law successfully.

The Victoria office of AHPRA provides services for:

- the state board of the Medical Board of Australia, and its state committees on registration, notifications, performance and professional standards and health
- the state board of the Nursing and Midwifery Board of Australia and its state committees on immediate action, notification and registration
- the state board of the Physiotherapy Board of Australia
- the regional board (Victoria, Tasmania and Australian Capital Territory) of the Psychology Board of Australia and its committees on immediate action and registration and conduct
- the regional board of the Dental Board of Australia and its regional committees on registration and notifications and immediate action
- the national notifications and registration committee of the Chiropractic Board of Australia
- the national notifications and registration / examinations committees of the Pharmacy Board of Australia and
- the national registration and notifications committee of the Podiatry Board of Australia.

Figure 12: Organisation structure - AHPRA Victoria office



AHPRA Western Australia office

The Western Australia office of AHPRA is located at Level 1, 541 Hay Street, Subiaco and has 90 full-time equivalent staff providing services to health professionals and the community in Western Australia, which is home to more than 51,000 health practitioners.

Robyn Collins, State Manager Western Australia has many years of experience in senior health care management positions. Most recently, she was Chief Executive Officer and Registrar of the Nurses and Midwives board of Western Australia. Robyn is an inaugural member of the School of Nursing and Midwifery Board at Curtin University of Technology and an Adjunct Associate Professor at Curtin University.

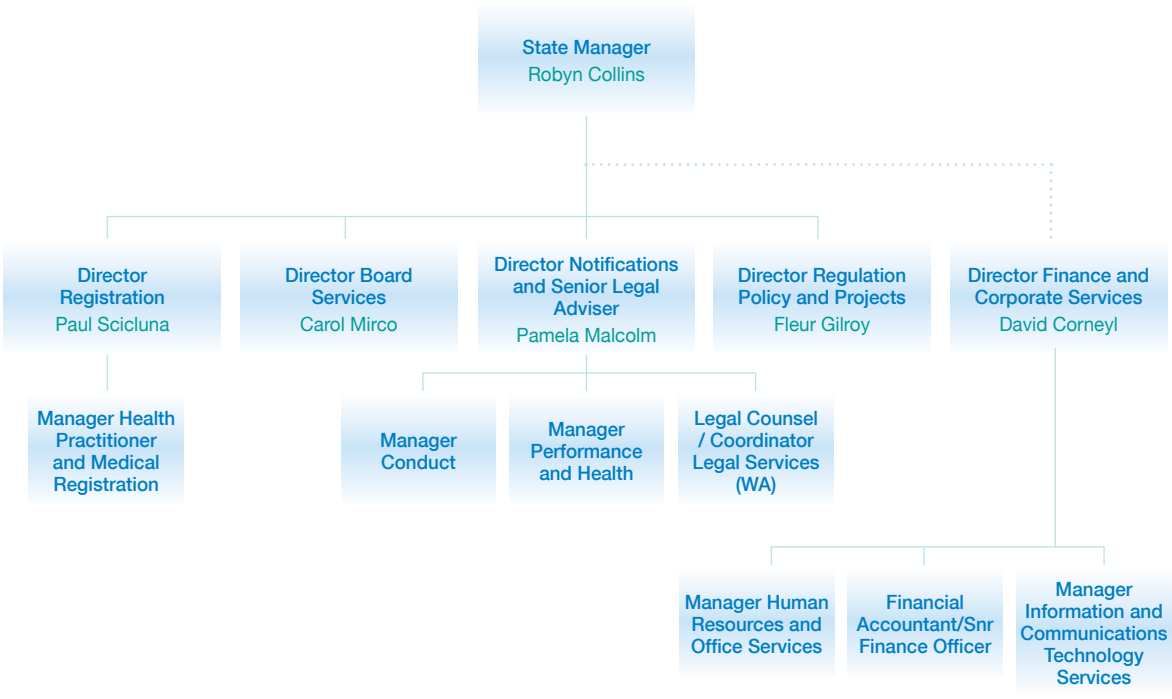
Major highlights for the first year of operations of AHPRA's Western Australia office included:

- creating and implementing a paperless framework for board and committee meetings, and gaining a 5-star, 'green office' accreditation application - this encouraged AHPRA to introduce an electronic document system to support boards and committees wherever possible – and WA has also implemented electronic faxing which has now been incorporated into all of the other state and territory offices and
- developing an online knowledge base to enable staff to access quickly documents, policy, and other information specific to the Western Australia office. This knowledge base include such diverse information as a local staff telephone and workstation list; occupational health and safety committee members; emergency contact details; links to AHPRA documents; and local parking and transport information. This knowledge base will assist new staff to become familiar with many aspects of the local office that might otherwise take weeks to learn.

The Western Australia office of AHPRA provides services for:

- the state board of the Dental Board of Australia and its state committees on immediate action and registration and notification
- the state board of the Medical Board of Australia, and its state committees on health, notifications, performance and professional standards and registrations
- the state board of the Nursing and Midwifery Board of Australia and its state committees on immediate action, notification and registration
- the state board of the Physiotherapy Board of Australia and
- the regional board (Western Australia and South Australia) of the Psychology Board of Australia and its state committees on registration and conduct and immediate action.

Figure 13: Organisation structure – AHPRA Western Australia office



Developing the AHPRA team

In the past year, key areas supporting the development of AHPRA as a new organisation have involved:

- transition and recruitment of staff
- enterprise agreement planning
- work environment safety
- operational people support.

Transition and recruitment of staff

Our recruitment and hiring focused on service support for staffing our AHPRA offices and national functions. Foundation services included publishing internal job opportunities, establishing an AHPRA profile on external job boards and streamlining of suppliers and processes. Support has been provided for the recruitment and re-appointment processes for state and territory boards. The year also involved recruitment for the newly-established Executive Officers for the professions which are due to enter the National Scheme in July 2012.

Enterprise agreement planning

Following the transition of previous boards' staff to AHPRA in October 2010, the planning for AHPRA's enterprise agreements re-commenced. A key priority was to align the enterprise agreements to support the AHPRA corporate plan, which is the 'cornerstone' for one organisation. AHPRA aims that the enterprise agreements will establish common terms and conditions. After many months of due due diligence and careful planning and internal decision-making, the draft enterprise agreement for Victoria, Australian Capital territory and Northern Territory was released in July 2011.

During 2011-12, AHPRA will progress planning work on agreements to be made under the relevant industrial relations laws in Western Australia, South Australia, Tasmania, New South Wales and Queensland.

Work environment

Our occupational health and safety program established processes to support AHPRA's commitment to protecting the health and safety of our staff, board members, visitors and the public. In this first year, our corporate services network supported the set-up of our occupational health and safety committees, made up of staff and local management. AHPRA also provides an employee assistance program which provides staff and family members with counselling support for both work and personal issues, accessible on a confidential basis at any time.

People support

AHPRA delivers operational human resources support in each office through our corporate services network, in collaboration with the national office human resource team leading organisation-wide initiatives.

Figure 14: People of the National Scheme in Australia

Registrations

The core role of AHPRA and the National Boards is to protect the public and to facilitate access to health services. One of the ways they do this is by making sure only practitioners with the skills and qualifications to provide safe care to the Australian community are registered to practise their profession.

The National Boards consider every application for registration carefully and assess it against the requirements for registration set by each board.

Under the National Law, each board sets registration standards, approved by the Ministerial Council, which every registered health practitioner must meet. These standards are designed to ensure patient safety.

All National Boards have registration standards on continuing professional development, criminal history, professional indemnity insurance, recency of practice and English language skills.

Many boards have developed additional registration standards, as well as codes, guidelines, policies and other supporting documents relevant to their profession.

A core challenge in health practitioner regulation is balancing the at times competing priorities of workforce supply and the safety and quality of health services delivered to the Australian public. Assessing and making determinations about eligibility for registration is not just an administrative process. To undertake its statutory role responsibly, AHPRA makes sure its operational processes support a thorough assessment of applications for registration. It aims to do this in a timely way, noting that there are no externally-agreed performance benchmarks for registration processes beyond the maximum period specified in the National Law. During 2010-11, AHPRA committed to working with the professions, the community and other stakeholders to develop a service charter. This work will begin in 2011.

Registration types

Under the National Law, there are consistent types of registration between professions across states and territories. These are:

- *general* registration means a practitioner is either Australian-qualified, or has met the requirements of the relevant accreditation authority for training to be recognised as equivalent to accredited training in Australia; practitioners with general registration do not need to be supervised
- *specialist* registration means a practitioner has undergone additional training in a particular field of practice and has met the requirements of the relevant board, accreditation authority and / or specialist college to be recognised as

specialising in that particular field; specialist registration applies to the medical and dental professions and podiatric surgeons

- *provisional* registration is granted to new practitioners of a profession, such as interns; provisional registrants are supervised and must meet a number of requirements, including regular reports on their progress from their supervisors before progressing to general registration
- *student* registration was launched nationally for the first time in Australia in April 2011; under the National Law, the student register is not public and the role of boards in student registration is limited to student health impairment matters or when there is a criminal conviction of a serious nature, either of which may affect public safety adversely and
- *limited* registration covers a number of sub-types of registration, including practising in an area of need, teaching and research and in the public interest. It applies requirements to practise, such as allowing a practitioner to practise only at a specific location and/or in a particular field of a profession. Practitioners with limited registration must be supervised by practitioners with general registration. Many overseas-trained practitioners apply for limited registration so they may practise while undergoing further training to achieve full registration in Australia. There are specific registration application processes that apply to overseas-qualified health practitioners.

The time it takes to process applications for registration varies according to the type of registration requested and the particular requirements of the application. Routine applications for renewal of registration take less time to manage and assess than more complex registration applications.

Registration process

An application for registration will pass through at least five stages, but may pass up to eight stages.

Stage 1: Application - When the hard copy or online application form is submitted, it is reviewed by AHPRA staff for completeness.

Stage 2: Assessment - The supplied information is assessed against registration standards. At this stage, the applicant may be required to supply further information or undergo various tests or examinations.

Stage 3: Recommendation - A recommendation is then made, which may be to register, register with conditions or refuse. If the application is straightforward and the recommendation is to register, a delegate of the board may register the applicant without referring to the relevant National Board. Complicated cases will be referred to the National Board or its committee for resolution. The board or its delegate may accept the recommendation or take some other action. The board's decision will be to register, register with conditions or refuse the application.

Stage 4: Registration - Registration is finalised and relevant letters and certificates are prepared for the applicant.

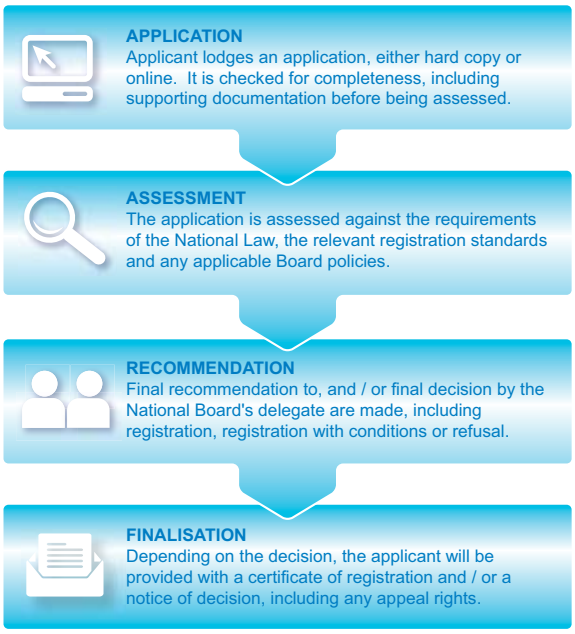
Stage 5: Submission - If a National Board accepts the application with conditions or refuses the application, the applicant will be informed at this stage. The applicant may then elect to make a submission to the board.

Stage 6: Submission assessment - Following Stage 5, the response from the applicant is considered and a final decision is made.

Stage 7: Tribunal - If applicants do not agree with the final decision of the board, they may take their case to a tribunal for a review.

Stage 8: Withdrawn incomplete - If a required response from the applicant is not received within a reasonable period, the application is closed as withdrawn and incomplete.

Figure 15: Flowchart of registration process



Registration renewals

Health practitioners in Australia must renew their registration annually.

The annual registration renewal dates for professions are being aligned under the National Scheme. From 2012, the following dates will apply across all health professions:

31 May	**Nursing and midwifery**
30 September	**Medical**
30 November	**Chiropractic, Dental, Optometry, Osteopathy, Pharmacy, Physiotherapy, Podiatry and Psychology**

Practitioners with limited registration may be required to renew registration more often as their registration is specific to the position and location in which they work.

The late period and lapsing registration

One of the significant changes under the National Law is the introduction of a 'late period'. Practitioners have one month after their registration expiry date in which they remain registered and able to practise their profession. If practitioners do not apply to renew their registration within this late period, their registration must lapse. Under the National Law, neither AHPRA nor the boards have the power to change this. Practitioners who do not renew before the end of the late period and who wish to continue to practise must make a new application for registration. AHPRA has worked with the National Boards to establish a fast-track process for practitioners whose registration lapsed and who wish to apply for registration again within four weeks of the end of the late period.

What's new in registrations in the National Scheme

In developing the National Law, Ministers drew on the strengths of existing health practitioner legislation and adopted the highest standards of public safety already in place in different jurisdictions.

The National Scheme introduced a number of new requirements for health practitioners – including through the registration standards set by the boards - that stem from the core principle of public safety. These requirements provide a more robust regulatory system designed to better protect the public than the systems previously in place. They also ask more of practitioners and can add to the complexity and time involved in the registration process.

More than 530,000 health practitioners are on the national registers across the 10 professions.

More than 46,000 health practitioners have registered, many for the first time, since 1 July 2010.

AHPRA has managed more than 630,000 health practitioner renewals.

The national registers are available online, enabling the public, health practitioners and employers to check a practitioner's registration status quickly and easily.

Spotlight on criminal record checks

A significant new requirement of the National Law is that applicants for initial registration must undergo a criminal record check. National Boards may also require criminal record checks at other times.

Applicants seeking registration must disclose any criminal records when they apply for registration. This information is then submitted to an independent agency for a report. AHPRA may also seek a report from a police commissioner or an entity in a jurisdiction outside Australia that has access to records about the criminal history of persons in that jurisdiction.

While failure to declare a criminal record by a registered health practitioner does not constitute an offence under the National Law, such a failure may constitute behaviour for which a National Board may take health, conduct or performance action.

The 2010-11 year is the first time criminal record checking has been conducted nationally in health practitioner regulation. AHPRA currently has 140 personnel who hold accreditation with the independent agency. The accreditation process is significant and accredited officers are subject to a number of undertakings and agreements about their access to and use of the record checking system and information related to criminal history.

Results of criminal record checks

In 2010-11, AHPRA requested 52,445 criminal record checks. Of these, 2,992 (6%) of results indicated that the applicant had a criminal history. Of these, 449 (15%) were assessed as having the potential to affect registration.

After consideration by a National Board, 40 (9%) of the 449 assessed as having the potential to affect registration, led to action on applications, as follows:

- one application refused: psychology
- six applications withdrawn: two medical, two psychology, one dental, one pharmacy
- 31 conditions or undertakings imposed on registration: 16 nursing and midwifery, eight medical, four pharmacy, two psychology, one physiotherapy
- two practitioners had conditions imposed on registration at renewal: one nursing and midwifery, one pharmacy.

Available data indicate that the introduction of mandatory criminal record checks has reduced risk to public safety.

Of the 52,445 criminal record checks requested, 49,191 results (94%) were reported as 'clear', five requests were unable to be processed and were addressed manually on a case-by-case basis and 257 requests, received on 30 June 2011 remained open at the end of the reporting period.

The 2,992 results indicating the check subject did have a criminal history were released to AHPRA as 'disclosable court outcomes' (DCOs). While the exact definition of releasable 'criminal history' and the nature of disclosable court outcomes information released varies between policing and law enforcement bodies in each state and territory - for example, some but not all jurisdictions include traffic offences in their definition of 'criminal history' - definitions and release of disclosable court outcomes information is largely consistent across the jurisdictions in the more serious offence categories. More detail on disclosable court outcomes arising from requests submitted for criminal record checks by each state and territory is recorded in *Table 3: Disclosable court outcomes by jurisdiction.*

Table 3: Disclosable court outcomes by jurisdiction

State or territory	No. of disclosable court outcomes	No. of criminal record checks submitted	% of disclosable court outcomes resulting from criminal record checks submitted
ACT	34	597	6%
TAS	114	870	13%
NT	30	423	7%
SA	277	3,384	8%
WA	423	4,818	9%
VIC	510	18,112	3%
QLD	668	10,820	6%
NSW	936	13,421	7%
Total	**2,992**	**52,445**	**6%**

While New South Wales recorded the highest number of disclosable court outcomes arising from criminal record checks, Tasmania recorded the highest proportion of disclosable court outcomes returned (114 DCO results of 870 checks submitted, or 13%, compared to an average of 6% across all jurisdictions). Liaison with the independent agency and Tasmanian police indicates this result is attributable to the different definitions in each state or territory policing jurisdiction as to what constitutes 'criminal history', as well different information release policies.

Most other states or territories returned a percentage of results consistent with the national result of 6%. This national result is similar to that recorded by those states and territories which undertook criminal record checks before national registration was introduced on 1 July 2010.

In Victoria, only 510 (3%) of the total 18,112 checks returned disclosable court outcomes results. This is attributed to the fact that Victoria is the nominated 'coordinating jurisdiction' for AHPRA's criminal history checks and, as such, Victorian police have the final vetting authority over information release. In addition to this, the Victorian jurisdiction operates under a comparatively narrow definition of 'criminal history', coupled with a comparatively stringent information release policy.

While AHPRA's legislation requires all criminal history be released, regardless of where or when it originated (under sections 79(3) and 135(3) of the National Law), this is still affected by the definition in each relevant state or territory of what constitutes 'criminal history'.

If a certain offence does not fall within the jurisdiction's definition of 'criminal history', then it will not be released. For example, Tasmanian police include traffic offences in their definition of 'criminal history' and will release offences such as speeding and seatbelt use. Queensland police, on the other hand, do not include traffic offences in their definition of 'criminal history' and will not release information on these offences in response to AHPRA's requests for criminal history checks. AHPRA is considering options to manage this disparity between 'criminal history' definitions and information release across jurisdictions in the context of AHPRA's operation as a national statutory body, empowered by state and territory legislation, and working towards national consistency.

Importantly, it is clear from liaison with the criminal record agency and police representatives in each state and territory that information about more serious offences and offences with any direct link to the purpose of criminal record affecting registration to practise as a health professional is released in a uniform manner across all jurisdictions. Also importantly, National Boards do not consider criminal history disclosable court outcomes that are not relevant to registration as a health practitioner. Each National Board has a registration standard on criminal history that details what the board expects in relation to criminal history declarations and how this links to registration.

Registration data

There were more than 530,000 health practitioners in 10 professions registered to practise in Australia on 30 June 2011. Holding registration means that the board has assessed that a practitioner is safe and competent to practise in the profession. It does not mean the practitioner is actively working in that profession at the time.

Registration by profession and principal place of practice

Nursing and midwifery are the professions with most practitioners, with 290,072 nurses, 1,789 midwives and 40,324 practitioners registered as both nurses and midwives.

followed by Victoria (136,651 practitioners) and Queensland (99,200 practitioners). This trend continues across individual professions except for midwifery-only practitioners, osteopaths and podiatrists, where the largest numbers nominate Victoria as their principal place of practice.

Student registration

Student registration was launched nationally for the first time in Australia in April 2011. The register of students is not publicly available and the role of the National Boards in relation to students is limited to student health impairment matters or when there is a criminal conviction of a serious nature, either of which may adversely impact on public safety. National Boards have no role to play in the academic progress or conduct of students. This continues to be a core responsibility of educational providers.

Table 4: Registered practitioners by profession and principal place of practice [1]

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [2 3]	Grand total
Chiropractor	51	1,456	21	667	347	41	1,138	463	166	4,350
Dental practitioner	326	5,619	113	3,542	1,561	315	4,092	2,076	675	18,319
Medical practitioner	1,638	27,686	817	16,761	6,926	1,994	21,238	8,250	2,983	88,293
Midwife	15	325	9	227	306	7	625	170	105	1,789
Nurse	3,824	79,210	2,760	54,542	26,886	7,560	76,830	28,422	10,038	290,072
Nurse and midwife[4]	660	14,169	552	7,623	2,616	734	10,375	3,215	380	40,324
Optometrist	64	1,493	25	925	205	78	1,094	329	229	4,442
Osteopath	30	514	2	133	25	33	715	50	93	1,595
Pharmacist	373	8,110	165	5,008	1,836	607	6,308	2,782	755	25,944
Physiotherapist	416	6,589	113	4,114	1,828	386	5,417	2,600	921	22,384
Podiatrist	42	919	13	585	346	78	1,084	347	47	3,461
Psychologist	744	10,014	198	5,073	1,431	504	7,735	2,999	444	29,142
Grand total	**8,183**	**156,104**	**4,788**	**99,200**	**44,313**	**12,337**	**136,651**	**51,703**	**16,836**	**530,115**

Notes
1. Data is based on registered practitioners as at 30 June 2011
2. PPP = Principal Place of Practice
3. No principal place of practice will include practitioners with an overseas address
4. Practitioners who hold dual registration as both a nurse and a midwife

Medical practitioners are the second largest group, with 88,293 practitioners registered, followed by psychologists (29,142 practitioners), pharmacists (25,944 practitioners), physiotherapists (22,384 practitioners) and the 18,319 dentists, dental specialists, dental therapists, dental hygienists, oral health therapists and dental prosthetists who make up dental practitioners.

The remaining professions of optometry (4,442 practitioners), chiropractic (4,350 practitioners), podiatry (3,461 practitioners) and osteopathy (1,595 practitioners) make up the balance of Australia's registered health practitioners.

New South Wales has the largest number of registered practitioners, with 156,104 practitioners across the 10 professions,

There were 98,934 students registered across Australia on 30 June 2011. The largest number of students were studying nursing (61,416 students), followed by medicine (16,839 students) and pharmacy (7,627 students). Most students (98,657 students) were undertaking approved programs of study, being a course approved by a National Board which leads to general registration.

The Psychology Board of Australia does not register students and uses provisional registration for this purpose. Psychologists wishing to apply for provisional registration must do so either at the beginning of the 4+2 internship program or their higher degree pathway.

Table 5: Registered students by profession [1]

Profession	Approved program of study [2]	Clinical training [3]	Annual total
Chiropractor	998		998
Dental practitioner	3,028		3,028
Medical practitioner	16,814	25	16,839
Midwife	2,483		2,483
Nurse	61,415	1	61,416
Optometrist	214		214
Osteopath	549		549
Pharmacist	7,617	10	7,627
Physiotherapist	4,366	241	4,607
Podiatrist	1,173		1,173
Total	**98,657**	**277**	**98,934**

Notes:
1. *Student registration commenced 31 March 2011*
2. *Approved program of study refers to those students enrolled in a course that has been approved by a National Board and leads to general registration*
3. *Clinical training refers to those students undertaking practical training that does not lead to registration with one of the National Boards. This could mean a course that is accredited by an external body but not yet approved by the board, a student from an international university who is completing a clinical rotation within an Australian institution and so on.*

Registration by profession, principal place of practice and registration type

There are many types of registration in professions, including general registration (practitioners are either Australian-qualified or recognised as equivalent to accredited training in Australia and do not need to be supervised); specialist registration (practitioners have undergone additional training and have met requirements to be recognised as specialising in particular fields of medical, dental and podiatric practice); provisional registration (new practitioners of a profession, such as medical and pharmacy interns, who are supervised and must meet a number of requirements to progress to general registration); student registration; and limited registration (sub-types of registration, where conditions are applied to practice and practitioners must be supervised by a practitioner with general registration).

Most practitioners in Australia hold general registration, although there are more medical practitioners with general and specialist registration (45,544 practitioners) than with general registration only (23,995 practitioners) or specialist registration only (5,377 practitioners). There are more dental practitioners with general registration (16,218 practitioners) than with general and specialist registration (1,427 practitioners) or specialist registration only (36 practitioners).

There are 6,221 medical practitioners with limited registration – typically international medical graduates working in areas of need as they progress to general registration. New South Wales has the largest number of medical practitioners with limited registration (1,631 practitioners).

Medicine has the largest number of practitioners with non-practising registration (2,455 practitioners), followed by pharmacy (817 practitioners). There are 1,695 medical practitioners with limited registration (public interest – occasional practice), a type of registration only available as a one-off transition to the National Scheme and which only applies to practitioners who, on 30 June 2010 (or 18 October 2010 for practitioners in Western Australia), held a type of registration that allowed them to refer and/or prescribe, but not receive a fee for providing that service. The National Law does not allow the board to grant this type of registration to new applicants.

Table 6: Registered practitioners by profession, principal place of practice and registration type

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [2]	Grand total
Chiropractor										
General	51	1,446	20	651	340	40	1,085	460	98	4,191
Limited		2						1	10	13
Non-practising		8	1	16	7	1	53	2	58	146
Chiropractor sub total	51	1,456	21	667	347	41	1,138	463	166	4,350

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [2]	Grand total
Dental practitioner										
General	283	5,026	106	3,189	1,384	281	3,582	1,868	499	16,218
General and specialist	35	440	4	281	131	5	346	140	45	1,427
Limited	7	103	2	55	42	7	95	28	90	429
Non-practising		45	1	16	4	5	62	40	36	209
Specialist	1	5		1		17	7		5	36
Dental practitioner sub total	326	5,619	113	3,542	1,561	315	4,092	2,076	675	18,319
Medical practitioner										
General	460	7,485	280	4,771	1,758	469	5,864	2,046	862	23,995
General and specialist	837	15,192	323	7,980	3,890	1,018	11,811	3,840	653	45,544
Limited	74	1,631	126	1,181	562	175	1,344	795	333	6,221
Limited (public interest - occasional practice)	57	817		401	2	55	9	338	16	1,695
Non-practising	30	507		289	136	33	503	218	739	2,455
Provisional	91	873	22	712	244	84	659	296	25	3,006
Specialist	89	1,181	66	1,427	334	160	1,048	717	355	5,377
Medical practitioner sub total	1,638	27,686	817	16,761	6,926	1,994	21,238	8,250	2,983	88,293
Midwife										
General	15	309	9	227	306	7	619	169	104	1,765
Non-practising		16					6	1	1	24
Midwife sub total	15	325	9	227	306	7	625	170	105	1,789
Nurse										
General	3,801	78,768	2,750	54,518	26,828	7,549	76,711	28,367	10,015	289,307
Limited			1					2	1	4
Non-practising	23	442	9	24	58	11	119	53	22	761
Nurse sub total	3,824	79,210	2,760	54,542	26,886	7,560	76,830	28,422	10,038	290,072
Nurse and midwife										
General	654	14,029	551	7,618	2,608	732	10,366	3,209	375	40,142
General and non-practising [1]	4	66	1	1	4	1	1	4		82
Non-practising	2	74		4	4	1	8	2	5	100
Nurse and midwife sub total	660	14,169	552	7,623	2,616	734	10,375	3,215	380	40,324
Optometrist										
General	61	1,476	25	915	205	78	1,074	328	216	4,378
Non-practising	3	17		10			20	1	13	64
Optometrist sub total	64	1,493	25	925	205	78	1,094	329	229	4,442
Osteopath										
General	30	511	2	130	22	32	685	50	87	1,549
Non-practising		3		3	3	1	30		6	46
Osteopath sub total	30	514	2	133	25	33	715	50	93	1,595
Pharmacist										
General	341	7,348	152	4,575	1,647	558	5,588	2,431	593	23,233
Limited		3		1			2	1		7
Non-practising	12	118	2	54	41	3	307	119	161	817
Provisional	20	641	11	378	148	46	411	231	1	1,887
Pharmacist sub total	373	8,110	165	5,008	1,836	607	6,308	2,782	755	25,944
Physiotherapist										
General	407	6,473	113	4,047	1,778	377	5,133	2,556	817	21,701

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [2]	Grand total
Limited	3	37		22	43	3	88	34	19	249
Non-practising	6	79		45	7	6	196	10	85	434
Physiotherapist sub total	416	6,589	113	4,114	1,828	386	5,417	2,600	921	22,384
Podiatrist										
General	42	913	13	581	330	78	1,043	329	44	3,373
General and specialist		3		1	4		3	1		12
Non-practising		3		3	12		38	9	3	68
Specialist								8		8
Podiatrist sub total	42	919	13	585	346	78	1,084	347	47	3,461
Psychologist										
General	612	8,720	157	4,140	1,199	417	6,312	2,487	398	24,442
Limited	1									1
Non-practising	21	87	1	79	40	10	116	34	27	415
Provisional	110	1,207	40	854	192	77	1,307	478	19	4,284
Psychologist sub total	744	10,014	198	5,073	1,431	504	7,735	2,999	444	29,142
Grand total	**8,183**	**156,104**	**4,788**	**99,200**	**44,313**	**12,337**	**136,651**	**51,703**	**16,836**	**530,115**

Notes:
1. Practitioners holding general registration in one profession and non-practising registration in the other profession
2. No principal place of practice will include practitioners with an overseas address

Registration by profession, principal place of practice and age

The largest group of registered practitioners across the 10 professions is aged 50 to 54 years (72,457 practitioners), followed by practitioners aged 45 to 49 years (65,308 practitioners) and practitioners aged 40 to 44 years (65,203 practitioners). The age group 50 to 54 years represents almost 14% of the total number of registered practitioners.

The smallest group of registered practitioners across the professions is aged 75 to 79 years (2,640 practitioners), representing 0.5% of the total number of registered practitioners; nursing is the only profession with practitioners aged 19 years or less (43 practitioners).

The medical profession has the largest proportion of practitioners aged 80-plus years (2% of medical practitioners), followed by podiatry (1.4% of podiatry practitioners). Pharmacy has the largest proportion of practitioners aged 20 to 24 years (8.4% of pharmacy practitioners), followed by podiatry (8% of podiatry practitioners). Nursing and midwifery is the only profession with a proportion of practitioners aged under 20 years (0.01% of nursing practitioners).

On a per-profession basis, the largest age groups are:

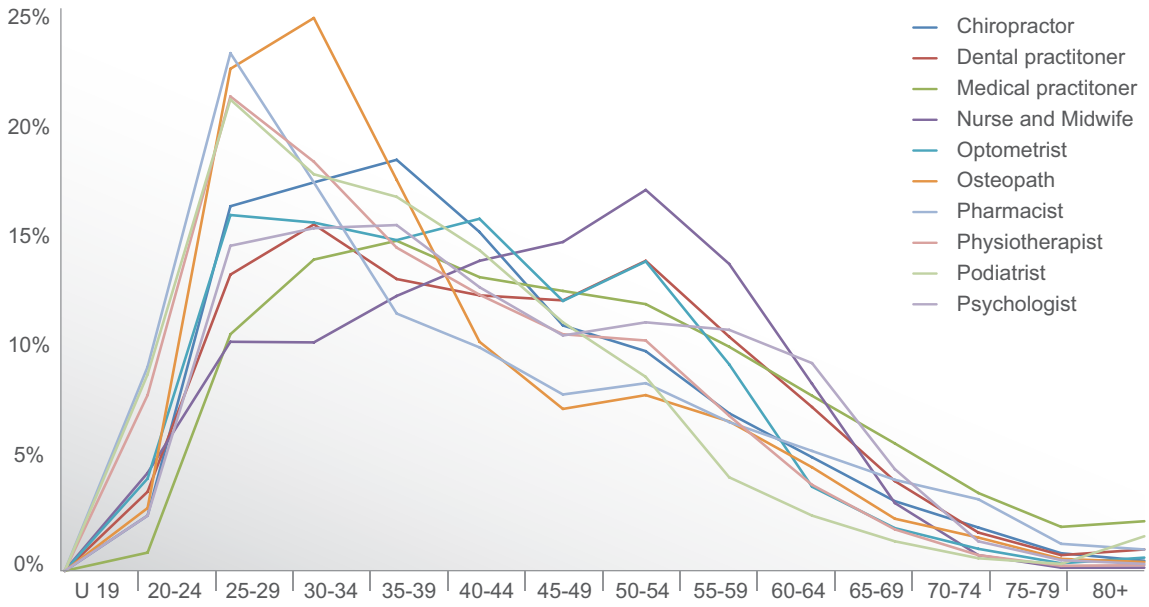
- Chiropractic: 35 to 39 years (16.87% of registered chiropractors)
- Dental: 30 to 34 years (14.24% of registered dental practitioners)
- Medical: 35 to 39 years (13.55% of registered medical practitioners)
- Nursing and midwifery: 50 to 54 years (15.65% of registered nursing and midwifery practitioners)
- Optometry: 25 to 29 years (14.61% of registered optometrists)
- Osteopathy: 30 to 34 years (22.7% of registered osteopaths)
- Pharmacy: 25 to 29 years (21.27% of registered pharmacists)
- Physiotherapy: 25 to 29 years (19.49% of registered physiotherapists)
- Podiatry: 25 to 29 years (19.36% of registered podiatrists) and
- Psychology: 35 to 39 years (14.2% of registered psychologists).

Table 7: Registered practitioners by profession and age range

Profession	U 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 +	Grand total
Chiropractor		99	651	694	734	605	439	392	281	203	125	77	32	18	4,350
Dental practitioner		595	2,231	2,609	2,197	2,072	2,037	2,333	1,760	1,233	678	291	120	163	18,319
Medical practitioner		653	8,578	11,297	11,968	10,660	10,150	9,683	8,119	6,342	4,621	2,827	1,594	1,801	88,293

Profession	U 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 +	Grand total
Midwife		162	278	244	285	298	227	133	78	48	29	6		1	1,789
Nurse	43	13,043	29,778	29,403	35,009	38,557	38,787	43,070	33,271	19,824	7,076	1,591	292	328	290,072
Nurse and midwife		184	1,237	1,491	2,247	3,447	5,845	8,795	8,532	5,661	2,154	536	109	86	40,324
Optometrist		169	649	635	603	642	492	565	377	154	78	40	14	24	4,442
Osteopath		41	329	362	256	150	106	115	98	68	34	22	8	6	1,595
Pharmacist		2,177	5,518	4,137	2,740	2,383	1,879	1,998	1,585	1,280	969	762	286	230	25,944
Physiotherapist		1,617	4,362	3,761	2,970	2,539	2,174	2,119	1,424	791	381	147	48	51	22,384
Podiatrist		279	670	564	532	456	353	276	133	79	42	18	10	49	3,461
Psychologist		664	3,895	4,105	4,139	3,394	2,819	2,978	2,882	2,485	1,216	357	127	81	29,142
Grand total	43	19,683	58,176	59,302	63,680	65,203	65,308	72,457	58,540	38,168	17,403	6,674	2,640	2,838	530,115

Figure 16: Registered practitioners by profession and age range as a proportion of total practitioners registered in the profession



Registration by profession, principal place of practice and gender

There are more females than males practising psychology, pharmacy, nursing and midwifery, podiatry and physiotherapy. There are more males practising medicine, chiropractic, dental practice, optometry and osteopathy. In many cases, previous state and territory boards did not record data on gender, so there are multiple professions where no recorded gender data has transferred into the National Scheme.

Table 8: Registered practitioners by profession, principal place of practice and gender

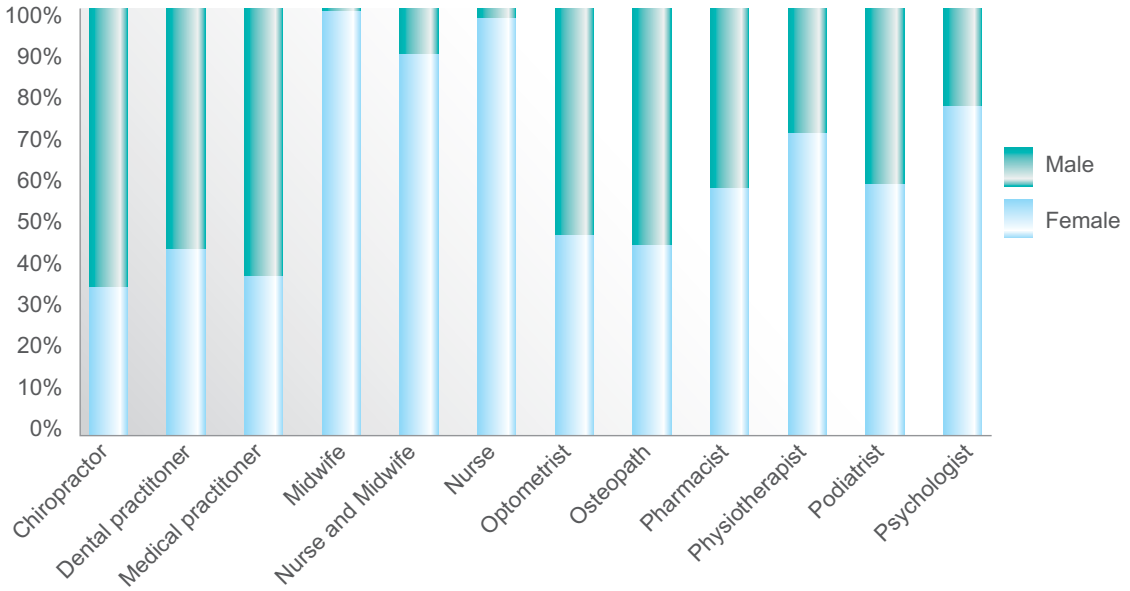
Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [2]	Grand total
Chiropractor										
Female	22	520	8	206	115	12	421	172	43	1,519
Male	29	934	13	461	232	29	715	290	123	2,826
Not stated [1]		2					2	1		5
Chiropractor sub total	51	1,456	21	667	347	41	1,138	463	166	4,350
Dental practitioner										
Female	152	2,307	56	1,570	178	25	1,827	1,091	211	7,417
Male	173	3,287	55	1,958	159	162	2,249	857	429	9,329
Not stated [1]	1	25	2	14	1,224	128	16	128	35	1,573
Dental practitioner sub total	326	5,619	113	3,542	1,561	315	4,092	2,076	675	18,319

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [2]	Grand total
Medical practitioner										
Female	699	10,437	379	6,138	2,508	757	8,236	3,132	1,011	33,297
Male	939	17,212	437	10,623	4,398	1,236	12,984	5,107	1,969	54,905
Not stated [1]		37	1		20	1	18	11	3	91
Medical practitioner sub total	1,638	27,686	817	16,761	6,926	1,994	21,238	8,250	2,983	88,293
Midwife										
Female	15	321	8	218	61	5	621	168	101	1,518
Male		1	1	1			2			5
Not stated [1]		3		8	245	2	2	2	4	266
Midwife sub total	15	325	9	227	306	7	625	170	105	1,789
Nurse										
Female	3,402	69,480	2,329	48,483	3,492	6,627	68,789	25,718	7,664	235,984
Male	391	9,518	376	5,792	513	908	7,863	2,531	1,186	29,078
Not stated [1]	31	212	55	267	22,881	25	178	173	1,188	25,010
Nurse sub total	3,824	79,210	2,760	54,542	26,886	7,560	76,830	28,422	10,038	290,072
Nurse and midwife										
Female	644	13,865	521	7,449	266	709	10,240	3,146	349	37,189
Male	15	288	28	153	11	22	131	51	11	710
Not stated [1]	1	16	3	21	2,339	3	4	18	20	2,425
Nurse and midwife sub total	660	14,169	552	7,623	2,616	734	10,375	3,215	380	40,324
Optometrist										
Female	32	744	12	417	10	27	556	125	107	2,030
Male	32	743	13	506	30	50	534	200	120	2,228
Not stated [1]		6		2	165	1	4	4	2	184
Optometrist sub total	64	1,493	25	925	205	78	1,094	329	229	4,442
Osteopath										
Female	11	201		47	11	22	122	21	8	443
Male	19	308	2	83	12	11	76	28	13	552
Not stated [1]		5		3	2		517	1	72	600
Osteopath sub total	30	514	2	133	25	33	715	50	93	1,595
Pharmacist										
Female	236	4,633	96	2,896	1,042	343	3,272	1,636	458	14,612
Male	135	3,429	68	2,104	789	262	2,383	1,142	271	10,583
Not stated [1]	2	48	1	8	5	2	653	4	26	749
Pharmacist sub total	373	8,110	165	5,008	1,836	607	6,308	2,782	755	25,944
Physiotherapist										
Female	297	4,672	73	2,841	236	292	726	1,844	471	11,452
Male	110	1,850	38	1,234	108	82	309	721	188	4,640
Not stated [1]	9	67	2	39	1,484	12	4,382	35	262	6,292
Physiotherapist sub total	416	6,589	113	4,114	1,828	386	5,417	2,600	921	22,384
Podiatrist										
Female	24	530	3	349	203	8	126	211	20	1,474
Male	18	377	8	233	133	2	108	133	18	1,030
Not stated [1]		12	2	3	10	68	850	3	9	957
Podiatrist sub total	42	919	13	585	346	78	1,084	347	47	3,461

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [2]	Grand total
Psychologist										
Female	576	7,775	147	3,954	1,037	400	6,043	2,348	326	22,606
Male	168	2,234	51	1,119	394	103	1,672	649	116	6,506
Not stated [1]		5				1	20	2	2	30
Psychologist sub total	744	10,014	198	5,073	1,431	504	7,735	2,999	444	29,142
Grand total	**8,183**	**156,104**	**4,788**	**99,200**	**44,313**	**12,337**	**136,651**	**51,703**	**16,836**	**530,115**

Notes:
1. Not stated: In many cases, boards in place prior to 1 July 2010 did not record data on gender of registrant
2. No principal place of practice will include practitioners with an overseas address

Figure 17: Registered practitioners by profession and gender as a proportion of total profession registrations



As a proportion of total number of practitioners registered in a profession, males have the highest representation in chiropractic with 65% of chiropractors recorded as male. Females have the highest representation in midwifery with 99.67% of midwives-only recorded as female.

Registration by profession, principal place of practice and registration endorsement

Nine of the 10 professions (excluding pharmacy) have endorsements on registration. Endorsement of a practitioner's registration is a legal mechanism under the National Law through which particular groups of practitioners, who have an additional qualification or advanced practice recognised by the board, can be identified through the national register. An endorsement on registration indicates that a practitioner has expertise in an advanced area of practice in addition to the level of training required for general registration in the profession.

There are 221 medical practitioners, 40 chiropractors, nine physiotherapists and three osteopaths registered in Australia with an endorsement for acupuncture.

There are 970 optometrists, 384 nurses, 360 nurses and midwives and 42 podiatrists with an endorsement for scheduled medicines.

Having a notation made on the register of midwives as an eligible midwife indicates the applicant is qualified to provide pregnancy, labour, birth and postnatal care to women and their infants, including the capacity to provide associated services and order diagnostic investigations appropriate to the eligible midwife's scope of practice. An eligible midwife may also prescribe scheduled medicines in accordance with relevant state and territory legislation once an endorsement for scheduled medicines under section 94 has been attained. There are 97 eligible midwives in Australia, with Queensland recording the highest number of eligible midwives (53).

Table 9: Registered practitioners by profession, principal place of practice and holding a registration endorsement or relevant notation

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[1]	Grand total
Chiropractor										
Acupuncture							39		1	40
Dental practitioner										
Conscious sedation	1	48	1	7	1		3	2	1	64
Medical practitioner										
Acupuncture		1					220			221
Nurse										
Nurse practitioner	20	141	8	120	49	17	59	95	3	512
Scheduled medicines	1	14	6	315	2	1	40	3	2	384
Nurse and midwife										
Midwife practitioner		1								1
Nurse practitioner	2	28	3	35	9		13	21	1	112
Scheduled medicines	1	15	5	314	5		17	1	2	360
Midwife										
Eligible midwives		13		53	5	4	16	6		97
Optometrist										
Scheduled medicines	10	137	8	158	35	44	530	24	24	970
Osteopath										
Acupuncture							1		2	3
Physiotherapist										
Acupuncture							9			9
Podiatrist										
Scheduled medicines		1		1	4		10	26		42
Psychologist										
Area of practice[2]	124	1,995	25	792	419	142	1,882	958	54	6,391
Grand total	**159**	**2,394**	**56**	**1,795**	**529**	**208**	**2,839**	**1,136**	**90**	**9, 206**

Notes:
1. No principal place of practice will include practitioners with an overseas address
2. See Table: Nature of area of practice endorsements for psychologists for details

Psychology has the largest number of practitioners with an endorsement on registration (6,391 practitioners), specifically an area of practice endorsement. The approved areas of practice for endorsement of registration for psychologists are detailed in *Table 10: Nature of area of practice endorsements held by psychologists*.

Registration by profession, principal place of practice and registration division

Nursing and midwifery and dental practice each have divisions of practitioners, representing professions of different levels of training and scope of practice contained within these two larger professional groups. Nursing and midwifery is made up of nurses (enrolled nurses and registered nurses), midwives and nurse practitioners. Dental practice comprises dental hygienists, dental therapists, oral health therapists, dental prosthetists, dentists (and dental specialists).

Table 10: Nature of area of practice endorsements held by psychologists

Area of practice sub-type	No. of endorsements [1]
Clinical neuropsychology	395
Clinical psychology	4,523
Community psychology	44
Counselling psychology	758
Educational and developmental psychology	441
Forensic psychology	336
Health psychology	173
Organisational psychology	334
Sport and exercise psychology	69
Grand total	**7,073**

Notes:
1. A number of psychologists hold one or more area of practice endorsement

Table 11: Registered dental and nursing practitioners by division

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[2]	Grand total
Dental practitioner										
Dental hygienist	36	337	6	118	203	12	161	251	24	1,148
Dental hygienist and dental prosthetist [1]				1						1
Dental hygienist and dental prosthetist and dental therapist [1]		1					1			2
Dental hygienist and dental therapist [1]	7	56	7	273	88		127	49	3	610
Dental prosthetist	18	351	4	212	46	48	323	76	82	1,160
Dental therapist	15	259	18	215	116	56	183	340	4	1,206
Dentist	245	4,507	77	2,580	1,071	198	3,231	1,360	561	13,830
Oral health therapist	5	108	1	143	37	1	66		1	362
Dental practitioner sub total	326	5,619	113	3,542	1,561	315	4,092	2,076	675	18,319
Nurse										
Enrolled nurse (Division 2)	636	14,779	357	10,413	7,342	1,304	19,937	4,976	157	59,901
Registered and enrolled nurse (Division 1 and 2) [1]	13	472	15	361	185	17	853	136	5	2,057
Registered nurse (Division 1)	3,175	63,959	2,388	43,768	19,359	6,239	56,040	23,310	9,876	228,114
Nurse sub total	3,824	79,210	2,760	54,542	26,886	7,560	76,830	28,422	10,038	290,072
Nurse and midwife										
Midwife and enrolled nurse (Division 2) [1]		5		2	3		9			19
Midwife and registered and enrolled nurse (Div 1 and 2) [1]		1					8	1		10
Midwife and registered nurse (Division 1) [1]	660	14,163	552	7,621	2,613	734	10,358	3,214	380	40,295
Nurse and midwife sub total	660	14,169	552	7,623	2,616	734	10,375	3,215	380	40,324
Grand total	**4,810**	**98,998**	**3,425**	**65,707**	**31,063**	**8,609**	**91,297**	**33,713**	**11,093**	**348,715**

Notes:
1. Practitioners who hold dual registration
2. No principal place of practice will include practitioners with an overseas address

Specialist registration

The National Scheme provides for specialist registration standards, including approved lists of specialties and protected specialist titles for medical specialists, dental specialists, and podiatric surgeons. The National Scheme also provides for the establishment of the first national Specialists Register which will help the community recognise the expert status of practitioners eligible for specialist registration, and work has commenced on construction of the medical Specialists Register, continuing into 2012.

There were 57,552 practitioners with specialist registration across three professions – dental practice, medical practice and podiatry - registered to practise in Australia at 30 June 2011.

Of these, 1,520 practitioners were registered to practise in a dental specialty; 56,012 practitioners were registered to practise in a medical specialty; and 20 practitioners were registered to practise as podiatric surgeons.

New South Wales was the principal place of practice nominated by the largest groups of dental and medical specialists (nominated by 476 dental specialists and 17,835 medical specialists). Western Australia was the principal place of

practice nominated by the largest group of podiatric surgeons (nine practitioners).

The largest group of practitioners with a dental specialty was registered to practise orthodontics (566 practitioners) with the largest group of these nominating New South Wales as the principal place of practice (181 practitioners).

The smallest group of practitioners with a dental specialty was registered to practise oral and maxillofacial surgery (eight practitioners).

The largest group of practitioners with a medical specialty was registered to practise in the specialty of general practice (22,555 practitioners) with the largest group of these nominating New South Wales as the principal place of practice (7,280 practitioners).

The smallest groups of practitioners with a medical specialty were registered to practise sports and exercise medicine (104 practitioners) and sexual health medicine (106 practitioners).

Sub-specialties of the specialty of paediatrics and child health, namely the sub-specialties of paediatric clinical pharmacology (one practitioner) and paediatric haematology (one practitioner) were the smallest groups of specialist registrations within a specialty.

Table 12: Health practitioners with specialties as at 30 June 2011 [1]

Count of Specialties										
Profession	**ACT**	**NSW**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**	**No. PPP**	**Grand Total**
Dental practitioner	36	476	5	294	131	22	361	141	54	1,520
Dento-maxillofacial radiology				6			1	1		8
Endodontics	6	37		28	14	1	35	15	6	142
Forensic odontology	1	7	1	1	4	2	4	5		25
Oral and maxillofacial surgery	4	49	2	38	14	3	51	17	6	184
Oral medicine		7		6			13	3	3	32
Oral pathology		7		6	2		5	2	3	25
Oral surgery	2	41		3			1		1	48
Orthodontics	10	181	2	116	51	12	124	50	20	566
Paediatric dentistry	2	31		17	9		21	8	5	93
Periodontics	6	52		35	13	4	47	24	3	184
Prosthodontics	5	59		34	19		45	16	6	184
Public health dentistry (community dentistry)		4		1	2		7			14
Special needs dentistry		1		3	3		7		1	15
Medical practitioner	1,045	17,835	432	10,362	4,739	1,279	14,254	4,995	1,071	56,012
Addiction medicine	2	65	1	27	13	7	32	14	3	164
Anaesthesia	61	1,155	20	790	339	99	958	387	122	3,931
Dermatology	6	168	1	70	34	7	110	33	7	436
Emergency medicine	21	308	13	250	73	31	327	136	48	1,207
General practice	385	7,280	209	4,371	1,848	592	5,551	2,106	213	22,555
Intensive care medicine	17	193	4	137	65	14	157	56	23	666
Medical administration	15	87	4	88	21	4	61	28	5	313
Obstetrics and gynaecology										
Gynaecological oncology		16		8	4	1	9	4		42
Maternal-fetal medicine	1	13	1	5	3		8	4	1	36
Obstetrics and gynaecological ultrasound		12		5	3		57	3	1	81
Reproductive endocrinology and infertility		26		4	5	1	15	2		53
Urogynaecology	1	10		5	1		7	4		28
No subspecialty declared	27	433	10	298	117	33	344	119	45	1,426

Count of Specialties										
Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No. PPP	Grand Total
Occupational and environmental medicine	17	84	2	37	28	8	70	39	12	297
Ophthalmology	13	321	4	148	71	17	215	68	17	874
Paediatrics and child health										
Clinical genetics		6		2			3			11
Community child health		2		1			3			6
General paediatrics	21	552	23	288	128	30	398	147	32	1,619
Neonatal and perinatal medicine	5	19		14	3	1	17	9	1	69
Paediatric cardiology		1		3			3	2		9
Paediatric clinical pharmacology		1								1
Paediatric emergency medicine		4		1	2		1	1		9
Paediatric endocrinology				2				1		3
Paediatric gastroenterology and hepatology		1		1			3	1		6
Paediatric haematology								1		1
Paediatric immunology and allergy		2			1					3
Paediatric infectious diseases			1	1	1		2			5
Paediatric intensive care medicine		2								2
Paediatric medical oncology		2		1			2	1		6
Paediatric neurology		3		2			1		1	7
Paediatric rehabilitation medicine		2								2
Paediatric respiratory and sleep medicine		2		1			1			4
Paediatric rheumatology		1					1			2
No subspecialty declared	2	32	7	16	13		29	19	11	129
Pain medicine	1	71		41	27	7	35	27	4	213
Palliative medicine	4	82	2	41	19	12	46	23	7	236
Pathology										
Anatomical pathology (including cytopathology)	15	226	2	148	62	17	161	77	5	713
Chemical pathology	2	19		15	11	1	18	12	2	80
Forensic pathology		9	1	10	3	2	9	2		36
General pathology	12	208	3	114	68	15	157	51	7	635
Haematology	11	134	2	65	32	10	104	27	1	386
Immunology	6	42		10	6	1	17	13		95
Microbiology	6	69	1	34	15	3	32	25	2	187
No subspecialty declared	1	9		9			1	7	4	31
Physician										
Cardiology	15	322	4	204	93	14	268	72	33	1,025
Clinical genetics		27		9	8		13	4	1	62
Clinical pharmacology		12		10	9		11	3	3	48

Count of Specialties										
Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No. PPP	Grand Total
Endocrinology	8	163	3	83	31	9	152	41	4	494
Gastroenterology and hepatology	20	215	1	115	57	7	190	55	16	676
General medicine	39	396	11	275	240	33	563	112	34	1,703
Geriatric medicine	7	157	1	59	36	8	136	44	8	456
Haematology	9	146	4	76	36	10	119	29	5	434
Immunology and allergy	6	50	1	12	10		25	14	2	120
Infectious diseases	6	68	9	34	26	5	110	23	7	288
Medical oncology	8	116	1	68	34	9	146	28	11	421
Nephrology	6	119	7	64	27	9	119	27	10	388
Neurology	8	159	1	60	37	5	147	36	8	461
Nuclear medicine	5	92		28	26	5	57	17	3	233
Respiratory and sleep medicine	9	173		103	44	11	125	49	8	522
Rheumatology	8	104	1	40	30	7	83	25	6	304
No subspecialty declared	7	163	5	33	10	10	48	75	18	369
Psychiatry	51	922	15	526	269	54	855	247	64	3,003
Public health medicine	26	128	24	85	36	10	74	35	13	431
Radiation oncology	11	104		57	19	9	94	15	7	316
Radiology										
Diagnostic radiology	28	528	2	290	155	38	409	180	113	1,743
Diagnostic ultrasound		1			1		2			4
Nuclear medicine	2	30		58	13	5	56	5	4	173
No subspecialty declared	5	22		4	3	1	9	5	10	59
Rehabilitation medicine	7	196	2	43	30	7	113	10	2	410
Sexual health medicine	5	48	1	18	4	1	23	5	1	106
Sport and exercise medicine	8	37	1	12	5	2	32	7		104
Surgery										
Cardio-thoracic surgery	4	53		37	11	3	54	9	5	176
General surgery	22	621	12	330	157	33	503	116	40	1,834
Neurosurgery	5	68		36	18	5	53	17	2	204
Oral and maxillofacial surgery	4	19	2	20	7		22	6	1	81
Orthopaedic surgery	25	387	7	247	108	20	268	104	35	1,201
Otolaryngology - head and neck surgery	9	149	2	78	38	8	107	40	10	441
Paediatric surgery	4	33		12	10	2	24	6	1	92
Plastic surgery	5	108	1	60	40	9	116	38	4	381
Urology	5	111	1	67	29	10	91	31	3	348
Vascular surgery	3	56	1	45	16	5	53	13	1	193
No subspecialty declared	3	60	1	1		2	19	3	4	93
Podiatrist		3		1	4		3	9		20
Podiatric surgeon		3		1	4		3	9		20
Grand total	**1,081**	**18,314**	**437**	**10,657**	**4,874**	**1,301**	**14,618**	**5,145**	**1,125**	**57,552**

Notes:

1. The data above records the number of practitioners with registration in the specialist fields listed. Individual practitioners may be registered to practise in more than one specialist field.

Notifications

The core roles of the National Boards and AHPRA are to protect the public and to facilitate public access to health services in the public interest. One of the ways in which the National Boards act to protect the community is by investigating concerns raised about individual practitioners. When necessary, this can involve sanctioning practitioners who have been found to have engaged in unprofessional conduct or unsatisfactory professional performance or managing practitioners, through health programs, when their health is impaired and may place the public at risk.

The National Boards are 'notified' of an issue. The word 'notification' is deliberate and reflects that a board is not a complaints resolution agency. It is a protective jurisdiction. The role of the National Scheme is to protect the public by dealing with practitioners who may be putting the public at risk as a result of their conduct, professional performance or health.

Notifications are dealt with by National Boards through formal delegations to their committees, working with AHPRA state and territory offices. For medicine, nursing and midwifery and physiotherapy, notifications are dealt with by state or territory boards in each jurisdiction. For psychology, notifications are dealt with through regional boards which combine states and territories. For chiropractic, dental, optometry, osteopathy, pharmacy and podiatry, notifications are dealt with through notifications committees.

In New South Wales, notifications are dealt with by separate health professional councils (which are supported by the Health Professional Councils Authority) and the Health Care Complaints Commission (HCCC). See www.hpca.nsw.gov.au or www.hccc.nsw.gov.au for further information.

Who can make a notification?

Anyone can make a notification to AHPRA, which receives it on behalf of a board. There are two types of notifications: mandatory (under section 140 of the National Law) and voluntary (under sections 144 and 145 of the National Law). More detail and data on mandatory notifications is published later in this section.

While registered health practitioners, employers and education providers may have mandatory reporting obligations imposed by the National Law, the majority of reports made to AHPRA are voluntary.

Typically, notifications are made by patients or their families, other health practitioners, employers and health complaints entities in each state and territory.

The National Law provides protection from legal liability for anyone who makes a notification in good faith.

Grounds for voluntary notifications

Grounds (or reasons) for voluntary notifications about registered practitioners include that:

- the practitioner's professional conduct is or may be of a lesser standard than that expected by the public or the practitioner's professional peers
- the knowledge, skill or judgement possessed, or care exercised by the practitioner is or may be below the standard reasonably expected
- the practitioner is not, or may not be, a suitable person to hold registration
- the practitioner has, or may have, an impairment
- the practitioner has, or may have, contravened the National Law
- the practitioner has, or may have, contravened a condition of his or her registration or an undertaking given to the board and/or
- the practitioner's registration was, or may have been, obtained improperly.

Preliminary assessment

AHPRA and the National Boards take seriously all notifications. After AHPRA receives a notification, a preliminary assessment is conducted to decide whether or not:

- the notification relates to a registered practitioner
- the notification relates to a matter that is a ground for notification and
- it is a notification that could also be made to a health complaints entity.

The boards also have the power to consider taking immediate action to limit a practitioner's registration if it believes there may be a serious risk to the health and safety of the community. More detail on this is published later in this section.

In deciding that a matter is grounds for a notification, the board can consider a single notification or a number of notifications that suggest a pattern of conduct. The board can also consider notifications made to a health complaints entity.

If the notification relates to a health practitioner from New South Wales, it is passed directly to the New South Wales Health Care Complaints Commission for action. The National Boards and AHPRA have no role in relation to handling notifications in New South Wales.

Relationship with the health complaints entities

The National Law requires the board and the relevant health complaints entity in each state and territory to share complaints and notifications and try to agree on how to deal with each complaint or notification. If the health complaints entity and the board cannot agree, the most serious action proposed must be taken.

The health complaints entities in each state and territory are:

- Australian Capital Territory Human Rights Commission
- New South Wales Health Care Complaints Commission (HCCC)
- Northern Territory Health and Community Services Complaints Commission
- Queensland Health Quality and Complaints Commission
- South Australia Health and Community Services Complaints Commissioner
- Tasmania Health Complaints Commissioner
- Victoria Office of the Health Services Commissioner and
- Western Australia Health and Disability Services Complaints Office.

AHPRA has worked with the health complaints entities across Australia to develop a Memorandum of Understanding (MoU) which sets out roles and responsibilities and ways of working. The MoU is available on the AHPRA website at www.ahpra.gov.au.

Board can decide to take no further action

A board may decide to take no further action in relation to a notification if:

- the board believes the notification is frivolous, vexatious, misconceived or lacking in substance or
- it is not practicable for the board to investigate or deal with the notification, given the amount of time that has elapsed since the matter that is the subject of the notification occurred or
- the person to whom the notification relates has not been, or is no longer, registered and it is not in the public interest to investigate or deal with the notification or

- the subject matter of the notification has already been dealt with adequately by the board or
- the subject matter of the notification is being dealt with, or has already been dealt with, adequately by another entity.

The decision to take no further action can be made at any time during the assessment or investigation of a notification, but only after careful consideration of the issues raised.

A decision by the board to take no further action in relation to a notification does not prevent the board or a tribunal (the independent authority in the courts system in each state and territory) taking the notification into consideration at a later time, as part of a pattern of conduct or practice by the practitioner. The board analyses the concerns raised in all types of notifications and uses this information to help educate the profession and share the lessons from the concerns raised.

Investigations

The board may decide to investigate a registered practitioner if it believes that:

1. the practitioner has or may have an impairment or
2. the way the practitioner practises is or may be unsatisfactory or
3. the practitioner's conduct is or may be unsatisfactory.

The board may also investigate to ensure that a practitioner is complying with conditions imposed on his or her registration or an undertaking given by the practitioner to the board.

The investigation is conducted by an investigator appointed by the board, usually an AHPRA staff member.

How the investigation is conducted depends on the facts of the case. It will usually involve the investigator seeking extra information to inform the board's decision. This may include:

- further information from the person who raised their concern with the board (the notifier)
- responses and explanations from the practitioner about whom the notification was made
- examination of patient records
- information from other practitioners involved in the care of the patient or client
- information from other relevant people (family members / receptionist)
- expert opinions
- police reports and/or
- data from other sources such as pharmacy records, Medicare Australia data and so on.

In almost every case, practitioners and students who are being investigated will know about the investigation. They are given notice of the investigation and information about what is being investigated. The only exceptions are when the board believes that giving notice may seriously prejudice the investigation, or may place someone's health or safety at risk or may place someone at risk of harassment or intimidation.

After analysing the facts of the case, the investigator prepares a report for the board's consideration.

Health assessment

The board may require a practitioner to undergo a health assessment if it believes that the practitioner may have an impairment.

The health assessment is conducted by an experienced and appropriately-qualified, independent practitioner. The board pays for the assessment and the assessor writes a report for the board. The practitioner who was assessed is given a copy of the report unless the report contains information that may be prejudicial to his or her health or wellbeing, in which case it is given to a medical practitioner or psychologist nominated by the practitioner.

After receiving the report, the practitioner who was assessed must discuss the report, and ways of dealing with any adverse findings, with a person nominated by the board.

Performance assessment

The board may require a practitioner to undergo a performance assessment if it believes that the way the practitioner practises the profession is or may be unsatisfactory. Performance assessments will usually be conducted by two (or more) independent practitioners who have the expertise to assess a practitioner in a particular field of practice. The board pays for the assessment and the assessors write a report.

The practitioner who was assessed is given a copy of the report unless it contains information that may be prejudicial to his or her health or wellbeing.

After receiving the report, the practitioner who was assessed must discuss the report, and ways of dealing with any adverse findings, with a person nominated by the board, who must be a registered practitioner.

Actions a board can take

A board has the power to take a range of actions at any time after receiving a notification or after an investigation or a health or performance assessment.

These actions include:

- a decision to take no further action or
- referral to another entity such as a health complaints entity.

If a board believes that a practitioner's conduct or performance was unsatisfactory or his or her health was impaired, it can:

- caution the practitioner and/or
- accept an undertaking from the practitioner and/or
- impose conditions on registration.

Alternatively, a board may decide refer matters to a:

1. panel:
    a. health panel or
    b. performance and professional standards panel or
2. tribunal. There are tribunals in each state and territory:

- Australian Capital Territory Civil and Administrative Tribunal
- Northern Territory Health Professional Review Tribunal
- Queensland Civil and Administrative Tribunal
- Health Practitioners Tribunal of South Australia
- Tasmanian Health Practitioners Tribunal
- Victorian Civil and Administrative Tribunal and
- State Administrative Tribunal (Western Australia).

New South Wales

- Chiropractic Tribunal of New South Wales
- Dental Tribunal of New South Wales
- Medical Tribunal of New South Wales
- Nursing and Midwifery Tribunal of New South Wales
- Optometry Tribunal of New South Wales
- Osteopathy Tribunal of New South Wales
- Pharmacy Tribunal of New South Wales
- Physiotherapy Tribunal of New South Wales
- Podiatry Tribunal of New South Wales and
- Psychology Tribunal of New South Wales.

All notifications received by the National Boards and AHPRA are treated seriously and managed in line with legal requirements and due process, including confidentiality, privacy and natural justice provisions. More detail about the steps in an investigation is published on the AHPRA website at www.ahpra.gov.au.

Immediate action

A board has the power to take immediate action at any time. This is a serious step and the board can only take this action if it believes that it is necessary to protect the health or safety of the public because of a practitioner's conduct, performance or health.

Immediate action means:

1. suspension or imposition of a condition on the registration of a practitioner or student or
2. accepting an undertaking from the practitioner or student or
3. accepting the surrender of the registration of the practitioner or student.

Before taking immediate action, the board must give the registrant notice of the proposed immediate action and invite the registrant to make submissions to the board.

The board must then have regard to any submissions made when deciding whether or not to take immediate action.

2010-11 notifications

The introduction of the National Scheme makes it possible for the first time to collate national data on notifications about the conduct, performance and health of more than 530,000 health practitioners. The data published in this annual report details the notifications received by AHPRA on behalf of the National Boards in the National Scheme from 1 July 2010 to 30 June 2011.

Context

The first year of the National Scheme has some unique features. This is because, in addition to the new notifications made in 2010-11, a large part of the work of AHPRA and the boards has been to manage the 'legacy' notifications made to state and territory boards before 1 July 2010 which transferred as ongoing cases into the National Scheme.

These notifications must be handled in ways consistent with the legislation previously in place in each state and territory. The exception is South Australia, where the law requires all continuing

matters to be dealt with under the National Law, except those which were the subject of formal proceedings before a board or tribunal.

Outside South Australia, managing these legacy matters involves 65 different acts of parliament, each with different investigative requirements, possible outcomes and sanctions. As a result, this annual report provides only general information about the actions of the boards in managing legacy notifications during 2010-11.

New South Wales is a co-regulatory jurisdiction. Notifications in New South Wales are handled by the HCCC and the New South Wales health professional councils supported by the Health Professional Councils Authority. Overview data on notifications has been provided by the Health Professional Councils Authority to enable AHPRA to present a high-level, Australia-wide picture of 2010-11 notifications. Information about notifications in New South Wales is published by the Health Professional Councils Authority and the HCCC. Some detailed analysis of notifications data managed by AHPRA and the National Boards in this annual report does not include analysis of New South Wales cases.

AHPRA and the Health Professional Councils Authority are working jointly to align data and definitions for future national reporting purposes.

Western Australia joined the National Scheme on 18 October 2010. Data on notifications under the National Law in Western Australia relates to the period since that date.

Given this is the first year of the National Scheme, no comparison with previous years is possible. Future annual reports will publish comparative data to enable detailed trend analysis. AHPRA has an extensive program of work underway to ensure that common definitions and data sets are applied across AHPRA's work on notifications.

Highlights

The 2010-11 year is the first year that national data on notifications about registered health practitioners has been available. Although notifications about practitioners in New South Wales are managed separately, some data about New South Wales practitioners has been included in this annual report to enable a national snapshot to be presented. The standards set by National Boards also apply in New South Wales, so the expectations of practitioners are consistent across Australia.

In this first year, a significant proportion of notifications under active management by AHPRA and the National Boards are 'legacy' matters that transferred into the National Scheme on 1 July 2010. Most of these (except in South Australia) are being managed in line with previous legislation and are not able to be reported in detail in this annual report.

Members of the community - patients, their families and members of the public – appear to know where to go to lodge their concerns about health practitioners. This is demonstrated by data on the source of most notifications. This is reassuring given the challenges of early implementation.

The National Scheme is new and the National Law is different and gives the National Boards greater flexibility in managing notifications and greater power to protect the public. Direct comparisons with previously published regulatory data need to be treated with caution.

As it is the first year of the National Scheme, much of the data contained in the notifications section of the annual report is skewed towards matters that involve allegations of less serious professional conduct, performance or health issues. Matters involving allegations of more serious concerns are more likely to remain under active management by the boards and AHPRA, and are therefore not finalised and not reported in these data. More comprehensive information will be available over time as a more complete and balanced picture of notifications and outcomes will emerge. More detail on this is published later in this section.

Medical practitioners continue to be a major focus of notifications into the National Scheme, which is unsurprising given the complexity of modern medicine. Broadly, the geographic distribution of notifications reflects the size and distribution of registrants across states and territories.

National Law: Notifications received

There were 8,139 notifications received about health practitioners between 1 July 2010 and 30 June 2011. This represents notifications received about 1.3% of the total 530,115 health practitioners registered under the National Scheme as at 30 June 2011. *Table 13: Notifications received in 2010-11 by profession and state or territory* details these.

More than half (4,122 notifications) of the notifications in the National Scheme were received about medical practitioners, who represent 16% of registered health practitioners. To the extent that comparison is possible, this appears consistent with previous rates.

Notifications about dental practitioners and nurses / midwives each accounts for about 16% of the total notifications made during the year, with 1,322 notifications made about dental practitioners, who represent 3.4% of registered practitioners and 1,300 notifications about nurses and midwives, who represent 63% of registered practitioners. Dental practitioners include dentists, dental therapists, dental hygienists, dental prosthetists and oral health therapists.

Notifications about the remaining seven registered professions account for about 17% of notifications.

The Northern Territory recorded the fewest notifications (108 notifications) in 2010-11 and is the jurisdiction with the smallest number of health practitioners across all professions excluding midwifery.

Table 13: Notifications received in 2010-11 by profession and state or territory [1]

Profession	ACT	NT	QLD	SA	TAS	VIC	WA[2]	Sub total	NSW	Grand total
Chiropractor	1	1	25	22		17	9	75	29	104
Dental practitioner	12	6	230	69	12	285	39	653	669	1,322
Medical practitioner	86	47	1,050	308	151	836	189	2,667	1455	4,122
Midwife		1	34	6		5	5	51	11	62
Nurse	19	27	243	282	26	241	67	905	333	1,238
Optometrist	2	1	10	5	2	8		28	27	55
Osteopath			4	1		7		12	7	19
Pharmacist	2	1	114	29	16	98	21	281	138	419
Physiotherapist	3	2	22	8	4	27	10	76	35	111
Podiatrist			8	5	1	15	4	33	22	55
Psychologist	11	2	110	22	11	102	16	274	116	390
Not stated[3]	39	20	74	14	7	71	17	242		242
Grand total	**175**	**108**	**1,924**	**771**	**230**	**1,712**	**377**	**5,297**	**2,842**	**8,139**

Notes:
1. Based on the state or territory where the notification is handled for registrants who do not reside in Australia.
2. Data for Western Australia represent notifications received from 18 October 2010 when Western Australia joined the National Scheme.
3. Profession of registrant is not always identifiable in the early stage of a notification.

The smallest number of notifications received in 2010-11 involved osteopaths (19 notifications), which is the regulated profession with fewest registrants (1,595 practitioners).

In 2010-11, New South Wales was the state that recorded the highest number of notifications (2,842 notifications). New South Wales is the state with the highest percentage of practitioners cited as their principal place of practice. This excludes the professions of midwifery, osteopathy and podiatry in which there are more registered practitioners based in Victoria than in New South Wales.

Proportion of registrants subject to a notification

Table 14: Percentage of registrant base with notifications received in 2010-11 by profession and state or territory shows the percentage of registered health practitioners for whom a notification has been received per profession nationally.

Dental practitioners recorded the highest proportion of notifications in 2010-11 relative to the number of registrants.

Table 14: Percentage of registrant base with notifications received in 2010-11 by profession and state or territory [1]

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	NSW	Grand total
Chiropractor	2.0%	4.8%	3.4%	2.0%	0.0%	1.2%	1.9%	1.6%	1.8%
Dental practitioner	3.4%	5.3%	5.2%	3.7%	2.9%	5.7%	1.7%	9.3%	5.8%
Medical practitioner	4.6%	5.1%	5.2%	4.0%	6.8%	3.3%	1.9%	4.5%	4.0%
Midwife[2]	0.0%	0.2%	0.4%	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%
Nurse[3]	0.4%	0.7%	0.4%	0.8%	0.3%	0.3%	0.2%	0.3%	0.3%
Optometrist	3.1%	4.0%	0.9%	2.4%	2.6%	0.6%	0.0%	1.6%	1.1%

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	NSW	Grand total
Osteopath	0.0%	0.0%	3.0%	4.0%	0.0%	0.8%	0.0%	1.0%	1.0%
Pharmacist	0.5%	0.6%	2.0%	1.4%	2.1%	1.3%	0.6%	1.6%	1.4%
Physiotherapist	0.7%	1.8%	0.5%	0.4%	1.0%	0.5%	0.3%	0.5%	0.5%
Podiatrist	0.0%	0.0%	1.4%	1.2%	1.3%	1.3%	1.2%	1.8%	1.4%
Psychologist	1.5%	0.5%	2.0%	1.3%	2.2%	1.1%	0.5%	1.1%	1.2%
Grand total	**2.0%**	**2.0%**	**1.6%**	**1.5%**	**1.6%**	**1.0%**	**0.6%**	**1.5%**	**1.3%**

Notes
1. Percentages for each state and profession are based on registrants whose profession has been identified and whose principal place of practice is an Australian state or territory. Notifications when the profession of the registrant has not been identified and registrants whose principal place of practice is not in Australia are only represented in the state and profession grand totals above.
2. The registrant base used for midwives includes registrants with midwifery or with nursing and midwifery registration.
3. The registrant base for nurses includes registrants with nursing registration or with nursing and midwifery registration.

Reasons for the notifications

National Boards are responsible for overseeing investigations about the conduct, health and performance of Australia's registered health practitioners. AHPRA categorises all notifications into one of these streams. Grounds for voluntary notifications are described at the beginning of this section on notifications.

In 2010-11, AHPRA received 5,297 notifications about the conduct, health and performance of practitioners across professions and states and territories, excluding New South Wales:

- 3,672 notifications received related to the conduct of health practitioners
- 319 notifications received related to the health of health practitioners and
- 1,306 notifications received related to the performance of health practitioners.

Consistent with previous experience, most notifications related to practitioners' conduct.

Table 15: Notifications received in 2010-11 by profession and stream provides a breakdown of these data by profession.

Types of concerns

In the first 12 months of the National Scheme, AHPRA applied a classification system to categorise in more detail the issues of concern identified by the person making a notification which reflects broadly the notifications typology used by health complaints entities in Australia.

The 5,297 notifications made during 2010-11 span all issue categories across all professions. These data do not reflect the 2,842 notifications received in New South Wales.

Notifications were most commonly about treatment (1,622 notifications) and the professional conduct of practitioners (1,607 notifications).

During 2011, AHPRA and the National Boards developed a new classification system for notifications that reflects more accurately the issues of concern about health practitioners that are notified to the boards. That typology will be applied to all notifications made from 1 July 2011 and reflected in reporting in future annual reports.

Table 15: Notifications received in 2010-11 by profession and stream [1, 2]

Profession	Conduct	Health	Performance	Grand total
Chiropractor	65	1	9	75
Dental practitioner	465	6	182	653
Medical practitioner	1,760	103	804	2,667
Midwife	29	4	18	51
Nurse	593	162	150	905
Optometrist	19	1	8	28
Osteopath	12			12
Pharmacist	215	15	51	281
Physiotherapist	63	2	11	76
Podiatrist	27		6	33
Psychologist	239	11	24	274
Not stated	185	14	43	242
Grand total	**3,672**	**319**	**1,306**	**5,297**

Notes:
1. Does not include data for New South Wales.
2. Part 8 of the Health Practitioner Regulation National Law Act as in force in each state and territory provides for notifications related to health, performance or conduct.

Table 16: Notifications received in 2010-11 by profession and issue category [1, 2]

	Chiropractor	Dental practitioner	Medical practitioner	Midwife	Nurse	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not stated	Grand total
Access		6	19		1						1		27
Communication and information	15	46	236	1	45	8	3	21	8	6	38	40	467
Consent	1	8	29		2						3	1	44
Discharge and transfer arrangements			4		3						1		8
Environment / management of facilities	2	12	3	1	6			2	1		1	3	31
Fees and costs	6	34	45			1		2	3	1	4	1	97
Grievance processes		2	13		5	1		1			1		23
Medical records	2	5	45		4		2	1	3	2	7	5	76
Medication		1	119	2	108			110				10	350
No jurisdiction		1	4	1	5				1		1	5	18
Privacy / discrimination			27	1	5			3	1		5		42
Professional conduct	18	101	657	19	525	7	4	98	25	10	112	31	1,607
Reports / certificates	1		102		2				1		41	3	150
Telephone					1								1
Treatment	21	320	1,038	21	112	10	2	12	22	10	30	24	1,622
Other	3	8	115		30			10	2		6	10	184
Not stated[3]	6	109	211	5	51	1	1	21	9	4	23	109	550
Grand total	**75**	**653**	**2,667**	**51**	**905**	**28**	**12**	**281**	**76**	**33**	**274**	**242**	**5,297**

Notes:
1. Does not include data for New South Wales
2. The issue categories reflect the initial typology adopted at transition to the National Law. A new typology has been developed for implementation from 1 July 2011. This will form the basis for reporting in future years.
3. The issue categorisation is based on initial information provided by the notifier. An issue category is not always identified by the notifier.

Advertising

The National Law includes new powers in relation to advertising by registered health practitioners. National Boards have developed advertising guidelines that clarify the boards' expectations of practitioners in this area. For many professions and in many jurisdictions, both the legal framework and the standards expected by the National Boards are different from those previously in place. As a result, for the first year of the National Scheme, the boards have taken a largely educative approach to matters related to advertising, by helping practitioners understand the law and the new requirements set down in the guidelines of each National Board.

The 2012 year will see a more structured approach to addressing concerns about advertising. This will include an escalating series of warnings to practitioners, initially reminding them of their obligations about advertising and ultimately, possible prosecution for non-compliance with a board's standards. If a National Board deems that a practitioner's failure to comply with a board's

request warrants it, matters related to advertising can also be progressed through the conduct, health and performance pathways.

AHPRA will also be working with the Australian Competition and Consumer Commission (ACCC) to ensure the work in relation to false and misleading advertising dovetails effectively in protecting the public with the approach of AHPRA and the National Boards.

Advertising as a category of notification is therefore not recorded in the types of notification received in 2010-11.

Who made notifications?

Anyone can make a notification to AHPRA, which receives it on behalf of the boards. While registered health practitioners, employers and education providers have mandatory reporting obligations required by the National Law, the majority of reports are voluntary. The National Law provides protection from legal liability for persons who make a notification in good faith. Privacy obligations under the National Law prevent the identification of notifiers who report concerns about health practitioners' conduct, health or performance.

In 2010-11, the largest number of notifications (1,903 notifications or 36%) came directly from the community (patients, self-reports, relatives or the public). A total of 1,401 notifications (26%) across all professions was received from health complaints entities (HCEs) in each state or territory, reflecting the joint consideration of notifications between the National Boards and health complaints entities in the National Scheme. The HCEs were not the primary source of the concern. Data on the source of notifications excludes New South Wales.

Table 17: Notifications received in 2010-11 by profession and notification source [1]

	Chiropractor	Dental practitioner	Medical practitioner	Midwife	Nurse	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not stated	Grand total
Anonymous	5	14	42	2	18		1	10	3	3	10	14	122
Drugs and poisons agency			15		1			3					19
Education provider			2		10							4	16
Employer		4	72	11	344			9	4	3	3	10	460
Government department	3	7	58	5	44	1		21	5		10	5	159
Health complaints entity	8	248	968	10	70	10	2	17	5	5	16	42	1,401
Health advisory service		1	1		1			1	1				5
Hospital		2	8	1	34			1	1			3	50
Insurance company		1			1		1			1			4
Lawyer		2	18		5					1	5	2	33
Medicare			2										2
Member of Parliament								1					1
Member of the public	1	12	59	6	23	1	1	12	4		18	7	144
Other board			1										1
Other practitioner	14	73	260	5	130	1	2	63	10	3	37	37	635
Patient	26	207	671	5	44	12	2	77	23	9	94	32	1,202
Police			15		6			2					23
Relative	2	31	250	2	58	1		22	7	1	36	15	425
Self	1	8	50	1	51			9	2	1	7	2	132
Unclassified	12	21	94		44	1	1	19	6	4	27	17	246
Not stated	3	22	81	3	21	1	2	14	5	2	11	52	217
Grand total	**75**	**653**	**2,667**	**51**	**905**	**28**	**12**	**281**	**76**	**33**	**274**	**242**	**5,297**

Notes:
1. Does not include data for New South Wales

National Law: Notifications closed in 2010-11

It is important to note that the notifications analysed in detail in this section of the 2010-11 annual report are skewed towards matters involving allegations of less serious professional conduct, health or performance. This is because, in general, the total notifications being managed by AHPRA and the boards fall into four broad categories:

- allegations of the most serious unprofessional conduct, health or performance that have been made since 1 July 2010 under the National Law. These matters are generally more complex, take longer to investigate and remained open at the end of the reporting year. Outcomes are not yet known.
- allegations of the most serious conduct, health or performance that transferred into the National Scheme on 1 July 2010 as 'legacy' matters. These are the most complex cases that came into the National Scheme and are being managed under the previous legislation in place in each state and territory, which involves up to 65 pieces of legislation, each with different powers and sanctions. Meaningful, comparative analysis of these notifications is therefore not possible. Some of these were finalised during the year, others remained open at the end of the year. These are being actively managed and the number will reduce over time. The number of open and closed legacy matters is detailed later in this section.
- allegations of less serious professional conduct, health or performance that transferred as 'legacy' matters into the National Scheme on 1 July 2010 that were closed during the year. Legacy matters closed during the year are outlined at the end of this section of this annual report.
- allegations about less serious unprofessional conduct, health or performance made since 1 July 2011 that have been managed under the National Law. In general, the outcomes of these matters are the focus of this section of the annual report.

In 2010-11, 4,288 (52.7%) of the 8,139 new notifications lodged under the National Law were closed during the year. The remaining matters lodged during 2010-11 remained open on 30 June 2011, reflecting both the complexity of some cases and the point in time at which some were lodged.

Table 18: Notifications lodged under the National Law and closed in 2010-11 by profession and state or territory details the number of new notifications received by jurisdiction and profession. These data do not include 'legacy' matters managed by National Boards and AHPRA during 2010-11 that transferred to AHPRA on 1 July 2010 and (except for South Australia) are being managed under the legislation previously in place.

Matters managed in New South Wales, that were lodged and closed in 2010-11, are included in this table.

Table 18: Notifications lodged under the National Law and closed in 2010-11 by profession and state or territory

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	Sub total	NSW	Grand total
Chiropractor		1	8	4		5		18	13	31
Dental practitioner	1	2	83	33	5	130	9	263	472	735
Medical practitioner	13	15	497	165	96	462	36	1,284	1,075	2,359
Midwife			11	1		1		13	3	16
Nurse	2	3	84	140	13	87	17	346	208	554
Optometrist		1	4	3	1	6		15	22	37
Osteopath			1			2		3	5	8
Pharmacist	1	1	26	15	13	54	5	115	88	203
Physiotherapist	2		8	3	2	16	2	33	31	64
Podiatrist			4	3		8	4	19	17	36
Psychologist	1	2	52	6	4	39	3	107	73	180
Not stated[1]	1	2	27	3	3	29		65		65
Grand total	**21**	**27**	**805**	**376**	**137**	**839**	**76**	**2,281**	**2,007**	**4,288**

Notes:

1. Practitioner profession may not have been identified in early stages of a notification.

Managing notifications: stage at closure

During the year, there were six stages in managing a notification (matter). Under the National Law, a National Board has the power to decide no further action is required at any stage during the assessment or investigation of a notification. A matter can also be closed at any stage, and can be closed after a range of actions has been taken or sanctions applied.

Lodgement

Matters closed at lodgement are, on initial review, usually outside the jurisdiction of the board, do not meet the requirements for a notification under the National Law, or cannot be progressed because relevant information cannot be sourced.

Assessment

An assessment determines whether an investigation is warranted, or if another course of action is more appropriate. This assessment usually includes a detailed review of the substantive issues involved, made after further information has been sought from both the notifier and the practitioner. Matters closed at this stage usually do not reach the threshold under the National Law for potential unsatisfactory professional conduct. Of the total number of notifications closed in 2010-11, the majority were closed after assessment (1,644 closed notifications).

Investigation

At the end of an investigation, a board has a range of options, including whether to take no further action, to refer a matter to a panel or tribunal hearing or refer a practitioner for a health or performance assessment. Outcomes from closure at this stage of the process can include undertakings, cautions and conditions on registration, as well as no further action.

Health or performance assessment

Matters can be closed after a National Board has referred a practitioner for a health or performance assessment.

Panel and tribunal hearings

Under the National Law, allegations about the most serious unprofessional conduct, health or performance can be referred for hearing by panels or tribunals. Allegations of the most serious unprofessional conduct are often the most complex and take the most time to investigate. The limited number of matters closed at panel and tribunal hearing during 2010-11 reflects that it usually takes longer than 12 months for most complex cases to progress from notification, through investigation, referral to a panel or tribunal, listing and then hearing. Some matters in South Australia that were referred to a tribunal soon after the National Scheme began operation were concluded during 2010-11.

Table 19: National Law notifications closed in 2010-11 by profession and stage at closure shows the stage of closure for notifications received by AHPRA. This table does not include data from New South Wales.

Table 19: National Law notifications closed in 2010-11 by profession and stage at closure[1]

	Lodged[2]	Assessment	Investigation	Health or performance assessment	Panel hearing	Tribunal hearing	Grand total
Chiropractor	3	15					18
Dental practitioner	64	172	25	2			263
Medical practitioner	219	961	82	16	4	2	1,284
Midwife	3	7	2	1			13
Nurse	20	231	71	18	2	4	346
Optometrist	1	13	1				15
Osteopath	1	2					3
Pharmacist	11	80	21		2	1	115
Physiotherapist	5	24	4				33
Podiatrist	4	10	3	2			19
Psychologist	10	88	7	2			107
Not stated	24	41					65
Grand total	**365**	**1,644**	**216**	**41**	**8**	**7**	**2,281**

Notes
1. Does not include data for NSW
2. Includes enquiries.

Outcomes: Closed notifications

There are different outcomes for different notifications. Most do not lead to a restriction on a practitioner's registration. However, the fact that a notification has been made, in many cases indicates that not everything has gone well for the notifier in the consultation. In most cases, the boards inform practitioners that notifications have been made against them so they can learn from the experience and where necessary, they can alter the way they practise and that other patients do not face the same issues in the future.

When deciding to close a matter, a National Board has a number of options including:

- referring all or part of the notification to another body; this usually involves matters over which the board does not have jurisdiction under the National Law
- no further action – a board can decide to take no further action at any time during the assessment or investigation of a notification, but only after careful consideration of the issues raised
- accepting an undertaking, when a practitioner agrees to specific limitations or restrictions on practice; undertakings are recorded on the national register and the practitioner is subject to monitoring to ensure compliance
- issuing a caution to the practitioner to practise in a particular way
- issuing a reprimand to the practitioner, obliging the practitioner to modify his or her practice so the matter that was the subject of the original notification does not recur
- imposing conditions limiting the practice of the practitioner – the existence and detail of conditions are recorded under the practitioner's name on the national register in accordance with the National Law and the practitioner is subject to monitoring to ensure compliance
- suspending registration though immediate action, a power which the board may use at any time under the National Law if it has evidence there is a serious risk to the health and safety of the public. The board's decision to take immediate action and potentially suspend a practitioner's registration is a serious and interim action to protect the health or safety of the public and must be submitted for adjudication to the relevant tribunal as an independent body established under the courts system in each state or territory. Only a tribunal has the power to apply a long-term suspension or cancellation of a practitioner's registration.

In most cases (1,954 cases or 86%), the National Board determined that no further action was required.

A board decision to take no further action is only made after careful consideration of the allegations made. Under the National Law, a board can decide to take no further action in relation to a notification if:

- the board believes the notification is frivolous, vexatious, misconceived or lacking in substance or
- it is not practicable for the board to investigate or deal with the notification, given the amount of time that has elapsed since the matter that is the subject of the notification occurred or
- the person to whom the notification relates has not been, or is no longer, registered and it is not in the public interest to investigate or deal with the notification or
- the subject matter of the notification has already been dealt with adequately by the board or
- the subject matter of the notification is being dealt with, or has already been dealt with, adequately by another entity.

The proportion of cases closed with no further action appears relatively high and AHPRA and the National Boards will continue to closely monitor these data over the coming year to understand the contributing factors. Possible explanations include that:

- the bulk of matters opened and closed in the first year of the National Scheme are skewed towards less complex matters; therefore, more complex cases involving allegations of more serious conduct, performance or health issues that warrant action by National Boards are likely to not be included in this data set and
- community and broader stakeholder understanding of the National Law and what constitutes grounds for a notification will strengthen over time. This may lead to a potential decrease in referrals to the National Scheme that can be better dealt with by other agencies or matters that do not meet the legal threshold for action by a National Board.

The registration of five practitioners was suspended in 2010-11 as a result of a sanction by a panel or tribunal or as a result of a health assessment. Suspensions as a result of immediate action taken by a National Board are summarised later in this section. The small number of this type of sanction imposed is likely to result from the relatively small number of matters under the National Law that have progressed to hearing by the end of the reporting year. Details about most restrictions placed on a practitioner's registration – including suspensions, conditions, undertakings and reprimands, are published on the register of practitioners. The only restrictions not usually published relate to conditions on a practitioner's health.

Table 20: National Law notifications closed in 2010-11 by outcome at closure[1]

Profession	No further action[2]	Accept undertaking	Caution	Caution or reprimand	Impose conditions	Refer all or part of the notification to another body	Suspend registration	Grand total
Chiropractor	17		1					18
Dental practitioner	207	2	1			53		263
Medical practitioner	1,113	7	16			146	2	1,284
Midwife	12		1					13
Nurse	289	17	17	2	8	10	3	346
Optometrist	12					3		15
Osteopath	3							3
Pharmacist	95		12	2	1	5		115
Physiotherapist	31		1		1			33
Podiatrist	16	2	1					19
Psychologist	101		2			4		107
Not stated	58					7		65
Grand total	**1,954**	**28**	**52**	**4**	**10**	**228**	**5**	**2,281**

Notes:
1. Does not include data for NSW.
2. Includes enquiries that did not proceed as well as cases assessed as requiring no further action.

Immediate action

The board has the power to take immediate action at any time. This is a serious step and the board can only take this action if it believes that it is necessary to protect the health or safety of the public because of a practitioner's conduct, performance or health.

Immediate action means:

1. suspension or imposition of a condition on the practitioner's or student's registration or
2. accepting an undertaking from the practitioner or student or
3. accepting the surrender of the practitioner's or student's registration.

Before taking immediate action, the board must give the registrant notice of the proposed immediate action and invite him or her to make submissions to the board. The board must then have regard to any submissions when deciding whether or not to take immediate action.

The National Boards took immediate action in 209 matters during the year. In 166 (79%) of these cases, the practitioner's registration was restricted in some way as a result, usually pending the outcome of an investigation.

The majority of these related to the nursing profession (112 immediate action cases), followed by the medical profession (62 immediate action cases), consistent with the number of practitioners in each profession. *Table 21: Immediate action cases* details the action taken by the boards after considering immediate action. Under the National Law, the boards must act to protect the public, while restricting a practitioner's registration only as far as necessary. Data for New South Wales are provided.

Table 21: Immediate action cases[1,2]

		Action taken					
Profession	No action taken	Accept surrender of registration	Accept undertaking	Impose conditions	Suspend registration	Sub total	Grand total
Chiropractor				(2)		(2)	(2)
Dental practitioner	2		1	(5)	1(1)	2(6)	4(6)
Medical practitioner	15(7)	4(3)	19	15(28)	9(15)	47(46)	62(53)
Midwife			3			3	3
Nurse	24	4	23	26(41)	35(8)	88(49)	112(49)[3]

Profession	No action taken	Action taken				Sub total	Grand total
		Accept surrender of registration	Accept undertaking	Impose conditions	Suspend registration		
Optometrist				(1)		(1)	(1)
Osteopath				(3)		(3)	(3)
Pharmacist	1		2(3)	6	5(1)	13(4)	14(4)
Physiotherapist			1	3(2)		4(2)	4(2)
Podiatrist			1	1(1)	(2)	2(3)	2(3)
Psychologist	1		1	1(2)	5(2)	7(4)	8(4)
Total	**43(7)**	**8(3)**	**51(3)**	**52(85)**	**55(29)**	**166(120)**	**209(127)**

Notes:
1. Cases where immediate action has been initiated under Division 7 of the National Law.
2. NSW data on immediate action cases is provided in brackets ( ).
3. Data for NSW includes both nurses and midwives.

National Law: Mandatory notifications

The effect of the mandatory reporting provisions of the National Scheme is a question of considerable interest to the professions and the community. This section provides a snapshot of mandatory reporting data from the first year.

The National Law as in force in each state and territory requires health practitioners, employers and education providers to report 'notifiable conduct' to AHPRA.

Notifiable conduct in relation to registered health practitioners means the practitioner has:

- practised the profession while intoxicated by alcohol or drugs or
- engaged in sexual misconduct in connection with the practice of the profession or
- placed the public at risk of substantial harm in the practice of the profession because the practitioner has an impairment or
- placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

Similar models for mandatory reporting were in place in some states and territories before the National Scheme was introduced.

A mandatory report does not trigger a uniform response by a National Board. A mandatory report brings an issue of potential public risk to the attention of a National Board, which can then assess the information and respond as necessary to protect the public.

Guidelines for mandatory notifications have been published by each of the National Boards at their websites under the *Codes and guidelines* section.

What to report and when

The National Law defines the trigger for a mandatory notification and the conduct that must be reported. The threshold is high: first, a reporting practitioner or employer must have formed a reasonable belief that the behaviour constitutes notifiable conduct.

Similarly, the threshold that triggers a mandatory notification in relation to students is high: a reporting practitioner or education provider must reasonably believe that, due to an impairment, the student could place the public at substantial risk of harm in the course of the student's clinical training.

The mandatory notification provisions in the National Law enshrine commonly-held ethical principles of patient safety. The National Law includes provisions that protect anyone making a notification in good faith from legal liability. This protects those who report practitioners from liability and reinforces that making a mandatory notification under the National Law is consistent with good professional conduct and a practitioner's ethical responsibilities.

Mandatory reporting and impairment

Mandatory reporting does not apply to most practitioners with impaired health. The National Law only requires a health practitioner or an employer to notify AHPRA if they are aware that an impaired practitioner has:

- practised the profession while intoxicated by alcohol or drugs or
- placed the public at risk of substantial harm in the practice of the profession because the practitioner has an impairment.

An impairment or poor health do not provide, in themselves, sufficient grounds to trigger a mandatory report. A practitioner who recognises that he or she has an impairment and who obtains appropriate treatment or stops practising voluntarily before it affects practice does not need to be reported to AHPRA.

The National Boards and AHPRA encourage health practitioners and students whose health is impaired to seek and receive good medical or other health care. This will also reduce the likelihood of or need for a mandatory notification.

Exceptions to reporting

The National Law provides for a number of exemptions from the obligation to report. These are detailed in each board's mandatory reporting guidelines and include:

- when the practitioner, who would otherwise have had a duty to report, has formed the belief that a practitioner's conduct is notifiable during legal proceedings or while preparing legal advice
- is engaged by a professional indemnity insurer
- is a member of a quality assurance committee or
- knows that AHPRA has been informed of the notifiable conduct.

In Western Australia only, practitioners who are in a treating relationship with another practitioner are not required to make a mandatory notification to AHPRA.

Mandatory reporting data

In 2010-11, AHPRA received 428 mandatory notifications relating to registered health practitioners. In addition, seven mandatory notifications were received about registered students. Mandatory notifications represent eight per cent of all notifications received.

The following analysis relates to the notifications of registered practitioners (note that this data on mandatory notifications does not include data on New South Wales).

Distribution of mandatory notifications

Table 22: Distribution by jurisdiction provides an overview of the number of mandatory notifications by jurisdiction. There is considerable variation in the rates at which mandatory notification occurred across the states and territories. Rates were highest in South Australia with 27 notifications per 10,000 practitioners, compared with a national rate of eight (8) per 10,000 practitioners.

Table 23: Distribution by profession provides an overview of mandatory notifications by profession. More than 90% of mandatory notifications related to nurses (58%) or medical practitioners (34%). Pharmacists, psychologists, physiotherapists, midwives, and dental practitioners were the subject of smaller numbers of mandatory notifications. There were no mandatory notifications in relation to chiropractors, optometrists, osteopaths or podiatrists.

Taking into account the number of registered practitioners in each profession, medical practitioners had the highest rate of mandatory notifications (16 per 10,000 medical practitioners), followed by nurses (seven per 10,000 nurses) and pharmacists (six per 10,000 pharmacists).

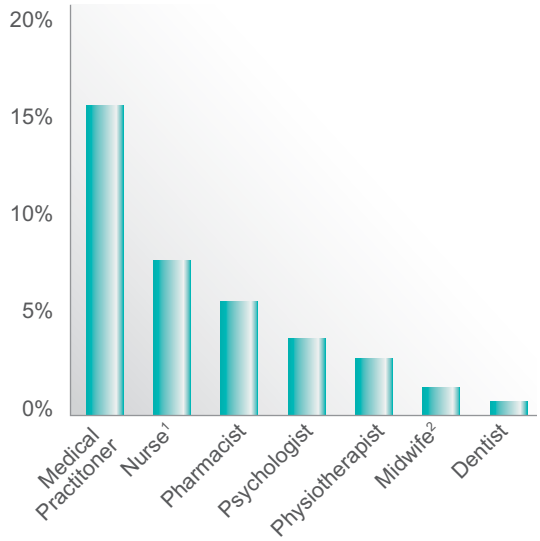
Table 22: Distribution of cases by jurisdiction

state	Number	Percent	Rate / 10,000 practitioners
Victoria	164	38.3	12.0
South Australia	121	28.3	27.3
Queensland	85	19.9	8.6
Western Australia	33	7.7	6.4
Tasmania	15	3.5	12.2
Australian Capital Territory	7	1.6	8.6
Northern Territory	3	0.7	6.3
Australia	**428**	**100.0**	**8.1**

Table 23: Distribution of cases by profession

Profession	Number	Percent	Rate / 10,000 practitioners
Nurse[1]	249	58.2	7.5
Medical practitioner	144	33.6	16.3
Pharmacist	15	3.5	5.8
Psychologist	9	2.1	3.1
Physiotherapist	5	1.2	2.2
Midwife[2]	5	1.2	1.0
Dentist	1	0.2	0.6
All professions	**428**	**100.0**	**8.1**

Figure 18: Mandatory notifications per 10,000 practitioners



Notes:
1. Includes practitioners with nursing registration or with nursing and midwifery registration.
2. Includes practitioners with midwifery registration or with nursing and midwifery registration.

Reasons for mandatory notifications and source of report

Around 60% of notifications were made by employers and 40% by other providers.

The grounds (reason) for nearly 60% of notifications were that a practitioner was placing the public at risk of harm due to practice that constituted a significant departure from accepted professional standards. Nearly one-third of notifications were based on concerns that a practitioner had an impairment that was placing the public at risk (*Table 24: Grounds of mandatory notifications*).

Table 24: Grounds for mandatory notifications

Grounds for notification	Number	Percent
Sexual misconduct	29	6.8%
Drug or alcohol	18	4.2%
Impairment	128	29.9%
Departure from standards	253	59.1%
Total	**428**	**100.0%**

Outcomes of assessment of mandatory notifications

Table 25: Mandatory notifications outcome from assessment details the outcome, by grounds, of National Boards' assessment of mandatory notifications. The assessment of 379 out of 428 mandatory notifications had been completed by the end of the reporting year. Of the mandatory notifications assessed in the reporting year, the majority (57.7% or 219 matters) were referred for investigation; in 64 matters (16.8%) National Boards took no further action in relation to a mandatory notification; in 23 matters (6%) immediate action was initiated.

Of the mandatory notifications made on the grounds of impairment that were assessed in the reporting year, 48 matters (42%) were referred to health or performance assessment; 42 matters (37%) were referred for investigation; six matters (5%) triggered consideration of immediate action and in 19 matters (16%) no further action was taken.

Outcomes of mandatory notifications

Of the 428 mandatory notifications, immediate action was taken in 74 cases (17%). The proportions of immediate action taken are reported in *Table 26: Immediate action arising from mandatory notifications* and the outcome of these immediate action considerations is detailed in *Table 27: Outcome of immediate action taken in mandatory reporting cases.*

Table 25: Mandatory notifications outcome from assessment

Grounds for notification	End matter	Initiate immediate action	Refer to another entity	Refer to health assessment	Refer to performance assessment	Refer to Health panel	Refer to investigation	Refer to tribunal	Grand total [1]
Sexual misconduct	3	4					21	1	29
Drug or alcohol	3	2		4			6		15
Impairment	19	6		46	2		42		115
Standards	39	11	1	13	5	1	150		220
Grand total	**64**	**23[2]**	**1**	**63**	**7**	**1**	**219**	**1**	**379**

Notes:
1. Assessment has not been finalised in all cases
2. In many cases, immediate action is initiated concurrent with assessment.

Table 26: Immediate action arising from mandatory notifications

Immediate action taken	Number	Percent
No	354	82.7%
Yes	74	17.3%
Total	**428**	**100.0%**

Table 27: Outcome of immediate action taken in mandatory reporting cases

Profession	Accept undertaking	Accept surrender of registration	Impose conditions	Suspend registration	Pending [1]	Grand total
Medical practitioner	6		6	4		16
Nurse	13	2	15	17	1	48
Pharmacist	2		2	2		6
Physiotherapist	1					1
Psychologist				3		3
Grand total	**22**	**2**	**23**	**26**	**1**	**74**

Notes:
1. Recent case with decision on nature of action pending.

In 2010-11, 131 (30.6%) mandatory notification cases were closed, taking an average of 117 days to reach closure. On 30 June 2011, 297 (69.4%) cases remained open.

In 97 of the 131 closed cases, the relevant board determined that no further action was required. The remaining 34 matters were resolved with a voluntary undertaking (11) in relation to scope or continuation of practice, which can include an agreement to surrender registration, a caution or reprimand (7), conditions (15) or surrender of registration (1).

Table 28: Outcomes of mandatory notifications

Outcome of closed matters	Number	Percentage
No further action	97	74.1%
Accepted undertaking	11	8.4%
Caution or reprimand	7	5.3%
Conditions imposed	15	11.4%
Surrender of registration	1	0.8%
Total	131	100%

National Law: Open matters

Every notification received is taken seriously and managed individually. Complex matters take longer to progress through the relevant investigative process.

There were 3,879 (out of the total 8,139) notifications received under the National Law in 2010-11 that remained open at 30 June 2011, including in New South Wales. Some of these open cases were received towards the end of the reporting year, and others were complex and required more time to manage. Additionally, in South Australia, the law requires all matters that transferred into the National Scheme to be dealt with under the National Law, except those which were the subject of formal proceedings before a board or tribunal.

Legacy notifications: Matters transferring into the National Scheme

The introduction of the National Scheme in 2010-11 required the National Boards and AHPRA to continue to handle notifications lodged under previous state and territory legislation as well as new notifications received under the National Law since 1 July 2010. Notifications received by AHPRA from 1 July 2010 are managed under the National Law; notifications received by state and territory boards before 30 June 2010 that transferred into the National Scheme are managed under the legislation in place in each jurisdiction except in South Australia, where the law requires all continuing matters to be dealt with under the National Law, except those which were the subject of formal proceedings before a board or tribunal.

All legacy matters are being progressively resolved by AHPRA and the National Boards.

There were 1,779 matters that transferred into the National Scheme on 1 July 2010 that were closed during the reporting year.

There were 1,517 notifications that transferred into the National Scheme, being managed under

Table 29: Open notifications at 30 June 2011 under National Law by profession and state or territory

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	Sub total	NSW	Grand total
Chiropractor	1	-	17	18	-	12	9	57	16	73
Dental practitioner	11	4	147	36	7	155	30	390	197	587
Medical practitioner	73	32	553	143	55	374	153	1,383	380	1,763
Midwife	-	1	23	5	-	4	5	38	8	46
Nurse	17	24	159	142	13	154	50	559	125	684
Optometrist	2	-	6	2	1	2	-	13	5	18
Osteopath	-	-	3	1	-	5	-	9	2	11
Pharmacist	1	-	88	14	3	44	16	166	50	216
Physiotherapist	1	2	14	5	2	11	8	43	4	47
Podiatrist	-	-	4	2	1	7	-	14	5	19
Psychologist	10	-	58	16	7	63	13	167	43	210
Not stated	38	18	47	11	4	42	17	177	-	177
Grand total	154	81	1,119	395	93	873	301	3,016	835	3,851

the legislation previously in place in states and territories before 1 July 2010 that remained open at the end of the reporting year.

Cancelled registrations

A list of the 56 practitioners whose registration has been cancelled since the introduction of the National Scheme is published on the AHPRA website. The website also publishes a link to a library, hosted by Austlii, of publicly available decisions made about registered health practitioners by panels and tribunals.

Table 30: Closed notifications under previous legislation by profession and state or territory

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	Sub total	NSW	Grand total
Chiropractor			6			8	1	15	14	29
Dental practitioner	1	1	28	1	1	18	18	68	181	249
Medical practitioner	16	7	207	1	19	142	112	504	428	932
Midwife						1	1	2	16	18
Nurse	9	6	51	8	6	68	16	164	103	267
Optometrist			2			1		3		3
Osteopath			1			2		3	2	5
Pharmacist	1		38		3	8	4	54	71	125
Physiotherapist			8		1		1	10	9	19
Podiatrist			8				1	9	4	13
Psychologist	2	1	39		1	21	9	73	36	109
Not stated		1	6			1	2	10		10
Grand total	**29**	**16**	**394**	**10**	**31**	**270**	**165**	**915**	**864**	**1,779**

Table 31: Open notifications at 30 June 2011 under previous legislation by profession and state or territory

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	Sub total	NSW	Grand total
Chiropractor			3	1		7	1	12	6	18
Dental practitioner	1	5	33			21	10	70	9	79
Medical practitioner	8	58	195		17	148	194	620	235	855
Midwife			1			3	5	9		9
Nurse	6	26	41		12	104	37	226	61	287
Optometrist			2		1	2	1	6		6
Osteopath		1	1			2		4	1	5
Pharmacist			45		4		4	53	34	87
Physiotherapist		2	10			1	1	14	3	17
Podiatrist			2				2	4		4
Psychologist	2	1	51		6	43	18	121	11	132
Not stated	2	2	10	1		3		18		18
Grand total	**19**	**95**	**394**	**2**	**40**	**334**	**273**	**1,157**	**360**	**1,517**

Legislative reporting and other matters

AHPRA national senior management team

Martin Fletcher, Chief Executive Officer began with AHPRA in December 2009. With more than 10 years' experience in patient safety in Australia, the United Kingdom and internationally, he brings strong expertise to the work of establishing and leading AHPRA. Before joining AHPRA, Mr Fletcher was Chief Executive of the National Patient Safety Agency, the leading National Health Service body for patient safety in England and Wales. He holds a Master of Management degree in public sector management, an Honours degree in behavioural sciences and an undergraduate degree in social studies.

Chris Robertson, Director National Board Services has more than 10 years' expertise in health policy and legislation, workforce planning and innovation. He was appointed to his current role at AHPRA in January 2010. Previously, Mr Robertson served as the National Director Policy and Legislation, National Registration and Accreditation Implementation Project. He holds a Graduate Certificate of Health Management from the Queensland University of Technology and a Bachelor of Commerce from Griffith University. He was previously a registered nurse working in critical care and holds a Diploma of Applied Science Nursing from Monash University.

John Ilott, Director Finance and Corporate Operations came to AHPRA with more than 30 years' experience as a senior executive in both the public and private health sectors. Before his current role at AHPRA he was General Manager, Victoria for St John of God Pathology and Chief Executive Officer of the Victorian Branch of the Pharmaceutical Society of Australia. Mr Ilott holds a Master of Arts by research from the Faculty of Law and Management, La Trobe University. He also holds an undergraduate degree in business. He is a Member of the Australian Institute of Company Directors and a Fellow of the Australian Society of Certified Practising Accountants.

Jim O'Dempsey, Director Business Improvement and Innovation has more than 20 years' experience in clinical practice and health management. Appointed to his current role in February 2011, Mr O'Dempsey joined AHPRA as State Manager, Queensland on 1 February 2010. He holds a Psychiatric Nursing Certificate (Baillie Henderson Hospital, Toowoomba) and a General Nursing Certificate (Repatriation General Hospital, Greenslopes).

Dominique Saunders, General Counsel, has more than 20 years' experience in the community, public and private sectors. Before joining AHPRA, Ms Saunders was Corporate Counsel, Executive Director at Western Health. Dominique holds a Bachelor of Social Work and a Bachelor of Laws. She is admitted to the High Court of Australia and the Supreme Court of Victoria.

Administrative complaints

AHPRA and the National Boards are committed to transparency and accountability in all their functions, as well as delivering high standards of service. AHPRA, together with all National Boards, have adopted a *Complaint Handling Policy and Procedure*. This formalises a process through which dissatisfied people can have concerns about AHPRA or the National Boards fairly considered and addressed. The policy applies to the National Law entities, being the Agency Management Committee, AHPRA and the ten National Boards.

The policy provides a procedure for responding to complaints about administrative procedures and decision-making within National Law entities. It also includes a process for internal review of complaints handling. The National Health Practitioner Ombudsman commenced on 1 October 2010 and provides an essential component of complaints management and quality assurance.

Under the policy, a person who believes he or she has been subject to conduct or behaviour which falls short of the standards expected of AHPRA or a National Board can make a complaint. AHPRA takes complaints seriously and recognises the benefit of investigating complaints to identify and rectify problems so that service standards and delivery can be improved.

Complaints officers have been appointed in each AHPRA state and territory office and training has been provided so AHPRA is better equipped to investigate complaints and take appropriate action. Further, AHPRA is equipped to record and track complaints received now so that it can identify common themes and address the underlying causes.

Since the recording system was introduced, AHPRA has received a total of 575 complaints. Of these, 517 were resolved in the reporting year. AHPRA directly received 172 complaints from the National Health Practitioner Ombudsman. Of these, 165 were resolved during the reporting year. Major issues included:

- timelines for assessing applications
- responsiveness of AHPRA to enquiries
- board policies such as requirements of practitioners in relation to English language
- skills and continuing professional development
- fees.

National Health Practitioner Ombudsman

The office of the National Health Practitioner Ombudsmanis created by the National Law to undertake ombudsman functions under the *Ombudsman Act 1976* (Cth), tailored for the National Scheme.

AHPRA works closely and collaboratively with the National Health Practitioner Ombudsman. The primary role of the National Health Practitioner Ombudsman is to receive complaints and help people who believe they may have been treated unfairly in administrative processes by the entities within the National Scheme. The Ombudsman provides a separate report on the operation of the office.

Freedom of information

The National Law establishes a national regulatory system for health practitioners. Section 215 of the National Law provides that the Commonwealth *Freedom of Information Act 1982* (FOI Act) applies to the National Law.

In the year to 30 June 2011, 128 applications were received under the FOI Act. These were handled as follows:

Table 32: Applications received under the Freedom of Information Act

Applications received	Number of applications
Granted in full	16
Granted in part	58
Access refused	8
Withdrawn	15
In progress at 30 June 2011	31
Total	**128**

There were six applications for internal review during the year – two applications resulted in greater access but not full; and in each of the other four applications, the decision of the Freedom of Information Officer was affirmed on review.

One application, which was lodged with the Queensland Civil and Administrative tribunal in the financial year, has not yet been determined.

Application fees of $4,080.00 and charges of $21,862.05 covering the cost of handling Freedom of Information requests and related responsibilities in 2010-11 were collected.

Freedom of Information Act, Section 8

The following information is presented in accordance with section 8 of the FOI Act:

Organisation and functions

The National Law establishes entities (the National Law entities) including:

- the Australian Health Practitioner Regulation Agency (AHPRA)
- the Agency Management Committee and
- National Boards for ten health professions.

The FOI Act applies to these entities. AHPRA is governed by the Agency Management Committee and supports the operations of the 10 National Boards in implementing the National Registration and Accreditation Scheme. AHPRA's functions include:

- receiving and managing notifications about registered health practitioners or students
- on behalf of the National Boards, managing investigations into the professional conduct, performance or health of registered health practitioners, except in New South Wales where this is undertaken by the health professional councils and the Health Care Complaints Commission
- on behalf of the National Boards, publishing registers of practitioners: publicly-accessible online registers detailing the registration status and details of health practitioners
- supporting the National Boards in the development of registration standards, and codes and guidelines and
- providing advice to the Ministerial Council about the administration of the National Scheme.

Consultative arrangements

The public release of documents is not a legislative requirement under the National Law or the FOI Act; however, the Agency Management Committee and the National Boards have decided to make available to a wider audience documents released under FOI applications that are relevant to the functions of the National Scheme and that may be of interest to the public. A disclosure log is available on the AHPRA website at www.ahpra.gov.au.

The National Law requires the National Boards to undertake wide-ranging public consultation about the content of proposed registration standards, codes and guidelines. The consultation process provides a framework for the development and/or review of registration standards, codes and guidelines. The boards may vary each consultation process to ensure all stakeholders can provide effective input.

To promote awareness of the National Law and functions of the National Law entities, AHPRA publishes detailed websites including standards, codes and guidelines, policies and communiqués in relation to its functions and National Boards.

Categories of documents

The categories of documents maintained or held by AHPRA include those relating to:

- corporate organisation and administration
- financial management and management of assets
- internal administration including policy development and program administration, reports, briefings, correspondence, minutes, submissions, statistics and other documents
- Agency Management Committee's recommendations relating to the business of AHPRA
- reference material used by staff including guidelines and manuals
- working files and
- legal advice.

The categories of documents listed above are maintained in a variety of formats. Some of these documents, along with information on AHPRA's organisation, structure and activities can be obtained at no cost through AHPRA's website at www.ahpra.gov.au.

Access to documents

Access to documents under the Freedom of Information Act can be obtained by forwarding a written request together with the prescribed fee to:

The FOI Officer

AHPRA
G.P.O. Box 9958
BRISBANE QLD 4000

Office Location

Level 18, 179 Turbot Street Brisbane QLD 4000

Email

foi@ahpra.gov.au

Healthcare provider

Under Section 9 of the *Healthcare Identifiers Act 2010*, the HI Service Operator and national registration authorities prescribed by the regulations are authorised to assign healthcare identifiers to individual healthcare providers.

During 2010-11, AHPRA was the only national registration authority assigning Healthcare Provider Identifier Individual (HPI-Is) numbers.

The HI Service Operator provided AHPRA with 5.1 million HPI-I numbers for allocation to their registrants. These numbers have been quarantined by the HI Service for AHPRA's use only. When AHPRA allocates a HPI-I to a registrant, the information is transmitted to the HI Service, and once all data validation checks are passed, the record is recorded in the HI Service.

As at 30 June 2011, there were a total of 521,367[1] healthcare provider identifiers in the HI Service.

Healthcare organisations

Healthcare organisations complete registration forms obtained from Medicare's website and apply directly to the HI Service to be assigned their Healthcare Provider Identifier – Organisation (HPI-O). As at 30 June 2011, there were a total of 171[2] healthcare organisation identifiers in the HI Service.

Maintenance of IHI, HPI-I and HPI-O information

The HI Service Operator maintains the systems that contain IHI, HPI-I and HPI-O information. The HI Service Operator provides the National E-Health Transition Authority with a schedule of change, which includes the scheduled maintenance for the HI Service systems. This schedule is provided weekly.

1 The HPI-I numbers reflect those HPI-Is collected from AHPRA or assigned to individual healthcare providers that have applied to the HI Service. Healthcare identifiers remain in the HI service regardless of whether the healthcare provider is registered or has failed to renew or chosen not to renew registration. However it is important to note that a healthcare provider that is not registered will be unable to access the HI Service.

2 The HPI-O numbers reflect those organisations that have registered with the HI Service. Healthcare identifiers remain in the HI Service regardless of whether an organisation continues.

The National Boards

National Boards structure: At a glance

National Board	National Committees
Chiropractic Board of Australia	Accreditation and assessment committee Continuing professional development committee Governance and finance committee Immediate action committee Notifications and registration committee Policy, codes, guidelines and standards committee
Dental Board of Australia	Accreditation committee Finance and administration committee Registration and notification committee
Medical Board of Australia	Finance committee
Nursing and Midwifery Board of Australia	Accreditation working group Finance and governance working group Policy working group
Optometry Board of Australia	Continuing professional development accreditation committee Finance and risk committee Policies, standards and guidelines advisory committee Registration and notifications committee Scheduled medicines advisory committee
Osteopathy Board of Australia	Policy and guidelines working group Registration and notification committee
Pharmacy Board of Australia	Registration and examinations committee (previously examinations committee – to April 2011) Finance and governance committee Policies, codes and guidelines committee Notifications committee (previously registration and notification committee – to April 2011)
Physiotherapy Board of Australia	Continuous improvement committee
Podiatry Board of Australia	Immediate action committee Registration and notifications committee
Psychology Board of Australia	Accreditation committee Conduct and health committee Financial management committee Registration committee

	Regional Boards	State and Territory Boards	State and Territory / Regional Committees
	None	None	None
	Australian Capital Territory, Tasmania and Victoria Northern Territory and South Australia	New South Wales Queensland Western Australia	Immediate action committee (excluding New South Wales) Registration Committee (New South Wales only) Registration and Notification Committee
	None	All States and Territories	Health Committee (excluding New South Wales) Notifications Assessment Committee (excluding New South Wales) Performance and Professional Standards Committee (excluding New South Wales) Registration Committee
	None	All States and Territories	Immediate action committee (excluding New South Wales) Notification committee (excluding New South Wales) Registration committee
	None	None	None
	None	None	None
	None	None	None
	None	All States and Territories	None
	None	None	None
	Australian Capital Territory, Tasmania and Victoria Northern Territory and Queensland South Australia and Western Australia	New South Wales	Immediate Action Committee Registration and Conduct Committee (excluding New South Wales)

Chiropractic Board of Australia

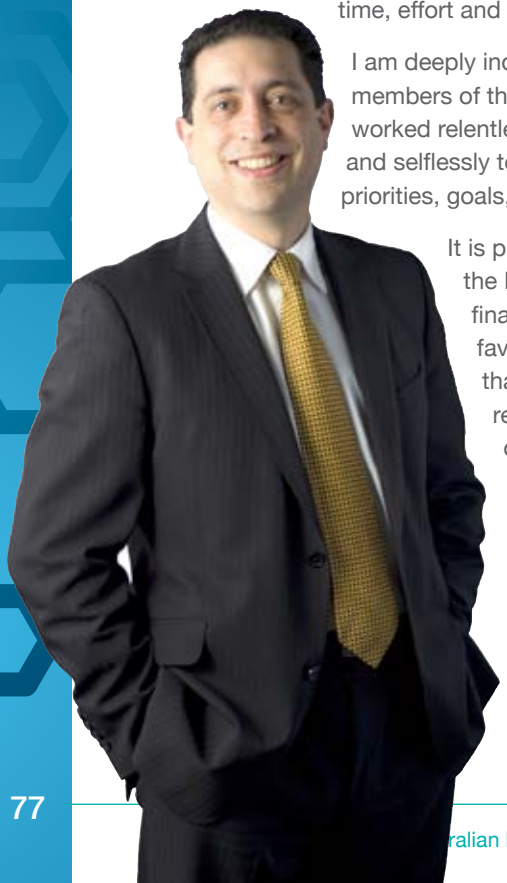
Message from the Chair

I take this opportunity to acknowledge and thank many who have assisted greatly in the activities, support and achievements of the Board.

The achievements of the Board have occurred in partnership with AHPRA and the other health professions within the National Scheme, where there has been, and continues to be, a joint sense of purpose, collaboration and cooperation. My thanks must go to Mr Martin Fletcher, Chief Executive Officer of AHPRA and his teams at State and Territory and national offices for their time, efforts, and services which have been above and beyond our hopes and ambitions.

During this time, the Board has been blessed with Executive Officers of exceptional calibre, skill and dedication to the Board and its needs. We thank Ms Leone Smith, Ms Tanya Vogt and Ms Helen Townley and our new Executive Officer, Dr Paul Fisher for their expert and tireless guidance, advice, and service to the Board.

I wish to thank and give appreciation to the Chairs of the Board's key committees – Dr Mark McEwan (notifications and registration committee and in his role as deputy for the National Board in my absence); Dr Stephen Crean (policy, codes, guidelines and standards committee); Dr Bevan Goodreid (joint continuing professional development committee); and Mr Peter Groves (governance and finance committee). Chairing these committees involves significant time, effort and commitment.



I am deeply indebted to all the members of the Board who have worked relentlessly, efficiently, and selflessly towards the Board's priorities, goals, and requirements.

It is pleasing to report that the Board finished the financial year in a more favourable position than initially projected, realising only a small deficit. It is also of note that in the Board's original budget projections, a surplus result was unlikely until the end of 2013. We are now confident of achieving this within this next financial year. I thank the members of the Board for their very economical approach to the Board's activities during the past 12 months.

In closing, the Board exceeded its targets and achievements in 2010-11 and looks forward to another diligent, productive and efficient year ahead. The Board thanks and continues to look forward to cooperative consultation with its stakeholders towards public interest and public safety.

Dr Phillip Donato OAM

Chair, Chiropractic Board of Australia

Board report

The 2010-11 year marks the first year of operations for both AHPRA and the Chiropractic Board of Australia. From 1 July 2010, the Board began its official role in regulating the chiropractic profession in the public interest. Over 2010-11, the Board met 11 times.

The Board must exercise the powers, authorities, duties and functions imposed on it by the National Law. It is responsible to the Ministerial Council in its regulation of chiropractors, fulfilling the principles, functions and objectives of the National Law and maintaining high standards of safety, conduct and performance in the provision of chiropractic services to the public.

The transition from regulation based in eight states and territories to a single National Scheme was a significant undertaking. The collaborative teamwork between all of the health professions boards and AHPRA has been a critical element in the successful navigation of this transition.

There were 4,350 chiropractors registered to practise in Australia on 30 June 2011. The largest group nominated New South Wales as the principal place of practice (1,456 chiropractors), while the Northern Territory was nominated as the principal place of practice for the smallest group (21 registered chiropractors). More information on the number of registered chiropractors is presented in *Table 34: Registered chiropractors by principal place of practice.* Detailed data about chiropractic practitioner registrations and notifications is published in earlier sections of this annual report.

Table 34: Registered chiropractors by principal place of practice.

ACT	51
NSW	1,456
NT	21
QLD	667
SA	347
TAS	41
VIC	1,138
WA	463
No PPP	166
Grand total	4,350

Under delegation from the Board, the notifications and registrations committee dealt with most of the operational decision-making around both applications for registration and notifications made about registered chiropractors. This committee continues to handle most of these core operational functions of the Board including assessing applications for registration and overseeing the management of notifications about the health, conduct and performance of registered chiropractors.

The National Scheme provides a new framework of regulation and introduces several new types of registration under the National Law that did not exist in many jurisdictions before transition to national registration. Much work has been done by the Board and its policy, codes, guidelines and standards committee in developing policies and guidelines to support these types of registration and other areas of the National Scheme.

In 2011, the Board consulted broadly on its proposed registration standard for limited registration for teaching and research and limited registration in the public interest. The Board values the feedback provided and expects to finalise and implement the revised standard in the 2012 year, subject to approval of Ministerial Council.

Considerable work has been done by the committee to plan and manage the review of the code of conduct for chiropractors to commence in July 2011.

The Board's governance and finance committee, with the National Board, has undertaken a detailed strategic planning project that schedules and defines the Board's work for the next few years. In addition to budget planning, this committee will have a significant workload in supporting the Board's commitment to best practice and 'right touch' regulation.

The Board's commitment to best practice stakeholder consultation and engagement led the way in developing a consultation framework that has been refined and adopted by AHPRA for use across all Boards as the standard process for stakeholder consultation.

One of the key new elements for chiropractors of the National Scheme is compulsory continuing professional development (CPD). This requirement is set down in a registration standard and supported by guidelines, frequently asked questions and answers and information sheets. The Board appreciates that CPD is a new requirement that may take some time for practitioners to integrate successfully into their professional behaviour. To this end, the Board determined that compliance with the registration standard on CPD would not be assessed until the first nationally-aligned renewal of registration by 30 November 2011. This would allow 17 months for a practitioner to compile the necessary CPD hours for his or her first year of registration.

The Board formed a joint CPD committee to support the development of CPD provision and administration for chiropractors. Both the Chiropractors' Association of Australia (National) Limited (CAA) and the Chiropractic and Osteopathic College of Australasia (COCA) are Board-approved, CPD-assessing authorities for formal learning activities. This committee has developed protocols for the assessment of the formal learning content of CPD activities for use by the two Board-approved assessment bodies.

The Board continues to have a positive and cooperative working relationship with the appointed accreditation authority for the chiropractic profession, the Council on Chiropractic Education Australasia (CCEA). Discussions with CCEA on the possibility of future specialist registration and scope of practice endorsement have led to the establishment of a joint working group of the Board and CCEA to determine the standards and processes involving these areas.

The Board is looking forward to further development and consolidation after what has been a successful transition year.

From left to right: Dr Amanda-Jane Kimpton, Dr Stephen Crean, Dr Geoffrey Irvine, Dr Phillip Donato OAM, Mrs Esther Alter, Dr Mark McEwan, Dr Bevan Goodreid, Ms Margaret Wolf, Mr Peter Groves.

Information on membership of the National Board and its delegates is published at www.chiropracticboard.gov.au.

During 2010-11, the Board was supported by Executive Officers Ms Tanya Vogt (July 2010), Ms Helen Townley (August 2010 – February 2011) and Dr Paul Fisher (March 2011 onwards).

Members of the Board

The members of the Chiropractic Board of Australia are:
Dr Phillip Donato OAM, Mrs Esther Alter, Dr Stephen Crean, Mr Peter Groves, Dr Geoffrey Irvine, Dr Amanda-Jane Kimpton, Dr Mark McEwan, Ms Margaret Wolf and Dr Bevan Goodreid.

Dental Board of Australia

Message from the Chair

The Dental Board of Australia has continued this year with consultation and consolidation in line with the Board-developed strategic work plan. While the National Law defines the objectives and guiding principles for the National Scheme, Board members have also resolved to conduct activities in a Board-specific fashion.

The main strategic focus has been to strengthen stakeholder engagement and communication. This has included identifying key organisations, participation in Board processes by stakeholders and fostering relationships with decision-makers. Another focus has been on the outcome of regulatory policy, including registration standards, codes and guidelines. The consultation processes with the public and organisational stakeholders has been at times exhausting. However, this approach is guided by the Australian Government's Office of Best Practice Regulation, which has centred the process on the public interest.

In activating strategies and achieving the goals of the Board's work plan, Board members have been hard-working and competent. The commitment of the Board's state, territory and regional board and committee members must also be recognised. The public and profession should be duly satisfied with the intensity of purpose and outcomes. As the Board members move into the final year of their term of appointments, reflection on achievements will turn to the required reviews, future terms, membership of the National Board and its committees and those of the state, territory and regional boards and committees and the objectives of the National Scheme.

The Board is grateful for the support and dedication of the Executive Officer and support staff and also recognises the attentive efforts of AHPRA in conducting the business of the National Scheme.

Dr John Lockwood AM

Chair, Dental Board of Australia

Board report

The members of the National Board were appointed in August 2009 and the first meeting of the Board was held on 20 September 2009. Over 2010-11, the Board met 11 times.

The Board has three national committees: finance and administration; registration and notification; and accreditation. To enable registration and notification matters related to individual registrants to be managed locally, the National Board established state and regional boards. In addition, to ensure local processes are timely and responsive, each state and regional board has a registration and notification committee (registration committee in New South Wales) and an immediate action committee (excluding New South Wales).

During 2010-11, the Board advised the Ministerial Council it would not require state and territory or regional boards from 1 July 2011. The Board based this decision on the reduced workload of the state and regional boards since transition and to increase future efficiency and national consistency. The Board's national registration and notification committee will provide the governance and oversee the management of the registration and notification functions of the continuing registration and notification and immediate action committees in each state and territory.

There were 18,319 dental practitioners registered to practise in Australia on 30 June 2011. The largest group nominated New South Wales as the principal place of practice (5,619 dental practitioners), while the smallest group nominated the Northern Territory as the principal place of practice (113 dental practitioners). More information on the number of registered dental practitioners is presented in *Table 35: Registered dental practitioners by principal place of practice.* Detailed data about dental practitioner registrations and notifications is published in earlier sections of this annual report.

Table 35: Registered dental practitioners by principal place of practice

ACT	326
NSW	5,619
NT	113
QLD	3,542
SA	1,561
TAS	315
VIC	4,092
WA	2,076
No PPP	675
Grand total	18,319

Major achievements

The Board acknowledges there have been many challenges with the transition to the National Scheme; however, recognition must be given to the fact that, for the first time, dental practitioners in Australia are regulated by a consistent set of registration standards and guidelines and there is one national register of dental practitioners, which is accessible publicly. The National Scheme has also provided for the establishment of a new endorsement for dentists, a new national division of dental practitioners and a standard group of specialist categories for dentists.

Key transition achievements of the Board have included the transition to the following types of dental practitioner registration or endorsement in accordance with Board guidelines:

- oral health therapists
- specialist registration - forensic odontologist and
- conscious sedation.

Consultations undertaken

The Board developed and consulted on the following registration standards:

- limited registration – for teaching or research
- limited registration – postgraduate training or supervised practice
- limited registration – public interest and
- general registration of practitioners with qualifications substantially equivalent to approved qualifications.

The Board consulted on these registration standards during 2010-11 and registration standards will be finalised for consideration by the Ministerial Council later in 2011.

New standards, policies and guidelines

The Board consulted on a guideline for supervision (for limited registration) which will be finalised later in 2011 and prepared a guideline for conscious sedation area of practice endorsement which will undergo consultation later in 2011.

The Board approved interim policies specifically for dental practitioners in relation to teeth whitening / bleaching, and the use of botulism toxin (Botox). The Board also approved a policy specifically for dental practitioners on cone beam computed tomography.

Key policy issues addressed

The Board has addressed a number of policy issues associated mainly with the transition of dental practitioners to the National Scheme. The Board is also considering a number of key policy issues, for example the definition of 'practice' and will further consult on this definition later in 2011. The Ministerial Council has also requested the Board review the registration standard on scope of practice in 2011-12.

Accreditation

The Australian Dental Council (ADC) was appointed as the accreditation authority for the dental profession for three years by the Ministerial Council from 1 July 2010. The role of the ADC under the National Scheme has remained largely unchanged, although the accreditation functions under the National Law have been expanded and contemporised to include all divisions of the national register of dental practitioners.

The Board has continued to work with the ADC to establish nationally-consistent dental practitioner accreditation standards and processes including:

- the accreditation of existing courses and a number of new courses for dental practitioners
- the development of national pathways for assessment of overseas-qualified dental hygienists and dental therapists and
- the development of an accreditation standard and pathways for accreditation of programs for dental prosthetists.

Future ambitions

The Board's key areas of focus for 2011-12 will be to finalise the transition process and continue the work of national consistency across both registration and notification management of dental practitioners. Specifically, the Board will work on nationally-consistent approaches to limited registration, return to practice after a period of absence and the recognition and assessment of overseas-educated dental practitioners.

From left to right, sitting: Mrs Myra Pincott, Mrs Jennifer Bishop, Ms Susan Aldenhoven, Dr John Lockwood, Mr Peter Martin, Ms Kirsten Hibberd (Board Support Officer), Ms Tanya Vogt (Executive Officer), Dr John Owen. From left to right, standing: Mr Michael Miceli, Dr Mark Leedham, Mr Stephen Herrick, Dr Gerard Condon, Dr Carmelo Bonnano, Mr Paul House.

Members of the Board

The members of the Dental Board of Australia are:

Dr John Lockwood AM, Ms Susan Aldenhoven AM, Mrs Jennifer Bishop, Dr Carmelo Bonnano, Dr Gerard Condon, Mr Stephen Herrick, Mr Paul House, Dr Mark Leedham, Mr Peter Martin, Mr Michael Miceli, Dr John Owen AM and Mrs Myra Pincott AO.

The members of the regional boards and committees of the Dental Board of Australia are:

Dr John Boucher, Dr Werner Bischof, Dr Pamela Dalgliesh, Ms Gabrielle MacTiernan, Mr Peter Martin, Mr Craig McCracken , Associate Professor Richard Logan, Dr Mark Leedham, Ms Inaam Aboukhizam, Ms Josie Bradley, Dr Jean Cohen, Dr Pat Collette, Mrs Jennifer Miller, Dr Steve Oppes, Ms Joanna Pethick, Ms Joanna Richardson, Ms Belinda Simons, Mr Neville Spencer, Dr Erika Vinczer, Ms Diane Walsh, Dr Owen Hales , Dr Robert McCray, Dr F Margaret O'Donnell, Mr Stuart Unwin, Dr Susan Upham, Mr John Mackay, Dr Ralph Neller, Professor Saso Ivanovski, Dr Bruce Newman, Ms Gloria Silcock, Professor Laurence Walsh, Mr Stephen Griffin, Ms Laila Hakansson Ware, Mr Maxwell Peter Howard, Ms Virginia Thorley, Mr Eduardo Gullotta, Ms Denise Toovey, Mr Brian Jeffries , Dr Neil Burman, Dr Gerard Parkinson, Ms Bronwyn Davies, Dr Martin Glick, Ms Marie Matthews, Dr Michael McGuiness, Ms Meredith Kay, Ms Leanne O'Shannessey, Dr John Dale, Dr Anna Enno, Adjunct Associate Professor Chris Griffiths, Adjunct Associate Professor John Highfield, Professor Iven Klineberg, Mr Stephen McGlynn, Ms Norah McGuire, Mr Charles Vandervord, Mrs Virginia von Faber-Castell, Ms Ewa Bury and Mr Martin Dunn.

Information on membership of the National Board and its delegates is published at www.dentalboard.gov.au.

During 2010-11, the Board was supported by Executive Officer Ms Tanya Vogt.

Medical Board of Australia

Message from the Chair

At the end of the first year of the National Registration and Accreditation Scheme, it is time to draw breath, reflect on challenges and achievements and look to the future. The scale and scope of the change from regulation based in states and territories to a National Scheme cannot be overestimated. It is scarcely surprising that some parts of the road have been rocky. Nevertheless, the first major achievement of the National Scheme came at the beginning, when national registration became a reality for more than 80,000 doctors and almost half a million other health practitioners. The progress made in the 12 months is a tribute to the dedication, skills and goodwill of the members of state and territory boards and committees who transitioned into the National Scheme and who continue to deal with registration decisions and act on notifications about doctors' conduct, performance and health in their jurisdictions; of the staff of AHPRA; and of my colleagues on the Medical Board of Australia.

I am confident that Australia now has the right structures and people in place to deliver, as charged by our legislation, a national regulatory scheme that is transparent, accountable, efficient and effective and fair and which promotes good medical practice for the Australian community.

Dr Joanna Flynn AM

Chair, Medical Board of Australia

Board report

The 12 members of the Medical Board of Australia were appointed in August 2009 by the Ministerial Council for a period of three years. Eight members are registered medical practitioners, one from each jurisdiction, and four are community members.

The Medical Board of Australia, with the assistance of AHPRA, is responsible for administering the National Law. Specific roles of the National Board include: to develop registration standards, codes and guidelines; to approve accreditation standards; to approve programs of study which qualify an individual for registration; and to negotiate the Health Profession Agreement with AHPRA.

The National Board is supported by state and territory boards and by a range of committees that have been appointed in every state and territory. The state and territory boards and committees have been delegated the necessary powers to deal with matters related to the registration of individuals and to deal with notifications about medical practitioners and students.

In 2010-11, the National Board:

- held 11 Board meetings
- participated in a meeting of all National Boards and AHPRA in August 2010; at this meeting, participants reflected on the past year and identified future priorities and ways of working together
- held a planning day in December 2010, including state and territory Chairs and
- ran the first National Board conference with state and territory boards of the Medical Board of Australia. This meeting involved around 70 board members and 40 AHPRA staff and promoted improved communication and consistency of decision-making across all jurisdictions.

The Board has appointed a finance committee. The role of the finance committee is to advise the Board on its financial position, the financial outlook for future years and the implications for medical practitioner fees.

State and territory board members are appointed by each jurisdiction's health minister and have been delegated powers by the National Board to deal with matters relating to individual practitioners. The committees based in states and territories are appointed by the National Board and while they are predominantly comprised of state and territory board members, the National Board has also appointed individuals who are not board members.

The Board's committees in each state and territory are:

- registration committee
- health committee (excluding New South Wales)
- notifications assessment committee (excluding New South Wales) and
- performance and professional standards committee (excluding New South Wales).

The role of the registration committee is to decide whether or not to approve applications for registration, in cases in which AHPRA staff have not been delegated these powers. The registration committee also makes recommendations to the state or territory board about proposals to refuse registration or to impose conditions on registration.

The role of the health committee is to consider all notifications received that raise concerns about the health of a medical practitioner or medical student, to oversee the assessment of the health of the practitioner or student and to work with the practitioner or student to manage the issue satisfactorily so the safety of the public is protected. If the registrant requires ongoing monitoring, it is the role of the health committee to oversee that monitoring.

The notifications assessment committee is responsible for assessing all notifications received about medical practitioners and medical students. The notifications assessment committee decides whether or not to investigate individual matters and whether to refer them to other agencies. When the notifications assessment committee decides to investigate a matter further, it defines the issues of concern and develops a strategy for the investigation, including whether a performance and/or health assessment is indicated. It also considers whether the notification raises issues which should lead to immediate action to restrict a practitioner's practice because of a serious risk to the public.

The role of the performance and professional standards committee is to consider and decide on the reports of investigations into the professional conduct of practitioners and performance assessments about practitioners and if necessary to refer the practitioner to a panel or tribunal hearing.

2010-11 areas of focus

There were 88,293 medical practitioners registered to practise in Australia on 30 June 2011. The largest group nominated New South Wales as the principal place of practice (27,686 medical practitioners), while the smallest group nominated the Northern Territory as the principal place of practice (817 medical practitioners). More information on the number of registered medical practitioners is presented in *Table 36: Registered medical practitioners by principal place of practice.*

Table 36: Registered medical practitioners by principal place of practice

ACT	1,638
NSW	27,686
NT	817
QLD	16,761
SA	6,926
TAS	1,994
VIC	21,238
WA	8,250
No PPP	2,983
Grand total	88,293

Detailed data about medical registration and notifications is published in earlier sections of this annual report. In addition to developing registration standards, codes and guidelines, much of the focus of the Board has been on working with AHPRA to deal with issues that have arisen as a result of the transition to the National Scheme and on enhancing communication, both internally and externally.

Internal communications

With new structures in place, internal communications have been aimed at achieving national consistency in processes and decision-making and delineating lines of reporting. To improve communication between the National Board and the state and territory boards, the National Board has established a range of meetings including:

- monthly meetings of the Chairs of state and territory boards following each meeting of the National Board
- quarterly meetings of the Chairs of each committee based in states and territories
- a national meeting of all state and territory board members and
- a planning meeting that included all state and territory board Chairs.

The National Board also sought actively the feedback of state and territory boards about a range of matters throughout the year.

External communications

The Board published a communiqué after every Board meeting to inform stakeholders of issues that the Board considered and decisions made. The Board published and distributed to all medical practitioners two editions of the Board newsletter, *Update.* The Board plans to publish three editions of *Update* each year. A hard copy of *Good*

Medical Practice: A code of conduct for doctors in Australia was mailed to every medical practitioner in Australia. As well, Board members met with a range of stakeholders locally and nationally and the Board regularly responds to media enquiries about the Board and the National Scheme.

Consultations undertaken

The Board undertook consultation on the following matters in 2010-11:

- registration standard for granting general registration to practitioners with the Australian Medical Council (AMC) certificate, in the standard pathway
- registration standard for specialist registration
- registration standard for acupuncture endorsement
- guidelines on sexual boundaries: a guide for doctors and patients
- guidelines for medical practitioners and medical students infected with blood-borne viruses and
- guidelines on supervised practice for limited registration.

Registration standards approved by the Ministerial Council

The following registration standards were approved by the Ministerial Council in 2010-11:

- registration standard for specialist registration and
- registration standard for granting general registration to practitioners with the AMC certificate, in the standard pathway.

Other codes and guidelines published

The following codes and guidelines were published in 2010-11:

- *Guidelines: Supervised practice for limited registration*
- information on returning to practice
- a template plan for professional development and re-entry to practice and
- information on how international medical graduates with limited registration can demonstrate satisfactory progress towards gaining general or specialist registration.

Other achievements

The National Board participated in several significant activities during 2010-11, including:

- the Board made a submission to the House of Representatives Inquiry into registration
- processes and support for overseas-trained doctors and the Chair of the Board appeared before the Inquiry
- the Chair appeared before the Senate Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency and
- the Board participated in a review of delegation of powers under the National Law in relation to the granting of limited registration. The changes improved timeliness and services to registrants and employers, to the benefit of the communities in which registrants work.

Key policy issues addressed

The Board focused on several key policy issues in 2010-11.

- The Board committed to consulting on the definition of 'practice'. The Board's definition of 'practice' – embedded in registration standards - is very broad and this has resulted in some unintended consequences, particularly for practitioners whose work is restricted to teaching and examining students and who have no patient care responsibilities. While an interim solution has been developed, which involves a reduced registration fee, a consultation paper has been prepared and the Board will consult on this issue in 2011-12.
- The Board has asked the AMC to provide it with advice about a range of matters related to the intern year. The Board and the AMC formed a working party and developed a registration standard for granting general registration to Australian and New Zealand medical graduates, after the intern year. The Board will be consulting on this in 2011-12.
- The Board has formed a working group to scope issues related to the assessment of internationally-qualified specialists
- The Board developed guidelines on sexual boundaries which will be finalised in 2011-12
- The Board addressed the issue of technology-based consultations. It will finalise guidelines in 2011-12.

Accreditation

The AMC has been appointed as the accreditation authority for medicine in the first three years of the National Scheme.

One of the objectives of the National Law is to facilitate the provision of high-quality education and training of health practitioners. The accreditation function is the primary way of achieving this objective. The National Law defines the respective roles of the Board and its appointed accreditation authority, the AMC, in the accreditation of medical schools and medical specialist colleges.

The AMC is responsible for developing accreditation standards for the approval of the Board. Accreditation standards are used to assess whether a program of study, and the education provider of the program gives people who complete the program the knowledge, skills and professional attributes to practise the profession. In developing accreditation standards, the AMC must undertake wide-ranging consultation about the content of the standard.

The AMC is also responsible for accrediting individual programs of study. The AMC must give the Board a report after it decides to accredit a program of study. After being given an AMC accreditation report, the Board may approve, or refuse to approve, the accredited program of study as providing a qualification for the purposes of registration. An approval may be granted subject to conditions.

Based on the accreditation advice from the AMC, the Board approved the following during 2011:

1. medical programs as providing a qualification for the purposes of registration in the medical profession:
    - Medical school of the University of Western Australia - to 31 December 2016
    - Flinders University – to 31 December 2014
    - University of Notre Dame, Sydney – to 31 December 2011
    - Bond University School of Medicine – to 31 December 2015 and
    - University of Sydney School of Medicine – to 31 December 2015
2. specialist college education and training programs and their continuing professional development programs for the purpose of specialist registration in the medical profession:
    - Royal College of Pathologists of Australasia – to 31 December 2012 and
    - Royal Australasian College of Physicians – to 31 December 2014
3. accreditation standards for medical schools and their programs of study - published on the Board's website and
4. accreditation standards for specialist medical education and training and professional development programs

Future plans

The Board's work plan for 2011-12 and beyond includes:

- implementing a registration standard providing for a national framework for the medical intern year
- continuing to work with state and territory boards and AHPRA on achieving national consistency
- continuing to develop and build relationships with stakeholders
- further developing guidance on a range of professional standards issues for the profession and
- completing the review of the implementation of pathways to registration for international medical graduates.

From left to right, sitting: Ms Prudence Ford, Dr Fiona Joske, Mr Paul Laris, Dr Joanna Flynn AM, Professor Belinda Bennett, Ms Sophia Panagiotidis. From left to right, standing: Dr Charles Kilburn, Dr Mary Cohn, Professor Mark McKenna, Associate Professor Peter Procopis (absent Dr Stephen Bradshaw, Dr Trevor Mudge).

Members of the Board

The members of the Medical Board of Australia are:

Dr Joanna Flynn AM, Professor Belinda Bennett, Dr Stephen Bradshaw, Dr E Mary Cohn, Ms Prudence Ford, Dr Fiona Joske, Dr Charles Kilburn, Mr Paul Laris, Professor Mark K McKenna, Dr Trevor Mudge, Ms Sophia Panagiotidis and Professor Peter Procopis AM.

The members of the state and territory boards and committees of the Medical Board of Australia are:

Dr Kerrie Bradbury, Ms Pamela Brown, Dr William Burke, Ms Megan Lauder, Dr Timothy McKenzie, Dr Sally Somi, Dr Maya Latimer, Dr Vida Viliunas, Ms Kay Barralet, Dr Lev Fridgant, Dr Anthony Eyers, Mr Antony Carpentieri, Dr Choong-Siew Yong, Dr Denis Smith, Associate Professor Frederick Palmer, Dr Gregory Kesby, Dr Gregory Stewart, Professor Kathleen Wilhelm AM, Dr Kendra Sundquist, Dr Kerry Chant, Ms Lorraine Poulos, Mr Michael Christodoulou, Professor Allan Spigelman, Dr Robyn Napier, Associate Professor Rod McMahon, Ms Rosemary Kusuma, Dr Stephen Adelstein, Dr Susan Ieraci, Dr Frances Black, Dr Joanna Hely, Professor Peter Klineberg, Dr Martin Mackertich, Dr Charles Kilburn, Dr Len Notaras, Ms Diane Walsh, Dr Jennifer Delima, Dr Paul Helliwell, Dr Christine Watson, Ms Judith Dikstein, Dr Anuja Kulatunga, Mr Wade Roper, Associate Professor Peter Woodruff, Mr Michael Clare, Ms Fiona Chapman, Dr Christopher Kennedy, Professor Tarun Sen Gupta, Dr Susan Harbison, Dr Jeannette Young, Dr Roger Rosser, Associate Professor Malcom Parker, Dr Geraldine Chew, Ms Peta Frampton, Associate Professor David Hendersen, Dr Susan Brady, Dr Donna O'Sullivan, Ms Donna Hancock, Ms Melinda Zerner, Dr Philip Henschke, Dr Richard Willis, Dr Carlien Kimber, Mr Paul Laris, Dr Christine Putland, Dr Stephen Stranks, Ms Kate Sullivan, Professor Anne Tonkin, Dr Mary White, Dr Roger Sexton, Adjunct Professor Jenny Beutel, Ms Leni Palk, Dr Helen Ingham, Dr Carolyn Edmonds, Dr Leslie Stephan, Dr Charlie Murray, Ms Patricia Rayner, Dr Rakesh Mohindra, Dr Maria Tomasic, Associate Professor Peter Sexton, Dr Kim Rooney, Dr Brian Bowring, Dr Philip Moore, Professor Peter Mudge, Dr Andrew Mulcahy, Dr John O'Sullivan, Ms Leigh Mackey, Ms Dee Potter, Dr Kristen FitzGerald, Dr Laurie Warfe, Dr Mitchell Chipman, Ms Kerren Clark, Mr Peter Dohrmann, Dr Felicity Hawker, Ms Christine Heazlewood, Mr Sean Lusk, Dr Leon Shapero, Dr Lakshmi Sumithran, Dr Bernadette White, Professor Con Michael AO, Professor Bryant Stokes AM, Dr Simon Towler, Associate Professor Peter Wallace, Dr Felicity Jefferies, Dr Michael McComish, Dr Steven Patchett, Professor Mark McKenna, Ms Anne Driscoll, Ms Virginia Rivalland and Ms Nicolette Ciffolilli.

Information on the membership of the National Board and its delegates is published at www.medicalboard.gov.au.

During 2010-11, the Board was ably supported by Executive Officer Dr Joanne Katsoris.

Nursing and Midwifery Board of Australia

Message from the Chair

The 2010-11 year has been yet another extraordinary and productive 12 months for the Nursing and Midwifery Board of Australia, following the implementation of the National Scheme in July 2010. The Board continued work to provide registrants with clear information about their requirements under the National Law, through the ongoing development of guidelines and policies. Board achievements include a review of the registration standard on English language skills through an extensive consultation process bringing it in line with the other nine National Boards; and completed policies onconcurrent registration as a registered nurse and enrolled nurse, and enrolled nurse, re-entry to practice program and a national midwifery formulary.

The Board continued to work with the Australian Nursing and Midwifery Accreditation Council (ANMAC) through its transition, to undertake the accreditation function for the National Board, assigned by the Ministerial Council in April 2010.

The Board undertook to liaise more closely with the state and territory committees by including the Chairs of the committees in the Board's strategic planning, and by rotating Board meetings to different states and territories as a way of meeting other committee members.

The Board would like to acknowledge and thank those key stakeholders and the members of the profession and the public who contributed to the consultations on draft standards and guidelines. This input has been very valuable to the Board's deliberation.

The Board continues to review its budget and plan of work with AHPRA as it prepares for the coming year.

Anne Copeland

Chair, Nursing and Midwifery Board of Australia

Board report

The members of the Nursing and Midwifery Board of Australia were appointed in September 2009. During 2010-11, the Nursing and Midwifery Board met 10 times.

The National Board has three working groups:

- the accreditation working group provides advice to the Board on issues relevant to nursing and midwifery education in Australia, and on the development and review of standards and policy related to accreditation
- the finance and governance working group makes decisions and advises the Board on the effective management of the Board's financial and governance functions and
- the policy working group focuses on policy development and evaluation for the Board; provides advice to the Board on emerging issues for the nursing and midwifery professions; and oversees research required to ensure that the Board continues to meet the needs of the Australian population with regard to the regulation of nursing and midwifery.

The Nursing and Midwifery Board of Australia has a board in each state and territory. Each of these boards has a registration committee, notification committee (excluding New South Wales) and an immediate action committee (excluding New South Wales).

There are 1,789 practitioners of midwifery, 290,072 practitioners of nursing and 40,324 practitioners of nursing and midwifery registered to practise in Australia.

The largest number of registered midwives nominated Victoria as the principal place of practice (625 practitioners) while the smallest group nominated Tasmania as the principal place of practice (seven practitioners).

New South Wales was nominated as the principal place of practice by the largest group of registered nurses (79,210 practitioners), while the smallest group nominated the Northern territory as the principal place of practice (2,760 practitioners).

Of those practitioners with nursing and midwifery registration, New South Wales was again nominated as the principal place of practice for the largest group (14,169 practitioners) while the Northern territory was again nominated by the smallest group (552 practitioners), excluding those who did not nominate a principal place of practice.

More information on numbers of practitioners of nursing and midwifery is available in *Table 37: Registered nursing and midwifery practitioners by profession and principal place of practice.* Detailed data about nursing and midwifery registrations and notifications is published in earlier sections of this annual report.

Table 37: Registered nursing and midwifery practitioners by profession and principal place of practice

	Midwife	Nurse	Nurse and midwife
ACT	15	3,824	660
NSW	325	79,210	14,169
NT	9	2,760	552
QLD	227	54,542	7,623
SA	306	26,886	2,616
TAS	7	7,560	734
VIC	625	76,830	10,375
WA	170	28,422	3,215
No PPP	105	10,038	380
Grand total	1,789	290,072	40,324

Over the past 12 months the Board has focused on developing standards and guidelines for registration and endorsement and revising existing standards where appropriate. The Board has worked to establish positive stakeholder relationships through consultation and regular meetings. The Board has worked closely with AHPRA nationally and in the state and territory offices to ensure that the regulation of nurses and midwives is managed effectively.

The Board recorded several achievements in 2010-11, including:

- successful engagement with stakeholders through openness and transparency of consultations; meetings and workshops
- presentation at conferences and forums by Board members and staff about the work of the Board
- development of international links through the International Council of Nurses and western Pacific and south-east Asian region nursing and midwifery regulators
- signing of a memorandum of understanding with seven international nursing and midwifery regulatory organisations; this agreement between these international organisations outlines the signatories' commitment to work closer, develop standards for the regulation of nurses and midwives and facilitate the free exchange of professional knowledge
- work with the Australian Nursing and Midwifery Accreditation Council (ANMAC) on systems and processes for approval of courses; ANMAC is a newly-created organisation that is responsible for the accreditation of courses for nursing and midwifery
- work with the state and territory offices of AHPRA to ensure there is national consistency in the use of standards, codes and guidelines and
- establishment of a process for the effective regulation of nursing and midwifery in Australia.

The Board undertook consultations in 2010-11 on:

- endorsement as a nurse practitioner
- concurrent registration as a registered and enrolled nurse
- English language skills and
- professional indemnity insurance for nurses and midwives.

In 2010-11, the Board published new registration standards, guidelines and policies comprising:

- a registration standard on endorsement as a nurse practitioner
- guidelines on endorsement as a nurse practitioner
- a registration standard on English language skills
- a position statement on concurrent registration as a registered nurse and enrolled nurse and
- a position statement on midwife practitioners.

In 2010-11, the Board addressed a number of key policy issues including:

- the Board approved the Safety and Quality Framework (S&QF) developed by the Victorian Government and incorporated the principles of the S&QF into all new documents relating to midwifery practice, including the *Guidelines and Assessment Framework for Registration Standard for Eligible Midwives and Endorsement for Scheduled Medicines*
- the guidelines for endorsement as nurse practitioners; were developed to provide detailed information to nurses applying for endorsement as nurse practitioners; in developing the guidelines the Board determined that the registration standard required review and a revised registration standard was approved by the Australian Health Workforce Ministerial Council in March 2011
- recognising that, before national regulation nurses in some jurisdictions were able to hold registration as a registered nurse and an enrolled nurse, the Board consulted with stakeholders about nurses holding concurrent registration, to ensure that there is a nationally-consistent approach to regulation; as a result of the consultation, the Board approved a position statement on concurrent registration

- after feedback from stakeholders, the Board reviewed its registration standard on English language skills in the later part of 2010. In this process, the Board applied the principles of protection of the public; national consistency; recognition of the differences in the educational preparation for nursing and midwifery; recognition of the two categories of enrolled nurse and registered nurse; establishing a rigorous registration standard that is not onerous; and implementing a standard that is understood easily and operationalised effectively and
- regulation of mental health nurses as, in July 2010, nurses with a sole qualification in mental health nursing transferred to national regulation differently, depending on the jurisdiction in which they were registered previously. The Board addressed this issue to ensure that there is national consistency in the regulation of nurses with a sole qualification in mental health nursing.

ANMAC is the accreditation body for nursing and midwifery courses. ANMAC was appointed to this role in April 2010 and has worked with the Board to develop the processes for course accreditation by ANMAC. Under the National Law, the Board has the power to approve, or refuse to approve, the accredited program of study as providing a qualification for the purposes of registration. At the time of transition to national regulation, there were more than 400 approved nursing and midwifery courses. There have been two courses submitted to and approved by the Board in the past 12 months.

The Board has established an effective relationship with ANMAC to ensure an effective relationship is in place to support the accreditation of nursing and midwifery courses in Australia. The accreditation working group is addressing the issues associated with recognition of prior learning, course requirements and development of accreditation standards for the professional practice review program for eligible midwives.

The Board has developed a comprehensive work program for the nursing and midwifery professions for the next three years. The Board has committed to undertaking a significant program to ensure the timely review, and development of the necessary registration standards, professional codes of ethics and codes of conduct for nurses and midwives and a range of new professional standards and guidelines for these professions.

From left to right, sitting: Mrs Lynne Geri, Ms Angela Brannelly, Ms Anne Copeland, Dr Lynette Cusack, Ms Margaret Winn, Professor Denise Fassett. From left to right, standing: Professor Mary Chiarella, Ms Mary Kirk, Ms Gillie Anderson, Dr Christine Murphy, Ms Louise Horgan, Mrs Heather Sjoberg.

Members of the Board

The members of the Nursing and Midwifery Board of Australia are:
Ms Gillie Anderson, Ms Angela Brannelly, Professor Elizabeth (Mary) Chiarella, Ms Anne Copeland, Dr Lynette Cusack, Professor Denise Fassett, Mrs Lynne Geri, Ms Louise Horgan, Ms Mary Kirk, Dr Christine Murphy, Ms Heather Sjoberg and Ms Margaret Winn.

The members of the state and territory boards and committees of the Nursing and Midwifery Board of Australia are:
Ms Donna Mowbray, Ms Emma Baldock, Ms Alison Chandra, Ms Pat Piedrafita, Ms Phyl Crawford OAM, Ms Jane Ferry, Ms Felicity Dalzell, Mr Alan Merritt, Ms Natalie Robinson, Ms Kathryn Adams, Ms Marie Clarke, Ms Susan Hendy, Ms Rebecca Roseby, Mr Ian Linwood, Adjunct Professor Debra Thoms, Mr Francis Ross, Mr Stephen Brand, Professor John Daly, Ms Margo Gill, Mr Steven Jeffs, Ms Betty Johnson AO, Mr Charles Linsell, Ms Margaret Winn, Ms Angela Brannelly, Ms Heather Sjoberg, Ms Kim Packer, Ms Angela Bull, Mr Phillip Harnas, Dr Brian Phillips, Professor Donal Gorman, Ms Veronica Casey, Professor Patsy Yates, Associate Professor Lesley Fleming, Ms Leanne Smith, Ms Nola White, Ms Desley Geraghty-Rudd, Associate Professor Karen Flowers, Mr John Chambers, Ms Sheridan Swindells, Associate Professor Linda Starr, Ms Wendy Harvey, Ms Maria Barredo, Ms Jen Byrne, Ms Susie Duggin, Dr Janina Gipslis, Ms Jeanette Hall, Dr Stephen Parker, Ms Nicolle Rantanen, Mr Michael Salt, Ms Sally Hampel, Dr Marion Eckert, Mr Franco Camattar, Dr Lynette Cusack, Emeritus Professor Derek Frewin, Mr Richard Schroeder, Ms Noelene Wadham, Ms Aurianne Webber, Ms Catherine Schofield, Ms Gillie Anderson, Ms Robyn Hopcroft, Ms Sue Hughes, Ms Liz van der Linde-Keep, Ms Kim Gabriel, Mr Andrew Robinson, Professor Denise Fassett, Ms Francine Douce, Mr Ben Quinn, Mr Greg Miller, Ms Naomi Dobroff, Dr Andrea Driscoll, Ms Lynne Geri, Ms Clare Harvey, Ms Melodie Heland, Ms Barbara Hingston, Mr John Molnar, Ms Christine Murphy, Ms Deborah Rogers, Ms Katrina Swire, Ms Alison von Bibra, Professor Selma Alliex, Ms Louise Horgan, Ms Belinda Bailey, Mrs Janice Butt, Mr Peter Groves, Adjunct Associate Professor Karen Gullick, Adjunct Associate Professor Christine Hanna, Ms Lynn Hudson, Mrs Jennifer Lush, Ms Marie-Louise MacDonald and Mrs Jennifer Wood.

Information on the membership of the Board and its delegates is published at www.nursingmidwiferyboard.gov.au

During 2010-11, the Board was supported by Executive Officers Mrs Anne Morrison from July 2010 to October 2010 and Ms Alyson Smith from November 2010 onwards.

Optometry Board of Australia

Message from the Chair

The first year of the National Scheme has been a challenging and fully satisfying one, resulting in the successful implementation of a complex scheme with minimal serious problems.

The highlight for me has been the excellent working relationship forged within the Optometry Board, with the other nine National Boards and, most importantly, with AHPRA. This has been helped by the appointment of the Board's own Executive Officer, Michelle Thomas. Martin Fletcher, AHPRA's Chief Executive Officer and Chris Robertson, Director National Board Services have supported the Board and encouraged a progressive agenda and open and inclusive dialogue with all the National Boards, particularly through the National Board Chairs meeting group.

The Board conducted a fruitful, preliminary consultation on the requirement of therapeutic qualifications for registration.

This first year saw the commencement of a number of projects critical to the success of the National Scheme by AHPRA and the Board. The Board will continue this work in the coming year focusing on increasing optometrists' understanding of the registration requirements of the National Scheme. The Board will commence the review of all its registration standards and guidelines. This continued effort and progress is required for the successful implementation of the most progressive health practitioner registration and accreditation scheme internationally.

Mr Colin Waldron

Chair, Optometry Board of Australia

Board report

The members of the Optometry Board of Australia were appointed in September 2009. During 2010-11, the Board met 11 times.

The Optometry Board of Australia has established a range of committees to assist and advise the Board in the exercise of its functions.

The Board's registration and notification committee is the delegated decision-maker for all registration and notification matters. There are optometry members in each state and territory to decide on local matters and provide optometry-specific advice to the local AHPRA office if required. The Board's other advisory committees undertake work at the request of the Board in line with their terms of reference.

The Board's main areas of focus have been the consultation process on the proposal that therapeutic qualifications become a requirement for general registration from 2014 and increasing optometrists' understanding of the registration requirements under the National Scheme.

There were 4,442 optometrists registered to practise in Australia on 30 June 2011. The largest number of optometrists nominated New South Wales as their principal place of practice (1,493 practitioners), while the smallest group of optometrists nominated the Northern Territory as their principal place of practice (25 practitioners). More information on numbers of registered optometrists is available in *Table 38: Registered optometrists by principal place of practice.* More detailed data about optometry registration and notifications is published in earlier sections of this annual report.

Table 38: Registered optometrists by principal place of practice

ACT	64
NSW	1,493
NT	25
QLD	925
SA	205
TAS	78
VIC	1,094
WA	329
No PPP	229
Grand total	4,442

Major achievements

The Board recorded a number of achievements in 2010-11, including:

- commencement of a consultation process on the proposal that therapeutic qualifications

become a requirement for general registration from 2014

- development of policies on the supply of novelty contact lenses and the supply of optical appliances
- production of the Board's first twice-yearly newsletter in February 2011 and
- a Board presence at all major Australian optometry conferences in the last six months of the year.

Consultations undertaken

The Board undertook the first stage of consultation on the proposal that therapeutic qualifications become a requirement for general registration from 2014.

New standards, policies and guidelines

The Board published two new policies in 2010-11 on the supply of:

- novelty contact lenses and
- optical appliances.

Key policy issues addressed

The Board has focused on developing and consulting on its proposed regulatory response to the change, to come into effect from 2013, that will see all graduates from approved programs of study in Australia and New Zealand hold qualifications that make them eligible for both general registration and scheduled medicine endorsement.

The Board has developed the requirements for limited registration for teaching or research and will develop and consult on a registration standard on this and other limited registration types in 2011-12.

Accreditation

The Optometry Council of Australia and New Zealand (OCANZ) is the Board's assigned accreditation authority. OCANZ has undertaken a review of its governance structures, developed a new constitution and changed membership to reflect the National Scheme. The new board of OCANZ will be finalised early in 2011-12.

Future ambitions

The Board will:

- complete the consultation process on the proposal that therapeutic qualifications become a requirement for general registration from 2014
- develop and consult on registration standards for some limited registration types in the second half of the 2011-12 year and
- spend 2011-12 planning for the review of all its registration standards, codes and guidelines in 2012-13. This will be a significant undertaking by the Board.

The Board is committed to providing clear information aimed at increasing the understanding of optometrists on the requirements of the National Scheme.

Left to right: Mr Lawson Lobb, Ms Peta Frampton, Mr Garry Fitzpatrick, Ms Jane Duffy, Mr Ian Bluntish, Mr Colin Waldron, Mr John Davis, Mr Derek Fails, Ms Judith Dikstein.

Members of the Board

The members of the Optometry Board of Australia are:
Mr Colin Waldron, Mr Derek Fails, Mr Garry Fitzpatrick, Mr Ian Bluntish, Ms Jane Duffy, Mr John Davis, Ms Judith Dikstein, Mr Lawson Lobb and Ms Peta Frampton.

The members of the national committees of the Optometry Board of Australia are:
Dr Phillip Anderton, Mr Mitchell Anjou, Mrs Nancy Atkinson, Mr Michael Burnside, Mr Alan Lance Chin Quan, Dr Mark Feltham, Ms Lisa Jansen, Mr John Kingshott, Mr Stephen Leslie, Ms Tess Presswell, Associate Professor David Pye, Ms Susan Sluce, Mr Greg Strachan, Ms Joanne Thomas, Dr Ann Webber, Mr David Welch, Associate Professor Peter Hendicott, Ms Shirley Loh, Mr Ken Thomas, Mr Joe Chakman, Dr Alex Gentle, Mr Stephen Marty, Professor Peter McIntyre, Dr Lisa Nissen, Associate Professor Mark Roth, Professor Fiona Stapleton and Dr Diane Webster.

Information on the membership of the Board and its delegates is published at www.optometryboard.gov.au.

During 2010-11, the Board was supported by Executive Officers Mr Joe Brizzi (July 2010 - October 2010) and Ms Michelle Thomas (November 2010 onwards).

Osteopathy Board of Australia

Message from the Chair

By the end of June 2011, all registered osteopaths will have transferred into the new National Scheme and renewed their registration. All practitioners should now be aware of the important role that the Board and AHPRA play in their professional lives. The period has brought with it the new responsibilities for the Board under the National Law.

As one of the first 10 professions to be regulated under the National Law, osteopathy is one of the smaller professions. Yet in many ways, the work of the Board has been commensurate with that of other National Boards. The Board has been determined to ensure consistency with their National Board counterparts where appropriate, while responding to and voicing the unique requirements of the osteopathy profession and practitioners. Working with other National Boards has brought with it many benefits and efficiencies. The Board has fully participated in the change process and its learnings and experience may be useful to smaller boards joining the National Scheme now and in the future.

The period ahead is no less dynamic with an ongoing agenda of public consultations, stakeholder engagement and further development of capabilities for osteopathic practice. There will be continuing interaction with international regulators and accreditation authorities to address the registration process for overseas-qualified osteopaths. In 2010, I was privileged to address the annual general meeting of the Osteopathic International Alliance (OIA) in San Francisco, and in September 2011, I will participate in an OIA inaugural forum for international osteopathy regulatory authorities in Berlin.

The Board extends thanks to Helen Townley for her invaluable work during 2010-11 as Executive Officer to the Board, a role she undertook while performing work for other National Boards and AHPRA. We welcome Cathy Woodward as the incoming Executive Officer, and are extremely pleased to announce that this is now resourced as a full-time position.

I would like to say a special thanks to the practitioner and community members of the Osteopathy Board of Australia, who have worked in a strong and cohesive way throughout the year, and to the AHPRA staff and management for their leadership and assistance. I have also enjoyed the collegiality and open exchange of ideas between the Chairs of National Boards which has occurred at the monthly meetings of this group.

Dr Robert Fendall

Chair, Osteopathy Board of Australia

Board report

The members of the Osteopathy Board of Australia were appointed in August 2009. During 2010-11, the Board met 11 times.

The Board operates nationally and does not have boards in any state and territory. The Board has a registration and notification committee which meets monthly to make key registration and notification decisions that are outside the routine functions delegated to AHPRA.The administrative support for this committee is provided by the Queensland office of AHPRA.

The Chair of the Board attends monthly meetings of all National Board Chairs. Board members participate in meetings and forums of National Boards and AHPRA, including the acupuncture accreditation standards project, strategic planning and the business process establishment project.

There were 1,595 osteopaths registered to practise in Australia on 30 June 2011. The largest group of osteopaths nominated Victoria as their principal place of practice (715 practitioners) while the smallest group of osteopaths nominated the Northern Territory as their principal place of practice (two practitioners). More information on numbers of osteopaths registered to practise in Australia is available in *Table 39: Registered osteopaths by principal place of practice.* More detailed data about osteopathy registration and notifications is published in earlier sections of this annual report.

Table 39: Registered osteopaths by principal place of practice

ACT	30
NSW	514
NT	2
QLD	133
SA	25
TAS	33
VIC	715
WA	50
No PPP	93
Grand total	1,595

The focus for the Board in 2010-11 has included:

- reviewing requirements for continuing professional development
- working with the Australian and New Zealand Osteopathic Council (ANZOC) on the process for assessment of overseas-qualified osteopaths and on accreditation
- initial work on further developing a statement of capabilities for osteopathic practice
- progressing a Memorandum of Understanding with New Zealand and the United Kingdom to develop a reciprocal understanding and recognition of educational qualifications and
- developing limited registration standards.

Major achievements

The Board has recorded a number of achievements in 2010-11, including:

- implementing and communicating the registration standards which came into effect on 1 July 2010, including registration standards on:
  - > continuing professional development
  - > criminal history
  - > English language skills
  - > professional indemnity insurance and
  - > recency of practice
- transferring all registered osteopaths to the new National Scheme on 1 July 2010
- developing the Board's strategic plan for 2011-14
- ensuring that osteopaths' use of the title 'Dr' appears in the national register consistent with the Board's guidelines for the advertising of regulated health services
- engaging with stakeholders, including the accreditation body, international osteopathy organisations and regulators, professional associations, education providers and groups of osteopathy students in their final year of study, including for consultation about professional registration standards and practice guidelines and
- implementing an interim approach (pending wider consultation on limited registration) for limited registration for supervised practice or to sit the ANZOC clinical examination for overseas-qualified osteopaths.

Consultations undertaken

The Board undertook a number of consultations during 2010-11, including:

- preliminary consultation (before public consultation) with targeted stakeholders on a range of standards and guidelines including:
  - > draft revised guidelines on continuing professional development
  - > draft registration standards for limited registration in the public interest, and limited registration for postgraduate training and supervised practice and
  - > draft guidelines for infection control and
- public consultations conducted on the proposed recognition of comparable qualifications and regulators, being progressed through a Memorandum of Understanding with osteopathy regulators in the United Kingdom and New Zealand.

New standards, policies and guidelines

Pending wider consultations, the Board has developed interim policies and guidelines for limited registration for supervised practice or for sitting the ANZOC clinical examination and also for infection control.

Key policy issues addressed

The Board addressed a number of key policy issues in 2010-11, including:

- developing its strategic plan for the next four years
- developing international regulatory links in an effort to make portability more accessible for the profession
- participating with other National Boards in work to explore clarifying the definition of 'practice' used in the Board's registration standards
- working with other National Boards on opportunities for consistency in registration standards for limited registration and
- participating in work with all other National Boards and accreditation authorities to develop shared perspectives on roles and responsibilities under the National Law.

Accreditation

ANZOC is appointed as the accreditation authority for the osteopathy profession for three years from 1 July 2012. Under the National Law, AHPRA entered into a contract with ANZOC for

the performance of the accreditation function for osteopathy. The Board met with ANZOC regularly to progress their respective roles under the National Law, and to build relationships between the two bodies.

The Board worked with ANZOC on clarification of the accreditation functions and held a number of joint meetings. A regular meeting between the executive of the National Board and ANZOC was established.

Details of approved programs of study and those substantially equivalent to an approved program of study are published on the Board's website. ANZOC conducted examinations for overseas-qualified osteopaths seeking registration in Australia.

Future ambitions

The Board is committed to the public consultation process in which it is engaged currently for developing draft registration standards and guidelines.

Future projects are the further development of capabilities for osteopathic practice, and the development (with ANZOC) of a work-based assessment of overseas-trained osteopaths.

In 2011-12, the Board will engage with other international osteopathic regulatory bodies to continue the international dialogue on issues of mutual interest.

From left to right, sitting: Dr Natalie Rutsche, Dr Melissa Coulter, Ms Belinda Webster, Ms Karen Stott, Ms Amanda Heyes, Ms Helen Egan. From left to right, standing: Dr Luke Rickards, Dr Robert Fendall, Adjunct Professor Philip Tehan.

Members of the Board

The members of the Osteopathy Board of Australia are:
Dr Robert Fendall, Dr Melissa Coulter, Ms Helen Egan, Dr Amanda Heyes, Dr Luke Rickards, Dr Natalie Rutsche, Ms Karen Stott, Adjunct Professor Philip Tehan and Ms Belinda Webster.

Information on membership of the Board and its delegates is published at www.osteopathyboard.gov.au.

The Board was supported in 2010-11 by Executive Officers Ms Helen Townley (July 2010 - March 2011) and Ms Cathy Woodward (March 2011 onwards).

Pharmacy Board of Australia

Message from the Chair

The past twelve months has been a period of implementation of the standards and guidelines prepared following consultation in the previous period. Each of the committees of the Board has worked diligently to complete matters delegated or referred to them in a timely and professional manner. They each have a work plan that articulates the Board's overall work plan for the 2011-12 period.

Implementation of a nationally-consistent registration examination has been greatly assisted by the appointment of a National Examinations Coordinator, Ms Debbie Murray, which has seen this important tool used to assess the competence of applicants for initial registration. Standardised training of assessors now ensures that the examination can be delivered in a standardised format.

The Board members have all contributed willingly to careful consideration and decision-making on matters brought before the Board along with the dedicated and professional support of the Board's Executive Officer, Mr Joe Brizzi. The notifications committee has met monthly to consider a large volume of matters concerning the conduct, performance and/or impairment of pharmacists with excellent support from Ms Jenny Sutton of AHPRA's Victoria office.

Significant progress has been achieved in working with senior AHPRA staff to enhance procedures and ensure the timely delivery of services to pharmacists and the public. I acknowledge the contributions made by many individual stakeholder representatives to assist the Board in its further development of policies, codes and guidelines.

I sincerely thank each Board member, the Executive Officer and AHPRA management and staff for their contributions and support throughout the year.

Mr Stephen Marty

Chair, Pharmacy Board of Australia

Board report

The members of the Pharmacy Board of Australia were appointed on 31 August 2009. During 2010-11, the Board met 12 times.

The Board has appointed committees to advise it and to make decisions when the Board has delegated powers under the National Law.

The Board's committees are:

- registration and examinations committee (previously examinations committee – until April 2011)
- finance and governance committee
- policies, codes and guidelines committee and
- notifications committee (previously registration and notifications committee – until April 2011).

Due to the increasing workload of its registration and notifications committee since commencement of the National Scheme, the Board revised its delegations and committees and delegated all notification matters to its notifications committee and all registration matters to its registration and examinations committee.

There were 25,944 pharmacists registered to practise in Australia on 30 June 2011. The largest group nominated New South Wales as their principal place of practice (8,110 practitioners) while the smallest group nominated the Northern Territory as their principal place of practice (165 practitioners). More information on numbers of registered pharmacists is available in *Table 40: Registered pharmacists by principal place of practice.* More detailed data about pharmacy registration and notifications is published in earlier sections of this annual report.

Table 40: Registered pharmacists by principal place of practice

ACT	373
NSW	8,110
NT	165
QLD	5,008
SA	1,836
TAS	607
VIC	6,308
WA	2,782
No PPP	755
Grand total	25,944

Major achievements

National oral examination

In 2011, the Board introduced a national oral examination to assess the competence of intern pharmacists. A pass in the oral examination is one of the requirements of the Board's registration standard on examinations for general registration which must be met for general registration. The scenario-based examination was developed through the work undertaken by a Board-appointed examinations working group, which reviewed the various formats of oral examinations in existence before 1 July 2010. The examination is administered by AHPRA staff and conducted by examiners appointed by the Board in all state and territory capital cities. The scenarios involve role play with patients and/or agents and prescribers, discussion with examiners and the requirement that candidates demonstrate knowledge, provide advice, problem-solve on a variety of issues and ensure that satisfactory outcomes are achieved and communicated as would be expected in the daily practice of pharmacy. The Board's examination's committee (now the registration and examinations committee) developed an oral examination candidate guide and oral examination appeals process which are published on the Board's website. The Board is grateful for the assistance of examiners in the assessment of pharmacy interns since commencement of the National Scheme.

Darwin visit

The Board conducted its first meeting outside Melbourne during a two-day visit to Darwin in the Northern Territory. The visit provided an opportunity for Board members to visit a community health centre to gain first-hand knowledge of the provision of pharmacy services to indigenous communities. The Board also took the opportunity to meet with local pharmacists to discuss issues affecting their professional practice. The Board plans to conduct at least one visit annually to other jurisdictions to meet with pharmacists to discuss issues of importance.

Consultations undertaken

The Board's consultation process to finalise guidelines was wide-ranging and provided the opportunity for input by stakeholders, members of the profession and the community. The Board was grateful for the views expressed by all who made submissions which greatly assisted the Board in finalising the following guidelines:

- guidelines for dispensing of medicines
- guidelines on practice-specific issues
- guidelines on specialised supply arrangements and
- guidelines on responsibilities of pharmacists when practising as proprietors.

The Board also commenced consultation on a revision of the guidelines on practice-specific issues – guideline 1 (list of references).

Key policy issues addressed

The Board published guidelines on responsibilities of pharmacists when practising as proprietors. The guidelines require that a registered pharmacist who is a proprietor of or who has a pecuniary interest in a pharmacy business must maintain and be able to demonstrate an awareness of the manner in which that pharmacy business is being conducted and where necessary intervene to ensure that the practice of pharmacy is conducted in accordance with applicable laws, standards and guidelines. While legislation in some jurisdictions may provide for ownership structures which allow for proprietors to hold non-practising registration, the Board considers that proprietor pharmacists can best meet their obligations, as outlined in the guidelines, by maintaining general registration and meeting the requirements of relevant registration standards on areas including recency of practice and continuing professional development.

Accreditation

The Australian Pharmacy Council is the accreditation authority for pharmacy in Australia. The council accredited new programs of study and re-accredited existing programs; and the Board considered accreditation reports from the council and approved programs which are listed on the Board's website as programs providing qualifications for registration. The council also accredited intern training programs, a requirement for general registration specified in the Board's registration standard on supervised practice arrangements which all interns seeking initial general registration must complete.

The registration standard on examinations for general registration specifies that each individual applying for initial general registration is required to demonstrate competence in both a written and an oral examination. The council conducts a written examination on behalf of the Board six times annually and provides a report of results of each examination to the Board. Interns are required to pass the written examination to gain entry to the Board's oral examination.

Additionally, the council authorises organisations to accredit providers of continuing professional development programs and assesses the knowledge and clinical skills of overseas-trained practitioners.

From left to right, sitting: Ms Karen O'Keefe, Ms Laila Hakansson Ware, Mr William Kelly, Mr Stephen Marty, Mr Trevor Draysey, Mr Ian Huett, Mr Gerard McInerney, Mrs Rachel Carr. From left to right, standing: Mr John Finlay, Mr Timothy Logan. Absent: Ms Bhavini Patel, Dr Rod Wellard

Members of the Board

The members of the Pharmacy Board of Australia are:
Mrs Rachel Carr, Mr Trevor Draysey, Mr John Finlay, Ms Laila Hakansson Ware, Mr Ian Huett, Mr William Kelly, Mr Stephen Marty, Mr Timothy Logan, Mr Gerard McInerney, Ms Karen O'Keefe, Ms Bhavini Patel and Dr Rod Wellard (appointed to the Board on 17 February 2011).

The members of the national committees of the Pharmacy Board of Australia are:
Mrs Helen Dowling, Mr Ken Cox, Ms Kerry Deans, Mr Andrew Tooms, Mr Peter Clarke, Mr Peter Mayne, Ms Elspeth Gorring-Baker, Mr Vaughn Eaton, Ms Sia Hassouros, Ms Suzanne Hickey, Mr Mark Dunn, Ms Karen Samuel, Mr Anthony Tassone, Professor Michael Garlepp, Mrs Manal Oz and Ms Allison Aylott.

Information on membership of the Board and its delegates is published at www.pharmacyboard.gov.au.

The Board was supported in 2010-11 by Executive Officer Mr Joe Brizzi.

Physiotherapy Board of Australia

Message from the Chair

As Chair, I met with most of the Board's delegated authorities (the state and territory boards of the Physiotherapy Board of Australia) to discuss their delegated duties, and the Board's registration standards, codes, guidelines and other policies that were developed before the commencement of the National Scheme. Dialogue has continued with state and territory Chairs plus one other board member by teleconference on a quarterly basis. These discussions are providing the National Board with excellent feedback on how the processes we developed are working in practice and on other matters of importance. Despite the major shift in requirements in some jurisdictions since 1 July 2010, the state and territory boards are providing excellent service to the profession and the public by upholding the principles of the National Law.

Apart from embedding the new requirements for registration and accreditation, the National Board is forging strong relationships with other important stakeholders such as the Physiotherapy Board of New Zealand; our accreditation authority, the Australian Physiotherapy Council; and the major professional body for physiotherapists, the Australian Physiotherapy Association.

Much international interest from the physiotherapy profession has been shown in Australia's new National Law. I presented to the World Congress of Physical Therapists in June 2011 in Amsterdam on the topic of Australia's National Scheme.

Mr Glenn Ruscoe

Chair, Physiotherapy Board of Australia

Board report

The members of the national Physiotherapy Board of Australia were appointed in August 2009. During 2010-11, the Physiotherapy Board of Australia met 11 times.

The Physiotherapy Board of Australia has a structure of state and territory committees to enable registrations and notifications to be managed locally by delegating relevant powers to those committees. There are no further sub-committee or working party structures within the state and territory committees. The state and territory committees are supported by the AHPRA offices in each jurisdiction.

The National Board has one committee – the continuous improvement committee, which meets regularly to develop key themes identified by the National Board.

There were 22,384 physiotherapists registered to practise in Australia on 30 June 2011. The largest group nominated New South Wales as their principal place of practice (6,589 practitioners), while the smallest group nominated the Northern Territory as their principal place of practice (113 practitioners). More information on numbers of registered physiotherapists is available in *Table 41: Registered physiotherapists by principal place of practice.* More detailed data about physiotherapy registration and notifications is published in earlier sections of this annual report.

Table 41: Registered physiotherapists by principal place of practice

ACT	416
NSW	6,589
NT	113
QLD	4,114
SA	1,828
TAS	386
VIC	5,417
WA	2,600
No PPP	921
Grand total	22,384

In 2010-11, the National Board concentrated on ensuring consistency of decision-making of its delegated authorities and ensuring that its registration standards, codes and guidelines were effective operationally.

The Board reviewed its guidelines for supervision and guidelines for limited registration and developed a registration standard for limited registration.

The Board developed several internal policies for its delegated authorities to enable consistency of operations. The Board also negotiated and commenced a project through its continuous

improvement committee to investigate the efficacy of ongoing competency tests for physiotherapists. A project to develop accreditation standards on acupuncture was initiated and led by the Physiotherapy Board of Australia on behalf of five other professions.

Major achievements

The Board recorded a number of achievements in 2010-11, including:

- embedding registration standards and codes and guidelines
- developing internal policies to assist delegated authorities
- leading the development of an accreditation standard for acupuncture
- strengthening relationships with stakeholders driving continuous improvement of the Board's functions
- developing and publishing its strategic plan for the next four years and
- establishing a beneficial relationship with its counterpart in New Zealand to facilitate matters of mutual interest and strengthening its relationship with its accreditation authority, the Australian Physiotherapy Council.

Consultations undertaken

The Board undertook a number of consultations in 2010-11 on:

- registration standards on limited registration
- guidelines on limited registration (review) and
- guideline for supervision (review).

Key policy issues addressed

The Board addressed a number of key policy issues in 2010-11, including:

- recognition of physiotherapy specialties which remains high on the agenda for the Board
- communication with its delegated authorities and wider stakeholder groups which is of importance to the Board and
- refining and clarifying policies and processes for all stakeholders.

Accreditation

The Australian Physiotherapy Council is the accreditation authority responsible for accrediting education providers and programs of study for the physiotherapy profession.

Future ambitions

From 2011-12 and beyond, the Board will concentrate on working towards application for specialist recognition and developing guidelines for:

- supervision of students and therapy assistants
- guidelines for overseas-trained physiotherapists and
- developing guidelines for infection control.

From left to right, sitting: Mrs Elizabeth Kosmala, Dr Susan Brady, Ms Alison Bell, Mrs Kathryn Grudzinskas, Mr Glenn Ruscoe, Dr Charles Flynn, Ms Karen Murphy, Ms Anne Deans. From left to right, standing: Ms Joanne Muller, Mr Paul Shinkfield, Ms Philippa Tessmann, Mr Tim Benson, Ms Jill Humphreys (Executive Officer).

Members of the Board

The members of the Physiotherapy Board of Australia are:
Mr Glenn Ruscoe, Ms Alison Bell, Mr Tim Benson, Dr Susan Brady, Ms Anne Deans, Dr Charles Flynn, Ms Kathryn Grudzinskas, Ms Elizabeth Kosmala OAM, Ms Joanne Muller, Ms Karen Murphy, Mr Paul Shinkfield and Ms Philippa Tessmann.

The members of the state and territory boards of the Physiotherapy Board of Australia are:
Ms Karen Murphy, Ms Kerry Boyd, Ms Lisa Gilmore, Ms Louise Bannister, Ms Annegret Ludwig, Ms Annette Cursley, Mr Alex Fahey, Mr Craig Purdam, Ms Elizabeth Trickett, Ms Anne Deans, Mr David Cross, Professor Ian Cameron, Ms Virginia Binns, Ms Christine Campbell, Ms Maria Quinlivan, Ms Helen Stirling, Ms Vicki Williams, Ms Lai Wong, Mr Michael Ryan, Dr Debra Shirley, Ms Philippa Tessmann, Ms Heather Malcolm, Ms Bernadette Petzel, Mr David Blair, Ms Margaret Seccafien, Ms Kathryn Grudzinskas, Ms Glenys Cockfield, Dr Sally Ruston, Ms Jane B H Leow, Mr Christopher O'Brien, Ms Margaret Shifter, Mr Robert Thams, Mr Robert Longland, Ms Tracy Spencer, Mr Geoff Rowe, Ms Josephine Bills, Professor Lorraine Sheppard, Dr Mary (Christine) Brown, Mr John Camens, Ms Jane Coffee, Ms Margaret Graham-King, Ms Elizabeth (Libby) Kosmala, Ms Elizabeth (Ann) Nelson, Ms Kerry Peek, Mr Paul Shinkfield, Ms Chelsea Trubody-Jager, Ms Margaret Archer, Mr Malcolm Upston, Ms Marie-Louise Bird, Dr Charles Flynn, Dr Leslie Cannold, Mr Brian Coughlan, Mr Mark Hindson, Ms Barbara Hingston, Ms Fiona McKinnon, Ms Gaye Mason, Ms Carmel Morfuni, Mr Glenn Ruscoe, Ms Kim Gibson, Ms Gwen Parry, Associate Professor Shane Patman, Dr Margaret Potter, Professor Anthony Wright, Mr Tim Benson and Mr Michael Piu.

Information on membership of the Board and its delegates is published at www.physiotherapyboard.gov.au.

The Board was supported in 2010-11 by Executive Officer Ms Jill Humphreys.

Podiatry Board of Australia

Message from the Chair

On 18 October 2010, Western Australia joined the National Scheme. I happened to be in Perth on this historic day. For the first time in Australia all podiatrists came under the one National Law.

National consistency has been the Board's main focus during the year. One law for the regulation of podiatry means that each podiatrist must meet the same registration standards, guidelines and code of practice; each podiatry program of study is assessed with the same accreditation standards by the one independent accreditation authority; all podiatrists are on the one electronic and searchable national register; and there is one agency with an office in each jurisdiction to accept and process registrations and notifications. The national system enables a podiatrist to register once and to practise anywhere in Australia.

Wide-ranging consultation for the development of standards and guidelines is another feature of the National Law. The Board has consulted broadly on a number of key issues, including the review of the guidelines for endorsement for scheduled medicines and more recently the guidelines on clinical records. At the biennial national podiatry conference, Board members met with delegates and were able to discuss concerns and answer questions about the National Scheme.

The Board appreciates the support demonstrated by registrants and stakeholders during this inaugural year of the National Scheme. I look forward to the progression of our work plan during the next 12 months.

Jason Warnock

Chair, Podiatry Board of Australia

Board report

The members of the Podiatry Board of Australia were appointed in August 2009. During 2010-11, the Board met 11 times.

The Board is supported by the following Committees:

- registration and notifications committee and
- immediate action committee.

There were 3,461 podiatrists registered to practise in Australia at 30 June 2011. The largest group nominated Victoria as their principal place of practice (1,084 practitioners), while the smallest group nominated the Northern Territory as their principal place of practice (13 practitioners). More information on numbers of practitioners is available in *Table 42: Registered podiatrists by principal place of practice.* More detailed data about podiatry registration and notifications is published in earlier sections of this annual report.

Table 42: Registered podiatrists by principal place of practice

ACT	42
NSW	919
NT	13
QLD	585
SA	346
TAS	78
VIC	1,084
WA	347
No PPP	47
Grand total	3,461

The transition to the National Scheme entailed a number of challenges for the Board and registrants and a major part of the Board's focus over the year has been familiarising itself with the provisions of the National Law and ensuring that the Board's decision-making reflects the objectives and guiding principles of that legislation.

To support registrants and other stakeholders in the transition to the National Scheme, Board members have made a number of presentations to stakeholders on the National Law and the role of the Board, and have held meetings with stakeholders, including the Australian and New Zealand Podiatry Accreditation Council (ANZPAC), on a regular basis. Members of the Board attended the National Australasian Podiatry Council Conference. This involved a plenary presentation by the Chair of the Board and an exhibition booth to facilitate discussions with podiatrists attending the conference.

The Board has worked towards national consistency in the regulation of podiatrists in Australia and has liaised with health departments across the jurisdictions to try to achieve a nationally-consistent list of scheduled medicines

available to all podiatrists with an endorsement for scheduled medicines.

Major achievements

The conference of National Boards in August 2010 was attended by all 10 National Boards; the Agency Management Committee; and AHPRA executive, including State and Territory Managers. This forum provided a wonderful opportunity for the National Boards and AHPRA to discuss common themes and issues relating to the National Scheme.

Consultations undertaken

The Board undertook consultations in 2010-11, comprising:

- review of the guidelines for endorsement for scheduled medicines
- review of the guidelines for podiatrists with blood-borne infections and
- consultation on the guidelines on clinical records.

New standards, policies and guidelines

The Board published new guidelines in 2010-11, specifically:

- guidelines for endorsement for scheduled medicines and
- guidelines on clinical records.

Key policy issues addressed

The Board has been working co-operatively with its accreditation authority, the Australian and New Zealand Podiatry Accreditation Council (ANZPAC), which is undertaking the accreditation of programs of study for podiatry. Once a program of study has been accredited by ANZPAC, the Board is given a report from ANZPAC and the Board decides whether to approve the accredited program of study as providing a qualification for the purposes of registration as a podiatrist.

The Board has also been working with other National Boards and AHPRA on a number of other issues including:

- developing a framework to ensure a consistent approach across professions and jurisdictions to the auditing of practitioner compliance with registration standards
- the development of an accreditation standard for acupuncture and
- succession planning for National Board members to ensure continuity of valuable corporate knowledge.

Accreditation

The Board's accreditation authority is the ANZPAC.

The Ministerial Council has approved the specialty of podiatric surgery. The Board also has Ministerial Council approval to endorse the registration of a podiatrist as qualified to administer, obtain, possess, prescribe, sell, supply or use schedule 2, 3, 4 or 8 medicines to patients for the treatment of podiatric conditions, from a list approved by the Board.

The Board has asked ANZPAC to develop accreditation standards for podiatric surgeons and endorsement for scheduled medicines. ANZPAC has undertaken wide-ranging consultation about the content of the standards. Once ANZPAC has developed the accreditation standards, these will be submitted to the Board and the Board must decide whether to approve the standards.

Future ambitions

The main goals for the Board in the coming year include consolidating and building on the foundation frameworks for national regulation that are in place currently. The Board holds its monthly meetings in Melbourne and plans to hold two Board meetings each year in other states and territories, which will include the opportunity to meet with stakeholders and registrants in those jurisdictions.

From left to right: Associate Professor Laurie Foley, Ms Helen Matthews, Ms Margaret (Joan) Russell, Mr Mark Gilheany, Mr Jason Warnock, Dr Paul Tinley, Ms Catherine Loughry, Mr Ebenezer Banful, absent: Mrs Anne-Marie Hunter

Members of the Board

The members of the Podiatry Board of Australia are: *Mr Jason Warnock, Mr Ebenezer Banful, Associate Professor Laurie Foley, Mr Mark Gilheany, Mrs Anne-Marie Hunter, Ms Catherine Loughry, Ms Helen Matthews, Ms Margaret (Joan) Russell and Dr Paul Tinley.*

Information on membership of the Board and its delegates is published at www.podiatryboard.gov.au.

The Board was supported in 2010-11 by Executive Officers Ms Jill Humphreys (July 2010 – January 2011) and Ms Jenny Collis (February 2011 - onwards).

Psychology Board of Australia

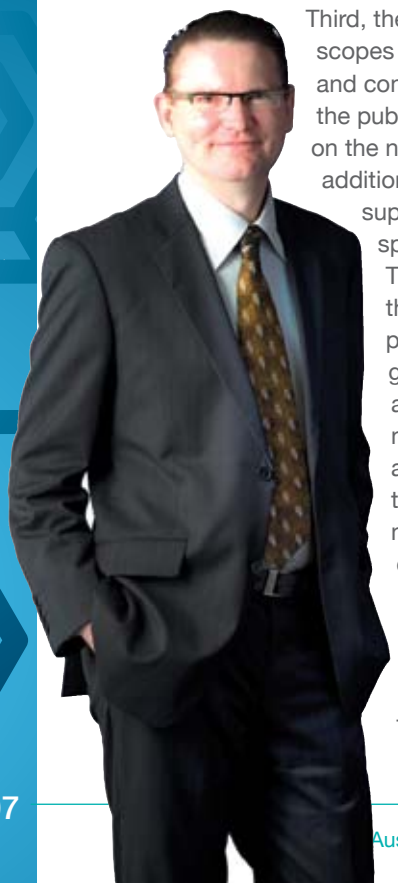
Message from the Chair

The establishment of the Psychology Board of Australia is a significant milestone in public protection and community wellbeing. Psychology and psychologists reach deeply into the community, in health services, schools, community services, justice and the military, sport, industry and business. The breadth of psychological work undertaken across the community reinforces the need for a strong Board with fair, internationally-recognised standards.

Following the commencement of the National Scheme on July 1 2010, the Board has engaged in an extensive period of open consultation and public forums with the community to seek to understand views on safety and quality in registration standards, codes and guidelines for psychology.

Three specific examples illustrate this work. First, the Board's ongoing development of a national psychology examination will realise the promise of psychology registration boards over several decades. Public confidence in a minimum level of applied knowledge and skill in psychologists from a variety of training pathways, including overseas, will be assured though the examination process.

Second, the establishment of a single, flexible registration standard on continuing professional development brings together the needs of the diverse psychology sector to ensure up-to-date knowledge and, importantly, the provision of peer review of practice through peer consultation.



Third, the recognition of endorsed scopes of practice, including health and community psychology, allows the public to identify psychologists on the national register who have additional qualifications and supervised experience in specific areas of psychology. The Board recognises the important work of all psychologists, who hold generation registration and are recorded on this single national register, but puts additional obligations on those with an endorsement notation to ensure public confidence is maintained. These obligations are further noted on the national register for accountability and transparency.

I am grateful to the support of the hard-working members of the National Board, the state and territory board appointees, and, in particular, the excellent partnership with AHPRA, the accreditation authority, government, and stakeholders in realising the work achieved in this first year.

Professor Brin Grenyer

Chair, Psychology Board of Australia

Board report

The members of the national Psychology Board of Australia were appointed in August 2009. During 2010-11, the Board met 11 times and held one joint Board meeting with the New Zealand Psychologists Board.

The Board is responsible for developing and approving registration standards, codes and guidelines; approving accreditation standards; and negotiating the Health Profession Agreement which determines funding and service arrangements with AHPRA.

The Board decided to have four state and territory and regional boards so that registrations and notifications related to individual registrants would continue to be managed locally. The Board set up a committee structure in each state and territory with delegated powers under the National Law. These state and territory and regional boards are:

- Australian Capital Territory, Tasmania and Victoria
- New South Wales
- Northern Territory and Queensland and
- South Australia and Western Australia.

During 2010-11, the Board's area of focus included:

- helping registrants and stakeholders to transfer successfully to the National Scheme and
- working towards national consistency across jurisdictions in the regulation of psychologists.

Major achievements

The Board recorded significant achievements in 2010-11, including:

- the addition of health and community area of practice endorsements and
- the establishment of forums and stakeholder meetings in every jurisdiction across the country to communicate the transition to the National Scheme to registrants and seek peer review and community feedback on the National Scheme.

Consultations undertaken

The Board consulted on the following matters:

- proposed revisions to the guidelines for area of practice endorsement
- risks to the protection of the public posed by the inappropriate use of psychological testing
- a proposed registration standard for limited registration for teaching or research
- an exposure draft for the guidelines for area of practice endorsement
- proposed revisions to the registration standard on professional indemnity insurance and
- guidelines on the national psychology examination.

The Board opened a consultation on a proposed amendment to the provisional registration standard to account for the 5+1 program.

New standards, policies and guidelines

To assist with operationalising the Board's codes and guidelines, the Board began work on or completed policies including:

- a policy for place of practice removal from the register
- a policy for 4+2 internship program: limited work role
- a policy for changing states for pre-1 July 2010 4+2 registrants
- a policy for applicants for general registration who hold overseas qualifications and
- a policy on working in addition to placements.

There were 29,142 psychologists registered to practise in Australia at 30 June 2011. The largest group nominated New South Wales as their principal place of practice (10,014 practitioners), while the smallest group nominated the Northern Territory as their principal place of practice (198 practitioners). More information on numbers of psychologists is available at *Table 43: Registered psychologists by principal place of practice.* More detailed data about psychology registration and notifications is published in earlier sections of this annual report.

Table 43: Registered psychologists by principal place of practice

ACT	744
NSW	10,014
NT	198
QLD	5,073
SA	1,431
TAS	504
VIC	7,735
WA	2,999
No PPP	444
Grand total	29,142

Key policy issues addressed

The Board has addressed a number of key policy issues over the year, including:

- waiving the application fee for registration as a provisional psychologist
- holding two further consultations on the guidelines for area of practice endorsement to ensure the Board has the policy balance right
- assisting registrants' understanding of the registration standard on continuing professional development
- developing fact sheets and frequently asked questions and answers about the registration standard on continuing professional development, supervision requirements and other policy decisions and
- developing a strategy for communication with registrants and the public.

The Board has also been working with other National Boards and AHPRA on a number of other issues including:

- developing a framework to ensure a consistent approach across professions and jurisdictions to the auditing of practitioner compliance with registration standards and
- succession planning for National Board members to ensure continuity of valuable corporate knowledge.

Accreditation

The Australian Psychology Accreditation Council (APAC) has been appointed as the accreditation authority for the psychology profession for three years from 1 July 2010. APAC is responsible for accrediting individual programs of study for approval by the Board.

APAC and the Board have met regularly to discuss the approval of courses, the development of standards and programs (such as the 5+1 pathway) and have participated jointly in the Forum of Australian Health Professional Councils.

Future ambitions

Areas of focus for the Board from 2011-12 and beyond include:

- developing the 5+1 pathway to general registration
- developing the supervisor training program for supervisors for the 4+2 internship program, 5+1 internship program and registrar program
- developing a searchable online list of Board-approved supervisors
- further developing the national psychology exam and
- international benchmarking.

From left to right, sitting: Professor Gina Geffen, Ms Antonia Dunne, Dr Shirley Grace, Professor Brin Grenyer, Mr Radek Stratil, Ms Ann Stark, Ms Fiona McLeod, Mrs Irene Hancock. From left to right, standing: Professor Alfred Allan, Mr Geoff Gallas, Mr Christopher O'Brien. Absent: Ms Kaye Frankcom.

Members of the Board

The members of the Psychology Board of Australia are: *Professor Brin Grenyer, Professor Alfred Allan, Ms Antonia Dunne, Ms Kaye Frankcom, Mr Geoff Gallas, Emeritus Professor Gina Geffen, Dr Shirley Grace, Mrs Irene Hancock, Ms Fiona McLeod, Mr Christopher O'Brien, Ms Ann Stark and Mr Radomir (Radek) Stratil.*

The members of the regional boards of the Psychology Board of Australia are: *Professor Barry Fallon, Ms Robyne Schwarz, Associate Professor Sabine Hammond, Dr Patricia Mehegan, Mr David McGrath, Mr Geoffrey Graham, Dr Caroline Hunt, Associate Professor Bill Warren, Ms Wendy McCartney, Associate Professor Michael Kiernan, Mr Bruce Toohill, Dr Shirley Grace, Ms Judith Dikstein, Ms Vidula Garde, Ms Dianne Mayo, Associate Professor Kenneth Pakenham, Dr Patrick Coates, Ms Narelle Dickinson, Ms Sallie Gardner, Professor Grace Pretty, Associate Professor Robert Schweitzer, Mr John Sharp, Dr KerriAnne Mellifont, Mr Kingsley Bedwell, Dr Leonie Coxon, Associate Professor David Leach, Dr Neil James McLean, Ms Amanda Olsen, Mr Alan Plumb, Mr Trevor Rule, Mr Theodore Sharp, Dr Jennifer Thornton, Ms Angela Davis and Dr Anne Gannoni.*

Information on membership of the Board and its delegates is published at www.psychologyboard.gov.au.

The Board was supported in 2010-11 by Executive Officer Dr Jillian Bull.

Financial Statements

for the 12 month period ended 30 June 2011

Contents

Overview

Who we are

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia.

AHPRA's operations are governed by the *Health Practitioner Regulation National Law Act 2009*, as in force in each State and Territory. The National Law came into effect on 1 July 2010 except in Western Australia where it came into effect on 18 October 2010. This law means that for the first time in Australia, 10 health professions are regulated by nationally consistent legislation.

AHPRA supports the 10 National Health Practitioner Boards that are responsible for regulating registered health practitioners. The primary role of the Boards is to protect the public and set standards and policies that all registered health practitioners must meet.

The Agency Management Committee oversees the work of AHPRA. The Chair is Mr Peter Allen. The Chief Executive Officer is Mr Martin Fletcher.

What we do

AHPRA supports the 10 National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme.

The National Registration and Accreditation Scheme Strategy 2011-2014 sets out AHPRA's vision, mission and strategic priorities. This statement has been developed jointly by the National Boards and AHPRA.

AHPRA:

- supports the National Boards in their primary role of protecting the public
- manages the registration processes for health practitioners and students around Australia
- has offices in each State and Territory where the public can make notifications about a registered health practitioner or student
- on behalf of the Boards, manages investigations into the professional conduct, performance or health of registered health practitioners, except in NSW where this is undertaken by the Health Professional Councils Authority and the Health Care Complaints Commission
- on behalf of the National Boards, publishes national registers of practitioners so important information about the registration of individual health practitioners is available to the public
- works with the Health Complaints Commission in each State and Territory to make sure the appropriate organisation investigates community concerns about individual registered health practitioners
- supports the Boards in the development of registration standards, and codes and guidelines
- provides advice to the Australian Health Workforce Ministerial Council about the administration of the national registration and accreditation scheme.

National Boards

Each health profession that is part of the National Registration and Accreditation Scheme is represented through a National Board.

The primary role of the Boards is to protect the public. The Boards are responsible for registering practitioners and students, as well as setting standards, policies and guidelines for their professions.

The 10 National Boards are:

- Chiropractic Board of Australia
- Dental Board of Australia
- Medical Board of Australia
- Nursing and Midwifery Board of Australia
- Optometry Board of Australia
- Osteopathy Board of Australia
- Pharmacy Board of Australia
- Physiotherapy Board of Australia
- Podiatry Board of Australia
- Psychology Board of Australia

All Boards are supported by AHPRA. On 1 July 2012, four additional health professions will be included in the National Scheme and will be represented by the following National Boards:

- Aboriginal and Torres Strait Islander Health Practice Board of Australia
- Chinese Medicine Board of Australia
- Medical Radiation Practice Board of Australia
- Occupational Therapy Board of Australia.

From 1st July 2011 the new National Boards commenced preparations for the introduction of the four professions to the National Scheme.

State, territory and regional boards

The National Law provides for a National Board to establish state and territory boards to exercise

its functions in the jurisdiction in a way that provides an effective and timely local response to health practitioners and other persons in the jurisdiction. Some National Boards have state or territory boards in all jurisdictions; some have multi-jurisdictional regional boards; and others do not have state or territory boards but have national committees.

These boards and committees make individual registration and notification decisions according to delegations from each National Board and based on national policies and standards set by the relevant National Board.

Agency Management Committee

The Agency Management Committee was appointed by the Ministerial Council in March 2009 in accordance with the Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008.

The role of the Agency Management Committee is to oversee the affairs of AHPRA, to decide the policies of AHPRA, and to ensure that AHPRA functions properly, effectively and efficiently in working with the National Health Practitioner Boards.

The Committee comprises 5 people:

- a Chair who is not a registered health practitioner and has not been a health practitioner in the last 5 years
- at least 2 people with expertise in health and/or education and training
- at least 2 people with business or administrative expertise who are not current or previous registered health practitioners

Mr Peter Allen, Chairperson

Peter Allen is Chair of the Agency Management Committee, and has been since March 2009.

Mr Allen is Deputy Dean of the Australia and New Zealand School of Government (ANZSOG), and Victoria's Public Sector Standards Commissioner. He joined ANZSOG after more than 20 years in the Victorian Public Service during which time he held several positions including Under Secretary in the Department of Human Services; Victoria's Chief Drug Strategy Officer; Secretary of the Department of Tourism, Sport and the Commonwealth Games; Secretary of the Department of Education; Director of Schools; and Deputy Secretary, Community Services.

Between 2001 and 2003, Mr Allen was a Vice-Chancellor's Fellow at the University of Melbourne, and prior to joining the public service, he was Director of Social Policy and Research at The Brotherhood of St Laurence.

Mr Allen's other roles include Director of the Victorian Institute of Forensic Medicine; National Vice President, and Victorian Vice-President of the Institute of Public Administration (Australia). He has previously been a member of the Councils of both the University of Melbourne and Deakin University.

Mr Allen holds a Bachelor of Arts and a Diploma in Journalism and was awarded a Centenary Medal in 2001.

Professor Constantine (Con) Michael AO

Con Michael was appointed to the Agency Management Committee in March 2009 as a member with expertise in health, education and training.

Professor Michael is the Consultant Medical Advisor for St. John of God Health Care Inc. and Emeritus Professor of Obstetrics and Gynaecology at the University of Western Australia.

Professor Michael is the current President of the Medical Board of Western Australia, a Director of the Australian Medical Council, a member of various State and National Medical Committees and Chair of the St John of God National Ethics Committee and Chair of the Reproductive Technology Council of Western Australia. He is a Director and Governor of the University of Notre Dame Australia and Chair of its Advisory Board of the School of Medicine Fremantle.

Professor Michael holds a Bachelor of Medicine and Bachelor of Surgery (UWA), Doctor of Medicine (UWA) and Diploma of Diagnostic Ultrasound. He is a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (a past President) and Fellow of the Royal College of Obstetricians and Gynaecologists, London (a previous Sims Black Professor).

Among his numerous awards, Professor Michael was named an Officer of the Order of Australia (AO) in 2001 for service to medicine, particularly in the field of obstetrics and gynaecology, as a contributor to the administration of the profession nationally and internationally and medical education.

Professor Genevieve Gray

Genevieve Gray was appointed to the Agency Management Committee in March 2009 as a member with expertise in health, or education and training.

Professor Gray is Professor of Nursing and Scholar in Residence at the Queensland University of Technology (QUT), Professor Emeritus University of Alberta and Adjunct Professor at

James Cook University. In recent years she has been a Nurse Scholar for the World Health Organization, Geneva, and worked in Canada as a Professor of Nursing, Dean & Director, WHO Collaborating Centre in Nursing & Mental Health for the University of Alberta and the World Health Organization. She is currently Director of QUT's Vietnam Nursing Capacity Building Program.

Professor Gray was previously Inaugural Chair of the International Academic Nursing Alliance, a member of the Multidisciplinary Board of the International Council of Women's Health Issues and member of the Deans Council, General Faculties Committee and Health Sciences Council of the University of Alberta.

Professor Gray has a General Nursing Certificate, Midwifery Certificate, diplomas in Nursing Education and Advanced Nursing Studies, a Master of Science (Nursing) and a Distinguished Life Fellowship from the Royal College of Nursing Australia.

Mr Michael Gorton AM

Michael Gorton was appointed to the Agency Management Committee in March 2009 as a member with business and administrative expertise.

Mr Gorton is a commercial lawyer with considerable experience providing legal advice on medical registration, training, education and administrative practice. As a principal of Russell Kennedy Solicitors, he has significant experience in business management and administration. He is a Board member of the Victorian Equal Opportunity & Human Rights Commission and a Chair of the Code of Conduct Committee of Medicines Australia.

Mr Gorton is a former Chair of the Infertility Treatment Authority, is a Board member of Melbourne Health, and has extensive experience in governance for a wide range of organisations including health and ethics committees.

Mr Gorton holds a Bachelor of Laws and Bachelor of Commerce.

In 2004, Mr Gorton received the Member of the Order of Australia (AM) for community service, particularly to the UN Association, Greening Australia, Aboriginal reconciliation and equal opportunity.

Professor Merrilyn Walton

Merrilyn Walton was appointed to the Agency Management Committee in March 2009 as a member with business and administrative expertise.

Professor Walton is Professor of Medical Education (Patient Safety) in the School of Public Health- Faculty of Medicine, at the University of Sydney and Visiting Professor and Affiliate of the Buehler Center on Aging, Health and Society, Chicago, USA. She is a member of the University of Sydney Academic Board, the NSW Institute for Medical Education and Training and is a member of the Australian Health Ethics Committee (National Health and Medical Research Council).

Previously, she was the Commissioner for the Health Care Complaints Commission NSW. (1993-2000).

Professor Walton holds a Bachelor of Arts, Bachelor of Social Work, Masters of Social Work and Doctor of Philosophy.

The members of the Agency Management Committee are (left to right, seated) Professor Genevieve Gray, Professor Merrilyn Walton, Professor Constantine (Con) Michael AO (left to right standing) Mr Peter Allen, Mr Michael Gorton AM

Overview of results for 2010/11

2010/11 was the first year of operation for the 10 National Boards under the National Registration and Accreditation Scheme and was a year of transition. AHPRA's financial performance includes the following features.

- The work program of the National Boards was developed throughout the year and the program incurred the full level of costs predominantly in the second half of the year.
- Registration fees collected were a mix of prepaid income from the former boards at lower fee levels and income collected during 2010-11 from the new national fees.
- The commencement of Western Australia in the National Scheme only from 18th October 2010.

It was expected that there would be a number of decommissioning costs relating to the assets and operations of the former boards and transitioning costs in establishing AHPRA's systems and processes. The decommissioning and transitioning costs in 2010/11 totalled $10.8 million.

Operationally AHPRA recorded a loss of $6.4 million in 2010/11 (including transitioning and decommission costs) which was $10.7 million better than the budgeted loss in 2010/11 of $17.1 million.

As a result, all ten National Boards achieved a net result better than budget with the Pharmacy Board of Australia, Physiotherapy Board of Australia and Podiatry Board of Australia achieving a net surplus for the year.

Reserves

The former state and territory boards transferred their closing reserves to AHPRA totalling $39.5 million. $5.8 million of these reserves were transferred in 2009/10. A further $17.3 million in cash was transferred from the former boards to AHPRA in 2009/10 and this was treated as advances received from the Health Boards during 2009/10. All remaining reserves were transferred in 2010/11.

It is expected that National Boards both as a group and individually would have reasonable and sufficient reserves to cover expected commitments although there can be no cross subsidisation between National Boards. An assessment at 30 June 2011 confirms that this is the case.

All Boards have a reserves objective which they expect to achieve in the first three years of operation (30 June 2013). National fees have been set or reviewed by each Board on this basis. At 30 June 2011 three of the ten Boards had achieved their target, four Boards were expected to achieve their target by 30 June 2012 and the remaining three Boards are expected to achieve their objective by the original target date of 30 June 2013

Nature of reserves transferred to AHPRA

The reserves transferred to AHPRA on behalf of the National Boards were based on the final audited position of each of the former boards. In a number of instances the value of fixed assets recorded by the former boards were transferred to AHPRA as part of those boards' opening reserves. These fixed assets were assessed for their impairment on transfer, and where deemed impaired, were then written off against those National Boards. Other boards wrote their fixed assets back to zero on transfer to the National Boards. As a result the method for valuing reserves transferred by state boards to National Boards was inconsistent depending on their treatment in their audited statements. However on transfer where those assets became impaired they were written off directly against their National Board and as a result flowed through to that Board's net result at the end of 2010/11. Their reserves position at 30 June 2011 is consistent and accurate.

Income

Income was stronger than expected for all ten National Boards during 2010/11 despite much of the revenue recognised being from the former boards at the lower fee rates. The 2011/12 year will be the first year where virtually all the income recognised will be from the fees paid at the new national rates.

Interest from investments throughout 2010/11 totalled $3.5 million. The Agency Management Committee adopted a conservative investment policy ensuring that the safety of capital is a dominant consideration in all investment decisions. AHPRA's portfolio investment is limited to Australian registered bank deposits, senior bank debt or bank accepted/endorsed bills.

Expenditure

Expenditure increased from a low base in July 2010 to the full work program levels in the second half of the year. This was reflected in National and State office resourcing levels and the establishment of working committees for each of the National Boards.

Decommissioning costs included the termination of a number of legacy leases from the former

Boards during the year. All legacy leases were settled in 2010/11.

Transitioning costs were incurred in 2010/11 relating to the enhancement of the registrant database and the establishment of core AHPRA systems, policies and processes. These were predominantly incurred in the first half of the year.

Cash flow

Cash and cash equivalents and investments increased from $19.5 million to $85.6 million during the year. This included the remaining transfer of funds from the former boards, particularly in the first half of the year.

Fees from registrants were received consistently throughout the year as renewal dates were largely dictated by previous state-based renewal cycles (the new renewal dates under the National Scheme are 30 September, 30 November and 31 May each year). Fees were received from renewals in each month throughout 2010/11.

The level of cash and cash equivalents and investments is required to fund the work program until the next renewal date including all current notifications. It is expected that cash and equivalents and investments will peak in future years during December and reach a low point in April prior to the commencement of the 31 May renewal program.

Balance sheet

Net assets increased from $1.3 million to $28.5 million during 2010/11 due to the transfer of the former boards' reserves to the National Boards. Investments at 30 June 2011 are the largest asset item at $82.5 million. The largest liability item relates to prepaid income and is predominantly made up of the portion or registrant fees which relate to the 2011/12 financial year.

The year ahead

2011/12 is expected to be the first full year where the full annualised work program for the ten National Boards will be delivered. As a result it is expected that operating costs will increase moderately to reflect the annualised cost of those programs. In addition almost all registrant fees will relate to the new national fees which are set by each National Board.

It is expected that AHPRA will make a moderate overall operating loss in 2011/12 before moving to net surplus result from 2002/13.

It is expected that 9 of the 10 Boards will achieve a break-even position or better in 2011/12 and the remaining Board will achieve a net surplus from 2012/13.

Government funding will be received for the four National Boards which will be in their establishment phase in 2011/12 for national registration. This program of work is expected to be fully covered by the external funding.

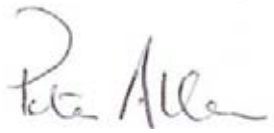
Declaration by Agency Management Committee, Chief Executive Officer & Director, Finance and Corporate Operations

We certify that the attached financial statements for the Australian Health Practitioner Regulation Agency have been prepared in accordance with Schedule 3, Part 3 of the *Health Practitioner Regulation National Law Act 2009* as in force in each State and Territory (the National Law), Australian Accounting Standards, Australian Accounting Interpretations and other mandatory professional reporting requirements.

We further state that in our opinion, the information set out in the Comprehensive Income Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement and notes to and forming part of the financial statements, presents fairly the financial transactions during the 12 month period ended 30 June 2011 and the financial position of the Australian Health Practitioner Regulation Agency as at 30 June 2011.

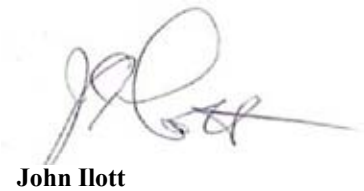
We are not aware of any circumstance which would render any particulars included in the financial statements to be misleading or inaccurate.

We authorise the attached financial statements for issue on this day.



Peter Allen
Chair, Agency Management Committee
16 September 2011

Martin Fletcher
Chief Executive Officer
16 September 2011



John Ilott
Director, Finance and Corporate Operations
16 September 2011

Australian Health Practitioner Regulation Agency
Comprehensive Income Statement
For the year ended 30 June 2011

	Notes	Year ended 30 June 2011	16 month period ended 30 June 2010
Continuing Operations		**$'000**	**$'000**
Income from Transactions			
Registrant Fee Income	2a	115,165	0
Interest		3,490	27
Other Income	2b	4,006	0
Total Income from Transactions		**122,661**	**27**
Expenses from Transactions			
Board Sitting Fees and Direct Board Costs		9,874	0
Notification Costs		11,324	0
HPCA Regulatory Fee	1f	15,349	0
Accreditation		3,095	0
Staffing Costs		53,022	2,536
Travel and Accommodation		2,071	973
Systems and Communications		6,656	96
Property Expenses		5,792	607
Strategic and Project Consultant Costs		3,630	0
Depreciation		705	0
Decommissioning and Transition Costs		10,756	0
Administration Expenses	3	6,805	332
Total Expenses from Transactions		**129,079**	**4,544**
Net Result for the year		**(6,418)**	**(4,517)**
Other Comprehensive Income		**0**	**0**
Comprehensive Result for the year		**(6,418)**	**(4,517)**

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency
Balance Sheet
For the year ended 30 June 2011

	Notes	As at 30 June 2011 $'000	As at 30 June 2010 $'000
Current Assets			
Cash and Cash Equivalents	4a	3,096	19,540
Investments	4b	82,500	0
Prepayments		110	50
Receivables	5	2,667	523
Accrued Income	6	964	0
Asset Held for Sale	7	2,049	0
Total Current Assets		**91,386**	**20,113**
Non-Current Assets			
Property, Plant & Equipment	8	6,456	752
Intangibles	8	86	0
Total Non-Current Assets		**6,542**	**752**
Total Assets		**97,928**	**20,865**
Current Liabilities			
Payables and Accruals	9	8,769	2,008
Income in Advance	10	54,754	17,252
Employee Benefits	11	4,784	257
Total Current Liabilities		**68,307**	**19,517**
Non-Current Liabilities			
Employee Benefits	11	1,084	23
Total Non-Current Liabilities		**1,084**	**23**
Total Liabilities		**69,391**	**19,540**
Net Assets		**28,537**	**1,325**
Retained Earnings		**(10,935)**	**(4,517)**
Reserves	12	**39,472**	**5,842**
Net Equity as at 30 June		**28,537**	**1,325**
Commitments for Expenditure	16		
Contingent Assets and Liabilities	17		

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency
Statement of Changes in Equity
For the year ended 30 June 2011

2011	Note	Changes due to: Accumulated Surplus / (Deficit) for the period $'000	Changes due to: Transactions with Health Boards $'000	Total $'000
Equity as at 1 July 2010		(4,517)	5,842	**1,325**
Comprehensive result for the period		(6,418)	-	**(6,418)**
Contribution by Health Boards	12	-	33,630	**33,630**
Total Equity at 30 June 2011		**(10,935)**	**39,472**	**28,537**

2010	Note	Changes due to: Accumulated Surplus / (Deficit) for the period $'000	Changes due to: Transactions with Health Boards $'000	Total $'000
Equity as at 1 March 2009		-	-	-
Comprehensive result for the period		(4,517)	-	**(4,517)**
Contribution by Health Boards	12	-	5,842	**5,842**
Total Equity at 30 June 2010		**(4,517)**	**5,842**	**1,325**

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency
Cash Flow Statement
For the year ended 30 June 2011

	Notes	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Cash Flows From Operating Activities			
Payments to suppliers, employees and others		(130,081)	(3,157)
Receipts relating to registrant fees		169,918	0
Other receipts		8,948	48
Interest received		2,526	27
Net Cash Flows from Operating Activities	18	**51,311**	**(3,083)**
Cash Flows From Investing Activities			
Payments for Property, Plant & Equipment		(6,495)	(471)
Receipts from the Sale of Assets		3,934	0
Transfers to Investments		(82,500)	0
Net Cash Flows From Investing Activities		**(85,061)**	**(471)**
Cash Flows From Financing Activities			
Remaining Receipts from Health Boards		17,306	23,094
Net Cash flows From Financing Activities		**17,306**	**23,094**
Net Increase / (Decrease) in cash held		(16,444)	19,540
Cash at the beginning of the year		19,540	0
Cash at end of the year	4a	**3,096**	**19,540**

All amounts are inclusive of GST

The transfer of equity from the former Boards to AHPRA includes a mix of cash flows from operating activities such as prepaid fees from registrants at 30 June 2010, and cash flows from financing activities where the amounts relate to equity transfers.

This statement should be read in conjunction with the accompanying notes.

Note 1 - Summary of Significant Accounting Policies

(a) Statement of Compliance

These financial statements are a general purpose financial report which have been prepared in accordance with the applicable Australian Accounting Standards and Interpretations (AASs) and other mandatory requirements. AASs include Australian equivalents to International Financial Reporting Standards.

The Financial Statements have also been prepared in accordance with the relevant requirements under the *Health Practitioner Regulation National Law Act 2009.*

(b) Basis of Accounting Preparation and Measurement

The accounting policies set out below have been applied in preparing the financial statements for the 12 month period ended 30 June 2011 (2010: 16 month period end 30 June 2010).

Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

The financial statements have been prepared using the accrual basis of accounting. Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition criteria for those items, that is they are recognised in the reporting period to which they relate.

The financial report is prepared in accordance with the historical cost convention. Cost is based on the fair values of the consideration given in exchange for assets.

In the application of AASs, management is required to make judgments, estimates and assumptions about carrying values of assets and liabilities that are not readily apparent from other sources. The estimates and associate assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making judgments. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis.

These financial statements were authorised by the Agency Management Committee on the 16th day of September 2011.

(c) Reporting Entity

The Australian Health Practitioner Regulation Agency (AHPRA) is given the authority to operate by way of the *Health Practitioner Regulation National Law Act 2009*.

AHPRA's principal address is 111 Bourke Street, Melbourne 3000.

The financial statements include all the controlled activities of AHPRA. A description of the nature of the organisation's operations and its principal activities is included in the Report of Operations.

AHPRA is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia.

AHPRA's operations are governed by the *Health Practitioner Regulation National Law Act 2009*, which came into effect on 1 July 2010. This law means that for the first time in Australia, 10 health professions are regulated by nationally consistent legislation.

AHPRA supports the 10 National Health Practitioner Boards that are responsible for regulating the 10 health professions. The primary role of the Boards is to protect the public and set standards and policies that all registered health practitioners must meet.

The Agency Management Committee oversees the work of AHPRA. The Chair is Mr Peter Allen.

AHPRA supports the 10 National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme.

(d) Corporate Structure

AHPRA is a statutory body governed by the Health Practitioner Regulation National Law Act 2009 as in force in each State and Territory (the National Law).

(e) Income from Transactions

Income is recognised to the extent that it is probable that the economic benefits will flow to AHPRA and that it can be reliably measured.

Registrant Fees

Registrations are payable periodically in advance. Only those registration fees that are attributable to the current financial year are recognised as income. Registration fees that relate to future periods are shown in the balance sheet as Income in Advance under the heading of Current Liabilities.

Where a registrant pays an application fee, the fee is recognised in the financial year in which it is received.

Interest

Interest income is accrued on a time basis by reference to the principal outstanding and at the effective interest rate applicable.

Other Income

Other income includes income that is not registrant fees or interest. Key income items of other income include certificates of registration status requested by registrants, government grants received and fees related to the Pharmacy Board of Australia's examinations.

Sale of Non-Current Assets

The net gain or loss of non-current asset sales are included as revenue or expenses at the date control passes to the buyer, usually when an unconditional contract of sale is signed.

The net gain or loss on disposal is calculated as the difference between the carrying amount of the asset at the time of the disposal and the net proceeds on disposal.

Assets which satisfy the criteria in AASB 5 as assets held for sale are transferred to current assets and separately disclosed as non-current assets held for sale on the face of the balance sheet. These assets are measured at the lower of carrying amount and fair value less costs to sell. These assets cease to be depreciated from the date which they satisfy the held for sale criteria.

(f) Expenses from Transactions

Board Sitting Fees and Direct Board Costs

Board sitting fees and direct board costs includes all national, state and regional board expenditure relating to meetings held by the board and their committees and for projects commissioned by the boards.

Notification Costs

Notification costs include all external costs relating to the managing the notification (complaint) process. These costs include legal fees paid to external firms and costs of civil tribunals.

HPCA Regulatory Fee

The HPCA regulatory fee is the amount paid to the Health Professional Councils Authority (HPCA) in NSW to support the co-regulatory model in their State.

Accreditation

Accreditation relates to payments to external accreditation bodies to assist AHPRA to develop accreditation standards and accredit education providers across all professions.

Staffing Costs

Staffing costs relate to AHPRA employee costs including oncosts and contractors.

Travel and Accommodation

Travel and accommodation relates to flights, taxis, parking and hotel costs incurred by AHPRA.

Systems and Communication

Systems and communication costs relate to the external cost of supporting the technology systems of AHPRA.

Property Expenses

Property expenses include rental, outgoings and maintenance of all leased and owned properties.

Strategic and Project Consultant Costs

Strategic and project consultant costs relate to one-off project costs incurred in the year.

Decommissioning and Transition Costs

Decommissioning costs relate to the closure of the former board operations including the costs of surrendering leases where appropriate.

Transition costs include the non-recurrent costs of establishing new systems.

Administration Expenses

Administration expenses include any expenses not listed above. The major component of administration expenses are corporate legal, bank charges and merchant fees, postage, freight & couriers, printing & stationery, insurance and recruitment.

(g) Cash and Cash Equivalents

Cash and cash equivalents include cash on hand, deposits held at call, and other short term liquid deposits.

(h) Investments

Investments include term deposits held at fixed interest rates for period of 3 months or greater.

(i) Receivables

The terms of trade are 30 days from invoice date. Receivables are recognised and carried at original invoice amount less any allowance for any uncollectable amounts. An estimate for doubtful debts is made when collection of the full amount is no longer probable. Bad debts are written off when identified.

(j) Plant, Equipment, Intangibles and Depreciation

Plant and equipment from the former boards are valued at the amounts transferred to AHPRA. Plant and equipment and Intangibles procured in 2010/11 are measured at cost less accumulated depreciation and impairment. These assets are depreciated at rates based on their expected useful lives, using the straight-line method, which is reviewed annually.

The depreciation rates used for major assets in each class are as follows:

	2011	2010
Furniture and Fittings	13%	13%
Computer Equipment	20% to 40%	20% to 40%
Intangibles	10% to 40%	10% to 40%
Office Equipment	15%	15%

Leasehold improvements are amortised over the term of the lease.

Work in progress (WIP) is not depreciated until it reaches service delivery capacity.

(k) Payables and Accruals

Payables are initially recognised at fair value, subsequently carried at amortised cost and represent liabilities for goods and services provided to AHPRA prior to the end of the financial year that are unpaid, and arise when AHPRA is obliged to make future payments in respect of the purchase of goods and services. Terms of settlement are generally 30 days from the date of invoice.

l) Prepayments

Prepaid expenditure is recognised as a prepayment when the expenditure amount relates to future periods. It is then recognised as expenditure to the period in which the service relates.

(m) Employee Benefits

(i) Annual Leave

Liabilities for wages and salaries, including non-monetary benefits and annual leave expected to be settled within 12 months of the reporting date are recognised in the provision for employee benefits in respect of employees' service up to the reporting date and are classified as current liabilities and measured at their nominal values.

Those liabilities are not expected to be settled within 12 months are recognised in the provision for employee benefits as current liabilities, measured at the present value of the amounts expected to be paid when the liabilities are settled using remuneration rates expected to apply at the time of settlement.

(ii) Long Service Leave

The long service leave entitlement under existing arrangements is recognised from an employee's commencement date and becomes payable according to the employment arrangements in place. The valuation of long service leave for employees who have met the conditions of service to take long service leave is recognised as a current liability whilst the valuation for those employees still to meet the conditions of service is measured as a non current liability.

The liability is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given to expected future wage and salary levels, experience of employee departures and periods of service. Expected future payments are discounted using interest rates on National Government guaranteed securities with terms to maturity that match, as closely as possible, the estimated future cash outflows.

(iii) Termination Benefits

Termination benefits are payable when employment is terminated before the normal retirement date or when an employee accepts voluntary redundancy in exchange for these benefits. AHPRA recognises termination benefits when it demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

(iv) Defined Superannuation Plans

The amount charged to the Comprehensive Operating Statement in respect of superannuation represents the contribution by AHPRA to the superannuation fund. Contributions to defined contribution superannuation plans are expensed when incurred and paid at the required rate.

(n) Employee Benefits On Costs

Employee benefits on- costs, including payroll tax, work cover insurance premiums and superannuation entitlements are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities.

(o) GST

All application, registration and late fees are exempt from Goods and Services Tax legislation. Revenues, expenses and assets are recognised net of GST except where the amount of GST incurred is not recoverable, in which case it is recognised as part of the cost of acquisition of an asset or part of an item of expense or revenue. GST receivable from and payable to the Australian Taxation Office (ATO) is included in the Balance Sheet. The GST component of a receipt or payment is recognised on a gross basis in the "statement of cash flows" in accordance with Accounting Standard AASB 107.

(p) Income Tax

Tax effect accounting has not been applied as AHPRA is exempt from income tax under Section 50-25 of the *Income Tax Assessment Act 1997.*

(q) Leases

Operating lease payments are recognised as an expense in the Comprehensive Operating Statement on a straight line basis over the lease term.

(r) Commitments

Commitments are disclosed to include those operating and capital commitments arising from non-cancellable contractual or statutory obligations. All amounts shown in the commitments note are inclusive of GST.

(s) Contingent Assets and Contingent Liabilities

Contingent assets and contingent liabilities are not recognised in the balance sheet, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

(t) Equity

Opening equity includes equity transferred from the former boards to AHPRA.

(u) Comparative Amounts

When required by accounting standards, comparative figures have been adjusted to conform to changes in presentation for the current financial year. The period ending 30 June 2010 is for a 16 month period as this was AHPRA's first period and was an establishment period.

(v) Functional and Presentation Currency

All amounts specified in these statements are presented in Australian dollars (AUD).

(w) Rounding of Amounts

Amounts in the financial report have been rounded to the nearest thousand dollars or in other cases to the nearest dollar.

(x) New Accounting Standards and Interpretations

Certain new Australian accounting standards and interpretations that are not mandatory for 30 June 2011 reporting period have been published.

As at 30 June 2011, the following standards and interpretations had been issued but were not mandatory for the reporting ended 30 June 2011. AHPRA has not and does not intend to adopt these standards early.

AASB 108 requires disclosure of the impact on AHPRA's financial statements of these changes. These are set out below.

Standard/Interpretation	*Summary*	*Applicable for annual reporting periods beginning on*	*Impact on AHPRA financial statements*
AASB-9 *Financial instruments*	This standard simplifies requirements for the classification and measurement of financial assets resulting from Phase 1 of the IASB's project to replace IAS 39 *Financial Instruments: Recognition and Measurement* (AASB 139 *Financial Instruments: Recognition and Measurement*).	Beginning 1 Jan 2013	Detail of impact is still being assessed.
AASB-124 *Related Party Disclosures (Dec 2009)*	Government related entities have been granted partial exemption with certain disclosure requirements.	Beginning 1 Jan 2011	Expected to have no significant impact.
AASB-1053 *Application of Tiers of Australian Accounting Standards*	This Standard establishes a differential financial reporting framework consisting of two tiers of reporting requirements for preparing general purpose financial statements.	Beginning 1 July 2013	Detail of impact is still being assessed.
AASB-2009-11 *Amendments to Australian Accounting Standards arising from AASB 9 [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 121, 127, 128, 131, 132, 136, 139, 1023 and 1038 and Interpretations 10 and 12]*	This Standard gives effect to consequential changes arising from the issuance of AASB 9.	Beginning 1 Jan 2013	Detail of impact is still being assessed.
AASB-2009-12 *Amendments to Australian Accounting Standards [AASB 5, 8, 108, 110, 112, 119, 133, 137, 139, 1023 and 1031 and Interpretations 2, 4, 16, 1039 and 1052]*	This standard amends AASB 8 to require an entity to exercise judgement in assessing whether a government and entities known to be under the control of that government are considered a single customer for purposes of certain operating segment disclosures. This standard also makes numerous editorial amendments to other AASs.	Beginning 1 Jan 2011	The amendments only apply to those entities to whom AASB 8 applies, which are for-profit entities except for-profit government departments. Expected to have no significant impact.

Standard/Interpretation	*Summary*	*Applicable for annual reporting periods beginning on*	*Impact on AHPRA financial statements*
AASB-2009-14 *Amendments to Australian Interpretation – Prepayments of a Minimum Funding Requirement [AASB Interpretation 14]*	Amendments to Interpretation 14 arise from the issuance of prepayments of a minimum funding requirement.	Beginning 1 Jan 2011	Expected to have no significant impact.
AAS- 2010-2 *Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements*	This Standard makes amendments to many Australian Accounting Standards, including Interpretations, to introduce reduced disclosure requirements to the pronouncements for application by certain types of entities.	Beginning 1 July 2013	Does not affect financial measurement or recognition, so is not expected to have any impact on financial result or position. May reduce some note disclosures in financial statements.
AASB-2010-4 *Further Amendments to Australian Accounting Standards arising from the Annual Improvements Project [AASB 1, AASB 7, AASB 101 & AASB 134 and Interpretation 13]*	This Standard makes numerous improvements designed to enhance the clarity of standards.	Beginning 1 Jan 2011	No significant impact on the financial statements.
AASB-2010-5 *Amendments to Australian Accounting Standards [AASB 1, 3, 4, 5, 101, 107, 112, 118, 119, 121, 132, 133, 134, 137, 139, 140, 1023 & 1038 and Interpretations 112, 115, 127, 132 & 1042]*	This amendment contains editorial corrections to a range of Australian Accounting Standards and Interpretations, which includes amendments to reflect changes made to the text of IFRSs by the IASB.	Beginning 1 Jan 2011	No significant impact on the financial statements.
AASB-2010-6 *Amendments to Australian Accounting Standards – Disclosures on Transfers of Financial Assets [AASB 1 & AASB 7]*	This amendment adds and changes disclosure requirements about the transfer of financial assets. This includes the nature and risk of the financial assets.	Beginning 1 July 2011	This may impact on the disclosure of financial assets to be trnasferred from the four professions commencing with the Scheme in 2012/13. Detail of impact is still being assessed.
AASB-2010-7 *Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12, 19 & 127]*	These amendments are in relation to the introduction of AASB 9.	Beginning 1 Jan 2013	This amendment may have an impact on AHPRA as AASB 9 is a new standard and it changes the requirements of numerous standards. Detail of impact is still being assessed.

Standard/Interpretation	*Summary*	*Applicable for annual reporting periods beginning on*	*Impact on AHPRA financial statements*
AASB-2010-8 *Amendments to Australian Accounting Standards – Deferred Tax: Recovery of Underlying Assets [AASB 112]*	This amendment provides a practical approach for measuring deferred tax assets and deferred tax liabilities when measuring investment property by using the fair value model in AASB 140 *Investment Property.*	Beginning 1 Jan 2012	This amendment provides additional clarification through practical guidance.
AASB-2010-9 *Amendments to Australian Accounting Standards – Severe Hyperinflation and Removal of Fixed Dates for First-time Adopters [AASB 1]*	This amendment provides guidance for entities emerging from severe hyperinflation who are going to resume presenting Australian Accounting Standards financial statements or entities that are going to present Australian Accounting Standards financial statements for the first time. It provides relief for first-time adopters from having to reconstruct transactions that occurred before their date of transition to Australian Accounting Standards.	Beginning 1 July 2011	No significant impact on the financial statements.
AASB-2011-1 *Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project [AASB 1, AASB 5, AASB 101, AASB 107, AASB 108, AASB 121, AASB 128, AASB 132 & AASB 134 and Interpretations 2, 112 & 113]*	This amendment affects multiple Australian Accounting Standards and AASB Interpretations for the objective of increased alignment with IFRSs and achieving harmonisation between both Australian and New Zealand Standards. It achieves this by removing guidance and definitions from some Australian Accounting Standards, without changing their requirements.	Beginning 1 July 2011	This amendment will have no significant impact on AHPRA.
AASB-2011-2 *Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project – Reduced Disclosure Requirements [AASB 101 & AASB 1054]*	The objective of this amendment is to include some additional disclosure from the Trans-Tasman Convergence Project and to reduce disclosure requirements for entities preparing general purpose financial statements under Australian Accounting Standards – Reduced Disclosure Requirements.	Beginning 1 July 2013	No significant impact on the financial statements.
AASB-2011-3 *Amendments to Australian Accounting Standards – Orderly Adoption of Changes to the ABS GFS Manual and Related Amendments [AASB 1049]*	This amends AASB 1049 to clarify the definition of the ABS GFS Manual, and to facilitate the adoption of changes to the ABS GFS Manual and related disclosures.	Beginning 1 July 2012	This amendment provides clarification to users on the version of the GFS Manual to be used and what to disclose if the latest GFS Manual is not used. No impact on performance measurements will occur.

Note 2a – Registration Income	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Registration income recognised from the former boards	38,789	0
Registration income received and recognised in 2010/11	65,313	0
Application fee income	11,063	0
Total Registration Income	**115,165**	**0**

Note 2b – Other Income	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Government grant income	602	0
Certificate of registration status	307	0
Pharmacy Board of Australia examinations	593	0
Other income	2,504	0
Total Other Income	**4,006**	**0**

Note 3 – Administration Expenses	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Legal – Corporate	701	84
Bank charges and merchant fees	666	23
Postage, freight and courier	1,337	8
Printing and stationery	629	20
Insurance	471	0
Recruitment	1,039	0
Other	1,962	197
Total Administration Expenses	**6,805**	**332**

Note 4 – Cash and cash equivalents and Investments

Note 4a – Cash and cash equivalents	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Cash on hand , at bank and term deposits less than 30 days	3,096	19,540
Total Cash and cash equivalents	**3,096**	**19,540**

Note 4b – Investments	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
90 day bank term deposits	27,500	0
Bank term deposits greater than 90 days	55,000	0
Total Investments	**82,500**	**0**

Note 5 – Receivables	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Trade receivables	2,170	277
GST receivable	576	246
Less allowances for doubtful debts	(79)	0
Total Receivables	**2,667**	**523**

Ageing of receivables	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Current	1,900	277
30-60 days	47	0
60-90 days	9	0
Beyond 90 days	214	0
Total	**2,170**	**277**

Note 6 – Accrued Income	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Accrued interest on term deposits	**964**	**0**

Note 7 – Assets Held for Sale

All buildings transferred by the former Health Boards to AHPRA were classified as assets held for sale and were sold during the financial year ended 30 June 2011, except for 1/165 Adelaide Terrace, East Perth relating to the former Nurses and Midwives Board of Western Australia. This was classified as asset held for sale at 30 June 2011with a written down value of $2.049million. All assets were transferred from the former Boards at their written down values.

Note 8 - Property, Plant and Equipment and Intangible Assets

	Land and Buildings	Leasehold Improvements	Furniture and Fittings	Computer Equipment	Office Equipment	WIP	Total PPE	Intangible Assets
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Gross Carrying Amount								
Balance at Start	0	0	0	0	0	0	0	0
Additions	0	388	7	7	69	281	752	0
Disposals	0	0	0	0	0	0	0	0
Balance at 30 June 2010	0	388	7	7	69	281	752	0
Additions	0	4,991	403	252	50	657	6,353	142
Transfers from former Boards	6,184	642	628	401	190	0	8,045	0
Transfers to Asset Held for Sale	(6,184)	0	0	0	0	0	(6,184)	
Disposals	0	(642)	(628)	(401)	(190)	0	(1,861)	0
Balance at 30 June 2011	0	5,379	410	259	119	938	7,105	142
Accumulated depreciation, amortisation and impairment								
Balance at Start	0	0	0	0	0	0	0	0
Depreciation	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0
Balance at 30 June 2010	0	0	0	0	0	0	0	0
Deprecation	0	(490)	(39)	(105)	(15)	0	(649)	(56)
Transfer from former Boards	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0
Balance at 30 June 2011	0	(490)	(39)	(105)	(15)	0	(649)	(56)
Net Book Value								
At 30 June 2011	0	4,889	371	154	104	938	6,456	86

Assets transferred from former Boards and which were disposed of on transfer are recognised as decommissioning expenses in the Comprehensive Income Statement.

Note 9 Payables and Accruals

Payables and Accruals	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Trade Creditors	4,601	961
Accrued Expenses	4,168	1,047
Total Payables and Accruals	**8,769**	**2,008**

Note 10 Income in Advance

10a. Amounts Received in Advance from Health Boards (i)	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Amounts received in advance	795	17,252
Total	**795**	**17,252**

10b. Prepaid Income (ii)	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Chiropractic Board of Australia	559	0
Dental Board of Australia	2,642	0
Medical Board of Australia	16,901	0
Nursing and Midwifery Board of Australia	24,659	0
Optometry Board of Australia	573	0
Osteopathy Board of Australia	216	0
Pharmacy Board of Australia	2,172	0
Physiotherapy Board of Australia	1,300	0
Podiatry Board of Australia	389	0
Psychology Board of Australia	3,220	0
Other	1,328	0
Total	**53,959**	**0**

i. $795,000 was received in 2010/11 from Health Workforce Australia in relation to the Aboriginal and Torres Strait Islander National Board establishment.

ii. At 1 July 2010 on commencement of the National Scheme the prepaid income amounts from the former boards were transferred to AHPRA. As a result $38,788,845 of prepaid income from the former boards was recognised by AHPRA in 2010/11 as income and a further $883,569 from the former Medical Board of Western Australia will be recognised as income by AHPRA in 2011/12. 'Other' prepaid income relates to funding for the four health professions commencing under the National Scheme.

Note 11 – Employee Benefits

Current	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Unconditional annual leave and expected to be settled within 12 months.	2,546	121
Unconditional annual leave expected to be settled after 12 months	654	0
Conditional long service leave and expected to be settled within 12 months.	1,584	136
Total Current Employee Benefits	**4,784**	**257**
Non-Current		
Conditional long service leave entitlements expected to be settled after 12 months	1,084	23
Total Non-Current Employee Benefits	**1,084**	**23**

Note 12 - Equity

It was agreed that a proportion of up to 30% of reserve balances would be transferred from the former State and Territory Health Boards to the National Boards prior to 30 June 2010. This was subject to the adoption of the national legislation within each jurisdiction.

On an Australian-wide basis, the fifth column shows amounts received by AHPRA for each National Board during the 16 month period ended 30 June 2010.

The accumulated loss incurred in the 16 month period to 30 June 2010 is allocated to each of the National Boards. Equity from the former Boards was transferred progressively during both the 2009/10 and 2010/11 financial periods. The net result from each Board for the year ended 30 June 2011 then contributed to the closing equity position at 30 June 2011.

	Net Result		**Equity**		**Reserves Transferred in**		
	2010	2011	2010	2011	2010	2011	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Chiropractic Board of Australia	(50)	(160)	121	954	171	993	1,164
Dental Board of Australia	(277)	(583)	225	2,260	502	2,618	3,120
Medical Board of Australia	(1,761)	(5,305)	(436)	5,191	1,325	10,932	12,257
Nursing and Midwifery Board of Australia	(1,671)	(716)	471	4,129	2,142	4,374	6,516
Optometry Board of Australia	(38)	(160)	175	863	213	848	1,061
Osteopathy Board of Australia	(11)	(107)	76	878	87	909	996
Pharmacy Board of Australia	(225)	966	441	3,457	666	2,050	2,716
Physiotherapy Board of Australia	(120)	399	294	3,007	414	2,314	2,728
Podiatry Board of Australia	(22)	34	62	432	84	336	420
Psychology Board of Australia	(342)	(786)	(104)	1,066	238	1,956	2,194
Other	0	0	0	6,300	0	6,300	6,300
Total	**(4,517)**	**(6,418)**	**1,325**	**28,537**	**5,842**	**33,630**	**39,472**

"Other" ($6.3million) represents funds which have been set aside from the sale of the Nurses Board of Victoria building in line with Victoria's commitment to provide a secure and sound basis for housing the National Scheme in Victoria.

Reserves

	Notes	Year ended 30 June 2011	16 month period ended 30 June 2010
(a) Contributed Capital		**$'000**	**$'000**
Balance at the Beginning of Financial Year		5,842	0
Capital Contributions from former boards		33,630	5,842
Balance at end of Financial Year		**39,472**	**5,842**
Expenses from Transactions			
(b) Accumulated Surplus			
Balance at the Beginning of Financial Year		(4,517)	0
Surplus/Deficit for the Year		(6,418)	(4,517)
Transfers (To)/From Reserves		0	0
Balance at end of Financial Year		**(10,935)**	**(4,517)**

Note 13 - Superannuation Contributions

Contributions of $5,458,530 were made to 228 superannuation funds during the course of the financial year. The contribution rate for the financial year is based on the statutory rate of employees' salaries.

		Year ended 30 June 2011	16 month period ended 30 June 2010
Name of Fund	**Type of Scheme**	**$**	**$**
AGEST Super	Accumulation	767,778	0
QSuper	Accumulation	686,503	6,507
Health Super	Accumulation	394,687	4,214
SA (Triple S) Scheme	Accumulation	323,850	0
QSuper	Defined Benefits	287,985	0
All Other funds	Accumulation/Defined Benefits	2,997,727	91,183
Total		**5,458,530**	**101,904**

Note 14 – Responsible Persons and Accountable Officer

(i) Australian Health Workforce Ministerial Council

The Ministerial Council comprises Ministers of the governments of the participating jurisdictions and the Commonwealth with the portfolio responsibility for Health. The following Ministers were members of the Australian Health Workforce Ministerial Council during the period 1 July 2010 to 30 June 2011.

Name	Position	State
The Hon Nicola Roxon MP	Minister for Health & Ageing	Federal Minister
The Hon Carmel Tebbutt (until 28 March 2011)	Minister for Health	New South Wales
The Hon Jillian Skinner (from 3 April 2011)	Minister for Health Minister for Medical Research	New South Wales
The Hon Daniel Andrews MP (until 2 December 2010)	Minister for Health	Victoria
The Hon David Davis MP (from 2 December 2010)	Minister for Health	Victoria
The Hon Paul Lucas (until 21 February 2011)	Minister for Health	Queensland
The Hon Geoff Wilson (from 21 February 2011)	Minister for Health	Queensland
The Hon John Hill MP (Chair)	Minister for Health, Minister for Mental Health and Substance Abuse	South Australia
The Hon Michelle O'Byrne MHA	Minister for Health,	Tasmania
The Hon Dr Kim Hames MLA	Deputy Premier Minister for Health Minister for Tourism	Western Australia
Ms Katy Gallagher MLA	Chief Minister Minister for Health Minister for Industrial Relations	Australian Capital Territory
The Hon Kon Vatskalis MLA	Minister for Health Minister for Children and Families Minister for Child Protection Minister for Primary Industry, Fisheries and Resources	Northern Territory

All dates are from 1 July 2010 to 30 June 2011 unless otherwise stated.

(ii) Agency Management Committee Members

	Period
Mr Peter Allen	1/07/10 – 30/06/11
Professor Con Michael, AO	1/07/10 – 30/06/11
Professor Genevieve Gray	1/07/10 – 30/06/11
Mr Michael Gorton, AM	1/07/10 – 30/06/11
Professor Merrilyn Walton	1/07/10 – 30/06/11

(iii) Remuneration of Agency Management Committee

Income		2011 No.	2010 No.
$0 - $9,999		0	5
$10,000 - $19,999		3	0
$20,000 - $29,999		1	0
$40,000 - $49,999		1	0
	Total Numbers	**5**	**5**
	Total Amount	**$115,211**	**N/A**

Amounts relating to responsible Ministers are reported in the financial statements of the relevant Minister's jurisdiction.

(iv) Related Party Transactions

Mr Michael Gorton, AM is a principal of Russell Kennedy Solicitors which provides legal services on notification matters to AHPRA on normal commercial terms and conditions.

Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
367	**0**

(v) Remuneration of Chief Executive Officer and National Executive Group

The Chief Executive Officer (CEO) is Mr Martin Fletcher who held the position for the period 1 July 2010 to 30 June 2011. The aggregate compensation made to CEO and the National Executive group is set out below:

	Total Remuneration		Base Remuneration	
	2011 No.	2010 No.	2011 No.	2010 No.
Income				
$130,000 - $139,999	0	1	0	1
$170,000 - $179,999	1	1	1	1
$200,000 - $209,999	1	0	1	0
$220,000 - $229,999	1	0	1	0
$240,000 - $249,999	1	0	1	0
$330,000 - $339,999	1	0	1	0
Total Numbers	5	2	5	2
Total Amount	$1,182,426	$307,399	$1,182,426	$307,399

Note 15 – Remuneration of Auditor

	At 30 June 2011 $'000	At 30 June 2010 $'000
Amount payable to VAGO for auditing the statements (excluding GST)	162	0
Amount payable to KPMG for auditing the statements (excluding GST)	0	20
	162	**20**

Note 16 - Commitments for Expenditure

(i) Capital Expenditure

Commitments in relation to capital are payable as:

	At 30 June 2011 $'000	At 30 June 2010 $'000
Not later than 1 year	0	375
Later than 1 year but not later than 5 years	0	0
Total Capital Commitments	**0**	**375**

(ii) Operating Lease Commitments

Commitments in relation to operating leases are payable as:

	At 30 June 2011 $'000	At 30 June 2010 $'000
Not later than 1 year	5,587	2,301
Later than 1 year but not later than 5 years	23,092	10,025
Later than 5 years	11,596	0
Total Operating Leases	**40,275**	**12,326**

Note 17 - Contingent Assets and Liabilities

As at 30 June 2011, AHPRA has no contingent assets or liabilities.

Note 18 – Reconciliation of comprehensive result to Operating Cash Flows

	Year ended 30 June 2011 $'000	16 month period ended 30 June 2010 $'000
Result from Ordinary Activities	**(6,418)**	**(4,517)**
Adjustments for:		
Depreciation	705	0
Other non cash items	1,861	(281)
Changes in assets and liabilities		
(Increase) / decrease in Receivables	(872)	(524)
(Increase) / decrease in Prepayments	16	(50)
Increase / (decrease) in Income in Advance	(964)	0
Increase / (decrease) in Prepaid Income	54,754	0
Increase / (decrease) in Payables and Accruals	1,313	2,008
Increase / (decrease) in Employee Benefits	916	281
Net Cash Flows from Operating Activities	**51,311**	**(3,083)**

The changes in assets and liabilities exclude items transferred by the former boards and taken up as equity on transfer.

Note 19 - Financial Instruments

(a) Financial Risk Management

AHPRA's principal financial instruments consist of at call variable interest deposits, term deposits and trade receivables and payables. AHPRA has no exposure to exchange rate risk.

Details of the significant accounting policies and methods adopted, including the criteria for recognition, the basis of measurement, and the basis of which income and expenses are recognised, with respect to each class of financial asset, financial liability and equity instrument above are disclosed in Note 1 to the financial statements.

(b) Credit Risk Exposure

Credit risk is the risk that a party will fail to fulfil its obligations to AHPRA resulting in financial loss. The maximum exposure to credit risk, excluding the value of any collateral or other security, at balance date to recognised financial assets, is the carrying amount, net of any provisions for impairment of those assets, as disclosed in the balance sheet and notes to the financial statements. AHPRA does not have any material credit risk exposure to any single receivable or group of receivables under financial instruments entered into by the entity.

There are no material amounts of collateral held as security at 30 June 2011.

Credit risk is managed by the entity and reviewed regularly. It arises from exposures to customers as well as through deposits with financial institutions.

The entity monitors the credit risk by actively assessing the rating quality and liquidity of counterparties.

Credit quality of contractual assets that are neither past due nor impaired

	Financial Institutions (AA credit rating)	Other	Total
2011	**$ '000**	**$ '000**	**$ '000**
Financial Assets			
Cash and Cash Equivalents	3,096	0	3,096
Investments	82,500	0	82,500
Receivables	0	2,091	2,091
Total	**85,596**	**2091**	**87,687**

Credit quality of contractual assets that are neither past due nor impaired

	Financial Institutions (AA credit rating)	Other	Total
2010	**$ '000**	**$ '000**	**$ '000**
Financial Assets			
Cash and Cash Equivalents	19,540	0	19,540
Investments	0	0	0
Receivables	0	524	524
Total	**19,540**	**524**	**20,064**

Ageing Analysis of Financial Assets

	Carrying Amount	Less than 1 month	1-3 months	3 months – 1 year
2011	**$ '000**	**$ '000**	**$ '000**	**$ '000**
Financial Assets				
Cash and Cash Equivalents	3,096	0	0	0
Investments	82,500	0	0	0
Receivables	2,091	1,821	56	214
Total	**87,687**	**1,821**	**56**	**214**

Ageing Analysis of Financial Assets

	Carrying Amount	Less than 1 month	1-3 months	3 months – 1 year
2010	**$ '000**	**$ '000**	**$ '000**	**$ '000**
Financial Assets				
Cash and Cash Equivalents	19,540	0	0	0
Investments	0	0	0	0
Receivables	524	524	0	0
Total	**20,064**	**524**	**0**	**0**

(c) Liquidity Risk Exposure

Liquidity risk is the risk that AHPRA will encounter difficulty in meeting obligations associated with financial liabilities. AHPRA manages liquidity risk by monitoring forecast cash flows and ensuring that adequate liquid funds are available to meet current obligations.

The following tables disclose the maturity analysis of AHPRA's financial liabilities

		Maturity Dates		
	Carrying Amount	**Less than 1 month**	**1-3 months**	**3 months – 1 year**
2011	**$ '000**	**$ '000**	**$ '000**	**$ '000**
Payables				
Trade Creditors	4,601	4,539	18	44
Accrued Expenses	4,168	4,168	0	0
Total	**8,769**	**8,707**	**18**	**44**

		Maturity Dates		
2010	**Carrying Amount**	**Less than 1 month**	**1-3 months**	**3 months – 1 year**
	$'000	**$'000**	**$'000**	**$'000**
Payables				
Trade Creditors	746	746	-	-
Accrued Expenses	1,047	1,047	-	-
Total	**1,793**	**1,793**	**-**	**-**

Trade Creditors over 30 days still to be paid relate to amounts which are being held for payment until all conditions for payment are met.

The maximum exposure to liquidity risk is the total carrying amount of the financial liabilities as shown above.

(d) Market Risk Exposure

Currency Risk

AHPRA have no exposure to currency risk at 30 June 2011.

Equity Price Risk

AHPRA have no exposure to equity price risk at 30 June 2011.

Interest Rate Risk

Exposure to interest rate risk is limited to assets bearing variable interest rates. AHPRA has a combination of deposits with floating and fixed interest rates. Exposure to variable interest rate risk is with financial institutions with AAA credit rating.

	Interest rate exposure of Financial Instruments				
2011	**Weighted average Interest rate**	**Non Interest Bearing $'000**	**Floating Interest Rate $'000**	**Fixed Interest rate 1 year or less $'000**	**Total $'000**
Financial Assets					
Cash and cash equivalents	3.88%	14	3,082	-	**3,096**
Investments	6.07%	-	-	82,500	**82,500**
Receivables	-	2,091	-	-	**2,091**
Total	**-**	**2,091**	**3,082**	**82,500**	**87,687**
Financial Liabilities					
Payables	-	4,601	-	-	**4,601**
Accrued Expenses	-	4,168	-	-	**4,168**
Total	**-**	**8,769**	**-**	**-**	**8,769**

	Interest rate exposure of Financial Instruments				
2010	**Weighted average Interest rate**	**Non Interest Bearing $'000**	**Floating Interest Rate $'000**	**Fixed Interest rate 1 year or less $'000**	**Total $'000**
Financial Assets					
Cash and cash equivalents	3.65%	1	19,539	-	**19,540**
Investments	N/A	-	-	-	**-**
Receivables	-	524	-		**524**
Total	**-**	**525**	**19,539**	**-**	**20,064**
Financial Liabilities					
Payables	-	746	-	-	**961**
Accrued Expenses	-	1,047	-	-	**1,047**
Total	**-**	**2,008**	**-**	**-**	**2,008**

Sensitivity Analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, AHPRA believes the following movements are 'reasonably possible' over the next 12 months.

- A parallel shift of +1% and -1% in market interest rates (AUD) from year-end rates of 6.07%.
- A parallel shift of +2% and -3% in the inflation rate (AUD) from year-end rates of 3.6%.

The following table discloses the impact on net operating result and equity for each category of financial instrument held by AHPRA at year end as presented to key management personnel, if changes in the relevant risk occur.

Financial Assets	Carrying Amount $'000	At -1.0% $'000 Surplus	At -1.0% $'000 Equity	At +1.0% $'000 Surplus	At +1.0% $'000 Equity
2011					
Cash and cash equivalents	3,096	(31)	(31)	31	31
Investments	82,500	(825)	(825)	825	825
Receivables	2,091	-	-	-	-
Financial Liabilities					
Payables	4,601	-	-	-	-
Accruals	4,168	-	-	-	-
		(856)	**(856)**	**856**	**856**

Financial Assets	Carrying Amount $'000	At -1.0% $'000 Surplus	At -1.0% $'000 Equity	At +1.0% $'000 Surplus	At +1.0% $'000 Equity
2010					
Cash and cash equivalents	19,539	(195)	(195)	195	195
Investments	-	-	-	-	-
Receivables	-	-	-	-	-
Financial Liabilities					
Payables	746	-	-	-	-
Accruals	1,047	-	-	-	-
		(195)	**(195)**	**195**	**195**

Other Market Risk

AHPRA have no exposure to other market risk at 30 June 2011.

(e) Net Fair Value

The net fair value of all on-balance sheet monetary financial assets and financial liabilities approximates their carrying value. There are no off-balance sheet financial assets or financial liabilities at balance date.

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

- the fair value of financial instrument assets and liabilities with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices; and
- the fair value of other financial instrument assets and liabilities are determined in accordance with generally accepted pricing models based on discounted cash flow analysis.

AHPRA considers that the carrying amount of financial instrument assets and liabilities recorded in the financial statements to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be paid in full.

The following table shows that the fair values of most of the contractual financial assets and liabilities are the same as the carrying amounts.

Comparison between carrying amount and fair value

	Carrying Amount 2011 $'000	Fair Value 2011 $'000	Carrying Amount 2010 $'000	Fair Value 2010 $'000
Financial Assets				
Cash and cash equivalents	3,096	3,096	19,539	19,539
Investments	82,500	82,500	0	0
Receivables	2,091	2,091	0	0
Total Financial Assets	**87,687**	**87,687**	**19,539**	**19,539**
Financial Liabilities				
Payables	4,601	4,601	746	746
Accrued Expenses	4,168	4,168	1,047	1,047
Total Financial Liabilities	**8,769**	**8,769**	**1,811**	**1,811**

Financial instruments are required to be classified at fair value based upon the reference of the source of inputs used to derive their fair value. Fair value measurements recognised in the balance sheet are categorised into the following levels:

- Level 1: quoted prices in active markets
- Level 2: quoted prices in non-active markets and inputs other than quoted prices that are observable, either directly or indirectly
- Level 3: inputs that are not based on observable market data

All financial assets (excluding receivables) are classified as either cash or investments, and are therefore categorised as Level 1 assets

Note 20 – Events occurring after the balance sheet date

There were no events subsequent to 30 June 2011

VAGO

Victorian Auditor-General's Office

INDEPENDENT AUDITOR'S REPORT

To the Agency Management Committee, Australian Health Practitioner Regulation Agency

The Financial Report

The accompanying financial report for the year ended 30 June 2011 of the Australian Health Practitioner Regulation Agency which comprises the comprehensive income statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the declaration by the Agency Management Committee, Chief Executive Officer and Director, Finance and Corporate Operations has been audited.

The Agency Management Committee's Responsibility for the Financial Report

The Agency Management Committee of the Australian Health Practitioner Regulation Agency is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards, including the Australian Accounting Interpretations, and the financial reporting requirements of the *Health Practitioner Regulation National Law Act 2009,* and for such internal control as the Agency Management Committee determines is necessary to enable the preparation of the financial report which is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on the audit, which has been conducted in accordance with Australian Auditing Standards. Those Standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Agency Management Committee as well as evaluating the overall presentation of the financial report.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

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Auditing in the Public Interest

VAGO

Victorian Auditor-General's Office

Independent Auditor's Report (continued)

Independence

The Auditor-General's independence is established by the *Victorian Constitution Act 1975*. The Auditor-General is not subject to direction by any person about the way in which his powers and responsibilities are to be exercised. In conducting the audit, the Auditor-General, his staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of the Australian Health Practitioner Regulation Agency as at 30 June 2011 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, including the Australian Accounting Interpretations, and the financial reporting requirements of the *Health Practitioner Regulation National Law Act 2009*.

Matters Relating to the Electronic Publication of the Audited Financial Report

This auditor's report relates to the financial report of the Australian Health Practitioner Regulation Agency for the year ended 30 June 2011 included both in the Australian Health Practitioner Regulation Agency's annual report and on the website. The Agency Management Committee of the Australian Health Practitioner Regulation Agency is responsible for the integrity of the Australian Health Practitioner Regulation Agency's website. I have not been engaged to report on the integrity of the Australian Health Practitioner Agency's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial report to confirm the information contained in the website version of the financial report.

MELBOURNE
16 September 2011

D D R Pearson
Auditor-General

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Auditing in the Public Interest

Notes

Notes

Notes

AHPRA

Chiropractic
Dental
Medical
Nursing and Midwifery
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

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