



Regulating for Results

Consultation Paper 1: Review of complexity in the National Registration and Accreditation Scheme

September 2024



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Acknowledgement

The Review team acknowledges the Traditional Owners of Country throughout Australia. We pay our respects to their Ancestors and their descendants, who continue cultural and spiritual connections to Country. We recognise their contributions to Australian and global society.

Executive Summary

The Review

The National Registration and Accreditation Scheme for the health professions (the National Scheme) is a cornerstone of the Australian Health System, established under the *Health Practitioner Regulation National Law* as in force in each state and territory (the National Law).¹ The National Scheme has been in place since 2010 and has the grounding purpose of protecting public health and safety, by ensuring that our health practitioners are appropriately skilled and trained, and meet expected standards of performance and conduct. It is a vital enabler of our health workforce.

To achieve this purpose and to maintain confidence and trust in our health system requires effective, transparent, empathic, and accountable regulatory processes and decision making across all regulation functions.

While the strong consensus is that the National Scheme remains as relevant and important as ever, many reviews have been conducted over the last decade and a half and these show concerns about some features of the Scheme and its performance.

The National Scheme is seen to be complex, and it is. This is largely because the regulatory task is complex as is the environment within which the Scheme operates.

The National Scheme must operate in ways that align with the actions of Commonwealth, state, and territory jurisdictions. It must ensure that decision making draws from the knowledge, expertise and leadership of the health professions that are regulated. Regulation also occurs against the backdrop of inevitable change and evolution in health service delivery and the broader health system.

The objectives of health practitioner regulation are easy to articulate but challenging to deliver. There are risks and interests that need to be balanced. Public safety requires the availability of health services as well as appropriate quality of service. The standard setting and guidance, registration, accreditation, and complaint handling functions of the Scheme must all work in concert to help achieve this balance.

Health practitioner regulation must keep pace with and support workforce strategy. It must interface effectively with other health-related regulation (such as the regulation of public and private health facilities, medicines and medical devices, and public health risks), and with regulation in related social care sectors (such as the NDIS and aged care). It must also recognise that health care providers work across a range of different settings, with teams that draw from many professions, and are often dependent upon one another to deliver comprehensive care.

At the heart of the health system are people. Patients and their carers expect safe and appropriate standards of treatment and care from health practitioners. They have diverse needs and place a high level of trust in those providing care, at moments of vulnerability.

Health Ministers have established this Independent Review - *Regulating for Results - Review of Complexity in the National Accreditation and Registration Scheme ('the Review')* – to look behind the inherent complexity of health practitioner regulation, to identify areas of unproductive and unnecessary complexity, and propose reforms that will enable the National Scheme to work

¹ Health Practitioner Regulation National Law Act 2009 (the National Law)


to its full potential. The ultimate objective is to ensure that the National Scheme remains ‘fit for purpose’ and meets community expectations.

The terms of reference for the Review require consideration of changes to:

- Enable the National Scheme to grow and adapt to meet the needs of the Australian health system, maintaining alignment with workforce strategy and supporting high standards of care.
- Ensure role clarity and accountability across all functions of the National Scheme.
- Identify and address significant risks to public health and safety quickly, effectively, and consistently.
- Streamline decision making structures and processes.
- Improve customer centrisms and complaints handling processes.

The Review Process

NRAS Complexity Review Project Phases

Regulating for Results 

**How can stakeholders
participate in the Review?**

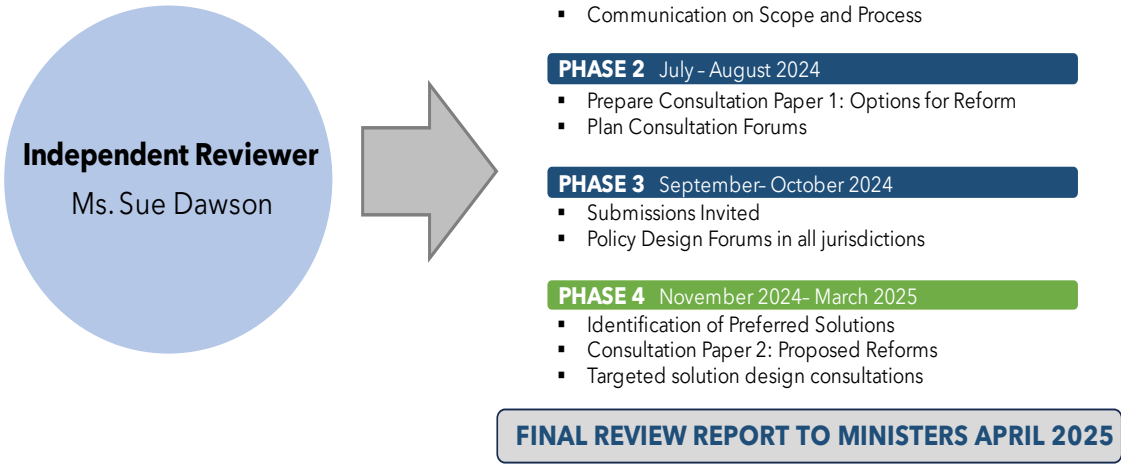


Figure 1 NRAS Complexity Review Project Phases

This Consultation Paper

The purpose of this Consultation Paper is to present the evidence collected to date, to inform and support stakeholder input on the issues and potential reform directions. This is intended to provide structure and focus for written submissions and for the Policy Design Forums with stakeholders that will occur over coming months. Through this Consultation Paper we are working towards a deeper consideration of reform options.

The Consultation Paper is divided into 4 sections.

Section 1: Background and review approach – Details the background to the review and the evidence gathering and analysis approach.

Section 2: Evidence to date and emerging themes – Presents the three themes that have emerged from the research and evidence gathering phase and frames the issues and problems within each of these themes.

Section 3: Reform directions and concepts – Presents potential reform directions arising from the themes, issues and challenges outlined in section 2, with three potential reform 'concepts' that may advance these reform directions. These concepts are intentionally at a high level and are not seeking to be fully formed proposals or recommendations. The objective of presenting these concepts is to help to stimulate discussion and ideas, to guide framing of possible reform pathways throughout the consultation process.

Section 4: Next steps – Outlines the consultation processes that flow from the Consultation Paper, highlighting the pathways for public and stakeholder participation and input, and providing tools to support written submissions. It highlights the next milestones for the review.

- 1) Formal written submissions process. [Utilise the Submission template on our website and submit by the deadline of 14 October 2024.](#)
- 2) **September to November 2024 Nationwide Policy Design Forums will be held with stakeholder groups.** The issues and potential reform directions raised in this Consultation Paper will inform the structure and delivery of the Forums.
- 3) In **January 2025 Consultation Paper 2** will be issued and this will identify preferred reform options and inform more detailed design of the reforms and their implementation.
- 4) **Further targeted consultation** will occur in **January to March 2025**, based on Consultation Paper 2.

Overview of Evidence to Date, Themes and Potential Reform Directions

Table 1: Overview of Evidence to Date, Themes and Potential Reform Directions

THEME Refer to Section 2	ISSUES AND EVIDENCE Refer to Section 2	POTENTIAL REFORM DIRECTIONS Refer to Section 3
Theme 1: Strengthen Governance and Stewardship	<p>Navigating the complex interfaces between health system structures, pressures, policy responses, and regulation requires unity of purpose and two-way strategic connection (between workforce policy makers and the National Scheme). These are not in place.</p> <p>The structures for achieving the necessary operational collaboration across health service regulators, and between regulators and government are not yet well developed and embedded.</p> <hr/> <p>Operational priorities and actions within the National Scheme do not fully align with statutory objectives.</p> <p>One significant consequence appears to be that the National Scheme is not sufficiently responsive to health service access and workforce pressures that concern governments and communities.</p> <p>Governance measures that could assist to address this are not in place.</p> <hr/> <p>Under the National Scheme powers and responsibilities are distributed across multiple structures, but with no single line of accountability to Health Ministers for meeting strategic objectives and delivering on priorities.</p> <p>The need to deliver reform through coordinating the efforts of multiple entities within the Scheme can compromise timeliness, efficiency, and effectiveness. This impedes its</p>	<p>Strengthen strategic connection between workforce strategy and the National Scheme - identifying the reforms required to better deliver workforce and service access imperatives.</p> <p>Strengthen regulatory connection between the National Scheme and other relevant health services regulators and other related agencies.</p> <p><i>The potential reform concept to progress these directions is Concept Diagram 1: Repositioning the National Scheme – applying a Stewardship Model.</i></p> <p>Augment current operational accountability within the National Scheme through accountability and governance enhancements that:</p> <ul style="list-style-type: none"> • Set National Scheme directions and strategies to align with workforce objectives and demonstrate a more proactive approach to regulation and regulatory reform. • Build stronger community voice in the structures and processes for setting strategy and priorities. • Ensure implementation of key priorities – including (but not limited to) reform

THEME Refer to Section 2	ISSUES AND EVIDENCE Refer to Section 2	POTENTIAL REFORM DIRECTIONS Refer to Section 3
	<p>ability to deliver proactive and rapid solutions to new and emerging challenges.</p> <p>Profession by profession decision making ensures that regulatory decisions draw on appropriate clinical expertise but, ultimately, structures within the National Scheme have been unable to adapt to deliver the necessary cross-profession approaches and solutions.</p> <hr/> <p>Following earlier reviews of accreditation functions, there is considerable current reform activity that is expected to strengthen this pillar of the National Scheme.</p> <p>However, there is still further work to be done to:</p> <ul style="list-style-type: none"> • ensure a stronger strategic connection between workforce strategy and accreditation functions. • drive implementation of necessary reforms within the National Scheme and ensure accountability to Ministers for delivery of these. <p>If the National Scheme fails to deliver to expectations, there are Ministerial powers to assist in aligning decision making with strategy, but these have limitations.</p> <hr/> <p>There are not sufficient mechanisms for community input to the National Scheme (community voice) or for calibrating the operation of the National Scheme to community expectations.</p>	<p>of accreditation arrangements.</p> <ul style="list-style-type: none"> • Prioritise establishment of cross-profession regulatory structures and business processes. • Embed risk based, data driven and strategically oriented performance reporting to support ministerial decision making. • Consider amending the National Law to extend powers of policy direction from health ministers to all functions across the National Scheme. <p><i>The potential reform concept to progress these directions is Concept Diagram 2: Resetting Accountabilities within and Alongside Ahpra.</i></p>

THEME Refer to Section 2	ISSUES AND EVIDENCE Refer to Section 2	POTENTIAL REFORM DIRECTIONS Refer to Section 3
Theme 2: Deliver Coherent and Effective Complaint Handling Arrangements	<p>There is scope to apply a sharper customer-centric lens to complaints handling structures and processes.</p> <p>Collectively, consumers and practitioners are confused and frustrated about the way that health care complaints and notifications are managed. These experiences continue to dent public confidence in health practitioner regulation in Australia.</p> <p>Ahpra and Health Complaints Entity (HCE) processes are not well aligned to mitigate this.</p> <p>Consumers want a single point of entry to make a complaint. They want to have access to the full range of solutions – including outcomes such as an apology, explanation and/or refund.</p> <p>Both consumers and practitioners seek improved timeliness, transparency and natural justice.</p> <hr/> <p>Complex decision-making structures and lack of delegation contribute to delay and inconsistency.</p> <p>Regulatory decision-making rests primarily with the National Boards, with limited delegation to Ahpra staff in notifications functions.</p> <p>Community voice at all levels of regulatory decision-making is not yet sufficiently embedded in the National Scheme.</p> <hr/> <p>There is a reasonable public expectation that that serious complaints and risks that are triggering escalating community</p>	<p>Simplify complaints handling structures and processes – a single front door for consumer complaints and clear guidance and information for consumers and practitioners.</p> <p>Negotiate a formal instrument defining roles and responsibilities between state and territory Health Complaints Entities and Ahpra.</p> <p>Stronger focus and process for management of serious complaints within the National Scheme.</p> <ul style="list-style-type: none"> • Reset the regulatory decision-making responsibilities and delegations between Ahpra and the National Boards. • Expand clinical expert input at the operational level. • Measures to strengthen community voice in regulatory decision making. • Strengthen risk-based tools for identifying and progressing high risk complaints. <p>Research to consider consistency in Tribunal processes and outcomes for disciplinary matters.</p> <p>The potential reform concept to progress these directions is Concept Diagram 2: Resetting Accountabilities within and Alongside Ahpra.</p>

THEME Refer to Section 2	ISSUES AND EVIDENCE Refer to Section 2	POTENTIAL REFORM DIRECTIONS Refer to Section 3
	<p>concern be managed in a timely and effective way.</p> <p>Regulation occurs profession by profession, with very limited cross-profession decision-making, even on primarily ‘profession neutral’ issues such as sexual misconduct or family and domestic violence allegations (where consistent and urgent decision-making is necessary).</p> <hr/> <p>Clinical advice is central to effective regulatory decision-making, but the current clinical advice model within the National Scheme appears underdeveloped.</p> <p>Additional clinical advice embedded at the operational level could facilitate increased delegation of decision-making.</p> <hr/> <p>There is understandable concern about potential inconsistency in tribunal decisions, including in sensitive matters such as sexual misconduct, boundary violation and family and domestic violence cases. Further research is required to examine this issue, to guide full consideration of possible solutions.</p>	
Theme 3: Measures to adapt the scope and manage expansion of the National Scheme	<p>There are many allied professions that are not included in the National Scheme and seek to be.</p> <p>While the argument in favour of this often focusses on risk, wider considerations are also in play and include professional recognition and trust and the expectation of equitable access to opportunities (such as access to Medicare benefits or ability to participate in funded programs or</p>	<p>Strengthen National Health Practitioner Regulation through adoption of a whole-of-system view of health workforce regulation that encompasses three-tiers of occupational regulation of health practitioners:</p> <ul style="list-style-type: none"> • Ahpra Registration - risk and benefit-based entry to the National Scheme.

THEME Refer to Section 2	ISSUES AND EVIDENCE Refer to Section 2	POTENTIAL REFORM DIRECTIONS Refer to Section 3
	<p>wider service delivery fora) that incidentally attach to the fact of registration - but are not related to the National Scheme purposes.</p> <p>The processes for expansion of the National Scheme to include additional professions align with its core purpose (public protection) and embed well-established principles and discipline for assessing the impacts and benefits of proposed new regulation. However, there is some advocacy for these criteria and processes to be more flexible and streamlined, to enable expansion of the National Scheme.</p> <hr/> <p>There is currently only one model of registration within the National Scheme. This is a costly and complex model and there is a prospect that adding additional professions under the current governance arrangements will be unsustainable.</p> <p>There are other models operating overseas which could be considered, that are less cumbersome, but effective.</p> <p>If there were other registration pathways within the National Scheme (modelled on successful international initiatives) these could be applied to those lower risk professions seeking to join the National Scheme, where costs of regulation under the current model outweigh the benefits.</p> <hr/> <p>Australia already has a 'negative licensing' system of regulation for non-registered practitioners, but this is not well understood.</p>	<ul style="list-style-type: none"> • Introduce a second alternative model of registration through Accreditation of Professional Bodies to maintain Voluntary Practitioner Registers. • Complete the implementation and strengthen transparency of Code of Conduct for non-registered health care workers. <p>Clearer processes for managing profession-based applications to enter the National Scheme.</p> <p>Build community and practitioner awareness and understanding of the three-tiered regulation model.</p> <p>The potential reform concept to progress these directions is Concept Diagram 3: A fully integrated 3-tier model of health practitioner regulation.</p>

THEME Refer to Section 2	ISSUES AND EVIDENCE Refer to Section 2	POTENTIAL REFORM DIRECTIONS Refer to Section 3
	<p>The system is not yet fully functioning in every state and territory, as it requires jurisdiction specific legislation and rollout of a new function in the responsible Health Complaints Entity.</p> <p>If this 'negative licensing' was operating to its full potential it:</p> <ul style="list-style-type: none"> • Is a relatively cost-effective means of protecting quality and safety across the entire health workforce and the model can also be extended to health services (such as massage facilities or cosmetic parlours) that operate on the fringes of the health system and not subject to facilities accreditation or licensing. • Builds confidence in a comprehensive system of health practitioner regulation. • Could relieve pressure to expand the National Scheme. • Could provide data to inform decisions about whether stronger regulation is required for a profession whose practice has high or escalating risks. 	

Section 1: Background and Review Approach

Context

The National Registration and Accreditation Scheme for health professions (the National Scheme) has been in place for a decade and a half, having commenced operation in 2010. Its purpose, the initial intergovernmental intentions regarding its operation, the entities making up the National Scheme and their functions are summarised in [Attachment A](#).

What has been achieved so far?

As Snowball acknowledged in his Independent Review of the National Scheme in 2014,² establishment of the National Scheme was an ambitious undertaking, and it successfully delivered a national approach to health practitioner regulation in Australia. Through enactment of the *Health Practitioner Regulation National Law*, legislated in the Queensland Parliament and adopted and applied in each state and territory parliament,³ the establishment of the National Scheme coincided with the repeal of 65 separate pieces of legislation and the abolition of 85 separate state and territory registration boards and the abolition of 85 separate state and territory registration boards. It set the platform for health workforce mobility across our nation and delivers a national online register so that anyone can look up the details of a registered health practitioner.

The National Scheme has shown elements of adaptability that have helped the nation to rise to some of the greatest health system challenges of our times. This adaptability arises from the strength of design of the legislation, which provides considerable flexibility to take action to address practical problems without requiring legislative change.

As Kruk observed, the National Scheme demonstrated in-built capacity to adjust regulatory requirements at short notice during the COVID-19 pandemic. For instance, the National Scheme regulators were able to respond to workforce demands by creating a pandemic response sub-register to temporarily increase the available health workforce. Eligible health practitioners who had been registered but had recently left practice or changed to non-practising registration were included on the sub-register. This streamlined the application and change of circumstance processes, as well as adding flexibility in supervising remote exams.⁴

The National Scheme now regulates close to 960,000 health practitioners across 16 different professions, from a base of around 500,000 in 2010.⁵

2 Snowball, K (2014) 'Independent Review of the National Registration and Accreditation Scheme for Health Professionals', Final Report.

3 Except for the Western Australian Parliament which passed complementary legislation with the same substantive provisions as the National Law.

4 Kruk, R. Independent review of Australia's regulatory settings relating to overseas health practitioners. December 2023 p. 29 Available at:

https://www.regulatoryreform.gov.au/sites/default/files/Final%20Report%20-%20Overseas%20Health%20Practitioner%20Regulatory%20Settings%20Review%202023%20-%20endorsed%20by%20National%20Cabinet_0.pdf

%20Overseas%20Health%20Practitioner%20Regulatory%20Settings%20Review%202023%20-%20endorsed%20by%20National%20Cabinet_0.pdf

5 Australian Health Practitioner Regulation Agency Publications Ten years of national health practitioner regulation in Australia Available at:

<https://www.ahpra.gov.au/Publications/Corporate-publications.aspx>

What are the challenges today?

These are undoubtedly significant achievements. Nevertheless, there is more that can be done. There are signs that the National Scheme needs to lift to meet the challenges of our times. It is time to consider what changes may be required to go to the next level.

This Independent Review of the National Scheme has been established in the context of public concern about significant risks to public health and safety and some erosion of confidence in health professions regulation. This has occurred in response to issues such as delays and inconsistencies in the management of notifications involving sexual misconduct and the difficulties in responding to consumer health issues – such as widespread and longstanding concerns about cosmetic services.

The Review is also a part of a broader national health reform agenda and is progressing alongside significant and intensive public policy work on barriers to accessing affordable primary health care and addressing the challenges of health workforce shortages.

This work includes:

- Streamlining arrangements for entry for overseas trained health practitioners.⁶
- Review of the Scope of Practice of health practitioners.⁷
- Working Better for Medicare Review – including examining the effectiveness of workforce distribution levers and improving patient access to GPs.⁸
- Implementation of a raft of reforms to the system of accreditation of education programs.⁹
- Implementation of the National Medical Workforce Strategy 2021–2031.¹⁰
- Development of the National Nursing Workforce Strategy.¹¹

These wider reviews are highlighting aspects of health practitioner regulation under the National Law that may require action or adjustment to support necessary service delivery and workforce priorities and reforms. The National Law has inherent flexibility- and there is potential to use this to better effect.

The Review must also consider the changing face of health care service delivery. Health care systems worldwide face challenges associated with:

- Ageing populations.
- An increase in chronic diseases and patients with multiple long-term health conditions.
- The increasing use and cost of health technologies.
- Rising public expectations and community demands of health services.

6 Kruk, R. op. cit., p. 29

7 Cormack, M, Unleashing the Potential of our Health Workforce (Scope of Practice Review) 2023-24 Available at: <https://www.health.gov.au/sites/default/files/2023-09/scope-of-practice-review-update-11-september-2023.pdf>

8 Reid, M. and Knight, S, Working Better for Medicare Review (Distribution Levers Review) 2023-24 Available at: <https://www.health.gov.au/our-work/working-better-for-medicare-review>

9 Woods, M., Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions (Accreditation Systems Review) (2017) Available at: <https://apo.org.au/sites/default/files/resource-files/2018-10/apo-nid235651.pdf>

10 See Australian Government Department of Health and Aged Care National Medical Workforce Strategy 2021 – 2031 Available at: <https://www.health.gov.au/our-work/national-medical-workforce-strategy-2021-2031> Available at: <https://www.health.gov.au/our-work/national-medical-workforce-strategy-2021-2031>

11 See Australian Government Department of Health and Aged Care National Nursing Workforce Strategy. Available at: <https://www.health.gov.au/our-work/national-nursing-workforce-strategy#next-steps>

- A global shortage of health care workers.

Australia is no different. Average life expectancy is increasing and is one of the highest in the world at 83.3 years.¹² The number of people living with diabetes increased almost 2.8-fold between 2000 and 2021, with one in twenty Australians now living with diagnosed diabetes.¹³ The 64% of adults living with obesity is well above the OECD average of 59%.¹⁴ Dementia is a significant and growing health issue.

More health services are competing for resources and significant workforce reform is necessary and underway. There is the need to take advantage of new technologies – including artificial intelligence, but as we have seen with telehealth, important technological innovation can also bring with it regulatory challenges.

In some areas, such as access to online prescribing and dispensing, services are being designed to respond to consumer demand, sometimes at the expense of the typical quality care features that would typically be expected of a health service, such as robust clinical assessment.

There is an ongoing and legitimate public expectation that, when something goes wrong in a health care journey, there will be timely and effective enquiry into the matter and corrective action will be taken if required. This is necessary to maintain public trust and confidence in the health system.

The experience internationally is that health care complaints continue to rise. The increase in the volume of complaints has been attributed to a broad range of factors, including:¹⁵

- Population growth, combined with the aging population whose members are more likely to have interactions with the health system.
- Advances in medical research and technology, expanding types of health services and traditional and complementary therapies combine to offer more new and experimental health services and treatments.
- Greater consumer expectations of the health system and access to medical information through the internet and social media.
- Greater awareness of complaint management opportunities and bodies.
- Mandatory reporting obligations placed on practitioners, employers, and others.

The opportunity in this Review

In establishing this Review, Ministers were mindful that there have been many previous reviews of the National Scheme. These reviews ranged from root and branch examination of all aspects of the National Scheme (most notably the Snowball Review in 2014)¹⁶, to narrower functional

¹² Australian Institute of Health and Welfare Deaths in Australia, Life Expectancy (2024) Available at: <https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/life-expectancy>

¹³ Ibid., Diabetes Australian Facts (2024) Available at: <https://www.aihw.gov.au/reports/diabetes/diabetes/contents/about>

¹⁴ Ibid., How Does Australia Compare Internationally, (2024) Available at: https://www.aihw.gov.au/reports/overweight-obesity/overweight-and-obesity/contents/overweight-and-obesity#international_comparison

¹⁵ NSW Health Care Complaints Commission, 2019-20 Annual Report.

Archer J, Regan de Brere S, Bryce, M, Nunn, S, Lynn N, Coombes, L Roberts, M. Understanding the Rise of Fitness to practise complaints from members of the public. Plymouth University 2014.

¹⁶ Snowball, K. op. cit.

reviews (such as the Review of Governance in 2017¹⁷, the various reviews of accreditation functions¹⁸ and the Review of Registration of International Medical Graduates¹⁹), to Ahpra initiated issue-specific reviews on topics such as use of chaperone conditions for practitioners who are subject to allegations of sexual boundary violations²⁰ and management of sexual misconduct notifications.²¹ All these reviews made significant recommendations, and to the extent that some of these recommendations have been accepted but not implemented, at least part of the question for this Review is to what extent there is ‘unfinished business’.

The initiation of this Review against a backdrop of a long history of reviews tells its own story. It is a complex history, with some external factors including government policy changes, and other factors within the Scheme such as the challenges and timeframes associated with delivering reform through distributed decision-making structures. It also suggests a history of weakness in the use of regulatory intelligence to proactively pursue workforce and regulatory reform.

Put simply, effective health practitioner regulation is essential to assuring the quality and safety of health services and maintaining the integrity of the health system. All the signs are that reform is necessary to ensure that the National Scheme remains ‘fit for purpose’ and meets community expectations.

The Review – Scope and Method

The overarching objective of *Regulating for Results - Review of Complexity in the National Regulation and Accreditation Scheme* (‘the Review’) is to identify areas of unproductive and unnecessary complexity within the National Scheme. The Review will recommend changes to improve regulatory outcomes for the community and health practitioners and advance the continuous development of a flexible, responsive, and sustainable Australian health workforce.

The Review builds from the premise that the health system is complex, and that some complexity is to be expected and arguably unavoidable.

It therefore seeks to go behind the concept of complexity, to seek greater clarity about what is needed from health practitioner regulation (which will change over time), who needs to be involved and in which functions, for the National Scheme to operate successfully, and how risk and principles-based decision-making may work to deliver the objectives of the National Scheme.

The Terms of Reference (ToR) for the Review are presented in [Textbox 1](#). They self-evidently require consideration of the individual core functions across the National Scheme (standard setting, registration, accreditation and complaints handling), as well as wider and deeper examination of the fundamental architecture of the National Scheme and its governance, stewardship, responsiveness and adaptability.

17 Frew et al., (2017) ‘Review of Governance of the National Registration and Accreditation Scheme (NRAS) Available at:

<https://www.ahpra.gov.au/search.aspx?q=review%20of%20governance%20of%20the%20nras>

18 Woods, M.op.cit., National Health Practitioner Ombudsman (NHPO), Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation, October 2023. Available at: <https://www.nhpo.gov.au/sites/default/files/2023-11/NHPO%20Processes%20for%20progress%20review%20report%20-%20Part%20one%20-%20A%20roadmap%20for%20greater%20transparency%20and%20accountability%20in%20specialist%20medical%20training%20site%20accreditation.pdf>.

19 Kruk, R. op. cit., p. 29

20 Paterson, R., Independent review of the use of chaperones to protect patients in Australia (2017) Available at: <https://www.ahpra.gov.au/News/2017-04-11-chaperone-report.aspx>

21 Australian Health Practitioner Regulation Agency - Blueprint to improve public safety in health regulation 2023. Available at:

<https://www.ahpra.gov.au/News/2023-02-14-reform-blueprint.aspx>

Textbox 1: Regulating for Results: Terms of Reference

1. Identify options to streamline and harmonise decision-making by existing regulatory bodies to improve consistency in the regulation of practitioner conduct, performance and impairment, including considering a reduction in the number of decision-making bodies within the National Scheme. *
2. Consider measures that would deliver more consumer driven, consistent, accessible, and efficient complaints management and disciplinary processes through the National Scheme. *
3. Consider how regulatory decisions, particularly those relating to professional misconduct, under the National Law are considered by civil and administrative tribunals in each jurisdiction, and whether there are options within the National Law or more broadly to ensure greater consistency of decision making. *
4. Review current regulatory performance principles for the National Scheme to ensure that they align with National Scheme objectives and guiding principles and make recommendations on improvements to increase effectiveness and efficiency, and promote a stewardship approach, without adding unnecessary complexity (Kruk Review recs 27 & 28). **
5. Consider whether the National Scheme entry criteria as specified in the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions are still fit for purpose, including what mechanisms for admission of future professions and establishment of
6. future Boards will best support further expansion of the National Scheme, particularly in relation to allied health professions.
7. Consider whether Health Ministers have sufficient powers to direct entities exercising accreditation functions under the National Law, in accordance with their functions described in Part 2 of the National Law.

*Noting co-regulatory jurisdictions (NSW and QLD) are out of scope for elements 1-3.

** In confirming these Terms of Reference, Ministers also noted that the review should consider two specific issues, both of which relate primarily to Term of Reference 4:

- Health Ministers should periodically develop and deliver a statement of expectations to all entities within the National Scheme (with a requirement for each to then respond with a statement of intent) that covers health workforce reform directions, and Ministers' expectations about performance of the functions and responsibilities of National Scheme entities, the priorities expected to be observed in delivering functions and conducting operations and the relationships of National Scheme entities with governments (note this also aligns with Kruk Review recommendation 25, 27 & 28)
- Amending the National Law to allow either a practitioner or community member to be the Chair of a National Board.

To address these Terms of Reference the scoping phase of the Review has considered the following.

- The current structure of the National Scheme and the role of each decision-making body, including the governance, legislative and regulatory principles and mechanisms that underpin them.
- Recommendations of past reviews and inquiries relevant to questions of complexity.
- Regulatory performance principles and their alignment with the National Scheme objectives and guiding principles, including Kruk review recommendations regarding National Scheme stewardship.
- The roles of Ahpra and the National Boards as stewards of the system of registration and regulation of health professions.
- Whether there are gaps in the powers of Health Ministers to provide oversight of the National Scheme, including, but not limited to, the powers of Health Ministers to issue directions about policies relating to accreditation functions.
- Where the National Scheme interacts with other oversight and regulatory organisations (such as complaints made to the National Health Practitioner Ombudsman relating to co-regulatory jurisdictions) and shared activities/connections between National Scheme entities, state and territory Health Complaints Entities (HCEs), and other national regulators.
- The roles of bodies making regulatory decisions about registered health practitioners adjacent to the National Scheme bodies (such as jurisdictional civil and administrative tribunals) and the frameworks used to make appropriate and consistent decisions.
- Ahpra insights on the handling of regulatory matters by tribunals.
- How additional professions could be added to the National Scheme in a manner that supports its objectives, without unnecessarily increasing complexity in governance and operation of the National Scheme.
- Any intersections between the Review and the findings and recommendations of the Review of Scope of Practice.

Noting the plethora of previous reviews since the inception of the National Scheme, a core element of our research has been a ‘stocktake’ of the findings and recommendations of these previous reviews. This ‘Review of Reviews’ stocktake involved:

- Documenting all recommendations from previous reviews that are relevant to the Terms of Reference for this Review.
- Identifying those recommendations that were accepted and those not accepted by Health Ministers.
- Recording what was done to implement the accepted recommendations and the status of any further action.
- Analysis of whether there is further action/consideration required in this Review.

There was also extensive collaboration with jurisdictional officials, National Scheme entities, decision makers, and broader stakeholders.

The purpose was to gather detailed information on the current structures, processes, and linkages within and beyond the National Scheme, to obtain a clearer understanding of the current state across all of the National Scheme functions, and to inform a strong contemporary assessment of the potential areas for reform.

Research was also undertaken on initiatives in other jurisdictions that may offer insights into possible reforms and how they might operate. This research:

- Identified best practice regulation principles and practice in other regulatory schemes in Australia and in other comparable jurisdictions, including the emerging ideas and concepts of regulatory stewardship.
- Models of governance and accountability of regulators, including overseas models for multi-profession governance structures.
- Other types of occupational regulation, including co-regulation and negative licensing models in Australia and UK.

This Consultation Paper outlines evidence gathered to date, reform themes and our preliminary thinking about possible directions for reform.

Through the Phase 3 stakeholder consultation process, preferred options will be identified and subject to further analysis, development, and targeted consultation.

Benefits Assessment – Desired Outcomes

Throughout the Review, options for reform will be assessed through the lens of the following six desired outcomes/benefits of national health practitioner regulation:

- Inherent **design and capability to evolve** and respond effectively to current and emerging risks and public policy imperatives, including global and national challenges in health service access and delivery, consistent with the principles of regulatory stewardship.
- Decision-making that has due regard to **all seven objectives of the National Scheme**, weighing public health and safety alongside the need to promote access to health services and a more flexible, responsive, and sustainable health workforce.
- **Consumer-centrism** to maintain **confidence and trust** in the integrity of regulation and the Australian health system.
- **Efficient and effective decision making and consistent outcomes (where these are necessary)** throughout the National Scheme, embedding best practice regulation principles and practices.
- **Internal coherence**, such that the structures and processes across all parts and levels of the National Scheme are working towards agreed strategic priorities and pulling in the same direction.
- Effective and integrated design and role clarity at the **interfaces with other decision makers** that sit around the National Scheme (including all state and territory Health Complaints Entities and other national standard setting and regulatory bodies.²²

²² For instance: Australian Commission of Safety and Quality in Health Care; Aged Care Quality and Safety Commission; National Disability and Insurance Scheme Quality and Safeguards Commission; Therapeutic Goods Administration; Australian Competition and Consumer Commission, Medicare; and Border Force).

Section 2: Evidence to date and emerging themes

Theme 1: Strengthening Governance and Stewardship

Linkage to the Terms of reference

Term of Reference 4 requires this Review to consider the regulatory principles for the National Scheme, to explore their alignment with National Scheme legislative objectives and principles and to make recommendations on changes that will increase effectiveness and efficiency and promote National Scheme stewardship.

Strengthening governance is also essential to successfully address the issues in all remaining Terms of Reference. In this sense it will become a key reform pillar.

This Theme also directly addresses Term of Reference 6, which requires consideration of the scope of the current Ministerial Council direction power (primarily as it relates to accreditation of education programs).

What are the issues and challenges?

1.1 Health Practitioner regulation in context – impact requires connection and proactivity

Regulatory best practice principles have evolved into regulatory stewardship approaches, core features of which are a whole of system perspective and an outward looking and proactive posture.

A starting point for considering the effectiveness of our current National Scheme for health practitioner regulation is how well it is aligned with and supports the delivery of health system priorities and strategy, how well it safeguards public safety and its ability to respond to the challenges associated with new models of health care.

The approach to understanding what is required, and what it might mean for health practitioner regulation more broadly is well illustrated in the *National Medical Workforce Strategy*. While this Strategy is specific to the context of the medical workforce, its observations on what is required for success applies to health professions more generally.

Medical workforce planning in Australia is complex and multifaceted, with accountabilities split between various workforce planning stakeholders. The nature of Federation means that decision making is distributed and reflects the different priorities of the Commonwealth and individual states and territories. While recognising and respecting these differences, there is considerable value in working together towards a shared vision and goals where possible and practical.

Australia's medical workforce is supplied through domestic medical training of local and international students, and through immigration. The pathway to independent practice as a vocationally recognised specialist is long and involves multiple jurisdictions, portfolios, regulators, and public and private employers. It is important that their work is aligned to a shared view about the shape of the medical workforce that Australia needs into the future.

That Strategy draws out the importance of structures for determining overarching strategic directions and priorities, set jointly by Ministers in all jurisdictions across Australia, to guide the

mutually reinforcing actions of all those who need to contribute to delivering effective solutions - including health practitioner regulators.

Setting priorities and strategic directions must be a collective endeavour. Ministers need an evidence base that draws on regulatory intelligence, to identify and assess the risks, emerging threats and opportunities, trade-offs, and strategic priorities. The design and operation of the National Scheme must be such as to generate this intelligence, as well as align with agreed directions, to deliver necessary reforms and actions in a timely and effective way.

Reflecting this approach, the Snowball Review recommended the establishment of a time limited professional standards council, the purpose of which was to provide a mechanism to inform the National Scheme of workforce priorities and undertake reviews regarding safety issues at the direction of the Ministerial Council.²³ It is apparent in examining the deliberations following this recommendation that there was little appetite to add another structure and entity into an already complex picture and the establishment of such a body was ultimately not agreed to.

Nevertheless, the problem of the lack of strategic alignment of the National Scheme to deliver to Health Ministers expectations was evident at that time.

This issue resurfaced again in the 2017 Accreditation Systems Review. That Review recommended that the Ministerial Council:

Periodically deliver a Statement of Expectations encompassing all entities within the National Scheme that covers:

- a. key health workforce reform directions, including policies and objectives relevant to entities in the National Scheme*
- b. expectations about the role and responsibilities of National Scheme entities, the priorities expected to be observed in conducting operations and their relationships with governments.*
- c. expectations of regulator performance, improvement, transparency and accountability.*²⁴

This recommendation was accepted in principle but has never been implemented. It is unclear why. It may be that there has not been clarity as to how a Statement of Expectations for the Scheme should be developed or by whom.

The 2021-31 *National Medical Workforce Strategy* returned to this theme, acknowledging that the formation of joint medical workforce planning and advisory structures with sufficient authority, reach and expertise to advise and make recommendations in relation to the size and structure of the medical workforce is essential.

This approach, with its systems emphasis and outward facing focus reflects the evolving application of the concept of 'regulatory stewardship' in the Australian health context.

[Textbox 2](#) provides some detail from the literature on regulatory stewardship.

The Department of Health and Aged Care *Health Regulatory Policy Framework*²⁵ states:

²³ Snowball, K. op. cit., p. 5

²⁴ Woods, M. op. cit., See recommendation 3 and 4.

²⁵ See Australian Government Department of Health and Aged care webpage: Health Regulatory Policy Framework 2020 Available at: [health-regulatory-policy-framework-health-regulatory-policy-framework-hrpf.pdf](https://www.health.gov.au/health-regulatory-policy-framework-health-regulatory-policy-framework-hrpf.pdf)

Regulatory stewardship ensures that regulation is effective at meeting its goals. We do this by protecting the health and safety of the community while minimising regulatory burden.

Effective regulatory stewardship involves:

- d. a system wide view of regulation*
- e. a proactive and collaborative approach to monitoring, reviewing, and reporting on our regulatory systems.*

Textbox 2: Regulatory stewardship - a snapshot from the literature

- The attention level is lifted to regimes, thereby helping departments focus on the ultimate policy outcomes sought by the government, encouraging them to bring a systems perspective to their monitoring and analysis (i.e. looking at how related instruments and their associated institutional actors interact in pursuit of those key outcomes), which a focus on individual acts or regulations would be less likely to do.²⁶
- For government agencies, regulatory stewardship means adopting a whole-of-system, proactive, collaborative, and long-term approach, that can anticipate, and respond to, change over time.
- What constitutes the regulatory system is defined – an individual regulatory system will often impact on, or be impacted by, another regulatory system and will sometimes share common or overlapping components.²⁷ This cross-system perspective promotes good system governance. Under a regulatory stewardship desired approach:
 - Regulatory systems are considered living systems and, as such, are subject to change. Hence governments need to continually review the system's performance and anticipate and respond to those changes.
 - Regulatory arrangements are seen to be important assets that should be actively managed, like physical, financial, and other assets.²⁸
 - Introducing some very basic asset management concepts to the regulatory environment:
 - seeks to shift attention from a narrow focus on the 'flow' of proposed regulatory changes to a broader focus on the performance and condition of the underlying 'stock' of regulation.
 - encourages good policy design – most governments in OECD countries now require regulatory impact analysis and consultation on regulatory proposals.
 - shifts from a 'set and forget' approach to regulation to one where the regulatory regime is monitored, evaluated, maintained, and improved over time²⁹.

²⁶ Ayto, J (2014): Why departments need to be regulatory stewards Policy Quarterly – Volume 10, Issue 4 p. 27 Available at: https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE23836344

²⁷ Ministry of Business, Innovation & Employment (New Zealand) Regulatory systems and stewardship (2023) Available at: <https://www.mbie.govt.nz/cross-government-functions/regulatory-stewardship/regulatory-systems>

²⁸ Ayto, J. op cit., p. 23.

²⁹ Ibid., p. 27.

The recent Health Ministers announcement of the establishment of the **Medical Workforce Advisory Collaboration**³⁰ is one model of collaboration in planning for and addressing health workforce issues that reflects the type of regulatory stewardship approach that is now being advocated in Australia and internationally. Its establishment reflects the need for stewardship structures that support government consideration and implementation of the findings and recommendations of key reviews, such as the Scope of Practice Review³¹ and the Working Better for Medicare Review.³²

Arguably, it is the absence of such stewardship structure(s) that has compromised the timely and full implementation of recommendations accepted from previous reviews of the National Scheme. It is also potentially compromising the effective delivery of the multiple workforce reform projects and tasks that have been jointly agreed by Health Ministers. This requires nationally coordinated actions in the workforce projects space, alongside adjustments to registration and accreditation policies and procedures, and in turn connection and coordination with Border Force processes.

One important question is how strategic collaboration/stewardship structures might build on and integrate with existing structures and pathways through which Health Ministers seek and receive policy advice relevant to workforce planning and decision-making more generally, and in turn how National Scheme priorities and issues feed into these structures and processes and up to Health Ministers.

The current policy and program advice pathways to Health Ministers are set out at [Attachment B](#) and include:

- The **Health Workforce Taskforce (HWT)** – The Terms of Reference for which have been recently amended to confirm its role and focus and its line of accountability to the Health Chief Executives Forum. The Taskforce is chaired by the NSW Health Secretary and has workforce expertise representation from all state and Territory jurisdictions.
- This Taskforce currently receives advice from a **Policy and Legislation Sub-Committee** through which jurisdiction-led initiatives are presented to HWT. An Ahpra representative attends meetings of this Committee.
- **The Sub-committee is supported by jurisdiction leadership as follows:**
 - In relation to the policy advice pathways, emerging policy initiatives are typically assigned to Victoria to lead (although there may be cases where another jurisdiction leads such as the current Queensland led Regulatory Impact Statement work relating to the potential addition of the audiology profession to the National Scheme).
 - If changes to the National Law are required, the process of drafting amendments is led by Queensland.
 - Policy advice also comes forward directly from the Ahpra Board to Ministers, through a **Jurisdiction Lead Officials Committee**, to a **Jurisdictional Advisory Committee (JAC)** chaired by the Ahpra CEO.
- The **Medical Workforce Advisory Collaboration** will provide a further channel of advice to the Health Workforce Taskforce on medical workforce matters.

30 See Australian Government Department of Health and Aged care webpage: Medical Workforce Advisory Collaboration (2024) Available at:

https://www.health.gov.au/committees-and-groups/mwac?language=en&utm_source=miragenews&utm_medium=miragenews&utm_campaign=news

31Ibid., Unleashing the potential of our Health Workforce – Scope of Practice Review (2024) Available at: <https://www.health.gov.au/our-work/scope-of-practice-review>

32Ibid., Working Better for Medicare Review (2024) Available at: <https://www.health.gov.au/our-work/working-better-for-medicare-review>

- On operational policy matters, such as changes to registration or other regulatory standards, **Ahpra and the National Boards report to Ministers** through the JAC and HCEF.

A general observation is that there is an extremely high volume of mission critical workforce reform activity under way, and at a national level this is being driven through the Health Workforce Taskforce. This Taskforce is chaired by the NSW Health Secretary and has representation from all states and territories and the Commonwealth. It has a central role in ensuring effective implementation of the recommendations of the Kruk Review, to deliver a robust framework for accelerated registration of international health practitioners. Added to these responsibilities is oversight of implementation of the Medical Health Workforce Strategy and also the proposed Maternity Strategy.

As HWT is a 'taskforce', it is, by definition, assigned tasks to progress actions that have already been determined by Ministers to have strategic relevance and priority, typically flowing from higher level strategic policy reviews. It is a practical model for achieving shared responsibility for delivering change. Use of the term 'taskforce' also implies that it has a time limited role.

What the HWT is not designed or tasked to do is to develop the national workforce strategic directions and priorities, a responsibility which rightly rests with governments and Ministers. Nor is the HWT accountable for related actions that fall to the National Scheme to deliver (although it has developed some important and practical informal mechanisms to assist in this). Under the current model, significant operational policy matters relating to the National Scheme do not necessarily go through the HWT pathway to Health Ministers.

To the extent that there is a gap in the architecture around workforce strategy and reform, it seems to be the absence of a channel or mechanism for identifying the desired national workforce futures and setting policy direction and priorities around this (including for health practitioner regulation), coordinating the actions that are required across the jurisdictional health systems, both at a national level and within the National Scheme, and reporting on the delivery of the agreed priorities.

There are also signs that there is insufficient focus on extracting regulatory intelligence and taking proactive steps to address emerging risks from within the National Scheme or to inform strategic priority setting. While there has been an ongoing legislative reform program, this has typically been off the back of reviews or an individual Minister's initiative in response to escalating public concerns about a specific issue. There appears to be little acknowledgement of the need for a cyclical program of legislative reform to keep the National Law up to date.

This returns us to the question of what further regulatory stewardship processes and/or structures may be required.

Some further adjustments in health intergovernmental structures may be necessary, to build the necessary strategic alignment between workforce futures and the reform of the National Scheme.

If there were overarching strategy setting structures to align workforce priorities to health professions regulation activity and guide the National Scheme, this would need to be augmented by stewardship-oriented adjustments within the National Scheme. This stewardship mindset must also be shared by others with a regulatory contribution to make. Saliently, layers of collaboration are required – strategic collaboration must be met with regulatory collaboration.

At an operational level, effective regulatory stewardship requires integrated and purposeful management of the 'people, places and products' drivers of quality and safety. The people

delivering the service must be qualified and trained and subject to appropriate standards of performance and conduct. The places in which they work must be safe and appropriately equipped. The products that are used must be tested and safe.

The National Scheme regulators must therefore be proactive and part of an integrated network of regulators to deliver the desired policy outcomes. It must operate in constant connection with the other parts, where there are other levers to achieve shared outcomes. Note for instance:

- Setting National Safety and Quality Health Service Standards for the delivery of health care and accreditation of public and private facilities against these standards through the Australian Commission on Safety and Quality in Health Care.
- Regulating private health facilities through jurisdictional licensing schemes.
- Regulation of medicines and devices through the Therapeutic Goods Administration.
- Regulating possession, distribution, sale, supply, prescription and administration of medicines, drugs and poisons through state and territory legislation.
- Setting admitting and visiting rights to hospitals and other health care facilities.
- Sector based arrangements to regulate workforces delivering services to highly vulnerable consumers such as those relying on aged care and disability services, through the NDIS Quality and Safeguards Commission and the Aged Care Quality and Safety Commission.

To the extent that the National Scheme adopts a networked approach to health practitioner regulation through collaboration with other national and state level regulators, this has historically tended to be typically more bilateral than multi-lateral and a regular cycle for these bilateral meetings is relatively recent. It is unclear whether these forums achieve both strategic and operational connections.

There is evidence of evolution of connection across the relevant regulators. The recent cross-agency and cross-jurisdictional collaborative forum on the regulation of medicinal cannabis is a worthy illustration (see Textbox 3). It demonstrates the application of integrated 'people, place and product' regulation when addressing emerging risks. While this sort of initiative is promising, it nevertheless falls short of a structured program of cross-agency and cross-sectoral collaboration which requires defined structures supported by regular processes.

Textbox 3: Proactive collaboration on regulating medicinal cannabis– Extracts from Communique 20/02/2024

Ahpra hosted a forum on Medicinal Cannabis in February 2024, to bring together health regulators who oversee the medicines themselves, the health professionals who prescribe and provide them, and the premises where they are stored and dispensed.

The data and evidence highlighted the imperative for this:

- The use of unregistered medicinal cannabis products has spiralled in recent years, from around 18,000 Australian patients using products in 2019 to more than one million patients using medicinal cannabis up to January 2024.
- The number of prescribers accessing the Authorised Prescriber and the Special Access Scheme has also risen sharply to more than 5,700 medical and nurse practitioners using these schemes to prescribe and dispense medicinal cannabis products that have not been evaluated by the Therapeutic Goods Administration (TGA) for safety, quality, or efficacy.

Ahpra recognised the need to maintain a balance between access and the safety of medicinal cannabis amid, amid the growing number of prescriptions and the emergence of telehealth, online prescribing, and direct-to-consumer health services. This reflected a clear understanding of the importance of a joined-up solution, to examine how all the responsible regulatory agencies can work well in a rapidly growing field to ensure clarity of roles, clear information flows and use of all our regulatory tools to best reduce potential harms to the public.

Through the forum the Pharmacy Board of Australia Chair Brett Simmonds stressed the importance of the regulators coming together to share knowledge, information, and approaches:

‘This is particularly important with newly available medicines such as medicinal cannabis and in areas of healthcare that are rapidly evolving and changing, such as telehealth and online prescribing.’

TGA head Professor Tony Lawler said the recent large rise in the number of patients accessing unapproved medicinal cannabis medicines and the changing way in which these products are prescribed and dispensed through telehealth consultations and medicinal cannabis clinics means the regulatory system has to keep pace, to ensure patients are not being harmed.

“Only two medicinal cannabis products have been evaluated for safety, quality and efficacy by the TGA and included in the Australian Register of Therapeutic Goods (ARTG),’ Prof Lawler said.

‘While patients are accessing around 500 unregistered products under the TGA’s special access pathways, the TGA would welcome more products included in the ARTG to ensure Australian patients have access to products that have been subject to evaluation for safety, quality, and effectiveness by the TGA.

Of course, responsibility for achieving this regulatory collaboration cannot be laid solely at the feet of Ahpra. It should be, and is, a leader in this work, but equally a collaboration mindset is required across the interrelated regulatory agencies.

By way of example, workforce regulation reforms are afoot in both the aged care and disability sectors, arising from the Royal Commissions into those sectors. These appear to be sector-specific reforms, unlinked, or only loosely linked to the National Scheme and to the complementary non-registered practitioner regulation frameworks. As of yet, there is no evidence that consideration has been given to either a consistent or single integrated model of regulation, that could apply across both health and social care sectors and deliver more effective and efficient quality assurance of these workforces. This is opportunity knocking.

Summary of issues

Navigating the complex linkages and touchpoints between health system pressures, policy responses and regulation requires strategic connection and unifying purpose, aligned to national workforce priority setting processes.

The structures and role clarity required to achieve the necessary regulatory collaboration across health service regulators and other agencies are evolving but not yet fully matured.

1.2 Regulatory stewardship also requires strong governance within the National Scheme

The operation of the National Scheme must be more strongly linked to the broader strategic workforce agenda through strong governance arrangements. Absent this, the National Scheme may drift from its statutory purpose.

In terms of the design of the National Scheme itself, the Kruk Review has linked regulatory stewardship with contemporary regulatory best practice principles (as applied by the Commonwealth, state, and territory governments), and has proposed some best practice principles applicable to the National Scheme – see Textbox 4.

Textbox 4: Regulatory Best Practice Principles for NRAS Entities – Proposed in the Kruk Review³³

Principle 1: Transparency: NRAS entities clearly communicate regulatory requirements and processes and are transparent about their decision-making criteria and fee setting.

Principle 2: Accountability: NRAS entities, supported by effective oversight, ensure they are delivering NRAS' objectives and the expectations of Australian governments and the community.

Principle 3: Risk-based and data driven: NRAS entities take a holistic view of risk management, which balances risks associated with workforce supply and demand with safety and quality of care, informed by reliable data.

Principle 4: Continuous improvement and stewardship: NRAS entities consider how regulatory activity and decisions affect the regulatory system as a whole and community health outcomes, in the context of changing needs.

A necessary starting point is to examine the statutory obligations of regulators under the National Scheme and the obligations and tools that are applied within the Scheme to connect all operational functions of the National Scheme to the broader strategic workforce context. These should clearly identify what is expected of the National Scheme regulators to deliver to the desired outcomes. This requirement is reflected in Kruk's Principle 2.

The statutory objectives set out in the National Law should underpin all regulatory principles and practices of the National Scheme entities and decision makers. There are seven objectives of the National Scheme under section 3(2) of the National Law – see Textbox 5

Alongside these objectives sit the Guiding principles of the National Law – see Textbox 6.

Textbox 5: Health Practitioner Regulation National Law Objectives

Section 3(2)

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and

³³ Kruk, R. op. cit., p. 103.

- (b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
- (c) to facilitate the provision of high-quality education and training of health practitioners; and
- (ca) to build the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples; and
- (d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
- (e) to facilitate access to services provided by health practitioners in accordance with the public interest; and
- (f) to enable the continuous development of a flexible, responsive, and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

Textbox 6: Health Practitioner Regulation National Law guiding principles

Section 3A Guiding principles

(1) The main guiding principle of the national registration and accreditation scheme is that the following are paramount—

- (a) protection of the public.
- (b) public confidence in the safety of services provided by registered health practitioners and students.

(2) The other guiding principles of the national registration and accreditation scheme are as follows—

- (a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;
- (aa) the scheme is to ensure the development of a culturally safe and respectful health workforce that—
 - i) is responsive to Aboriginal and Torres Strait Islander Peoples and their health; and
 - ii) contributes to the elimination of racism in the provision of health services;
- (b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;
- (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

Both the objectives and the guiding principles reflect the recommendations of the 2005 Productivity Commission report *Australia's Health Workforce*, which highlighted health workforce shortages and the complex and interdependent health workforce arrangements.³⁴

The statutory objectives capture the interrelated responsibilities of regulators in setting standards for entry to practice – to balance the need to assure safety and quality of services delivered by registered practitioners, while at the same time avoiding unnecessary restrictions that may limit patient access to health services, for example, by setting the competency and qualifications requirements for entry to practice so high that they unnecessarily limit the supply of practitioners.

The guiding principles also articulate the pre-eminent considerations of public safety and public confidence and capture the essential imperative – to maintain balance between workforce quality and supply.

Central to the regulatory craft that gives effect to the National Law objectives and guiding principles is the approach to assessment of risk to public health and safety. Risks of harm to patients arise not only from poorly trained or poorly performing practitioners, but also from workforce shortages that mean long waiting lists for services or no service at all. National Scheme regulators have an obligation to consider both types of risk when making decisions that are likely to impact workforce supply and distribution.

In short, the success of the National Scheme in meeting the stated objectives and guiding principles will be heavily dependent on how these are interpreted and applied in practice.

Ahpra (and the National Boards) have developed *Regulatory Principles of the Scheme* – see Textbox 7. These regulatory principles are intended to “reflect community expectations and ministerial directions” and to articulate the approach to interpreting and applying the National Law objectives and guiding principles. The Ahpra website explains:

These regulatory principles underpin the work of the National Boards and Ahpra in regulating Australia's registered health practitioners in the public interest. They shape our thinking about regulatory decision-making and have been designed to encourage a culturally safe and responsive, risk-based approach to regulation across all professions. The regulatory principles consider community expectations and reflect ministerial directions.³⁵

This Review has mapped these regulatory principles against the National Scheme objectives and guiding principles. Generally, the Ahpra *Regulatory Principles* reflect the National Law principle that protection of public health maintaining public confidence are paramount and links this to practitioner training and credentialing, risk-based complaints handling, and working objectively. However, nowhere in the Ahpra Regulatory Principles is there content that addresses how the National Scheme operationalises the National Law objectives of facilitating service access and a flexible, responsive and sustainable health workforce.

³⁴Productivity Commission (Cth), *Australia's Health Workforce*, (Research Report, 2005) <https://www.pc.gov.au/inquiries/completed/health-workforce/report>.

³⁵ Australian Health Practitioner Regulation Agency *Regulatory Principles for the National Scheme* Available at: <https://www.ahpra.gov.au/About-Ahpra/What-We-Do/Regulatory-principles.aspx>

Textbox 7: Ahpra and National Board regulatory principles

1. The National Boards and Ahpra administer and comply with the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory. The scope of our work is defined by the National Law.
2. Public protection is our paramount objective in the National Registration and Accreditation Scheme. We act to support safe, professional practice and the safety and quality of health services provided by registered health practitioners.
3. We protect the health and safety of the public by ensuring that only registered health practitioners who are suitably trained and qualified to practise in a competent and safe manner are registered.
4. In all our work we:
 - a) identify the risks that we need to respond to
 - b) assess the likelihood and consequences of the risks
 - c) respond in ways that are culturally safe, proportionate, consistent with community expectations and manage risks so we can adequately protect the public
 - d) take timely and necessary action under the National Law.

This applies to all our regulatory decision-making, the development of standards, policies, codes and guidelines as well as the way we regulate individual registered health practitioners.

5. The primary purpose of our regulatory response is to protect the public and uphold professional standards in the regulated health professions. When we learn about concerns regarding registered health practitioners, we apply the regulatory response necessary to manage the risk, to protect the public.
6. Our responses consider the potential risk of the registered health practitioner's health, conduct or performance to the public including:
 - People vulnerable to harm
 - Aboriginal and Torres Strait Islander Peoples
7. When deciding on regulatory responses, we are fair and transparent, and consider the importance of maintaining standards of professional practice that support community confidence in regulated health professions.
8. We work with our stakeholders including patient safety bodies, healthcare consumer bodies and professional bodies to protect the public. We do not represent the health professions, registered health practitioners or consumers. However, we work with practitioners and their representatives and consumers to achieve outcomes that protect the public.

The mapping suggests some gaps in the Ahpra/National Board *Regulatory Principles*.

- 1) Most of the objectives of the National Scheme are not specifically reflected in the Ahpra/National Board regulatory principles:

Under Objective (b) National Scheme regulators are expected to facilitate workforce mobility - this is not addressed directly or indirectly in the regulatory principles, although this may be understandable as the very fact of national registration removes impediments to mobility for practitioners.

Under Objective (c), National Scheme regulators are expected to facilitate high quality training and education of health practitioners - this is not directly or indirectly addressed in the regulatory principles.

Under Objective (ca), National Scheme regulators are expected to build workforce capability to improve cultural safety across the health system, whereas the regulatory principles relating to cultural safety are more limited to consideration of impact on Aboriginal and Torres Strait Islander peoples when assessing risk and Ahpra staff cultural competency.

Under Objective (d), National Scheme regulators are expected to facilitate responsive and rigorous assessment of overseas trained health practitioners. However, there is an indirect but arguably too loose a connection between this objective and regulatory principle 4, and the establishment of the Kruk review arguably highlighted the practical lack of focus on this objective.

Under Objective (e), National Scheme regulators are expected to facilitate access to health services in accordance with the public interest. Generally, the regulatory principles do not articulate the need for regulators to consider service access in regulatory decision-making when performing any of their standard setting, registration, accreditation or notifications management and discipline functions.

Under Objective (f), National Scheme regulators are expected to take an active approach to supporting or enabling a flexible, responsive and sustainable health workforce and innovation in education and service delivery. This objective is not directly addressed in the regulatory principles and the establishment of the recent Scope of Practice Review has, arguably, highlighted the practical lack of focus on this objective.

- 2) There is no mention in the regulatory principles of how the National Law guiding principles of transparency, accountability, efficiency, effectiveness and fairness are addressed in regulatory decision-making.
- 3) Apart from the references to public protection being the 'primary purpose' and the 'paramount objective' (which is not what the National Law says), there is no detail in the regulatory principles about how the National Boards and Ahpra weigh potentially competing National Law objectives in regulatory decision-making. This would be necessary and expected, noting that at times there may be tensions (for example, between ensuring public protection and at the same time facilitating access to services) that are likely to impact decision-making.

In the absence of these features within the Ahpra/National Board regulatory principles, one might expect to see references to workforce and service access considerations feature elsewhere, perhaps within the strategic priorities for the National Scheme.

Looking to the *National Scheme Strategy* (extracted at [Attachment A](#)) there are features that link back to capability building and workforce sustainability. These are:

Responsive accreditation systems.

Strengthened contribution to accessible and sustainable health care.

Eliminating racism for Aboriginal and/or Torres Strait Islander Peoples.

These are important strategic priorities, but what could not be found in relation to the first two of these priorities is more detail about the specific actions underway or planned to advance each of these priorities or the accountability across the National Scheme entities for delivering those

actions. By contrast, purposeful and impactful work is evident in relation to the important third element of elimination of racism.

The *National Scheme Strategy* is understood to be provided to Health Ministers but is not subject to review and endorsement via HCEF or HMM, which would be an appropriate mechanism for confirming (and reconfirming over time) that the Strategy reflects broader health workforce and health system priorities and the expected National Scheme contribution to those priorities.

This signals a gap in governance, with insufficient mechanisms for Health Ministers to be satisfied that the National Scheme does what it is intended and needs to do.

This governance gap in the National Scheme has been pointed out in previous reviews, with different structural and non-structural solutions proposed.

For instance, the Snowball Review recommended the establishment of a time limited Professional Standards Council, to establish performance standards (including financial standards) to be reported to the Ministerial Council by Ahpra, the National Boards and Accreditation Authorities.³⁶ Similarly, the 2017 Accreditation Systems Review recommended that performance standards be applied and a set of clear, consistent and holistic performance indicators for the National Scheme be developed.³⁷

Continuing the generally unremarkable proposition that a central feature of sound governance is performance reporting and transparency, 2017 Review of Governance in the National Scheme, also addressed this issue, recommending that Ahpra and its Board should:

- annually provide Ministers and jurisdictions with a “short form” report on achievement of National Scheme objectives. This could be incorporated in the current reporting framework, and
- develop KPIs based on the NRAS Strategy 2015-2020.³⁸

These recommendations for performance reporting were accepted in principle. However, neither the recommendations for establishing and reporting on performance measures nor for aligning the reporting with the *National Scheme Strategy* were progressed.

In terms of external reporting, Health Ministers receive an extensive Quarterly Report from Ahpra on the operation of the National Scheme. This report is a thorough overview of achievements and actions taken, drawn from more detailed operational reporting. However, feedback suggests that it is not a helpful document for decision-makers, who are looking for a crisper and clearer ‘health of scheme’ snapshot that delivers an understanding of progress on key ministerial priorities and commitments, areas of under-performance, and data or evidence of emerging risks to which additional attention may need to be directed from within the National Scheme or more broadly.

Additionally, there does not appear to be a structured top line suite of performance indicators and reporting tools to inform strategic thinking, priority setting and operational resourcing.

It is noted that there is extensive internal monitoring and reporting, particularly on the notifications function, feeding into the Regulatory Performance Committee and National Boards also receive regular reports on ‘old notifications’. The question is whether this extensive

³⁶ Snowball, K. op. Cit., pg. 5. See recommendation 1.

³⁷ Woods, M., op cit.

³⁸ Frew et al., op cit. See recommendation 4.

operational reporting drives reprioritisation, leads to a clear understanding of the drivers for any delays in performance, or points to adjustments that could be made to reduce or avoid delays. It is also less clear what reporting is available to National Boards and the Ahpra Board in relation to other functions, including accreditation.

Ultimately, it appears that the governance measures within the National Scheme have not yet reached a level of maturity that would support the National Scheme to meet its full suite of objectives, and to provide a transparent picture to the Ahpra Board and to Health Ministers of performance across all of the main statutory functions.

The *Regulatory best practice principles for NRAS entities* advocated in the Kruk Review appropriately emphasise the need for cohesive accountability expressed as follows:

NRAS entities, supported by effective oversight, ensure they are delivering NRAS' objectives and the expectations of Australian governments and the community.³⁹

Summary of issues

Operating principles, priorities and strategic plans of the National Scheme do not fully align with statutory objectives set out in the National Law.

One significant consequence appears to be that the National Scheme is not sufficiently responsive to health system pressures and workforce challenges.

Governance measures that could assist to address this misalignment are not in place.

1.3 Fragmented accountability within the National Scheme

There is no single entity accountable for the performance of the National Scheme.

A fundamental issue for the National Scheme is fragmentation, in both responsibility and accountability.

As the Kruk Review noted, the functions and responsibilities of the National Scheme are deliberately dispersed. The National Scheme is best described as a 'network governance' model, with private, professional and non-government bodies exercising functions to regulate the standards and performance of health professional and services.⁴⁰

It is somewhat of a paradox that the features of the National Scheme that assisted in its establishment are now features which appear to be a handbrake on its capacity to perform and evolve to expectations, noting that it is a significant endeavour to drive change and reform through so many decision-making bodies and to do this in a timely way.

This network governance model of organisation has strengths – it maintains the expert voice of the professions while bringing a more diverse range of views to the regulatory table. It is more democratic, pluralist and inclusive than the governance arrangements of regulators of the past:

³⁹ Kruk, R. op. cit., p. 70.

⁴⁰ Bennett, B; Carney, T; Chiarella, M; Walton, M; Kelly, P; Satchell, C and Beaupert, F. Australia's National Registration and Accreditation Scheme for health Practitioners: a National Approach to polycentric regulation, Sydney Law review, 2018, v 40, 159. p.162.

- The National Scheme is ‘owned’ by all eight states and territories equally, with all jurisdictions’ Health Ministers (including the Commonwealth Health Minister) having an equal voice on the Ministerial Council, the policy setting body for the National Scheme.⁴¹
- A range of bodies share regulatory power, governments (through the Ministerial Council and its suite of associated intergovernmental committees comprising state, territory and Commonwealth officials), the 15 National Boards, the Ahpra Board and Ahpra, the National Health Practitioner Ombudsman and Privacy Commissioner, the health complaints entities (HCEs), and the state and territory tribunals.
- Each National Board is constituted with a mix of practitioner and community members.
- Checks and balances on the exercise of power operate both internally and externally, that is: the HCEs, appeal bodies (the National Health Practitioner Ombudsman and Privacy Commissioner, the tribunals, judicial review); and integrity agencies and instruments (financial audit, freedom of information, whistle blowing protections, anti-corruption commissions, and human rights charters).⁴²

And yet, as has recently been observed, the consequence of this distributed power is the fact that *“no single entity is responsible or has accountability for the regulatory system as a whole, the end-to-end journey [of those being regulated] or the resulting impacts on health practitioners supply”*.⁴³

Multiple agencies and regulators have siloed responsibilities, with insufficient obligation to work in concert, with the associated risk that they may fail to work to a common purpose.⁴⁴

The Snowball Review made a similar observation a decade earlier:

*“[W]hile each agency working within the National Scheme is accountable to the Australian Health Workforce Ministerial Council...and reports annually on its operational activities, there is neither obligation nor accountability for the performance of the National Scheme as a whole in terms of meeting its objectives.”*⁴⁵

This raises important questions of efficiency and sustainability, but also goes well beyond this. This structural complexity touches on the deeper concerns about limitations on the ability of the National Scheme to adapt to new challenges and priorities, continuously improve and work as a whole. It seems trite but necessary to observe that the more individual entities there are, the more difficult it will be to ensure that they are all moving in the same direction, at the same pace, and to a common end.

The desired ‘whole of National Scheme’ mindset is also diluted by the assignment of regulatory powers profession by profession. On the one hand this is faithful to the principle of knowledge and expertise-driven policy and decision-making that underpins the design of the National Scheme. However, there is an imperative to adopt a multi-profession approach to address many emerging issues, and profession by profession deliberation in this context increases the risk of inconsistent decision-making across professions (on matters where consistency would be expected) as well as lack of alignment of decisions across different functions of the National

41 Carlton A, (2017) The Forces Shaping Regulation of the Health Professions in Australia: From ‘Club Government’ To Inclusive Regulatory Institutions p. 376 Available at: https://www.researchgate.net/publication/350458577_AL_Carlton_Dr_Public_Health_Thesis_-_Latrobe_University

42 Ibid.

43 Kruk, R. op. cit., p. 70 Independent review of Australia’s regulatory settings relating to overseas health practitioners. December 2023 pg. 70 Available at: https://www.regulatoryreform.gov.au/sites/default/files/Final%20Report%20-%20Overseas%20Health%20Practitioner%20Regulatory%20Settings%20Review%202023%20-%20endorsed%20by%20National%20Cabinet_0.pdf

44 Ibid p., 71.

45 Snowball, K op cit., p. 15.

Scheme. It goes to the heart of the quality of decision making across the National Scheme and its overall coherence.

The existing plethora of regulatory structures within the National Scheme is also a significant concern when considering the possibility of expansion to include additional professions. Put simply, unless the governance arrangements change, for each new profession added, the full suite of profession-determined regulatory structures, processes and associated costs is expected to follow.

The structural complexity of the National Scheme and the associated concerns about sustainability and scheme performance are not new ones. They remain unresolved, but not for want of attention.

Multiple reviews have considered the issues of ‘streamlining’ and / or “cross professional” approaches to regulatory decision-making. Examples of relevant recommendations not accepted or not implemented are listed below.

- The Snowball Review proposed (recommendations 2 and 3) consolidation of 9 “*low regulatory workload*” National Boards into a single multi-profession “*Health Professions Australia Board*” drawing on the UK model of multi-profession regulation.⁴⁶ This was ultimately not accepted by Health Ministers, although a new power was established in the National Law for Health Ministers to consolidate National Boards via the mechanism of a regulation, following public consultation.⁴⁷
- The Snowball Review (recommendation 21) also recommended that National Boards and Ahpra complete “a review within 12 months of the 60 Committees supporting National Boards, the 20 State and Territory or Regional Boards, and their 78 supporting committees to consolidate committee functions, remove committees that duplicate the Ahpra corporate support role (for example, finance committees), and review and revise delegation instruments to remove double handling of operational matters”. This review was not completed, although some rationalisation has been achieved over time.
- In considering the National Scheme’s implementation of reforms to the use of chaperones in 2020, Professor Ron Patterson acknowledged the progress made in centralising assessment of notifications about sexual misconduct by medical practitioners under a single (community member chaired) national level committee for Sexual Boundary Violation Notifications (SBNC), and recommended expansion of this model across all professions as follows⁴⁸:

In my view, a multi-profession SBNC would ensure a reasonable volume of cases and enable consistency of practice. I note that a multi-profession Immediate Action committee is already operating across the smaller health professions (excluding nursing, medical, psychology, pharmacy and dental). Over time, the recommended multi-profession SBNC could encompass all professions, including medicine. In the meantime, for consistency of practice it would be optimal to have a common chair (preferably a lay member) for any sexual boundaries notifications committee.

- The Independent Accreditation Systems Review ⁴⁹ conducted by Professor Michael Woods recommended that National Boards develop:

⁴⁶ Ibid., p. 5.

⁴⁷ Health Practitioner Regulation National Law Act 2009 Available at: <https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-045>

⁴⁸ Paterson R, Three years on: changes in regulatory practice since Independent review of the use of chaperones to protect patients in Australia. 2020. p. 27.

⁴⁹ Woods, M., op. cit.

profession-specific competency standards in accordance with the legislative provisions established for the development of registration standards to achieve

- a. standardised definitions and terminology*
- b. agreement on those competencies that are common to all health professions and profession-specific performance criteria and indicators*
- c. inclusion of specific and consistent standards for quality and safety, including collaborative practice and team-based care, developed in partnership with the ACSQHC andNational Scheme's Aboriginal and Torres Strait Islander Health Strategy Group.*

One attempt to address the higher order issue of ensuring that the many different decision-making bodies work together and to consistent standards was through governance reform following the 2017 *Review of Governance in the National Scheme* (the Governance Review), which was established by Health Ministers following the conclusion of the Snowball Review. The explicit brief for that Governance Review was to ensure clear accountability from the National Scheme to the Ministerial Council and that National Scheme entities have appropriate functions to achieve effectiveness in the National Scheme.

The Governance Review recommended there was a need for a single cohesive line of reporting and accountability to the Ministerial Council and made a number of recommendations. Subsequently, legislative changes were made to give effect to that recommendation that:

The National Law should explicitly provide for AHPRA's function of providing advice and information to the Ministerial Council on the operations and achievements of National Scheme entities and the achievement of the statutory objectives of the National Scheme. The current power in paragraph 25(j) of the Law should be amended to specifically articulate these functions. Relevant National Scheme entities should have the function of providing information and advice to AHPRA to enable it to exercise this function.⁵⁰

This recommendation and subsequent legislative change solved the threshold question of the line of reporting to Ministers. What it did not solve is the question of accountability for the Scheme as a whole. Arguably the Governance Review conflated questions of reporting and accountability when providing the rationale for its recommendation, stating as follows (**emphasis added**):

*The Review agrees that lines of accountability to the Ministerial Council need to be clear, and the Ministerial Council requires a single line of reporting and advice to ensure its oversight function can be properly exercised. The Review considers that, in practice, AHPRA fulfills the role of being the single line of **accountability** and advice from the National Scheme to the Ministerial Council regarding the operation of the Scheme as a whole. To the extent that the National Boards' obligations are vested independently in them, AHPRA still acts as the conduit through which the Ministerial Council is informed and advised of the carrying out of these obligations. AHPRA manages this through its co-operative arrangements with the National Boards. **In practice, AHPRA is held responsible for meeting Ministerial expectations of the National Boards, other National Scheme entities, and itself. Where it is the National Boards or other National Scheme entities that have not met expectations, AHPRA communicates this to those entities on behalf of the Ministerial Council.**⁵¹*

It is an unremarkable proposition that Health Ministers should receive a single line of advice about the performance of the National Scheme and in the current arrangements Ahpra was

⁵⁰ Frew et al., op. cit., p. 15.

⁵¹ Ibid., p 12.

sensibly recommended by the Governance Review as providing the necessary “conduit”. Less clear is how, in the event of poor performance of the National Scheme, Ahpra could be held accountable for correcting any identified problems. Ahpra can certainly communicate to National Boards and other National Scheme entities a failure to meet expectations and it can encourage corrective action, but it does not have the power to determine what corrective action is required, or to ensure that it is delivered, as it has no powers to direct the entities across the National Scheme in regard to their operational or resourcing priorities (where the statutory powers reside with the National Boards, HCEs or a state or territory tribunal).

Notwithstanding some streamlining of committee structures within National Boards that has occurred following the Snowball Review recommendations, the broader agenda of structural reform envisaged by Snowball has been relatively slow and incomplete.

Each National Board continues to maintain its own separate decision-making structures for most regulatory functions and, in some cases, there remain multiple layers of decision-making, generally attributable to the volume of regulatory activity.

There remain 119 regulatory decision-making bodies within the National Scheme, spread across registration, notification, accreditation, policy and accreditation functions and activities.

From an efficiency perspective, there are streamlining opportunities that would seem to offer opportunity for savings in the domain of governance and policy. For instance, in the context of clear Scheme-wide Ahpra Board structures for administration and negotiation of finances, it is not entirely clear what additional functions individual National Boards require from their finance committees. Similarly, there may be scope for joined up communications committees, given the centralised communication and media arrangements supporting the National Scheme.

In terms of the broader concerns about regulatory complexity, rationalisation of the structures for the delivery of the regulatory functions should be an immediate priority.

For regulatory decision-making purposes, at a national level, there are 15 National Boards, under which 40 profession-specific committees sit to deliver registration, notification and accreditation decisions for each profession. The committee structures under the National Boards differ across professions.

Most National Boards have transitioned from state by state to national decision-making structures. The Review has heard that this transition to national committees has occurred for all but two professions and by all accounts has worked well. It has been seen to improve the clarity and consistency of decision-making for those participating National Boards, assisted in achieving process improvements, and mitigated fee increases for registrants.

The National Boards for the medical and nursing and midwifery professions have multiple decision-making layers, with State and Territory Boards that sit underneath the National Boards, and State committees in turn sit under those State and Territory Boards. There are 16 State and Territory Boards and 17 committees sitting under those State and Territory Boards across medicine, and nursing and midwifery. The retention of State and Territory boards in these professions appears to be most directly linked to the volume of notifications and associated regulatory decisions.

There has been little movement to establish cross-profession regulatory decision-making structures. Cross-profession collaboration and streamlining is achievable within the National Scheme without legislative change or Ministerial Council direction. However, it requires each National Board to agree. It is noted that there is forum of NRAS Chairs, which offers an avenue

for collaboration and information sharing across National Boards, this is not currently a decision-making body for these sorts of purposes.

Structural responses to the need for cross-profession collaboration and decision-making have been achieved only on a very limited scale:

- Across the National Scheme, there are no all-profession regulatory decision-making structures.
- There are only two multi-profession committees, and these have very specific functions within the notifications management process. There is a multi-profession Immediate Action Committee (IAC), made up of representatives from 10 out of the 15 National Boards, that has delegated decision-making under section 156 of the *National Law* to take immediate action in relation to a registered practitioner. The Boards involved in this structure are:
 - ATSI Health Practice Board
 - Chinese Medicine Board
 - Chiropractic Board
 - Medical Radiation Practice Board
 - Occupational Therapy Board
 - Optometry Board
 - Osteopathy Board
 - Paramedicine Board
 - Physiotherapy Board
 - Podiatry Board

In June 2024 the Dental Board resolved to dissolve its immediate action committee and delegate immediate action decision-making to the multi-profession IAC. Therefore, the coverage of this multi-profession IAC will increase to 11 professions.

In relation to the Boards for Medicine, Nursing and Midwifery, Pharmacy and Psychology, the rationale for not participating in the multi-profession IAC is unclear but seems most likely to relate primarily to workload and the higher volume of matters that may require immediate action for those professions.

- The second such committee is a multi-profession Registration & Notifications Committee, which is convened on an as needs basis in the uncommon circumstances where members of a National Board are conflicted to an extent that a notification needs to be determined by others.

Recent activity to standardise the English Language Skills Registration Standards (ELS standards) across all regulated professions shows some practical impacts of the absence of structures to support multi-profession decision-making. All 16 regulated professions have a registration standard for English language skills. These standards apply to all applicants for initial registration, whether they qualified in Australia or overseas. Since inception of the National Scheme, the standards have been common across some professions but with separate standards for several professions. The separate profession-specific standards follow a common template except that they set different requirements for the level of English language competence.

The need for standardisation was raised more than a decade ago in the 2012 Senate Committee report *Lost in the Labyrinth*⁵² and again in the Snowball Review in 2014⁵³.

During 2023/24 (in response to the Kruk Report) regulators have made some progress on this issue. All ELS standards have been reviewed through a rigorous process. However, this has occurred Board by Board and ultimately not all National Boards have aligned their ELS requirements to a common standard, as was the initial aspiration. While there are no doubt reasons for the differences in ELS standards, arguably a cross-profession process may have generated both more timeliness in advancing the issue and transparency on the drivers for any proposed differences in the standards and testing arrangements for some professions.

On this important topic of the case for multi-profession decision making processes, more will be said later in this paper about the management of sexual misconduct notifications which, despite the recommendations of Profession Paterson in his 2020 review, continues to be managed by profession-specific National Board committees.⁵⁴

The tentative moves toward multi-profession decision making are acknowledged and welcome, but the dominant picture is one of cumbersome arrangements for considering cross profession solutions. In circumstances where a multi-profession response to pressing scheme-wide issues would be both expected and achievable, the default to profession by professions solutions is disappointing.

It is noted that Health Ministers have the regulatory power to consolidate National Boards,⁵⁵ but this power has not yet been exercised.

Summary of issues

The National Scheme has distributed powers and responsibilities across multiple statutory entities, but no single line of accountability for meeting strategic objective and delivering on priorities.

This affects the efficiency and effectiveness of the National Scheme and is a significant impediment to its ability to adapt to meet new challenges and to maintain strategic alignment across all functions over time.

Profession by profession decision-making ensures that regulatory decisions draw on appropriate expertise but, ultimately, structures within the National Scheme have been unable to evolve to deliver the necessary cross-profession approaches and solutions.

52 The Parliament of the Commonwealth of Australia Standing Committee on Health and Ageing *Lost in the Labyrinth*, Report on the inquiry into registration processes and support for overseas trained doctors (2012) Available at:

https://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/overseasdoctors/report.htm

53 Snowball, K. op. cit., p. 7.

54 Paterson, R. op.cit.

55 Following enactment of the Health Practitioner National Law and Other Legislation Amendment Act (Qld) 2017.

1.4 Accreditation in the spotlight

The National Scheme-wide issues of fragmented accountability and lack of alignment with strategic purpose are most pronounced in the delivery of its accreditation functions.

Accreditation functions are a lynchpin of the National Scheme – see Textbox 8. Accreditation serves to ensure that individuals seeking registration to work in the health workforce have the knowledge, skills and professional attributes to practice safely and competently (including that they can assess overseas qualified health practitioners).⁵⁶

It is fair to say that, due to historical institutional legacies, the structures through which accreditation functions are delivered is as complex, if not more so, than any other part of the National Scheme.

Again, one dimension of the complexity is the profession-specific structures, processes and standards and the limited cross-profession collaboration across all National Scheme functions.

There are however further dimensions of complexity because the external accreditation entities are separately constituted bodies that carry out accreditation functions on behalf of the National Boards, under contract from Ahpra. These complex features are described below.

Textbox 8: Design features of the National Scheme accreditation function

- Accreditation functions are defined under section 3 of the National Law.
- Under section 43 of the National Law, each National Board decides whether its accreditation functions are to be exercised by an 'external accreditation entity', or by a 'accreditation committee' established by the National Board. If the National Board has decided on an external accreditation entity, the National Agency (Ahpra) enters into a contract with the entity, on behalf of the National Board, for the performance of the accreditation functions.
- There are currently 16 accreditation authorities, ten of which are external accreditation entities and six are internally constituted accreditation committees (noting the accreditation functions for nursing and midwifery are apportioned between the Australian Nursing & Midwifery Accreditation Council, and external accreditation entity which manages the accreditation of programs of study and the Nursing and Midwifery Accreditation Committee, an internally constituted accreditation committee which is responsible for assessment of overseas qualified nurses and midwives).
- Once an accreditation authority (either an external accreditation entity or an accreditation committee) is appointed, it is responsible for the exercise of accreditation functions without reference back to the responsible National Board, although accreditation standards developed by an accreditation authority are subject to approval by the responsible National Board. The National Board may also accept or reject advice about the accreditation status of a program of study when deciding whether to approve the qualification for registration purposes.

⁵⁶ The annual Accreditation Snapshot – a collaborative publication between Ahpra, the National Boards and the Health Professions Accreditation Collaborative Forum (HPACF or simply, 'the Forum') – provides an overview of accreditation in the National Scheme, accreditation activities and the roles of different entities in accreditation. Ahpra and the National Boards, Accreditation in the National Registration and Accreditation Scheme (NRAS): A snapshot 2022/23. Available at: <https://www.ahpra.gov.au/Accreditation/Accreditation-snapshot.aspx>

- Accreditation of specialist medical college training places in health services is not an accreditation function under the National Law, but it is a function that is assigned by the external accreditation entity (the Australian Medical Council) to the specialist colleges and is undertaken as a contractual activity.
- The Ministerial Council's policy direction powers under section 11 of the National Law do not extend to directing an external accreditation entity, although a direction may be issued to Ahpra and/or a National Board in relation to the terms of the contracts negotiated by Ahpra with these entities.
- Under section 11 of the National Law, the Ministerial Council may give a direction to a National Board or Ahpra in relation to a proposed accreditation standard, but only if:
 - in the Council's opinion, the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners; and
 - the Council has first considered the potential impact of the Council's direction on the quality and safety of health care.

Governance of accreditation is commensurately complex. There is a network of oversight and delivery roles. The specific roles of individual entities are outlined in [Table 2](#).

Table 2: Governance of accreditation functions under the National Scheme

Body	Role	Focus
Nationals Boards	<p>Decide whether an external accreditation entity or a committee of the Board is to exercise accreditation functions.</p> <p>Approve accreditation standards developed by an accreditation authority.</p> <p>Approve an accredited program of study as providing a qualification for registration or endorsement of registration.</p>	Profession specific
Ahpra Board	<p>Governance framework for accreditation authorities:</p> <ul style="list-style-type: none"> • Gives advice to the Ministerial Council on issues with the Scheme. • Approves health profession agreements with National Boards and contracts with external accreditation entities. • Approves terms of reference for accreditation committees. • Approves procedures for developing accreditation standards. 	Accreditation system Multi-profession

Body	Role	Focus
Independent Accreditation Committee of Ahpra Board	Reform and improvement to implement Ministers Policy Direction (2020-01). Provides guidance to National Scheme entities on reform and improvements.	Multi-profession
National Health Practitioner Ombudsman	Receives and investigates complaints about accreditation authorities. National Scheme wide review of accreditation issues as requested by jurisdictions e.g. complains and appeals processes.	Profession specific complaints Multi-profession reviews
Health Professions Accreditation Collaborative Forum	Peak body for all National Scheme accreditation authorities. Collaboration on shared issues e.g. interprofessional education.	Multi-profession collaboration
Accreditation authorities	Exercise accreditation functions for a regulated health profession as decided by the responsible National Board.	Profession specific

Issues associated with the delivery of accreditation functions were identified in the Snowball Review of 2014.⁵⁷

This led jurisdictions to commission the 2017 *Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions* (the Wood Review) the purpose of which was communicated as follows:⁵⁸

Health Ministers noted the findings from the 2014 Independent Review of NRAS which advised of significant concerns with the high cost, lack of transparency, accountability, duplication and approach of the existing accreditation processes.

Health Ministers requested further investigation including consideration of the findings of the 2005 Productivity Commission Report on Australia's Health Workforce. In particular, the Accreditation Systems Review was to address:

- *the cost effectiveness of the existing systems for the delivery of accreditation functions*
- *governance structures including reporting arrangements*
- *opportunities for the streamlining of accreditation including consideration of other educational accreditation processes*
- *the extent to which accreditation arrangements support educational innovation in programs including clinical training arrangements, use of simulation and inter-professional learning*

⁵⁷ Snowball, K op cit., p.7.

⁵⁸ COAG Health Council Bulletin, Independent review of Accreditation systems within the National Registration and Accreditation Scheme for health professions. December 2017.

- *opportunities for increasing consistency and collaboration across professions.*

In early 2020, following the Wood Review and in accordance with its recommendations, Health Ministers agreed that a further independent review should be undertaken into the procedural aspects of accreditation processes. Health Ministers requested that the National Health Practitioner Ombudsman (NHPO) undertake this review, and that it should give particular attention to the processes of specialist medical colleges in relation to the accreditation of specialist medical training sites.

The NHPO's report *Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation* was published in 2023.⁵⁹ This highlighted that:

- *Efficient accreditation of specialist medical training sites is necessary to support safe and quality patient care.*
- *There are concerns in relation to specialist medical training site accreditation standards and requirements, and further in their capacity to respond fittingly to current workforce needs and the wider workforce planning.*
- *Intricate arrangements that form the foundation of accreditation in the National Scheme have created an environment where gaps have developed in the accountability mechanisms for processes related to the accreditation of specialist medical training sites. For instance, the accreditation of specialist medical training sites is not an accreditation function that is recognised under the Health Practitioner Regulation National Law (the National Law).*⁶⁰

Taken together, the findings and recommendations of these reviews reinforce the view that further adjustments to the design and delivery of accreditation functions within the National Scheme are likely to be required and that reform objectives should:

- support workforce reform and system needs, including through initiatives that foster innovative approaches to education and service delivery, and
- strengthen transparency, accountability and efficiency in accreditation systems and the delivery of accreditation functions within in the National Scheme.

In response to these reviews, an active and multi-faceted reform agenda is underway:

- Of the five policy directions issues by ministers since the commencement of the National Scheme, two have been issued in the past four years related to Accreditation. This reflects the increased urgency to ensure the operation of the accreditation functions better supports the delivery of government and system wide priorities.
 - [Policy Direction 2020-01 – Independent Accreditation Committee advice](#)

This direction sought to address elements of the fractured accountability arrangements, by establishing an independent body to advise on accreditation reform and to guide Ahpra, the Boards and the accreditation authorities in their decision making.

Under this Direction, other external entities performing accreditation roles as part of the National Scheme, such as specialist colleges and postgraduate medical councils, are also obliged to consider the Independent Accreditation Committee's advice, where relevant.

- [Policy Direction 2023-01 – Medical college accreditation of training sites](#). This direction to the MBA and Ahpra sought to address some adverse impacts of Specialist

⁵⁹ National Health Practitioner Ombudsman (NHPO), op cit.

⁶⁰ Ibid., p. 11.

Medical College accreditation decisions on workforce supply and service access and the inconsistency in procedures across colleges.

- Health Ministers are working directly with the sixteen specialist medical colleges, the Australian Medical Council (AMC), the Australian Health Practitioner Regulation Agency (Ahpra), the Medical Board of Australia (MBA), and the National Health Practitioner Ombudsman (NHPO) to ensure progress on reforms and improvements for training of the medical specialist workforce in Australia.⁶¹ This has affirmed shared commitments as follows:
 - *Specialist medical colleges and the AMC will continue to implement the recommendations of the NHPO's report into site accreditation reform, including developing model accreditation standards.*
 - *Specialist medical colleges will continue to work with jurisdictions, and other key stakeholders, on strategies to deliver the medical workforce in the right numbers and in the right locations, particularly in rural and regional areas.*
 - *Specialist medical colleges will continue to work with jurisdictions, and other key stakeholders, to build the generalist capability of the medical workforce.*
 - *Health Ministers committed to continue sharing workforce distribution, supply and demand data to provide an evidence base for national workforce planning.*
 - *Specialist medical colleges, the AMC, Ahpra and the MBA will continue to develop and implement expedited pathways for SIMGs, reducing the wait time to receive an outcome regarding their competency and ability to work in Australia's health system.*

Recent initiatives and actions related to the delivery of accreditation functions under the National Scheme are summarised in [Table 3](#).

⁶¹ See Australian Government Department of Health and Aged care webpage: Health Ministers Meeting (HMM) Communique 16 August 2024 Available at: <https://www.health.gov.au/resources/publications/health-ministers-meeting-hmm-communique-16-august-2024>

Table 3: Governance of accreditation functions under the National Scheme Summary of accreditation reforms within the National Scheme

Reform	Lead	Status
Development of the future health workforce		
Development and implementation of the Interprofessional Collaborative Practice (IPCP) Statement of Intent ⁶² – a joint commitment to action by 53 stakeholders to embed IPCP across the health and education systems to address the barriers to IPCP which impact on the safety and quality of care.	Ahpra Board Accreditation Committee	In progress
Ahpra's Health Strategy Unit is leading the development of a national, multi-year Cultural Safety Accreditation and Continuing Professional Development framework and strategy.	Ahpra	In progress
The National Prescribing Competencies Framework. Ahpra has been contracted by the Department of Health and Aged Care to host the Framework on its website until December 2029 and to review the Framework by June 2025.	Ahpra	In progress
Development of guidance to embed good practice in clinical placements, simulation-based learning and virtual care education in initial health practitioner education. ⁶³	Ahpra Board Accreditation Committee	In progress
Strengthening accreditation systems		
A glossary of accreditation terms to build a shared language and understanding of accreditation items, recognising that differences in language can be a barrier to reform. ⁶⁴ The glossary was developed in partnership with accreditation authorities through the Forum.	Ahpra Board Accreditation Committee	Completed
Good practice guidance for the development of professional capabilities that is more responsive to future workforce and health service delivery needs.	Ahpra Board Accreditation Committee	In progress
Reduce duplication in program accreditation (across the National Scheme professions and with external agencies such as TEQSA and ASQA).	Ahpra Board Accreditation Committee	In progress

62 Australian Health Practitioner Regulation Agency Publications (2024) Interprofessional Collaborative Practice Statement of Intent Available at: <https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx>

63 Ibid., Information paper: good practice approaches to embedding clinical placements, pedagogical innovations and evidence-based technological advances in health practitioner education Available at: <https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx> .

64 Ibid., Glossary of accreditation terms Available at: <https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx>

Reform	Lead	Status
Principles to strengthen the involvement of consumers in accreditation. ⁶⁵	Ahpra Board Accreditation Committee	Completed
Consolidate skills assessments for overseas qualified practitioners – accept one skills assessment for both registration and visa purposes rather than two.	Australian Government	In progress
Streamline and align qualifications assessment processes and reduce timelines for assessing overseas trained practitioners.	Ahpra	In progress
Explore opportunities for greater consistency in qualifications assessment processes across all accreditation entities.	Ahpra	In progress
Cultural safety training for accreditation assessors is being delivered by the Forum in collaboration with ABSTARR Consulting.	HPACF	In progress
Review of accreditation processes for all professions.	NHPO	Reports are imminent

Against this backdrop of a broad and active program of reforms to the design and operation of accreditation functions, there are the key issues of particular relevance and focus for this Review.

The first relates to the stewardship question – the need to strengthen the strategic connection between the National Scheme and its service context, and the importance of ensuring accreditation operational settings are aligned with broader national health workforce and service access priorities and strategies.

The second relates to the role of the Independent Accreditation Committee of the Ahpra Board. This was established following the Wood Review to advise on accreditation reform. It therefore has a particularly significant role in the National Scheme. Arguably there is potential to strengthen its mandate to foster improved stewardship, accountability and performance working with the authorities responsible for delivering accreditation functions.

The third is the specific issue raised in the sixth Term of Reference for the review, being the inability of Health Ministers to direct an external accreditation entity (and even more specifically the concerns about the impacts of Specialist Medical Colleges that operate beyond the direct reach of National Scheme accountability).

With respect to the Ministerial Council powers of direction under the National Law:

- Section 11 provides that the Ministerial Council may give directions to the National Agency (Ahpra) or a National Board about policy matters.

⁶⁵ Ibid., Principles to strengthen the involvement of consumers in accreditation Available at: <https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx>

- Section 11 (3) (d) provides that any such direction may relate to a particular proposed accreditation standard or amendment of an accreditation standard, but only if Ministers consider that the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners; and also considered the potential impact of the Council's direction on the quality and safety of health care.

There is no provision for the Ministerial Council to issue a policy direction directly to an external accreditation entity (contracted by Ahpra following a National Board decision under section 43 of the National Law) or to another body that delivers accredited training programs for registration purposes (as is the case with the accreditation by the Specialist Medical Colleges of specialist medical training sites).

The inability to issue a Ministerial Council direction to a body delivering specialist medical training or to an accreditation entity operating under a contractual arrangement with Ahpra has seen such directions issued directly to Ahpra.

While this indirect approach may ultimately achieve the same end, a power to direct is likely to have a more immediate impact when it is delivered without attenuation through other entities such as Ahpra or a National Board. Also from first principles, if a power of Ministerial Council direction is an element of the governance and accountability framework of a scheme, it could be expected to apply across all entities of a National Scheme.

There may therefore be a principles-based argument for extending the Ministerial Council's power of direction to apply directly to accreditation entities.

That said there are three important observations to be made.

First, if the strategic connections, structures and processes envisaged under a stewardship approach are operating optimally, it would be hoped that Ministerial Council expectations would be both well understood and acted upon within the core accountability framework of the National Scheme. This would include a stronger leadership and oversight role for the Independent Accreditation Committee of the Ahpra Board and stronger and more specific requirements in Ahpra performance agreements with external accreditation entities. If this were achieved, it is highly unlikely that corrective action through a Ministerial Council policy direction would be required.

Second, such a power would not in itself deliver the ability to direct the Specialist Medical Colleges in relation to the accreditation processes and procedures at training sites, because these functions are delivered on a contractual basis (between the relevant college and the health service) outside of the National Scheme. Other measures for achieving the ability to direct decision-making relating to accreditation of specialist medical training sites would be required.

Third, if a problem was to be addressed via Ministerial Council policy direction, the risk of unintended consequences would need to be considered and addressed through a structured process.

Summary of Issues

Following earlier reviews of accreditation functions, there is considerable current reform activity that is expected to strengthen this pillar of the National Scheme.

However, additional measures may be required to:

- ensure a stronger strategic connection between workforce strategy and the delivery of accreditation functions;
- drive implementation of necessary reforms within the National Scheme and ensure accountability to Health Ministers for delivery of these important functions.

If the National Scheme fails to deliver to expectations, there are Ministerial Council powers to assist in aligning decision making with strategic workforce priorities, but these have limitations.

1.5 Community Voice

There are insufficient mechanisms for calibrating the National Scheme to community expectations.

This is a National Scheme that has people at the centre. It exists to ensure that the public enjoys access to safe and quality health services.

There are several mechanisms for securing community input to the National Scheme. These include minimum requirements for public consultation, for example, on registration standards and guidelines, outreach activities and work to draw on community feedback to improve complaint handling processes.

One of the important settings to ensure a strong community voice within the National Scheme is the Ahpra Community Advisory Council (CAC). The CAC has provided informal advice during scoping discussions on its current role within the National Scheme.⁶⁶

The forerunner to the CAC was the Ahpra Community Reference Group (CRG), established in June 2013. This was the first time that a national group of this kind was established in Australia. Its original purpose was to provide feedback, information and advice on strategies for building better knowledge in the community about health practitioner regulation. In addition, it was to advise on how to better understand and meet community needs.

In 2019 the COAG Health Council issued two policy directions to Ahpra and the National Boards which directly impacted the representation of community voices in the National Scheme:

- Under Policy Direction 2019-01, in defining public protection as the 'paramount' guiding principle, the National Boards and Ahpra must consider the impact of health practitioners' conduct on the public and to consider how regulatory action could engender public confidence in the health professions. In investigating a practitioner's conduct, Ahpra and the National Boards must give equal weight to public expectations and the professional expectations of the practitioners' peers.⁶⁷

⁶⁶Ibid., Community Advisory Council Available at: <https://www.ahpra.gov.au/About-Ahpra/Our-engagement-activities/Advisory-groups/Community-Advisory-Council.aspx>

⁶⁷Ibid., Policy Direction 2019- 01 Available at: <https://www.ahpra.gov.au/Search.aspx?q=policy%20direction%202019-%2001>

- Under Policy Direction 2019-02, Ahpra and the National Boards must consult with patient safety and health consumer bodies on every new and revised registration standard, code and guideline, and, in each case, to publish patient health and safety impact assessments. They must consider potential impacts on priority groups such as children, older persons, people living with disability, and those experiencing family and domestic violence.⁶⁸

In 2019/20, via a co-design process, the Community Reference Group and the Ahpra Board reviewed the mandate and standing of the Community Reference Group and made changes to make the role more strategic and proactive, including renaming it as the Community Advisory Council, requiring it to be chaired by one of its members and present to Ahpra Board twice per year, with an opportunity to hosting an annual joint forum with the Ahpra Board. The terms of reference were updated accordingly.

These were important changes aimed at strengthening the community voice beyond the operational level. The changes were based on a series of values and principles that:

- confirmed the value of community input to decision-making and policy development;
- acknowledged the need for further embed community voices at more levels in the National Scheme;
- acknowledged insufficient community engagement;
- endorsed a more proactive approach to health practitioner regulation including outreach to diverse communities;
- identified the need to meet the 'publics' in their own spaces e.g., social media.

These values and principles are more than symbolic and remain foundational to an effective and responsive National Scheme.

This Review has noted that implementation of these values and associated changes is still in process whilst public awareness and expectations are also evolving. Thus, strengthening the community voice in the National Scheme cannot be seen as a set and forget proposition.

As the CAC indicated during scoping discussions, in 2023 it became evident that public expectations of health practitioner regulation are changing. There is more to be done for the National Scheme to keep pace. Further adjustments are needed to enliven the principles that have informed recent changes to strengthen the CAC's structure and mandate.

For instance, risks associated with consumer use of cosmetic services have escalated, and with more prominence in the media, some suggest the National Scheme regulators have been slow to respond. While regulation of cosmetic procedures is complex, with multiple agencies with overlapping responsibilities, the National Scheme regulators have accepted a central role in addressing these risks.

Following an independent review of cosmetic surgery commissioned by Ahpra,⁶⁹ a multifaceted regulatory strategy has been put in place to address the risks. Responses to these issues have required close collaboration between Ahpra and the National Boards on changes to use of the title 'surgeon' and practitioner endorsement, with increased public protection afforded through

⁶⁸ Ibid., Policy Direction 2019-02 Available at: <https://www.ahpra.gov.au/About-Ahpra/Ministerial-Directives-and-Communiques/Policy-directions.aspx>

⁶⁹ Brown, A (2022) Independent review of the regulation of medical practitioners who perform cosmetic surgery Available at: <https://www.ahpra.gov.au/Resources/Cosmetic-surgery-hub/Cosmetic-surgery-review.aspx>

purpose-built consultation structures, including a dedicated patient hotline and more targeted outreach to consumer representatives.⁷⁰

While this multifaceted strategy appears to be proving effective in addressing regulatory gaps and taking a more proactive approach to public protection mechanisms to illuminate consumer concerns and trigger more immediate action to address would have been beneficial.

In addition to external pressure to better address community expectations, more effective structures and processes for providing more diverse community input into strategic planning and priority setting for the National Scheme has been identified as an opportunity for further improvement. The Community Advisory Committee perspective that now it is time to further broaden, embed and modernise the role of the public in the governance of the National Scheme is consistent with a regulatory stewardship approach.

Having committed and knowledgeable board members is also widely recognised as an important way to promote alignment of the National Scheme with community expectations and to ensure that regulatory standards and decisions reflect community mores. The role of community members in regulatory decision-making is addressed further in Section 2.1 under Theme 2.

Summary of Issues

At the strategic level, community signals must be read and understood, to ensure regulators are proactive and avoid the pitfalls of a predominantly reactive mode of regulation. There is scope for strengthening community voice at this level, either through the Community Advisory Council or other mechanisms.

⁷⁰ Australian Health Practitioner Regulation Agency Making cosmetic surgery in Australia safer Available at: Australian Health Practitioner Regulation Agency Publications (2024) Interprofessional Collaborative Practice Statement of Intent Available at: <https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx>

Theme 2: Delivering Coherent and Effective Complaints Management

Linkage to the Terms of reference

The Review Terms of Reference 1-3 recognise that the National Scheme will ultimately be judged by many on its ability to manage the concerns of consumers in a timely and appropriate manner and ensure that there is fairness and transparency for practitioners throughout the notification management and disciplinary process.

Term of Reference 1 reflects a specific concern about how effectively the National Scheme delivers on the core function of effective management of the most serious alleged departures by practitioners from expected standards of conduct or performance, or of impairment which compromises a practitioner's safe practice.

Term of Reference 2 is broader. It goes to the experiences and expectations of those making complaints or notifications and those subject to notifications, asking the Review to address concerns relating to consistency, transparency, and procedural fairness.

Term of Reference 3 focuses on the decision-making role of tribunals on the serious matters brought before them and envisages consideration of measures to achieve consistency and timeliness of decisions.

What are the issues and challenges?

2.1 Consumers and practitioners often do not understand the National Scheme and are confused and frustrated about the way that health care complaints and notifications are managed.

Consumers

The dimensions of consumer confusion and frustration have been canvassed in previous reviews of the National Scheme.⁷¹

Research undertaken by the Australian Commission on Safety and Quality in Health Care (ACQSHC) and Ahpra indicates that the primary sources of dissatisfaction for consumers are that they have difficulty working out where to make a complaint and are frustrated when they have ended up in the wrong place to get their issue resolved.⁷²

Consumers who have concerns about the adequacy of their healthcare have a range of avenues for making a complaint. Comparing these avenues can be challenging and deciding the best place to make a complaint is far from straightforward.

71 Review of files held by Medical Board of Queensland (MBQ), Queensland Board of the Medical Board of Australia (QBMBA) and AHPRA, Chesterman Report Recommendation 2 Review Panel (2013) Available at: <https://documents.parliament.qld.gov.au/tableOffice/TabledPapers/2013/5413T2375.pdf> ; Government Review (Queensland); National independent review of the National Registration and Accreditation Scheme (NRAS) (Snowball 2014) KPMG Review of notification and system processes (2015) Available at: <https://www.ahpra.gov.au/Publications/Corporate-publications.aspx>; Independent review commissioned by Ahpra Senate Community Affairs References Committee Inquiry into the complaint mechanism administered under the Health Independent review of the use of chaperones to protect patients in Australia (2017) Available at: <https://www.ahpra.gov.au/Publications/Corporate-publications.aspx>; Medical Board of Australia (MBA) commissioned Practitioner Regulation National Law (2017).

72 Australian Commission on Safety and Quality in Health Care and Ahpra, (2024) Final Report , Working together to improve the consumer healthcare complaints experience August p. 5 Available at:

<https://www.ahpra.gov.au/Search.aspx?q=final%20report,%20working%20together%20to%20improve%20the%20consumer%20healthcare%20experience>

Finding the best place to complain about a health service depends on a variety of factors such as: what type of health practitioner delivered the service (for example, a registered medical practitioner or a non-registered dietitian or massage therapist), which state or territory the practitioner's place of work is located in, what the concern is about, what type of health facility is involved (for example a public or private hospital, a medical centre or a private consultation room), and even the context in which the care is provided (for example, aged care or disability services).⁷³

While Ahpra is popularly understood to be a national complaint handling body, in fact the role of Ahpra and the place of the National Scheme in this complex network of practitioner regulation is very niche. The National Scheme is a professional standards scheme – it handles only those matters that relate to a health practitioner who is registered in one of the 16 regulated health professions, and only if the matter relates to an alleged departure from professional standards of conduct or performance (including because of impairment). The role of the National Scheme regulators is not to 'resolve' a complaint to the satisfaction of the parties (the complainant and the practitioner) but rather, to address any professional practice issues raised and ensure that the practitioner remains safe and competent to practice or is no longer able to practice if this cannot be achieved.

This differs from the complaints handling schemes operated by the state and territory HCEs, where their jurisdiction is to receive the broader range of complaints about a health service. Their role is not limited to departures from professional standards, but also considers a wider range of circumstances that affect the experience of a health consumer and their trust and confidence in the health system.

The broader complaints remit of HCEs includes dealing with consumer concerns such as: inability to access a service, excessive waiting times, poor communication with patients or family, and costs to access records. Such concerns may not be so serious as to require disciplinary action but may benefit from other non-disciplinary resolution/restorative actions such as an apology, a refund, open disclosure, and refocussed care planning.

State and territory HCEs have a broad range of restorative options when dealing with a complaint, including in some jurisdictions the ability to facilitate compensation. Conciliated financial settlements are not available as an outcome from the notification management process under the National Scheme.

If a matter that is lodged with Ahpra does not meet the threshold for regulatory action set out in the National Law, it will often be closed with no further action. Ahpra and the National Boards are unlikely to deal with the type of complaints outlined above unless they also involve a departure from accepted professional standards that is serious enough to warrant disciplinary action of some kind. The term "notification" is therefore used within the National Scheme to distinguish these from complaints.

The challenge of finding the right place (and the consequences of landing in the wrong place) currently rest with the consumer.

- If a consumer has a complaint about a health experience that does not relate to a registered health practitioner, then Ahpra will not process that complaint as a notification – it will close it as an enquiry without further action. In these cases, the consumer is advised that they may still go to the relevant state and Territory Health Complaints entity with their

⁷³ Ibid., p. 7.

complaint, but if they are unable to do so they may not get access to the resolution that they may be seeking – such as an apology, a refund, access to documentation, and in some cases compensation.

- Similarly, if a HCE receives a complaint about an aged care or disability service provider, this complaint may fall within the jurisdiction of the National Aged Care Quality and Safety Commission or the NDIS Quality and Safeguards Commission and the HCE will most likely refer the complaint on to that entity, to relieve the burden on the consumer.
- Complaints about non-registered practitioners and health service organisations can only be managed by HCEs (except for a non-registered practitioner who holds themselves out as a registered practitioner).

Only two states, NSW and Queensland, have a single point of entry for complainants. In each of these jurisdictions, the HCE receives and assesses all complaints that relate to health practitioners or health service organisations, including those that fall within the National Law definition of a ‘notification’. This initial assessment is done by the HCE in consultation with practitioner experts and Ahpra staff as required.

The joint ACQSHC and Ahpra research project found that consumers want “*a streamlined, consistent process that is focused on their needs rather than the system’s structures*”.⁷⁴ Understandably, the technical distinctions between a notification and a complaint, between a registered and non-registered practitioner, between a nationally regulated health organisation and a state or territory regulated health organisation) mean little or nothing to the consumer. Indeed, often their complaint will include elements of all these things. It should not be the complainant’s responsibility to navigate their way from one entity to another to find the right place.

Put simply, it is reasonable to expect that once the consumer has lodged their complaint, suitable actions will be taken and if there are multiple actions (restitution as well as disciplinary action) these will occur in parallel.

Some internal workings of the National Scheme may inadvertently have compounded the challenges for consumers. Business processes should be assessed through a sharper customer centric lens, both at the time of design and periodically during implementation.

For instance, the recent introduction of Ahpra’s revised triaging process warrants closer scrutiny.

Section 25(i) of the National Law requires Ahpra to “**establish an efficient procedure for receiving and dealing with notifications against persons who are or were registered health practitioners and persons who are students, including by establishing a national process for receiving notifications about registered health practitioners in all professions**” (emphasis added).

Consistent with the requirements of section 25(i) and in an effort to reduce delays in processing of notifications, Ahpra has advised this Review that its revised intake and assessment process includes:

- strengthened early decision-making about whether or not a matter raised in meets the definition of a notification that can be made under the National Law, and
- earlier identification of serious matters requiring more forensic investigation, to enable earlier referral of such matters into the formal investigation pathway.

⁷⁴ Ibid., p.2.

One consequence is that around 15% of notifications lodged are now closed more quickly, as they may not be about a matter where the National Scheme has jurisdiction. These matters are closed on the basis of “no grounds” and are classified as enquiries rather than notifications.

The efficiency benefits of this reform are evident, with a greater proportion of notifications in 2022-2023 being finalised in less than three months than in 2021-2022. This effect appears to be having flow on effects, with a reduced number of notifications open between 3-12 months.⁷⁵

There are two issues that have been raised with the Review that go to the question of the satisfaction of consumers (and indeed practitioners) with the National Scheme.

- *First*, there appears to have been less focus than is desirable on addressing the problems of aged notifications (that is, those open for longer than 12 months). The data shows an approximate 5% increase in the proportion of matters open for 12 months or more between 2021-22 and 2022-23.⁷⁶
- *Second*, in complaining to the National Health Practitioner Ombudsman (NHPO), some consumers view early closure of their notification as a failure to properly consider the concerns they have raised.

For those consumers whose notifications fall within the 15% that are closed on the basis of ‘no grounds’, while such an outcome may be appropriate and may accord with Ahpra’s obligations under the National Law, it appears that some consumers are left feeling confused and frustrated that they must take their concerns elsewhere. This undermines trust in the regulatory system. Once a consumer has gone to the trouble of lodging a notification, if their complaint does not meet the threshold for disciplinary action under the National Law, having raised the notification the consumer expects that Ahpra would nevertheless be passed through for consideration of resolution, rather than being re-directed to the HCE to commence another process.

There also appears to be increasing consumer dissatisfaction linked to the growing proportion of notifications that are closed with no further action (NFA). For those matters that progress through the assessment process (and are not filtered out as ‘no grounds’), a further 60% result in a decision following assessment that no further action is required. This outcome may be because the allegations made are unable to be substantiated, or are considered vexatious, or because information gathered during the assessment stage indicates that the professional practice concerns have already been addressed.

Combining the no-grounds and NFA categories, around 75% of all notifications lodged do not progress past the assessment process and are closed with no further action.

Both these issues have been raised by the National Health Practitioner Ombudsman (NHPO), who has highlighted concerns, particularly where there is no statutory right of review for a notifier of the outcome of the initial notification assessment process.

The Review has been advised that in 2023–24 the NHPO received a total of 34 complaints from consumers about the failure of National Scheme regulators to progress their notification beyond the preliminary assessment stage. While this is not a large number relative to the volume of notifications, it is of note that they included decisions where:

- no grounds for a notification were found by Ahpra

⁷⁵ Australian Health Practitioner Regulation Agency, Annual Report 2022/ 23 – Growing a Safe Workforce, p74-77 Available at : <https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-2023.aspx>

⁷⁶ Ibid.

- there were considered to be insufficient particulars to process the matter as a notification
- the matter was referred to a HCE
- the matter was considered to relate to a previous notification that had been finalised
- the matter was treated by Ahpra as an administrative complaint.

The NHPO has advised that the Office continues to receive a broad range of complaints about the National Scheme, including about the adequacy and manner of communication with notifiers.

In summary, the issues raised by consumers and the NHPO suggest there is a need to take additional steps to apply a customer-centrism test to business process changes, which may assist to guide further refinement of Ahpra's triaging and assessment processes. There are indications that Ahpra's continuous business improvement agenda includes efforts to improve communication with consumer notifiers about the nature of decisions taken with respect to their notification and the reasons for these decisions. However more may be required.

While business process improvements are important, arguably the more significant question is whether there is a need to reconfigure the complaints/notifications handling systems and structures in ways that make it more intuitive and accessible for consumers. One solution to the problems experience by consumer notifiers is to establish a single point of entry for complaints and notifications about registered health practitioners within their own state or territory and a more effective interface between the HCEs and Ahpra, so that consumer complaints can find their way to the most appropriate regulator in an efficient, timely and transparent way.

For the coherence and effectiveness of the National Scheme, if there were a more appropriate place and a more efficient process for managing the 75% of notifications that are currently received by Ahpra and do not require further action (at either the triage point or following preliminary assessment), this would enable the National Scheme regulators to focus on the remaining 25% of matters that require more concerted regulatory attention.

Practitioners

Practitioners also experience frustration and dissatisfaction about how the National Scheme regulators deal with them when they are the subject of a notification. Some concerns such as delays and communication issues parallel the experiences of consumers. However, practitioners have additional specific concerns.

The essence of the difficulty for practitioners is that the National Scheme is principally about ensuring practitioners are safe and competent to practise. Alleged departures from professional standards are examined through the lens of possible disciplinary action. A notification can have a significant impact on a practitioner, the way they work, their professional reputation and in some cases whether they can work at all. For a practitioner, being the subject of a notification is an inherently stressful experience.

If a notification results in no further action, as it does in 75% of cases, the stress on the practitioner has nevertheless already occurred.

Progressive reforms to the triaging and assessment of notifications outlined above are an important step to minimise the delay and associated stress of a notification, but Ahpra investigations continue to be protracted and the impact on practitioners is more likely to be amplified when this happens.

The Review acknowledges in this regard the excellent proactive work of Ahpra in researching aspects of practitioner distress and its continuous program of initiatives in this area.⁷⁷ Efforts to minimise the stress for practitioners should continue to be an important focus for National Scheme regulators.

Outcomes of Complaints

It is reasonable to expect that decisions taken in response to notifications will reflect community expectations and values. The question is whether current decision-making structures and processes are equipped to deliver this outcome.

Having committed and knowledgeable board and committee members is broadly recognised as an important way to maintain alignment with community expectation and to ensure that regulatory decisions reflect community mores.

The role of community members on National Boards and committees is a longstanding and largely unresolved issue for the National Scheme. The membership requirements for National Boards are set out in section 33 of the National Law. Emblematic of the limitations on community voice in the National Scheme is section 33(9) which requires the Chairperson of a National Board to be a practitioner member.

A decade ago, the Snowball Review recommended that the National Law be amended to enable the Ministerial Council to appoint a community member as Chairperson of a National Board.⁷⁸ This recommendation was originally accepted by Health Ministers but it was later determined that it would not be implemented. It remains the case today that there is no National Board chaired by a community member.

The Review could not find any reasonable justification for the National Law provisions that exclude the option for the Ministerial Council to appoint a community member as Chairperson for a National Board. Appointments should be made on merit, through a robust arms-length appointment process. There are ample precedents, both in Australia and internationally, that demonstrate the effectiveness non-practitioner chairs.

Parity in the number of community and practitioner members on National Boards and committees also remains a live issue. While there is no formal policy position to strive for parity, there is some progress in this direction, particularly following consideration of processes and structures for managing notification regarding sexual boundary violations. A promising sign, and one that signals the potential of strengthened community voice in decision-making, is that the Special Interest Committee of the Medical Board, which deals with notifications relating to allegations of sexual assault and family and domestic violence, is chaired by a community member and this Review has been advised that it is generally considered to be operating effectively. Also, there are moves towards parity on State Boards in accordance with the wishes of the relevant ministers – the Nursing and Midwifery State Board for Victoria and the Medical Boards for Victoria and Tasmania have parity of members.

Reference has already been made to the absence of a right of review of notification decisions of National Boards, and this is considered to be out of step with best practice complaint management standards. Some jurisdictional complaints entities do have a statutory right of

⁷⁷ Australian Health Practitioner Regulation Agency Publications (2023) Identifying and minimising distress for practitioners involved in a regulatory process
Available at: <https://www.ahpra.gov.au/search.aspx?q=biggar%20practitioner%20distress>

⁷⁸ Snowball, K. op. cit., p. 5.

review.⁷⁹ Even if there is no statutory right of review, a transparent and arms-length administrative process within the National Scheme to review notification decisions is desirable. Ahpra has advised that there is an administrative review process of review in place within the National Scheme. However, the Review could not establish what this process is, who performs it, and whether it is sufficiently visible to those who make a notification.

Summary of issues

There is a need to apply a sharper customer-centric lens to notification management structures and processes.

Collectively, many consumers and practitioners are confused and frustrated about the way that health practitioner notifications are managed, and these experiences can dent public confidence in health practitioner regulation in Australia.

Ahpra and HCE notification and complaint handling processes are not well aligned.

Consumers want a single point of entry to make a complaint and access to a range of solutions, including outcomes such as apologies, explanations and refunds.

Both consumers and practitioners seek improved timeliness and transparency, in accordance with the principles of natural justice.

Community voice at all levels of regulatory decision making is not yet sufficiently embedded.

2.2 Structures and processes within the National Scheme do not drive consistency and timeliness.

Efficiency and consistency in processes and outcomes are not a 'nice to have' in a complaint and notification context. They are a must have. They have a direct and significant effect on the experiences of those relying on the National Scheme and help to maintain confidence in the integrity of health practitioner regulation.

Efficiency and effectiveness are currently particularly difficult to achieve in notifications decision making at any point in time and over, as there are 26 committees that make notification decisions across the 16 professions.

As noted in Theme 1, decision making on a profession-by-profession basis and the absence of cross-profession decision making in the current design of the National Scheme is one element of the risks of inefficiency and inconsistency.

Some erosion of confidence has arisen from a perceived inability to have a uniform process for assessing and deciding matters that are similar across all professions and dominant in this picture has been the management of allegations relating to sexual misconduct. In such highly sensitive cases, regulatory decisions are expected to align with contemporary values and community expectations and be consistent. Outcomes would not be expected to differ depending on the specific profession of the health practitioner.

Also, at the heart of concerns about sexual misconduct notifications (but equally about matters such as sustained domestic violence conviction or other criminal matters) is that there is not

⁷⁹ Note for instance NSW where section 28A of the Health Care Complaints Act, 1993 provides a review right for assessment decisions.

sufficient agility within the National Scheme to identify those matters quickly and to ensure that associated assessment and investigation is thorough and consistent. Some instances of practitioners returning to practice and reinstatement of practitioners by tribunals having been subject to sustained findings of sexual misconduct feature in that narrative.

Paterson (and others) have considered this issue in depth, highlighting two key areas for attention.

As Paterson pointed out,⁸⁰ at the operational level, serious matters of this nature typically require a level of regulatory expertise to ensure that associated investigations are conducted in a robust but also sensitive fashion. Centralisation of such expertise and associated specialised training assists.

Second, at the decision-making level, consistent principles and risk factors must apply. Patterson argued persuasively the merits of a harmonised approach across all professions, supported by cross -profession structures. This has not yet occurred, but a strong case has been made for it.⁸¹

It is noted from the monitoring of implementation of recommendations of previous reviews that the National Scheme has made very favourable progress in relation to training and specialisation, as summarised in [Table 4](#).⁸²

Table 4: Training and specialisation recommendations from previous reviews of the National Scheme

Review	What was recommended?	Implemented
Snowball 2014	Ahpra conduct specific education and training programs for investigators to develop more consistent and appropriate investigative standards and approaches, consistent with the requirements of the National Law, including the primacy of public safety over other considerations.	YES
Senate Complaints Inquiry 2017	Ahpra to conduct additional staff training to ensure an appropriately broad policy understanding and provide staff with ongoing professional development related to the undertaking of investigations.	YES
Paterson - Chaperone Review 2017	Ahpra develop highly specialised staff and investigators for handling sexual misconduct cases, who can establish rapport and deal with victims empathetically, and prioritise the investigation of allegations of sexual misconduct. The MBA develop highly specialised delegated decision-makers for decision-making about sexual misconduct cases.	YES
Paterson Reform - 3-	Ahpra require all staff involved in handling sexual boundary matters to undertake the three-day sexual boundaries	YES

⁸⁰ Paterson, R. op. cit.

⁸¹ Ibid., p. 8.

⁸² See Commonwealth Department of Health and Aged Care, Monitoring improvement in management of professional misconduct: Assessing the implementation of previous reviews of the National Registration and Accreditation Scheme. Unpublished internal document.

Review	What was recommended?	Implemented
year Review 2020	training course, offer periodic refresher courses, and develop a shorter training course for all staff.	

Also, of note has been progress towards establishing structures which centralise decision making on high-risk matters. Paterson noted with favour, the initiative of the Medical Board to establish a Special Issues Committee to receive and assess all complaints about sexual misconduct to ensure that they are dealt with in a consistent fashion, moving away from the prior use of state-based boards and notification committees for that purpose.⁸³

Less progress has been made in the domain of cross-profession regulatory decision making.

Again, this is largely a by-product of the profession-by-profession decision making paradigm, even in cases where the central issue is not profession specific, but rather applying the expected conduct of a registered practitioner in any profession. In the case of sexual misconduct allegations for instance, the primary question is whether inappropriate sexual touching occurred. This is arguably not a profession specific question. There may be a question as to whether it is possible that the touching was incidental to a treatment procedure and therefore not regarded as having sexual in motivation. However, this question can be answered by seeking relevant clinical input to the assessment or investigation process. It does not necessarily require a person of the same profession and experience to make the regulatory decision.

Part of the question too is whether the tools used within the National Scheme are adequate to drive case management discipline and to present a clear picture at any point in time of the status of high priority or high-risk matters.

Ahpra has a well-established risk assessment model, which is applied throughout triaging, assessment, and investigation operational processes. That said, consistency also requires that the same risk factors and interpretation of those factors is applied at the point of decision making. The more decisions making bodies involved, the more the potential for differing interpretation and application of risk factors, even for matters of a similar nature.

A common governance response to this problem would be resetting the distribution of decision-making functions across the National Scheme through delegation of decision making, driven by consistent application of an endorsed risk assessment tool and supported by a strong performance reporting regime, through which both quality and timeliness would be overseen, and necessary process adjustments identified and actioned.

Looking at the National Scheme there is little evidence of use of delegations in the notification, to improve efficiency and consistency. Generally, notification decisions rest with committees of the National Boards or are retained by the National Boards themselves, resulting in the 26 notification decision structures.

To the extent that National Boards do delegate, higher order decisions are delegated to Committees and not to Ahpra. Delegations to Ahpra are very limited and reflect a model within which Ahpra's role would be described more as administrative regulatory support rather than regulation decision making. For example, in relation to immediate action decisions under s156 of the National Law, Ahpra may only take action if:

⁸³ Paterson, R. op. cit.

- If the decision to take immediate action is consistent with the Board's proposal.
- If the delegate agrees that immediate action should be taken for the reasons proposed by the Board.
- No relevant additional information has come into possession.

Similarly, under section 178(2)– Preliminary Assessment or Investigation – Outcome – Relevant Action, Ahpra can only decide to take relevant action through section 178(2) if:

- They hold a reasonable belief under section 178(1)(a)
- The delegate agrees that relevant action should be taken for the reasons proposed by the Board.
- No relevant additional information has come into possession.

Operational performance reporting would also be expected to be part of the governance picture, to ensure that operational effort aligned with both timeliness and risk-based priorities. Perhaps because regulatory decisions rest with National Boards and their committees, but perhaps for other reasons, the operational systems and processes do not appear to focus on high level reporting to ensure National Scheme-wide or profession specific visibility of serious matters and managing those matters to timely outcomes.

As noted in Theme 1, the National Scheme is replete with operational monitoring and reporting but perhaps it is not all fit for purpose. It is one thing for a notification committee or a Regulatory Performance Committee of the National Board to receive a report listing the number of notification or even all notifications in process over a certain time frame. It is another to see what sort of notification are in that category, to have supporting analysis of the reasons for delay and to have actions flowing to reset priorities across those matters.

Summary of Issues

Complex decision-making structures, absence of cross profession decision-making and lack of delegation of regulatory decision making contribute to delay and inconsistency of decisions between professions and over time.

There is a reasonable public expectation that that serious complaints and risks that are triggering escalating community concern be managed in a timely and effective way.

The community voice in decision making is limited.

The operational performance monitoring and accountability regime does not focus strongly enough on high-level monitoring of the management of serious complaints

2.3 The clinical input that is considered necessary to effective decision making needs to be more widely available.

Ahpra currently integrates clinical input as part of its notification assessment processes, and there are designated clinical advisors employed for this purpose.

There is a recognition that access to clinical advice increases the robustness of notification assessment processes. Clinical input is obtained and documented on any concern that is associated with clinical practice or performance, to assist notifications staff to assess regulatory risk and advise decision makers on the need for further regulatory action.

At present, Ahpra has 59 clinical advisors with expertise across the 5 largest professions as shown in [Table 5](#). They assist at several stages of a notification process to ensure that clinical issues are understood and correctly interpreted and analysed.

Table 5: Ahpra clinical advisors

ADVISOR PROFESSION	NUMBER OF ADVISORS
Clinical Advisor (Dental)	5
Clinical Advisor (Medical)	19
Clinical Advisor (Nursing and Midwifery)	13
Clinical Advisor (Pharmacy)	12
Clinical Advisor (Psychology)	10

At the point of receipt of a notification, Clinical Advisors assist notifications staff with:

- Identifying concerns.
- Finalising the risk assessment.
- Outlining the sources that stipulate fitting standards.
- Reaching a view on the best management strategy for the notification.
- Organising and facilitating case discussions.
- Deciphering health and performance assessments in addition to Independent Practitioner Opinion reports.
- Assisting with the identification of best sources and methods for acquiring extra relevant information.

Clinical advice is also to be used throughout the notifications process to assist with:

- Identifying and outlining risk levels.
- Outlining the range of the assessment and determine appropriate health/performance issues that necessitate assessment and may also determine the appropriate form of assessment.
- Identifying, framing, and documenting concerns.
- Identifying relevant professional standards.
- Identifying relevant sources to gather relevant information or evidence.
- Undertaking case discussions.
- Providing support with drafting questions to ask the practitioner.
- Reinforcing a decision to seek an Independent Opinion.

Clinical advice assists Boards and committees to:

- 1) Identify grounds on which a determination that no further action is necessary can be made.
- 2) Recognise and articulate how a practitioner's statements inform a belief that there has been a departure from standards.

- 3) Identify and explain how the practitioner records support a recommendation on a notification.
- 4) Decide if the regulatory action suggested by the notifications officer is feasible, accessible, and suitable to address any identified departure from expected standards.

The National Scheme also relies on advice from independent clinical experts, particularly in support of investigations and disciplinary proceedings. An independent expert is important to provide strong evidence and guidance to support Board actions, particularly in relation to:

- Whether a health practitioner is performing their work to a reasonable standard.
- Undertaking independent health assessments. Health assessors are specifically medical practitioners who are registered or psychologists that have been approved by the National Board to provide independent health assessments in line with section 169 of the National Law.
- Undertaking performance assessments. Performance assessors are health practitioners who are registered in the same profession as the practitioner for whom the performance assessment is sought.

The issue that has been put to the Review is the need to consider whether and if so how the model of clinical advice could be expanded. This seems to relate primarily to the desire for a broader range of clinical experts to support notifications assessment functions. However, there may also be merit in considering the depth and breadth of the pool of independent experts and the processes to orient them to the National Scheme and the role of clinical evidence, as this will remain a central feature of robust and effective regulatory decision making.

The expansion of clinical advice within the notifications and investigation processes may reduce reliance on National Boards and committees for this expertise and could assist in evolving to a regime of increased delegation of decision making to Ahpra.

Summary of issues

Clinical advice is central to effective regulatory decision making, but the current clinical advice model is focussed on medical practitioner advice and does not extend to other professions.

Additional clinical advice embedded at the operational level could facilitate increased delegation of decision making from National Boards to Ahpra.

2.4 There is concern from the National Scheme that the state and territory Tribunal decisions and processes are not consistent

Currently, tribunals in each state and territory hear and determine the most serious National Law disciplinary matters, under their jurisdiction-specific tribunal legislation.

The National Boards and Ahpra have expressed significant concerns about inconsistencies in Tribunal processes as well as outcomes for matters of similar character.⁸⁴ The crux of their issue is that a practitioner's experience of the disciplinary processes under the National Law may vary depending on which jurisdiction their matter is heard in, with potential inequities in

84 Australian Health Practitioner Regulation Agency Documentation (Inconsistencies in process) internal document provided to inform the NRAS Complexity Review (2024).

disciplinary outcomes. Plainly if there were stark inconsistencies this would raise questions about the coherence and effectiveness of a national system of practitioner regulation.

In relation to process issues, the Ahpra research has identified the following process inconsistencies:

- Costs orders from tribunals.
- Approach to dispute resolution, which impacts costs, timeliness and experience.
- Hearing panel composition, which impacts outcomes, timeliness and costs.
- Resourcing of tribunals.
- Limited or variable approaches to protect/support complainants in sexual misconduct matters.
- Immediate action decisions, which impacts the experience of the practitioner, the notifier, other patients and the community, as well as costs.

Ahpra has provided an overview of the nature and impact of these inconsistencies as shown in [Table 6](#).

Table 6: Examples of the nature of impact of tribunal decisions

Example of inconsistency	Impact
<p>Costs</p> <p>Tribunals around Australia have disparate approaches to awarding legal costs at the conclusion of a proceeding. For example:</p> <ul style="list-style-type: none"> • In Queensland (QCAT), the starting position is that each party must bear its own costs of the proceedings. This is a higher bar than in other jurisdictions. • In Victoria (VCAT), costs orders have not historically been made against practitioners (except in exceptional cases). • In NSW (NCAT) costs typically follow the event. <p>Whether a practitioner will be required to pay costs will therefore depend on the jurisdiction as these three outcomes show:</p> <ul style="list-style-type: none"> • In <i>MBA v Liyanage</i> the Western Australian State Administrative Tribunal (SAT) ordered that the practitioner pay the costs of the Board fixed in the sum of \$5,000 after the practitioner was found to have engaged in professional misconduct on the basis of serious sexual misconduct. • In <i>MBA v Yu</i> after the practitioner was found to have engaged in professional misconduct on the basis of child exploitation material, SACAT (with the parties' agreement) ordered the practitioner to pay costs in the sum of \$74,100. 	<p>Matters run before tribunals are costly for practitioners and the regulator.</p> <p>The awarding of costs can have consequences for tactical decisions made by the parties.</p>

Example of inconsistency	Impact
<ul style="list-style-type: none"> In MBA v XOT , VCAT made no order as to costs after the practitioner was found to have engaged in professional misconduct on the basis of serious sexual misconduct. This reflects the position that costs are not historically awarded in Victoria. 	
<p>Approach to dispute resolution</p> <ul style="list-style-type: none"> In Western Australia (SAT), mediations are routinely ordered, even if this is opposed by the parties. It is not uncommon for multiple mediations to be ordered⁸⁵ In Queensland (QCAT) and ACT (ACAT) mediations are optional and will not be imposed on the parties unless requested. In Vic (VCAT), matters are commonly listed for a compulsory conference (before a member of the tribunal). In SA (SACAT), matters can be listed for a compulsory conference if the parties seek one. 	<p>Dispute resolution can be costly for both parties and, subject to the suitability of the matter for mediation, may not result in a beneficial outcome.</p>
<p>Single member decisions and/or composition of the panel</p> <ul style="list-style-type: none"> In Western Australia (SAT), disciplinary decisions are often made or endorsed by a single member. In other jurisdictions, disciplinary decisions are generally made or endorsed by a panel. The size and composition of the panel varies between jurisdictions, for instance, ACAT requires 2 members; SACAT requires 3 members and QCAT requires 4 members. 	<p>The size and composition of the decision-making panel can affect the outcome.</p>
<p>Resourcing and timeliness</p> <p>Delays in having a matter heard and determined can be significantly impacted by practitioner member availability in each jurisdiction. For instance, presently:</p> <ul style="list-style-type: none"> there is no medical radiation practitioner member or optometry member available in Vic (VCAT) there is no dental practitioner member available in NT (NTCAT). 	<p>Delays in process can significantly impact the practitioner, the regulator, the notifier and potentially other affected members of the community.</p>

⁸⁵ The WASAT 2022/2023 Annual Report explains that the Vocational Regulation Stream has a target of completing 80% of their matters within 27 weeks. After recognising the complexity of health related matters, the Report notes that the Tribunal's emphasis on mediation ("as a means to resolve matters in the VR stream without the need for a hearing, and with less cost to the parties") has seen the Tribunal's clearance rate increase to 95%. However, in *Nugawela v Medical Board of Australia (WA Branch)* [2024] WASC 15, the Supreme Court of Western Australia appropriately noted the limitation on Boards' ability to mediate matters in saying "the Medical Board has responsibilities under the HPL which constrain the extent to which it can negotiate. It is not in the position of a commercial party, which ordinarily has much greater scope to negotiate."

Example of inconsistency	Impact
Accordingly, matters involving practitioners from those professions are unable to be progressed to hearing (pending appointment of the relevant practitioner members to the responsible tribunal).	
<p>Immediate action decisions</p> <p>In Queensland (QCAT), there is no provision for the practitioner to seek a stay of an immediate action decision pending a final review hearing in the Tribunal.</p> <p>In most other jurisdictions, a practitioner can seek a stay of an immediate action decision pending a final review hearing in the Tribunal.</p>	Delays in processes and decision making have significant impacts upon the practitioner, the regulator, the notifier, and potentially other affected members of the community.

The review recognises that these differences in process can have an impact, and that this should be discussed with the state and territory Tribunals to determine whether there is scope and a mechanism for harmonising processes across the jurisdictions, appreciating that this would also need to involve officials of Attorneys General with portfolio responsibility for the Tribunals and their legislation.

The picture of inconsistencies in outcome for practitioners from tribunal decisions is less clear. While some states and territories and some tribunal members have indicated that they do not consider lack of consistency in disciplinary decision to be a significant concern, Ahpra has pointed out that its concern arises from its unique cross jurisdictional remit in prosecuting matters and that the concerns are particularly acute in sensitive areas such as proceedings relating to family and domestic violence and sexual boundary violation.

The Review has been unable to assemble a sufficiently broad sample of case decisions to determine the nature or extent of any potential inconsistency. However, the issue is of sufficient importance that, at the very least there, does appear to be a need for further research and analysis.

It is noted that there is strong advocacy from within the National Scheme for a single national health practitioner tribunal to respond to any problem of consistency.

The Review notes that this option would need to be carefully considered in terms of the potential legal and constitutional impediments and also that any decision to progress down this path would be a matter for Attorneys General. As a matter of policy process, this option would also need to be evaluated alongside other strategies for strengthening processes for decision making and procedures for disciplinary decision making within the National Scheme, as these too have the potential to impact on disciplinary outcomes. This approach reflects that consistency will also be a function of factors such as:

- Decisions to take disciplinary action - who the decision rests with and what factors they must or may consider.
- Decision about whether to take action via a tribunal or a Panel - who the decision rests with and what factors they must or may consider.
- The practices of advocates in identifying and citing lines of authority when presenting cases to tribunals.

- The quality of witness evidence presented.

Summary of Issues

There is understandable concern about potential inconsistency in tribunal decisions, including in sensitive matters such as boundary violations and family and domestic violence cases. Further research is required to examine these concerns and to guide full consideration of possible solutions.

Theme 3: Scope and Expansion of the National Scheme

Linkage to the Terms of reference

Term of Reference 5 for the Review requires consideration of the entry criteria as specified in the Intergovernmental agreement for the National Scheme to determine if they are still fit for purpose. This acknowledges that mechanisms for adapting and growing the National Scheme are important, so that it continues to deliver effective regulation for those professions whose practice poses a risk to public health and safety.

Carefully managed growth and development of the National Scheme is also directly related to efficiency, effectiveness, and sustainability considerations, which are embedded in Term of Reference 4 for the Review and captured in the guiding principles of the National Law.

What are the issues and challenges?

3.1 There is considerable pressure to expand the National Scheme beyond the existing 16 professions.

To give context to this issue, upon its establishment in 2010 there was a staggered implementation of the National Scheme. Ten professions entered the Scheme from mid-2010, and registration for the remaining four professions commenced in 2012.

The first tranche of 10 health professions were those that, prior to the National Scheme had been registered via statute in every state and territory (or in the case of podiatrists in all but the Northern Territory). They were chiropractic, dental,⁸⁶ medical, nursing and midwifery,⁸⁷ optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology.

In 2012 four so-called 'partially regulated' professions were brought into the National Scheme: Aboriginal and Torres Strait Islander Health Practice, Chinese medicine, medical radiation practice and occupational therapy.

The profession of paramedicine was included in the National Scheme from 2018. Review of the regulatory impact assessment and an associated Senate Committee inquiry report⁸⁸ suggests that key considerations for addition of this profession were:

- Paramedics fulfill a complex role that requires them to perform many tasks that are equivalent to those performed by doctors and nurses. However, unlike doctors and nurses, paramedics often provide treatment in an unregulated environment with limited support, such as at the scene of a car accident. They are regularly required to make clinical decisions under pressure that have serious consequences for patients' lives. Whilst their colleagues, including doctors, nurses, and 12 other health professions have national registration systems, paramedics do not.
- Paramedicine is being practised increasingly through private health organisations.
- Incompetence or malpractice may be hard to detect in paramedicine, given that paramedics work without direct supervision, therefore requiring codified requiring codified and nationally consistent standards.

⁸⁶ Including dentists, dental therapists, dental hygienists and dental prosthetists.

⁸⁷ Midwifery subsequently became regulated as a separate profession in 2017, but still under the jurisdiction of the Nursing and Midwifery Board.

⁸⁸ Parliament of Australia Senate Standing Committee on Legal and Constitutional Affairs. Report on the Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community safety (2016) Chapter 4. Available at:

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Report

- Diversity of qualifications in the paramedic workforce - while professional recognition is important for students and recent graduates who have invested in university degrees in paramedicine, members of the current workforce, who may not have a degree, nevertheless have significant clinical experience that should be recognised.

The National Scheme currently includes 16 regulated health professions, regulated by 15 National Boards, with administrative support provided by Ahpra. Across these professions the number of health practitioners regulated by the National Scheme is fast approaching one million practitioners (currently around 960,000).

The initial scoping discussions for this Review revealed a widespread view that there is more history than logic as to which professions are in and which are out of the National Scheme. Many professions are seeking inclusion in the National Scheme – see Textbox 9.

There is also some evidence that many allied health professions with a significant risk profile are outside of the National Scheme and believe they should be included.

Textbox 9: Advocacy for additional professions in the National Scheme

Social workers

The Australian Association of Social Workers has campaigned over many years for inclusion in the National Scheme. The arguments for inclusion centre around the view that this will deliver improved protection of the public and also improve the professional recognition and standing of those practitioners.

- The social work profession was last assessed against the AHMAC criteria in 2018 and Health Ministers agreed that statutory registration was not warranted at that time. The Ministerial Council did not reach a consensus to include the profession in the National Scheme, accepting advice from the Practitioner Regulation Sub-Committee (PRSC) of the Health Workforce Principal Committee (HWPC) of AHMAC that the profession did not meet the entry criteria.
- Advocacy for inclusion continues and South Australia has recently enacted the [Social Workers Registration Act 2021 \(SA\)](#). It has been suggested that national registration would be a more complete solution.
- The AASW has envisaged that registration for social workers would be government funded and has sought recurrent funding of \$3 million per annum for that purpose.⁸⁹

Naturopaths

Professional associations that represent naturopaths have long sought statutory registration. In 2020, the Australian Naturopathic Council commissioned research concerning the risks, benefits and regulatory requirements for the profession of naturopathy. In November 2022, the ANC published a draft submission for consultation, again proposing the inclusion of naturopaths in the National Scheme and seeking the views of members of the profession and other stakeholders⁹⁰ The submission is yet to be formally submitted to governments.

⁸⁹ AASW, 2022-23 Australian Budget Priorities – AASW Submission, January 2022. p.4.

⁹⁰ ANC, 2022: <https://www.naturopathiccouncil.org.au/2022/11/16/public-consultation-nrrp-november-2022/>

Audiologists

In December 2023, Health Ministers agreed to progress consideration of the addition of audiology to the National Scheme, through a regulatory impact statement (RIS) process. This RIS considered options for the future regulation of the audiology profession, including regulation under the National Scheme).

The broad arguments presented in support of the inclusion of audiology are that: it is an area of practice where there is information asymmetry that places vulnerable individuals at risk; business models operating in this sector reflect financial interest conflicts, such that patient preferences and needs may not be fully considered in treatment decisions; and lack of profession-led action to deliver high quality training and clinical guidance. Ministers have agreed in principle to inclusion of audiology in the National Scheme, subject to further consideration of costs and benefits.

Debate about the role of health professional regulation and registration and the inclusion of other professions is by no means unique to Australia, with similar debates in the United Kingdom ('UK') over the inclusion of a number of other professions into registration schemes, including dance movement therapists, hearing aid dispensers, complementary and alternative medicine practitioners, psychologists, counsellors and psychotherapists, and social workers.⁹¹

However, there appears to be a distinct dynamic in Australia with pressures from the professions to expand the National Scheme unrelated to risk to public health and safety. The *Scope of Practice Review* has pointed to the unintended consequence for non-registered health practitioners of the use of the definition of health practitioner from the National Law for other purposes (such as identifying who can perform certain health service functions or access Medicare funding). As the *Scope of Practice Review* highlights, linking these opportunities to registration under the national Scheme effectively excludes non-registered practitioners who otherwise have the skills and experience to deliver the relevant services from doing so and therefore prevents them from working to their full potential.⁹²

Scoping discussions have also identified a degree of stakeholder scepticism about the process for assessing suitability of professions for entry into the National Scheme, although at this point it is unclear whether this relates to the risk criteria or the two staged process that is required, or both.

This issue has been considered most recently in the *Scope of Practice Review: Issues Paper 2*. The Review noted that:

*The self- and unregulated workforces sought greater acknowledgement of the regulatory differences that impact their practice when compared to the professions governed by the Health Practitioner Regulation National Law (the National Law) as part of NRAS. The importance of considering legislative and/or regulatory solutions that would enable these workforces to work to their full scope was highlighted, although clear consensus regarding how this would be operationalised was not reached.*⁹³

The two-stage assessment process that is already in place for assessing professions for entry to the National Scheme applies a public benefit test that assesses risks, costs, and benefits, as

91 Walton et al Regulation of Health Practitioners in Australia: A National Approach to Polycentric Regulation? (2018) p. 168 Available at:

https://www.researchgate.net/publication/326682236_Regulation_of_Health_Practitioners_in_Australia_A_National_Approach_to_Polycentric_Regulation

92 Cormack, M, op. cit.

93 Ibid., p. 18.

this is the fundamental purpose of the Regulatory Impact Analysis step. Therefore, if inclusion of a profession in the National Scheme would be expected to have positive benefits in relation to their scope of practice, this would be taken into account in the assessment of the benefits under the RIA.

The current approach to determining the addition of new professions is summarised in Textbox 10.

Textbox 10: Policy framework, criteria and process for entry of additional professions to the National Scheme

Textbox 10: Policy framework, criteria and process for entry of additional professions to the National Scheme

Key Documents

The policy framework guiding the assessment by governments of the need to extend statutory registration to additional health professions is set out in three key documents.

1. Intergovernmental Agreement for NRAS (NRAS IGA)⁹⁴
2. Regulatory Impact Analysis Guide for Ministers' Meetings and National Standard Setting Bodies (the RIA Guide)
3. AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions (the AHMAC Guidance)

Intergovernmental Agreement

The NRAS IGA, signed in 2008 by Australian state, territory and Commonwealth Governments committed all governments to the establishment of National Scheme.

Attachment B of the NRAS IGA sets out the arrangements for inclusion of other health professions in the National Scheme and adopts the six criteria for regulatory assessment that were first agreed upon by state, territory, and Commonwealth Governments through AHMAC in 1995.

Importantly, the NRAS IGA references two 'guiding principles' in applying these criteria: the sole purpose of registration is to protect the public interest; and the purpose of registration is not to protect the interests of health occupations.

AHMAC Criteria

There are six threshold criteria for entry to the National Scheme, set out below. These AHMAC criteria have not changed since they were first agreed in 1995⁹⁵ and they were formally applied in relation to the National Scheme.⁹⁶

⁹⁴ Australian Health Practitioner Regulation Agency. Intergovernmental Agreement For a National Registration and Accreditation Scheme for the Health Professions Available at:

<https://www.ahpra.gov.au/search.aspx?q=intergovernmental%20agreement>

⁹⁵ Ibid., p.22.

⁹⁶ Ibid., p.2.; Australian Health Practitioner Agency AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions (2018) Available at: <https://www.ahpra.gov.au/Search.aspx?q=AHMAC%20criteria%201995>

1. Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?
2. Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
3. Do existing regulatory or other mechanisms fail to address health and safety issues?
4. Is regulation possible to implement for the occupation in question?
5. Is regulation practical to implement for the occupation in question?
6. Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

Regulatory Impact Analysis Guide for Ministers' Meetings and National Standard Setting Bodies (the RIA Guide)

Whole of government Regulatory Impact Analysis requirements also apply, such that any proposal to change to the scope and operation of the NRAS requires an RIA and has done since the outset of NRAS.⁹⁷

The Process

The AHMAC Guidance 2018 codified the process to be followed by state, territory and Commonwealth health ministers when deciding whether to extend the scope of the NRAS to include a non-registered health profession.

This nationally agreed process provides for a professional association that represents members of an 'unregistered' health profession to make a submission to any participating jurisdiction (a state, territory or Commonwealth health department), requesting a regulatory impact assessment in accordance with the AHMAC process.

The AHMAC Guidance details:

- How ministers consider submissions for inclusion in the National Scheme, applying the six 'threshold criteria' from the NRAS IGA that a profession must meet in order to be considered for regulation under the NRAS and the assessment process.
- The second stage process of regulatory impact assessment (RIA).⁹⁸

The preliminary view of this Review is that the two staged assessment process for assessing professions for entry to the National Scheme that has been in place since its commencement remains fit for purpose – the process aligns with the core purpose of the National Scheme, targeting those professions whose practice poses a risk to public health and safety.

There is also evidence that the process accords with international best practice regulation principles. In January 2024, the Canadian Health Workforce Network published a report of a review of the global literature on health practitioner regulation (HPR) commissioned by the

⁹⁷ The current policy document was published in 2023 on the website of the Australian Government Department of Prime Minister and Cabinet's Office of Impact Analysis. Available at: <https://oia.pmc.gov.au/>

⁹⁸ While there are some changes in terminology in the most recent RIA requirements, the process of assessment appears largely the same, albeit giving the Ministerial Council some greater discretion as to whether a RIA is done.

World Health Organization.⁹⁹ This report reviewed the literature on how countries make regulatory policy decisions about which professions to regulate via statute.

Annex 7 of the report presents comparative data on the mechanisms used in a sample of jurisdictions for assessing changes to the scope of a statutory registration scheme to include additional professions. It identified key features of the regulatory policy and practice in five jurisdictions including Australia, Good regulatory practice included the following:

- A published and transparent process for regulatory assessment which complies with rigorous whole of government Regulatory Impact Assessment protocols.
- Assessment at arm's length from the regulators.
- Following assessment, professions are included by Ministerial determination followed by legislation.
- Extensive policy documentation and process information is published on a government website.

The WHO report underscores the important point that the RIA is an integral component of best practice regulatory assessment:

- This strengthens evidence-informed policy making - ensuring any new or amended law avoids unnecessary restrictions on competition, minimizes regulatory burdens and costs to business or the community and demonstrates the 'highest net benefit'.¹⁰⁰
- It notes the literature which suggests that many governments have been subject to pressure from stakeholders to expand statutory registration schemes to include more health professions and occupations and that 'as a consequence, some occupational groups may be licensed when perhaps other regulatory models (such as negative licensing or co-regulation) may provide sufficient public protection'.¹⁰¹

99 Carlton et al., (2024). Health Practitioner Regulation Systems: A large-scale rapid review of the design, operation and strengthening of health practitioner regulation systems. Canadian Health Workforce Network Available at: <https://apo.org.au/node/325363>

100 Ibid., p. 50.

101 Ibid., p.50 - 51.

Summary of Issues

Many allied professions are not included in the National Scheme and seek to be.

While the argument in favour of this is generally framed in terms of risk, wider considerations are in play, including professional recognition and the expectation of equality of access to opportunities (such as access to Medicare or ability to participate in funded programs, health system policy and planning fora or wider service delivery) that incidentally attach to the fact of registration – benefits that incidentally attach to the fact of registration but are not related to the National Scheme purposes.

The processes for entry to the National Scheme align with its core purpose of protection of public health and safety and reflect well-established principles and disciplines for assessing the impact and benefits of regulation to inform decision-making.

3.2 There has not been a structured National Scheme-wide exploration of alternative models of registration that have potential to deliver protective benefits in a more sustainable way.

Including a profession in the National Scheme currently necessitates the creation of substantial profession-specific entities and processes to enable the delivery of standard setting, registration, title protection, accreditation and complaints handling functions. This drives cost and adds complexity.

It is important to note that statutory registration within the National Scheme is only one of a number of types of occupational regulation governing health workers in Australia and it can be restrictive and costly compared with other forms of regulation that may provide similar benefits at lower cost to the community. The other forms of regulation include:

- self-regulation
- negative licensing
- credentialling
- various forms of co-regulation ¹⁰²

It is noteworthy that the policy alternatives to registration through the National Scheme have not been revisited in a systematic way for the last decade. To the extent that other types of occupational regulation have been considered, this has been on a profession-by-profession basis (within regulatory impact assessments for adding specific professions to the Scheme).

What is necessary at this point, is to lift a level from profession-by-profession consideration of alternative regulatory pathways, to consider the threshold question of the scope and purpose of regulation of specific professions and occupations including from the perspective of the overall coherence and sustainability of the National Scheme and whether there is a case for alternative regulation models within the National Scheme.

The closest we have come to addressing the alternatives was in the regulatory impact assessment process for regulation of unregistered practitioners and the associated development of the *National Code of Conduct for health care workers* between 2011 and 2015.

¹⁰³ The Snowball Review in 2014 also touched on some of these issues in recommending that Ministers:

[E]nsure that health professionals not included in the National Scheme should not be excluded or disadvantaged professionally by either:

- Issuing a communique stating that the National Registration and Accreditation Scheme (the National Scheme) is for the purpose of additional regulation of specified professions only and is not to be used for any other purpose.*
- Making amendments to the Health Practitioner Regulation National Law 2009 (the National Law) to state that the National Scheme is for the purpose of additional regulation of specified professions only and is not to be used for any other purpose.*

¹⁰² Australian Health Practitioner Regulation Agency AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions (2018) op. cit., p.5

¹⁰³ Australian Government Department of the Prime Minister and Cabinet Office of Impact Analysis Options for the Regulation of Unregistered Health Practitioners COAG Consultation Regulation Impact Statement – Australian Health Workforce Ministerial Council (2011) Available at:

<https://oia.pmc.gov.au/published-impact-analyses-and-reports/options-regulation-unregistered-health-practitioners-coag>; Final report A National Code of Conduct for health care workers (COAG Health Council 2015).

c. *Establish a system of quality assurance for voluntary registers of self-regulated professions.*¹⁰⁴

The action taken by the Ministerial Council following the Snowball Review sought to address the unintended consequences for those professions operating outside the National Scheme. Ministers accepted and implemented option (a) of recommendation 8. As a result option (c) which would have involved deeper consideration of a new model of regulation for inclusion in the National Scheme (along the lines of the UK voluntary accredited registers), was not progressed. Textbox 11 provides details of the UK voluntary accredited registers program.

It therefore remains that there is a single model of regulation under the National Scheme (statutory registration) and no system-wide view of how the broader health workforce is or should be regulated.

This Review considers that it is now timely and necessary to further explore other types of occupational regulation, such as whether and how a government operated program of quality assured voluntary registers based on the UK model, might apply in the Australian context. This model is summarised below.

Textbox 11: The UK Professional Standards Authority Accredited Registers Program

Under the UK Accredited Registers program, the Professional Standards Authority (PSA) has published minimum standards for the operation of public registers of health and social care practitioners.

A professional association that operates a public register of qualified members may apply to the PSA for accreditation of its register.

The association pays a fee to the PSA for the assessment.

A practitioner who has met the membership requirements of the association and whose name appears on an accredited register may advertise that fact to the public.

When choosing a health service, consumers are encouraged to choose a practitioner who is a member of a PSA accredited register.

The PSA has statutory powers to suspend the accreditation of a voluntary registrant, apply conditions or remove a professional association's accreditation.

This model is still in operation, with 28 accredited registers covering over 130,000 practitioners.

A recent evaluation of the scheme articulated its value proposition as follows:

We see the future of the Accredited Registers programme as a robust system which supports efficient delivery of NHS healthcare and social care workforce plans across the four nations. We envision the programme as offering a greater contribution to personalised care for patients, and to support recovery in health and social care from the pandemic. The crisis has highlighted the need for greater integration of health and social care, as well as demonstrating the value of unregulated roles in supporting mental health needs. We would

¹⁰⁴ Snowball, K. op.cit

like to see employers ensuring that their healthcare practitioners in unregulated roles belong to Accredited Registers.

In the UK context, the principle of proportionality (in the sense of weighing costs and benefits) was a key consideration in establishing the Accredited Voluntary Registers program in 2012, as was the need to better address the breadth of the health care workforce and its intersection with the even larger social care workforce. The model was:

[E]nvisaged by Government as a proportionate way of ensuring that bodies registering these roles operate effectively and adhere to good standards, as well as giving assurance to employers and the public.¹⁰⁵

Following the lead of the UK Professional Standards Authority approach, Hong Kong has legislated to establish a similar scheme for its healthcare professions that are not registered under statute. This *Accredited Registers Scheme for Healthcare Professions* (AR Scheme) was launched in 2016 with the objective to “*enhance the current society-based registration arrangement under the principle of professional autonomy, with a view to ensuring the professional competency of healthcare personnel and providing more information to the public so as to facilitate them to make informed decision*”.¹⁰⁶

The Hong Kong Scheme includes 15 non-statutorily regulated healthcare professions including: audiologists, audiology technicians, chiropodists/podiatrists, clinical psychologists, dental surgery assistants, dental technicians/technologists, dental therapists, dietitians, dispensers, educational psychologists, mould laboratory technicians, orthoptists, prosthetists/orthotists, scientific officers (medical) and speech therapists.

It is important to note that in Australia there is self-regulation of professions that are currently outside of the National Scheme, by professional membership organisations and peak bodies.¹⁰⁷ The UK and Hong Kong Models differ as they are co-regulatory models, which ensure that there is statutory certification or accreditation of registers and associated quality and safety assurance relating to those on the register.

Consideration of such alternative models of registration within or alongside the National Scheme is unfinished business, and usefully addressed through this Review.

Summary of Issues

The scope of the National Scheme encompasses only one type of occupational regulation, that of statutory registration. This is a costly and complex model and there is a genuine prospect that expanding the National Scheme through this mode will soon reach a point of unsustainability.

There are other models operating overseas that are less cumbersome but effective and which could be considered.

¹⁰⁵ Professional Standards Authority for Health and Social Care (UK) Why we are undertaking a strategic review of the Accredited Registers programme (2021) Available at: <https://www.professionalstandards.org.uk/news-and-blog/blog/detail/blog/2021/02/05/why-we-are-undertaking-a-strategic-review-of-the-accredited-registers-programme>

¹⁰⁶ Hong Kong Department of Health Accredited Registers Scheme for Healthcare Professions Available at: https://www.dh.gov.hk/english/useful/useful_ar_scheme/useful_ar_scheme.html

¹⁰⁷ Including National Alliance of Self-Regulating Health Professions

If there were other registration pathways within the National Scheme (modelled on international initiatives) these could be available for lower risk professions seeking to join the National Scheme, where costs of full registration outweigh the benefits.

3.4 Improved management of the non-registered health workforce under the negative licensing model is also critical.

As the formal entry criteria for assessing professions for inclusion in the National Scheme indicate, a threshold question for entry to the scheme is: Do existing regulatory or other mechanisms fail to address health and safety issues?

Regulation of the entire non-registered health workforce (in the form of negative licensing) has been operating in some states and territories over the past decade and following ministerial agreement in 2015 this approach is now being implemented nationally. The regulation is all inclusive in that it applies to all non-registered health service providers and is not limited to named allied health or other professions.

The first negative licensing powers commenced in NSW in 2008 – see Textbox 12.

Textbox 12: Non-registered practitioner regulation – the example of NSW¹⁰⁸

Recognising that non-registered practitioners are an ever-growing part of health and personal care services landscape, NSW was the first Australian jurisdiction to regulate non-registered practitioners through what is known as ‘negative licensing’.

The NSW Parliament passed legislation in 2006 to address a perceived gap in regulation, by strengthening public protection for health consumers who use the services of unregistered health practitioners. The Health Legislation Amendment (Unregistered Health Practitioners) Act 2006 introduced a regulatory scheme for NSW with two main elements:

- A statutory Code of Conduct sets minimum practice and ethical standards that apply to all unregistered health practitioners (and registered health practitioners who provide health services unrelated to their registration). This Code provides a framework against which to objectively assess the conduct of unregistered health practitioners. It therefore facilitates the investigation of complaints and permits disciplinary action against practitioners found to be exploiting or taking advantage of vulnerable people.
- Adding to the powers of the Health Care Complaints Commission (HCCC), allowing it to receive and investigate complaints about practitioners who breach the Code and to issue a ‘prohibition order’ limiting their practice or removing them from practice altogether if required.

The NSW Code of Conduct for unregistered health practitioners came into effect on 1 August 2008. The Code of Conduct informs consumers about what they can expect from practitioners and the mechanisms by which they may complain about the conduct of, or services provided by, an unregistered health service provider.

¹⁰⁸ Extracted from Health Care Complaints Commission NSW Health Care Complaint Commission, Annual Report 2018-19, p. 27 Available at: <https://www.hccc.nsw.gov.au/Publications/Annual-Reports>

These powers differed from those that apply to registered practitioners. For practitioners who are in a registered profession, determination of disciplinary action for substantiated allegations is made by either the NSW Civil and Administrative Tribunal or a Professional Standards Committee following determination by the independent Director of Proceedings. In the case of unregistered practitioners, disciplinary action rests with the Commission under section 39(1)(g) and Division 6A of the Health Care Complaints Act 1993.

The HCCC is able to issue a prohibition order on a practitioner following investigation of a serious breach of the Code. A prohibition order may restrict the practitioner's practice or ban them from providing health services altogether if there is a risk to public health and safety. The Commission may also issue a public statement, to warn the public about the practitioner.

The HCCC is also able to issue an interim prohibition order during an investigation, if it reasonably believes there has been a breach of the Code and there is a serious risk to public health and safety that requires immediate protective action.

The HCCC maintains a register of all prohibition orders which is accessible to the public on its website.

The HCCC is also able to issue a public warning if an investigation shows that a particular treatment or health service poses a risk to public health and safety and a warning is necessary to protect the public, irrespective of whether it is provided by registered or unregistered providers (noting that such a public warning can also now name an individual practitioner).

NSW has also built on this negative licensing regime for individual practitioners, extending it to private health service provider organisations.

On 1 September 2022, the Public Health Regulation 2022 was amended to introduce a Code of Conduct for Health Organisations. This sets out mandatory minimum practice and ethical standards for relevant health organisations (which includes all health organisations except public hospitals, public health organisations and licensed private facilities) and its employees.

This allowed HCCC to commence making prohibition orders against relevant health organisations during or at the end of an investigation under Division 7A of the Health Care Complaints Act 1993.¹⁰⁹

The NSW arrangements illustrate the breadth and nature of regulation of non-registered practitioners, and similar provisions are being rolled out in other jurisdictions. This is an important model of regulation from the perspective of the National Scheme and for this Review, for two reasons.

First, pressure from occupations for inclusion in the National Scheme may arise in part because of a limited understanding of the arrangements for regulating non-registered practitioners or from a perception that these arrangements are not sufficiently effective in protecting the public.

Second, members of the public do not necessarily understand the distinction between the complaint management structures and processes for non-registered versus registered practitioners. Where they experience a problem with health service delivery, and they make the

¹⁰⁹ Ibid., Annual Report 2023-23, p. 10 Available at: <https://www.hccc.nsw.gov.au/Publications/Annual-Reports>

(sometimes difficult) decision to lodge a complaint, they expect a suitable response, and it is of little material interest to them whose responsibility it is to deliver that response and under what legislation.

In essence, effective management non-registered practitioners are essential to maintaining confidence in the National Scheme itself and health practitioner regulation as a whole.

There appears to be little understanding of the role and operation of these state and territory negative licensing powers in regulating non-registered practitioners and few indications that the effectiveness of this regulatory model has been assessed or even considered when proposals to extend the scope of the National Scheme are advanced.

For instance, professional associations sometimes claim that unsafe workers can continue to practice even if they have been subject to a complaint to the relevant professional association and that there is no ability for the actions of a non-registered practitioner who is engaged in serious misconduct to be notified to the public. Either the associations are poorly informed of the operation of these negative licensing powers, or these public protection measures are not working as well as they should, or both.

For instance, social workers are a non-registered profession whose members may provide health services that are subject to a statutory code of conduct in six states and territories. Where they breach the Code, they may be subject to investigation by the relevant Health Complaints Entity and if the allegations are sustained and the conduct meets the threshold test, a prohibition order may be issued.

The NSW HCCC received and managed 33 complaints against social workers in 2021-22 and 21 in 2022-23 and the numbers are growing.

The question of whether these powers are being applied effectively, when and where they are needed, is a more complex question, one that is important for this Review to address. It is a matter of concern to the National Scheme itself.

One concern is that the rollout of the National Code of Conduct has been patchy, requiring as it does separate legislation and funding in each state and territory. At present, a Code of Conduct, and the associated prohibition order powers of HCEs have been legislated and is in operation in six jurisdictions- NSW (2008), South Australia (2012), Queensland (2015), Victoria (2016), Western Australia (2022) and the ACT (2023). Tasmania passed legislative amendments in 2018 but is yet to commence the provisions. Northern Territory has not yet enacted the necessary legislation.

Therefore, national coverage of the non-registered health workforce has not yet been achieved and this appears to be a consideration for those advocating entry to the National Scheme.

There are also differences in the operational features of the jurisdictional arrangements and some of these differences are material. For instance:

- NSW appears to be the only jurisdiction where a code of conduct and prohibition order powers have been extended beyond individual practitioners, to cover private health organisations.¹¹⁰
- There are significant differences in the ability to publish reasons for decision. Some HCEs have active outward facing communication and a legislated ability to make public

¹¹⁰ <https://www.hccc.nsw.gov.au/Health-Providers/Health-Organisations/code-of-conduct>

statements, while others appear to have statutory constraints on the publication of information, beyond basic identifying information about the practitioner.

- In some cases, public warnings during and/or after investigations sit alongside public statements and these provide additional information to health consumers about steps that can be taken to avoid the risk that has arisen in the future.

It is also apparent that all HCEs have resourcing challenges with implementing the National Code. This is of concern given that the assessment and investigation of non-registered practitioners is typically very different and often more complex than for registered practitioners. Such practitioners often work alone and in unstructured practice arrangements and it is not uncommon to find use of an alias when providing services. Effective application of the negative licensing or code-regulation powers requires different investigative capabilities and tools, and building and maintaining such expertise is resource intensive.

It is also important to note that in 2015 Health Ministers agreed to the establishment of a national register of prohibition orders issued about non-registered practitioners. This has not yet been implemented.

It is noted that there are now powers for a range of regulators to issue prohibition orders under a variety of laws both Commonwealth and state/territory (the NDIS and aged care regulators, the National Scheme regulators, state and territory tribunals as well as HCEs). It may be timely to revisit the option of a national register to provide one place where all prohibition orders may be accessed to increase consumer understanding and public protection. This is particularly important when health care workers removed from the health workforce when they are not considered fit and proper to work with vulnerable patients/clients seek employment in community service sectors such as disability or aged care. Employers and prospective patients and clients need an easy way to find this information.

Summary of Issues

Australia already has a 'negative licensing' system of regulation that applies to the entire non-registered health workforce. These powers are not well understood and tend to be skated over or even overlooked by stakeholders when making a case for inclusion of their profession in the National Scheme.

However, the Code of Conduct and prohibition order powers are not yet fully implemented in every state and territory.

If these 'negative licensing' arrangements were operating to optimal potential they would:

- Provide a cost-effective means of setting and enforcing minimum non-standards of safety and quality, across the entire non-registered health workforce.
- Provide the option of extending minimum standards for all unlicensed and unaccredited health facilities (such as massage facilities or cosmetic parlours) that often operate on the fringes and.
- Provide a safety net for consumers that builds confidence in a comprehensive system of health practitioner regulation.

Section 3: Reform Directions and concepts

The themes and associated issues and challenges outlined in section 2 of this Consultation Paper confirm that change is necessary and timely. The National Scheme is valued but there is potential to evolve in a way that will deliver greater benefit and impact.

From the analysis to date, reform directions and three reform concepts have arisen. It is stressed that these concepts are at high level and emerging ideas from the Independent Reviewer. They are not settled positions or recommendations. They are presented to help stimulate spirited discussion and to help promote thinking about possible reform options. Other reform options are expected to be proposed by stakeholders for consideration alongside these concepts throughout the consultation process.

Concept 1: Repositioning the National Scheme- Applying a Stewardship Model

From the issues and concerns on Theme 1 of Stewardship and Governance emerge the following high level potential reform directions.

- Strengthen the strategic connection between national workforce strategy and the National Scheme - identifying the health practitioner regulation reforms required to support workforce and service access imperatives.
- Strengthen the two-way connection between the National Scheme regulators and other relevant health regulators.

The potential structure, role, and relationship adjustments that could assist to deliver these strengthened connections are presented in [Figure 2](#).

The concept is guided by the following considerations:

- Health Ministers are the ultimate stewards of the National Scheme.
- Health Ministers and Chief Executives require clear articulation of the way in which health practitioner regulation actions and priorities align with health workforce and service access imperatives, with visibility of the data and information that supports this as well as public safety.
- The HWT is functioning well to deliver intergovernmental priority tasks and other related tasks are led by Ahpra. This concept presumes that the HWT is intended as an ongoing body, and it would be useful if this were made explicit in its terms of reference. It would continue to focus on implementation of priority national workforce projects.
- It would be helpful for the role and tasks of the HWT to be understood in the context of an overarching workforce strategy, reviewed and refreshed on a regular cycle to keep priority national workforce projects and health practitioner regulation settings in lock step.
- Jurisdictional expertise needs to be harnessed at strategic and implementation levels through the proposed Health Workforce Strategy and Stewardship Forum with a commitment to national alignment as far as possible.
- Other regulators and standard setting bodies (including the Australian Commission on Safety and Quality in Health Care, the TGA, ACCC and sector specific regulators in aged care and disability services) have a contribution to make to designing more holistic solutions, balancing workforce shortages and service access, and the regulatory effort of

the National Scheme regulators should be in concert with the broader health workforce and health system reform agenda.

- Success also requires mechanisms that bring together evidence and data, community voice, policy proposals, and stakeholder input to achieve the necessary strategic connections.
- While these aspirations could be delivered through a new organisation with a stewardship mandate, this may be a costly approach and add yet another layer of complexity.
- Another alternative is to assign stewardship responsibility to an existing body (such as the Ahpra Board or the National Health Practitioner Ombudsman). Undoubtedly each of these bodies within the Scheme will have a stronger stewardship role, but they would not have the means to forge national strategic workforce directions from within the Scheme, and this is not their legislative remit.
- The concept presented here is therefore a third possible approach, recognising the ultimate objective is to achieve strategic connection and shared responsibility between existing bodies, without applying either a workforce specific or health professions regulation lens, but rather with the objective of connecting the two.
- The concept envisages that a Health Workforce Strategy and Stewardship Forum be convened on a regular cycle (e.g. annually) to bring together jurisdictions and the National Scheme regulators, to scan the environment identify ongoing or emerging risks, better understand community expectations, and set strategic directions and reform priorities accordingly. The product could be a Health Workforce Strategy & Stewardship Plan, endorsed by Health Ministers with which the HWT and National Scheme priorities/actions would be expected to align.
- To assist implementation, the HWT and the HCEF would need to be supported and advised, and there would need to be monitoring and reporting through to Ministers on delivery. A designated Coordinator-General style role, reporting to the HWT and HCEF, may be required to coordinate this work.

Repositioning the National Scheme – Applying a Stewardship Model

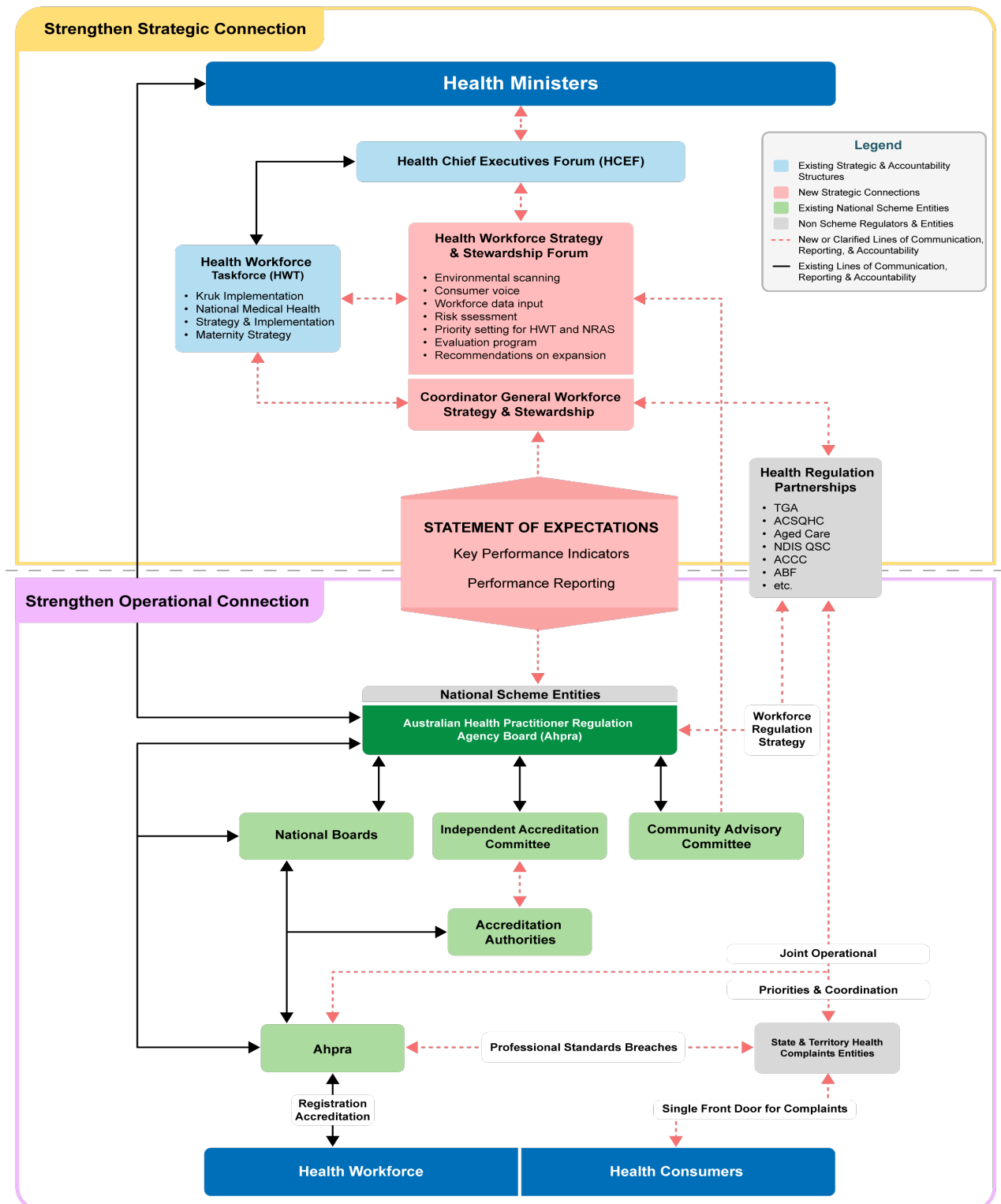


Figure 2: Concept 1: Repositioning the National Scheme – Applying a Stewardship Model

Concept 2: Resetting accountabilities within and alongside National Scheme Entities

From the issues and concerns identified in the Governance and Stewardship thematic analysis emerge the following high level potential reform directions.

- Augment current operational accountability within the National Scheme through accountability and governance enhancements that:
 - Ensure National Scheme direction and strategy setting aligns with workforce objectives and demonstrates a more proactive approach to regulation.
 - Build stronger community voice in setting strategy and priorities.
 - Ensure implementation of key reform priorities – including (but not limited to) accreditation functions.
 - Prioritise establishment of cross-profession regulatory structures and business processes.
 - Embed more strategic and risk based, data driven performance reporting, to better support Ministerial Council decision-making.
- Consider amending the National Law to extend Ministerial Council policy direction powers across the National Scheme entities and across all functions.

The issues and concerns in relation to complaint handling functions (and the associated confusions and dissatisfaction of some consumers and practitioners) are identified in Theme 2. They highlight the need to address fragmented responsibility and accountability both within the National Scheme itself and at the interface with other complaint handling and regulatory bodies. From that analysis, the following high level reform directions emerge:

- Simplify complaint handling structures and processes – implement within each state and territory a single front door for consumer complaints and clear guidance materials for consumers and practitioners.
- Negotiate formal protocols and nationally agreed thresholds in managing complaints and notifications in a head agreement defining the respective roles and responsibilities of Ahpra and each state and territory HCE.
- Provide a stronger focus and process for management of notifications that involve serious conduct matters within the National Scheme.
 - Reset the division of statutory decision-making responsibilities and delegations between Ahpra and the National Boards.
 - Expand clinical expert input at the operational level.
 - Measures to strengthen community voice in regulatory decision making.
 - Strengthen risk-based tools for identifying and progressing high risk complaints.
- Consider and progress measures to foster consistency in Tribunal processes and outcomes for disciplinary matters, if further research confirms that this is required.

The potential structure, role and relationship adjustments that could assist to deliver these proposed reform directions are presented in [Figure 3](#).

Resetting Accountabilities Within & Alongside AHPRA

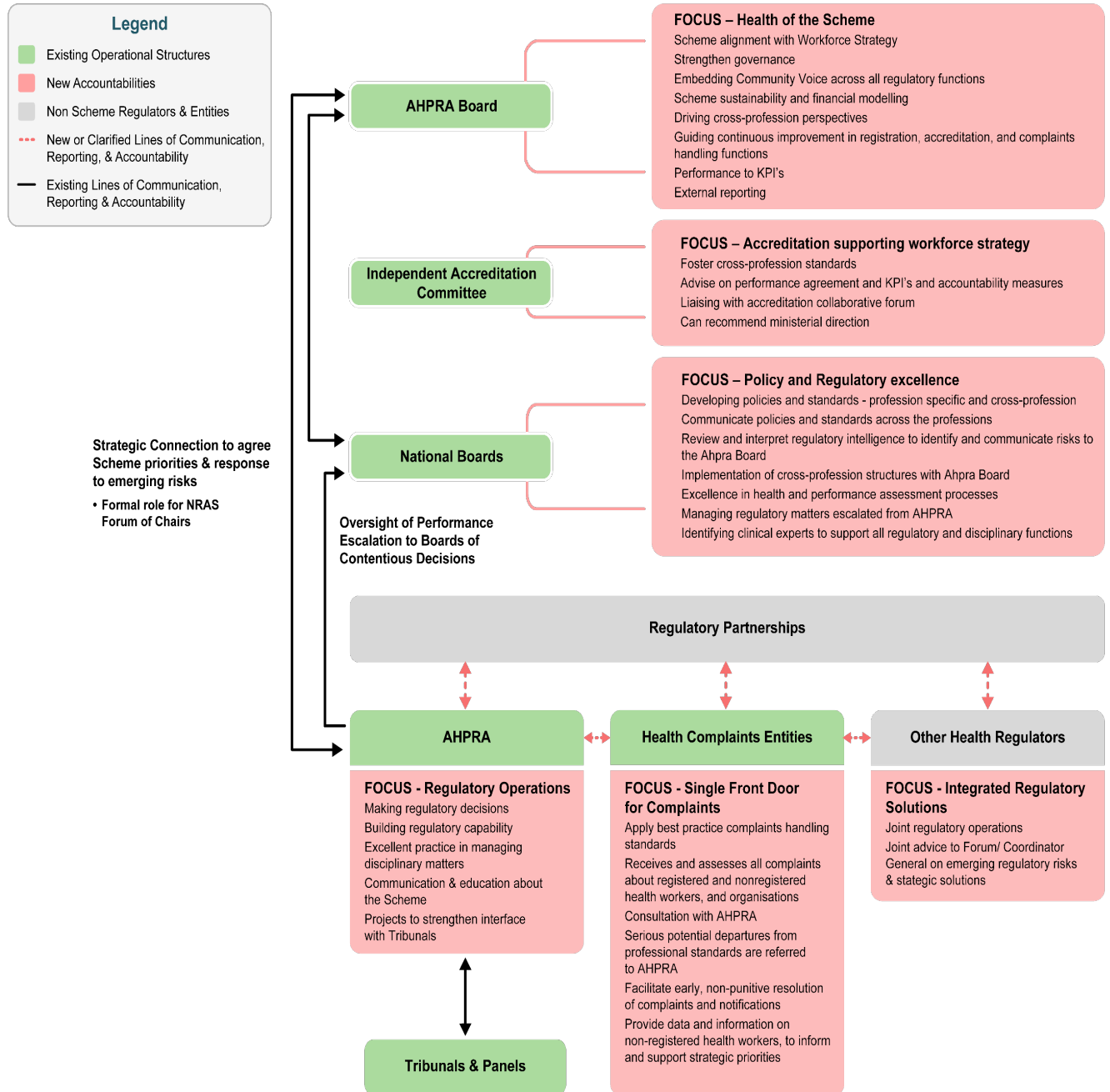


Figure 3 Concept 2: Resetting accountabilities within & alongside Ahpra

The concept is guided by the following considerations:

- There needs to be unambiguous accountability for aligning the National Scheme priorities and programs with the broader Health Workforce Strategy and Stewardship Plan, overseeing actions in accordance with Ministerial Directions or requests, and reporting on these. This is appropriately the role of the Ahpra Board
- The need for an agreed program of action to identify, prioritise and activate cross. A reconfigured and formally constituted NRAS Forum of Chairs together with Ahpra Board representation may be an avenue for progressing this Scheme-wide direction setting.
- Maintaining focus on aligning accreditation functions with workforce strategy remains a priority and the Independent Accreditation Committee of the Ahpra Board could potentially be re-mandated to drive this agenda.
- Previous recommendations for merging National Boards as a solution to the efficiency and inconsistency have strained against the core value of profession-specific expertise as a fundamental feature of effective regulation, on which the National Scheme was founded. Nevertheless, the complexity and sustainability of the plethora of existing decision-making structures, when more streamlined and flexible arrangements might work just as well, is a problem requiring resolution.
- An alternative to rationalising National boards is to retain the existing separate National Boards but reassign the functions between the Boards and Ahpra in a more efficient and coherent fashion, with a focus on the effort intensive notification decision making function. This could be achieved by removing day to day notification decision making from the National Boards and placing these to Ahpra.
- The National Boards would have a stronger policy, monitoring and strategy focus - such as standards setting, working across professions, assessing regulatory intelligence to identify and propose solution to emerging risks, identifying and implementing strategies for building clinical expertise across the National Scheme, overseeing implementation of profession specific reforms.
- Under this concept Ahpra may have fuller responsibility for day-to-day notification handling decisions.
- The concept would also provide the opportunity to reshape the interface between Ahpra and the Health Complaints entities, so that consumers have a single point of entry within their State or Territory but matters that are more serious are referred to Ahpra in a timely way. The revised arrangements would need to include ensuring that any mandatory report to Ahpra is referred for prioritised assessment.
- The concept would prompt consideration of the most suitable arrangements for operational collaboration with other health regulators and sector-based regulators.

Concept 3: A fully integrated 3 tier model of health practitioner regulation

From the issues and concerns identified in relation to the scope and expansion of the National Scheme, emerge the following high level potential reform directions.

- Strengthen National Health Practitioner Regulation through adoption of a whole-of-system view of health workforce regulation that encompasses three-tiers of occupational regulation of health practitioners:
 - Ahpra Registration - risk and benefit-based entry to the National Scheme.
 - Introduce a second alternative model of registration through Accreditation of Professional Bodies to maintain Voluntary Practitioner Registers.
 - Complete the implementation and strengthen transparency of Code of Conduct for non-registered health care workers.
- Clearer processes for managing profession-based applications to enter the National Scheme.
- Build professions and community awareness and understanding of the three -tiered regulation model.

The potential structure of a model to deliver these proposed reform directions are presented below in [Figure 4](#).

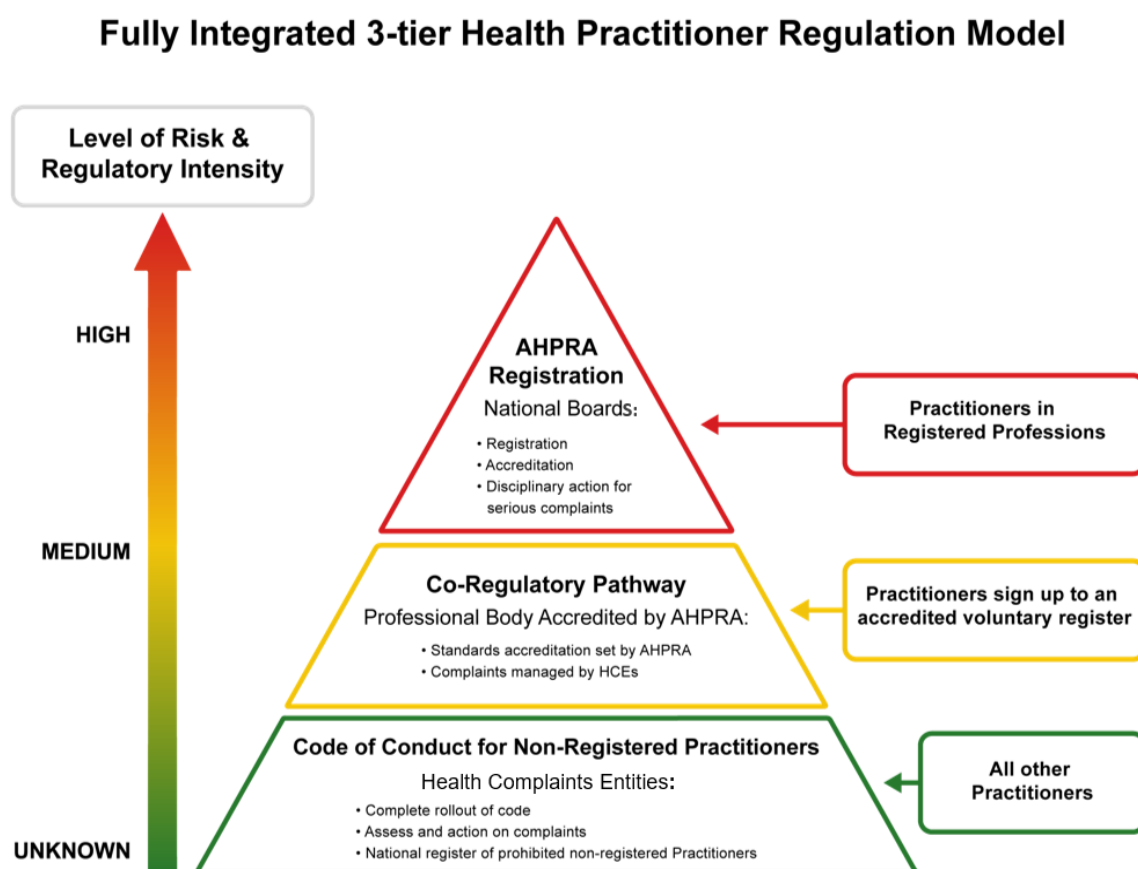


Figure 4: Concept 3: Fully Integrated 3-tier Health Practitioner Regulation Model

The concept is guided by the following considerations:

- As things stand there are two tiers of statutory regulation of health practitioners – Ahpra registration and regulation by State and Territory Health Complaints Entities via a *National Code of Conduct for Non-Registered Health Practitioners*.
- There are also profession-led self-regulatory arrangements in place that have an important part to play into the future.
- The National Code of Conduct and the capacity to issue prohibition orders to non-registered health practitioners for breaches of the Code is not well understood. This ‘negative licensing’ model is obviously outside of the National Scheme, but from the perspective of those seeking to understand the overall framework of regulation, it is directly linked to it.
- One reform objective is to bring the two existing levels of statutory regulation of registered and non-registered health practitioners into a coherent model.
 - Describing the regulation of non-registered practitioners more clearly as part of a broader model of health practitioner regulation would draw attention to the contribution of that to protection of public health and safety and the potential to strengthen that tier of regulation.
 - In terms of overall regulatory coherence, stronger baseline regulation may obviate the need for higher intensity regulation.
 - Under this reform concept regulation of non-registered practitioners would continue through the state and territory Health Complaints Entities, but with further actions to support implementation.
- The second objective in this reform concept is to provide scope for evidence-driven and sustainable growth of the National Scheme.
 - Statutory registration under the National Scheme would continue to deliver full registration administered by Ahpra and the National Boards, through the National Law.
 - For those health professions and occupations not currently included in the National Scheme, many seek to enter, but it is not always apparent whether the risks and benefits warrant this intensive level of regulation.
 - Sustainable health practitioner regulation requires a structured and evidence informed policy basis for determining whether Ahpra registration is a necessary and beneficial solution for a specific occupation, compared with other regulatory and non-regulatory options that may also address risks to public health and safety at a lower cost.
 - The current two staged policy and risk analysis process should therefore continue as the mechanism used to decide the inclusion of additional professions as registered professions under the national Scheme.
 - A new “middle tier” of regulation, where Ahpra accredits a professional membership body to establish and maintain a register of practitioners (who voluntarily sign up), drawing on the successful UK model of Accredited Registers. There would need to be recognition of practitioners on these registers within the National Law. This could potentially provide another registration pathway for those professions where full statutory registration is not yet considered to be necessary.
 - Such a mechanism may assist with the inherent difficulty of mounting a policy case for entry to Ahpra registration when the size of the profession to be regulated and the nature of the risks needs to be better understood.

- If this second tier of regulation was to be progressed, more detailed consideration would need to be given to:
 - *Funding issues: Registrant fees would be expected to apply, and funding for the accreditation/certification process to be conducted by Ahpra would need to be factored-in to this.*
 - *Complaints handling: It would be most logical for complaints about practitioners on a voluntary register to be managed through the same process as complaints for non-registered practitioners. Again, funding arrangements for HCEs to undertake this function would need to be established.*
- There could be benefit in a regular cycle of review of the regulatory intelligence data for each of tier of the three tiers of regulation, with the potential to move to a different category based on the data. For instance, if complaints relating to practitioners on the voluntary register were received and assessed by the Health Complaints entities, the related data could assist in presenting any later proposal for a transition to full registration under the National Scheme.

Section 4: Next Steps

Timeframes

The review is seeking written submissions and input via the Policy Design Forums. The timeframes for the steps in the consultation are as follows.

Next Steps and Timeframes

1. Formal written submissions process – Submission deadline is **14 October 2024**.
2. Nationwide Policy Design Forums with stakeholder groups **will occur from late September to early November 2024**. The issues and potential reform directions raised in this Consultation Paper have informed the structure and design of the Forums.
3. In **January 2025 Consultation Paper 2 will be issued** and this will identify preferred reform options and inform more detailed design of the reforms and their implementation.
4. **Further targeted consultation** will occur in **January to March 2025**, based on Consultation Paper 2.

Submissions process

The review is inviting submissions and asks that these be prepared in the [Submission Template](#) available on our website to assist in analysis across all submissions and to ensure that we understand your perspectives on the matters of specific interest in the context of the terms of reference and issues identified in the evidence to date.

Your completed submission template should be emailed to NRASComplexityReview@health.gov.au. You will receive confirmation of receipt of your submission.

Policy Design Forums

The Review is conducting 32 policy design forums for stakeholders across Australia.

These forums will be attended by those stakeholders who have registered interest, in response to the call for expressions of interest in the forums that occurred during phase 2 of the Review.

They will bring stakeholders together face to face, in an immersive and collaborative mode. The forums will be in a range of different compositions and configurations, to ensure that there is discussion across all of the reform themes, jurisdictionally based input, and scope for stakeholders with a shared interest to work together on aspects of greatest interest to them.

The forums will be striving to identify the best opportunities for reform and the best approach to seizing those opportunities. It is not intended that the design forums be in any way limited to consideration of the reform directions and concepts set out in the Consultation Paper. They are intended as stimulants for discussion. It is expected that there will be a range of views about these ideas and other ideas put for consideration. Participants in the forums will be encouraged to present alternative perspectives to help shape the collective thinking about a preferred reform agenda.

Developing the reform agenda

The ideas and perspectives presented in submissions and the forums will inform the preparation of a further consultation paper, the purpose of which will be to identify a preferred reform agenda which will then be subject to targeted discussion on design and implementation of the proposed directions and changes. This consultation paper will be presented to ministers in draft prior to finalisation and release for consultation.

References

AASW, 2022-23 *Australian Budget Priorities – AASW Submission*, January 2022. p.4.

AHWMC communique 8 May 2009 – Design of the scheme. Available at :

<https://www.ahpra.gov.au/About-erAhpra/Ministerial-Directives-and-Communiques/Establishment-of-the-scheme.aspx>

Australian Commission on Safety and Quality in Health Care and Ahpra, (2024) Final Report, Working together to improve the consumer healthcare complaints experience august p. 2-7 Available at:

<https://www.ahpra.gov.au/Search.aspx?q=final%20report,%20working%20together%20to%20improve%20the%20consumer%20healthcare%20experience>

Australian Government Department of the Prime Minister and Cabinet Office of Impact Analysis 2023. Australian Government Guide to Policy Impact Analysis Available at

<https://oia.pmc.gov.au/>

Australian Government Department of the Prime Minister and Cabinet Office of Impact Analysis Options for the Regulation of Unregistered Health Practitioners. COAG Consultation Regulation Impact Statement – Australian Health Workforce Ministerial Council (2011)

Available at: <https://oia.pmc.gov.au/published-impact-analyses-and-reports/options-regulation-unregistered-health-practitioners-coag>

Australian Health Practitioner Agency AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions 2018 Available at:

<https://www.ahpra.gov.au/Search.aspx?q=AHMAC%20criteria%201995> Australian Health Practitioner Regulation Agency. Intergovernmental Agreement For a National Registration and Accreditation Scheme for the Health Professions Available at:

<https://www.ahpra.gov.au/search.aspx?q=intergovernmental%20agreement> Australian Health Practitioner Regulation Agency Regulatory. Principles for the National Scheme (2024).

Available at: <https://www.ahpra.gov.au/About-Ahpra/What-We-Do/Regulatory-principles.aspx>. Australian Health Practitioner Regulation Agency. Blueprint to improve public safety in health regulation 2023. Available at: <https://www.ahpra.gov.au/News/2023-02-14-reform-blueprint.aspx>

Australian Health Practitioner Regulation Agency. Community Advisory Council Available at:

<https://www.ahpra.gov.au/About-Ahpra/Our-engagement-activities/Advisory-groups/Community-Advisory-Council.aspx>

Australian Health Practitioner Regulation Agency. Making cosmetic surgery in Australia safer Available at: [Australian Health Practitioner Regulation Agency Publications \(2024\)](#)

[Interprofessional Collaborative Practice Statement of Intent Available at: https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx](#)

Australian Health Practitioner Regulation Agency Publications 2023. Information paper: good practice approaches to embedding clinical placements, pedagogical innovations and evidence-based technological advances in health practitioner education Available at:

<https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx>

Australian Health Practitioner Regulation Agency. Policy Direction 2019- 01 Available at: <https://www.ahpra.gov.au/Search.aspx?q=policy%20direction%202019-%2001>

Australian Health Practitioner Regulation Agency. Policy Direction 2019- 02 Available at: <https://www.ahpra.gov.au/About-Ahpra/Ministerial-Directives-and-Communiques/Policy-directions.aspx>

Australian Health Practitioner Regulation Agency Publications (2023). Glossary of accreditation terms Available at: <https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx>

Australian Health Practitioner Regulation Agency Publications (2024). Principles to strengthen the involvement of consumers in accreditation Available at: <https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx>

Australian Health Practitioner Regulation Agency Publications (2024). Interprofessional Collaborative Practice Statement of Intent Available at: <https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx>

Australian Health Practitioner Regulation Agency Publications. Ten years of national health practitioner regulation in Australia Available at: <https://www.ahpra.gov.au/Publications/Corporate-publications.aspx>

Australian Health Practitioner Regulation Agency. *Annual Report 2022/ 23 – Growing a Safe Workforce*, p74-77 Available at : <https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-2023.aspx>

Australian Health Practitioner Regulation Agency Publications (2023). Identifying and minimising distress for practitioners involved in a regulatory process Available at: <https://www.ahpra.gov.au/search.aspx?q=biggar%20practitioner%20distress>

Australian Health Practitioner Regulation Agency Documentation (Inconsistencies in process) provided to Support NRAS Complexity Review (2024)

Australian Institute of Health and Welfare Deaths in Australia, *Life Expectancy* (2024) Available at: <https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/life-expectancy>

Australian Institute of Health and Welfare, *Diabetes Australian Facts* (2024) Available at: <https://www.aihw.gov.au/reports/diabetes/diabetes/contents/about>

Australian Institute of Health and Welfare, *How Does Australia Compare Internationally*, (2024) Available at: https://www.aihw.gov.au/reports/overweight-obesity/overweight-and-obesity/contents/overweight-and-obesity#international_comparison

Australian Capital Territory (<https://www.hrc.act.gov.au/health>), New South Wales (<https://www.hccc.nsw.gov.au/>), Northern Territory (<https://hcsc.nt.gov.au/>), Queensland (<https://www.oho.qld.gov.au/>), South Australia (<https://www.hcsc.sa.gov.au/>), Victoria (<https://hcc.vic.gov.au/>) and Western Australia (<https://www.wa.gov.au/service/health-care/health-protocols/make-health-and-disability-service-complaint>).

Ayto, J (2014): Why departments need to be regulatory stewards Policy Quarterly – Volume 10, Issue 4 p. 27 Available at: https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE23836344

Bennett, B; Carney T; Chiarella, M; Walton, M; Kelly, P; Satchell, C' and Beaupert, F. *Australia's National Registration and Accreditation Scheme for health Practitioners: a National Approach to polycentric regulation*, *Sydney Law review*, v 40, 159. P. 162

Brown, A (2022) Independent review of the regulation of medical practitioners who perform cosmetic surgery Available at: <https://www.ahpra.gov.au/Resources/Cosmetic-surgery-hub/Cosmetic-surgery-review.aspx>

Carlton A, (2017) *The Forces Shaping Regulation of the Health Professions in Australia: From 'Club Government' To Inclusive Regulatory Institutions* p. 374 Available at: https://www.researchgate.net/publication/350458577_AL_Carlton_Dr_Public_Health_Thesis_-_Latrobe_University

Carlton et al., (2024). Health Practitioner Regulation Systems: A large-scale rapid review of the design, operation and strengthening of health practitioner regulation systems. Canadian Health Workforce Network p.50-51 Available at: <https://apo.org.au/node/325363>

Commonwealth of Australia as represented by the Department of Health, 2021 Available at: <https://www.health.gov.au/our-work/national-medical-workforce-strategy-2021-2031>

COAG Health Council Bulletin, Independent review of Accreditation systems within the National Registration and Accreditation Scheme for health professions. December 2017.

Cormack, M, Unleashing the Potential of our Health Workforce (Scope of Practice Review) 2023-24 Available at: <https://www.health.gov.au/sites/default/files/2023-09/scope-of-practice-review-update-11-september-2023.pdf>

Cormack, M, Unleashing the Potential of our Health Workforce (Scope of Practice Review) 2024- Issues Paper 2 p. 18 Available at: <https://www.health.gov.au/resources/publications/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-issues-paper-2?language=en>

Except for the Western Australian Parliament which passed complementary legislation with the same substantive provisions as the National Law

Following enactment of the Health Practitioner National Law and Other Legislation Amendment Act (Qld) 2017.

For instance: Australian Commission of Safety and Quality in Health Care; Aged Care Quality and Safety Commission; National Disability and Insurance Scheme Quality and Safeguards Commission; Therapeutic Goods Administration; Australian Competition and Consumer Commission, Medicare; and Border Force)

Frew et al., (2017) 'Review of Governance of the National Registration and Accreditation Scheme (NRAS) Available at: <https://www.ahpra.gov.au/search.aspx?q=review%20of%20governance%20of%20the%20nr%20as>

Health Practitioner Regulation National Law Act 2009 (the National Law) Available at: <https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-045>

Health Practitioner Regulation National Law Application Act 2024 (WA) Available at: https://www.legislation.wa.gov.au/legislation/statutes.nsf/law_a147436.html

Health Care Complaints Commission NSW Health Care Complaint Commission, Annual Report 2018-19, p.27 Available at: <https://www.hccc.nsw.gov.au/Publications/Annual-Reports>

Health Care Complaints Commission NSW Health Care Complaint Commission, Annual Report 2023-23, p.10 Available at: <https://www.hccc.nsw.gov.au/Publications/Annual-Reports>

Hong Kong Department of Health Accredited Registers Scheme for Healthcare Professions Available at: https://www.dh.gov.hk/english/useful/useful_ar_scheme/useful_ar_scheme.html

Kruk, R. *Independent review of Australia's regulatory settings relating to overseas health practitioners*. December 2023 p. 29 -71 Available at: https://www.regulatoryreform.gov.au/sites/default/files/Final%20Report%20-%20Overseas%20Health%20Practitioner%20Regulatory%20Settings%20Review%202023%20-%20endorsed%20by%20National%20Cabinet_0.pdf

Ministry of Business, Innovation & Employment (New Zealand) Regulatory systems and stewardship (2023) Available at: <https://www.mbie.govt.nz/cross-government-functions/regulatory-stewardship/regulatory-systems>

National Health Practitioner Ombudsman (NHPO), Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation, October 2023. Available <https://www.nhpo.gov.au/sites/default/files/2023-11/NHPO%20Processes%20for%20progress%20review%20report%20-%20Part%20one%20-%20A%20roadmap%20for%20greater%20transparency%20and%20accountability%20in%20specialist%20medical%20training%20site%20accreditation.pdf>.

National Health Practitioner Ombudsman and Privacy Commissioner Accreditation Processes review (2023). Available at: <https://www.nhpo.gov.au/sites/default/files/2023-11/NHPO%20Processes%20for%20progress%20review%20report%20-%20Part%20one%20-%20A%20roadmap%20for%20greater%20transparency%20and%20accountability%20in%20specialist%20medical%20training%20site%20accreditation.pdf>. p. 11

Note for instance: The Australasian Sonographers Association 2019-20, *Australian Government Pre-Budget submission*; Sonographer Regulation Working Group – Ministerial Health Council Submission to include sonographers in the NRAS Scheme. Nov 2020

Note for instance NSW where section 28A of the *Health Care Complaints Act*, 1993 provides a review right for assessment decisions.

Note that an area of practice endorsement indicates that the practitioner has qualifications in addition to the qualification that is needed to become registered. An example is the psychology profession that has 9 areas of practice improved, including for clinical psychology and organisational psychology.

Note that a scheduled medicines endorsement on registration indicates that the practitioner is qualified to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicine. State and territory drugs and poisons legislation set what an endorsed practitioner is authorised for and this rests with individual Health Ministers.

NSW Health Care Complaints Commission, 2019-20 Annual Report;

Archer J, Regan de Brere S, Bryce, M, Nunn, S, Lynn N, Coombes, L Roberts, M. Understanding the Rise of Fitness to practise complaints from members of the public . Plymouth University 2014

NSW Special Commission of Inquiry into Healthcare Funding Available at:

<https://healthcarefunding.specialcommission.nsw.gov.au/>

The Parliament of the Commonwealth of Australia Standing Committee on Health and Ageing Lost in the Labyrinth, Report on the inquiry into registration processes and support for overseas trained doctors (2012) Available at:

https://www.aph.gov.au/Parliamentary_Business/Committees/House_of_RepresentativesCommittees?url=haa/overseasdoctors/report.htm

Parliament of Australia Senate Standing Committee on Legal and Constitutional Affairs. Report on the Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community safety (2016) Chapter 4. Available at:

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Report

Paterson, R., Independent review of the use of chaperones to protect patients in Australia (2017) Available at: <https://www.ahpra.gov.au/News/2017-04-11-chaperone-report.aspx>

Paterson R, *Three years on: changes in regulatory practice since Independent review of the use of chaperones to protect patients in Australia*. 2020. P. 27 Available at:

<https://www.ahpra.gov.au/search.aspx?q=chaperone%20review%20report>

Productivity Commission (Cth), *Australia's Health Workforce*, Research Report (2005). Available at: <https://www.pc.gov.au/inquiries/completed/health-workforce/report>

Professional Standards Authority for Health and Social Care (UK) Why we are undertaking a strategic review of the Accredited Registers programme (2021) Available at:

<https://www.professionalstandards.org.uk/news-and-blog/blog/detail/blog/2021/02/05/why-we-are-undertaking-a-strategic-review-of-the-accredited-registers-programme>

Reid, M. and Knight, S, *Working Better for Medicare Review (Distribution Levers Review)* 2023-24 Available at: <https://www.health.gov.au/our-work/working-better-for-medicare-review>

Review of files held by Medical Board of Queensland (MBQ), Queensland Board of the Medical Board of Australia (QBMBA) and AHPRA, Chesterman Report Recommendation 2 Review Panel (2013) Available at:

<https://documents.parliament.qld.gov.au/tableOffice/TabledPapers/2013/5413T2375.pdf>;

Government Review (Queensland); National independent review of the National Registration and Accreditation Scheme (NRAS) (Snowball 2014) KPMG Review of notification and system processes (2015) Available at: <https://www.ahpra.gov.au/Publications/Corporate-publications.aspx>;

Independent review commissioned by Ahpra Senate Community Affairs References Committee Inquiry into the complaint mechanism administered under the Health Independent review of the use of chaperones to protect patients in Australia (2017) Available at: <https://www.ahpra.gov.au/Publications/Corporate-publications.aspx>; Medical Board of Australia (MBA) commissioned Practitioner Regulation National Law (2017)

See Australian Government Department of Health and Aged Care webpage: Health Ministers Meeting (HMM)- Communique 16 August 2024 Available at:

<https://www.health.gov.au/resources/publications/health-ministers-meeting-hmm-communique-16-august-2024>

See Australian Government Department of Health and Aged care webpage: Health Regulatory Policy Framework 2020 Available at: [health-regulatory-policy-framework-health-regulatory-policy-framework-hrpf.pdf](https://www.health.gov.au/resources/publications/health-regulatory-policy-framework-hrpf.pdf)

See Australian Government Department of Health and Aged Care National Medical Workforce Strategy 2021 – 2031 Available at: <https://www.health.gov.au/our-work/national-medical-workforce-strategy-2021-2031> Available at: <https://www.health.gov.au/our-work/national-medical-workforce-strategy-2021-2031>

See Australian Government Department of Health and Aged care webpage: Medical Workforce Advisory Collaboration (2024) Available at: https://www.health.gov.au/committees-and-groups/mwac?language=en&utm_source=miragenews&utm_medium=miragenews&utm_campaign=news

See Commonwealth Department of Health and Aged Care, Monitoring improvement in management of professional misconduct: Assessing the implementation of previous reviews of the National Registration and Accreditation Scheme. Unpublished internal document.

See Australian Government Department of Health and Aged Care National Nursing Workforce Strategy. Available at: <https://www.health.gov.au/our-work/national-nursing-workforce-strategy#next-steps>.

See the Health Practitioner Regulation National Law and Other Legislation Amendment Act 2022. The disestablishment of AHWAC was a recommendation of the Review of governance of the National Registration and Accreditation Scheme (governance review) as it not necessary for the effective governance of the National Scheme

Snowball, K (2014) *'Independent Review of the National Registration and Accreditation Scheme for Health Professionals', Final Report*. pg. 5. See recommendation 1

The annual Accreditation Snapshot – a collaborative publication between Ahpra, the National Boards and the Health Professions Accreditation Collaborative Forum (HPACF or simply, 'the Forum') – provides an overview of accreditation in the National Scheme, accreditation activities and the roles of different entities in accreditation. Ahpra and the National Boards, Accreditation in the National Registration and Accreditation Scheme (NRAS): A snapshot 2022/23. Available from <https://www.ahpra.gov.au/Accreditation/Accreditation-snapshot.aspx>.

The Intergovernmental Agreement also outlined a process for other professions to be regulated – ultimately in May 2009 Health Ministers agreed to include the next four professions (Aboriginal and Torres Strait Islander Health Practice; Chinese medicine; Medical radiation practice; and occupational therapy) commencing 1 July 2012

The WASAT 2022/2023 Annual Report explains that the Vocational Regulation Stream has a target of completing 80% of their matters within 27 weeks. After recognising the complexity of health related matters, the Report notes that the Tribunal's emphasis on mediation ("as a means to resolve matters in the VR stream without the need for a hearing, and with less cost to the parties") has seen the Tribunal's clearance rate increase to 95%. However, in *Nugawela v Medical Board of Australia (WA Branch)* [2024] WASC 15, the Supreme Court of Western Australia appropriately noted the limitation on Boards' ability to mediate matters in saying "the Medical Board has responsibilities under the HPL which constrain the extent to which it can negotiate. It is not in the position of a commercial party, which ordinarily has much greater scope to negotiate."

Walton et al. Regulation of Health Practitioners in Australia: A National Approach to Polycentric Regulation? (2018) p. 168 Available at: https://www.researchgate.net/publication/326682236_Regulation_of_Health_Practitioners_in_Australia_A_National_Approach_to_Polycentric_Regulation

While there are some changes in terminology in the most recent RIA requirements, the process of assessment appears largely the same, albeit giving the Ministerial Council some greater discretion as to whether a RIA is done

Woods, M., Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions (Accreditation Systems Review) (2017)

Available at: <https://apo.org.au/sites/default/files/resource-files/2018-10/apo-nid235651.pdf>

Woods, M., National Health Practitioner Ombudsman (NHPO), Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation, October 2023. Available at: <https://www.nhpo.gov.au/sites/default/files/2023-11/NHPO%20Processes%20for%20progress%20review%20report%20-%20Part%20one%20-%20A%20roadmap%20for%20greater%20transparency%20and%20accountability%20in%20specialist%20medical%20training%20site%20accreditation.pdf>.

Attachments

Attachment A: An Overview of the National Registration and Accreditation Scheme (National Scheme)

Context

The National Scheme was created to regulate health professions to protect the public following the December 2005 Productivity Commission Research Report *Australia's Health Workforce*¹¹¹. That Report shed light on the individual state and territory regulatory arrangements and the importance of new measures to deal with workforce shortages/pressures faced by the Australian health workforce and to increase the flexibility, responsiveness, sustainability, mobility and reduce red tape for health practitioners.

The Report recommended that there should be a single national registration board for the health professions that should cover, at a minimum, cover all professions requiring registration (at that time) across the eight jurisdictions as well as a single national accreditation board for health professional education and training. The report further recommended that profession specific panels should be constituted within the board to handle matters such as the monitoring of codes of practice and those disciplinary functions best handled on a profession specific basis.

COAG subsequently agreed to establish a single national scheme, encompassing both the registration and accreditation functions.

Intergovernmental Agreement

The Intergovernmental Agreement for a National Registration and Accreditation Scheme for Health Professions (the Intergovernmental Agreement) was signed by the Council of Australian Governments (COAG) in March 2008, and Health Ministers were tasked with establishing the scheme.¹¹²

An 'adoption of laws' model was agreed to implement the National Scheme by all states and territories in 2009 and 2010, with Queensland named as the host jurisdiction under this model. This model is used for matters where national consistency is desired, but is generally within the states' and territories' legislative powers, and not that of the Australian Government. The commencement date of 1 July 2010 was set by Governments.

Entities within the National Scheme

The Intergovernmental Agreement set in place structures under the National Scheme, across which functions and powers were to be distributed. These were:

- a) The Ministerial Council
- b) The Australian Health Workforce Advisory Council
- c) The National Agency
- d) The Agency Management Committee
- e) Profession specific National Boards beginning with the nine professions currently registered in all jurisdictions. That is, physiotherapy, optometry, nursing and midwifery, chiropractic care, pharmacy, dental care (dentists, dental hygienists, dental prosthetists)

¹¹¹ Available at <https://www.pc.gov.au/inquiries/completed/health-workforce/report/healthworkforce.pdf>

¹¹² Available at <https://www.ahpra.gov.au/Search.aspx?q=intergovernmental%20agreement>

and dental therapists), medicine, psychology and osteopathy. Health Ministers subsequently decided to include podiatry as the 10th profession as it was regulated in every state and territory except the Northern Territory.¹¹³

- f) Committees of the Boards
- g) Accreditation bodies to exercise accreditation functions.

The *Health Practitioner Regulation National Law* was developed initially based on the IGA but also to reflect the outcome of extensive consultation with Governments, practitioner stakeholders and consumers.

Key design decisions made by Health Ministers in May 2009¹¹⁴ included:

- a) that the accreditation function will be independent of governments with accreditation standards being developed by an external accreditation body or an independent committee of the relevant National Board.
- b) a flexible arrangement for handling of complaints – with state and territory Governments deciding whether this function would be managed by National Boards or an existing state or territory health complaints arrangement.
- c) that the main committee of a national board in each state or territory where a committee is appointed will be known as a State or Territory (or regional) board.

With the exception of the Australian Health Workforce Advisory Council (AHWAC) which was removed from the National Scheme in 2022¹¹⁵ and the re-shaping of the National Health Practitioner Ombudsman and Privacy Commissioner, the entities in the scheme largely remain.

It is noted that there has been some simplification of committee structures. Whereas, at the start of the National Scheme in July 2010, five National Boards established state, territory and regional Boards. In 2024, only medicine and nursing and midwifery have state and territory boards which are appointed by individual Health Ministers.

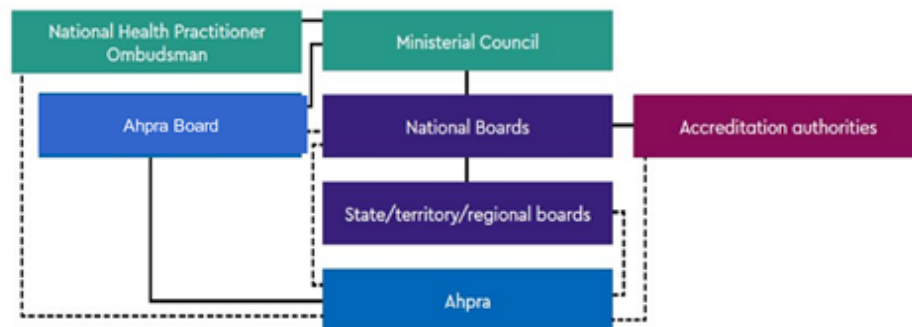
A diagram of the governance and inter-relationships between the entities within the National Scheme is below:

¹¹³ The Intergovernmental Agreement also outlined a process for other professions to be regulated – ultimately in May 2009 Health Ministers agreed to include the next four professions (Aboriginal and Torres Strait Islander Health Practice; Chinese medicine; Medical radiation practice; and occupational therapy) commencing 1 July 2012.

¹¹⁴ AHWMC communique 8 May 2009 – Design of the scheme. Available at : <https://www.ahpra.gov.au/About-Ahpra/Ministerial-Directives-and-Communiques/Establishment-of-the-scheme.aspx>

¹¹⁵ See the Health Practitioner Regulation National Law and Other Legislation Amendment Act 2022. The disestablishment of AHWAC was a recommendation of the Review of governance of the National Registration and Accreditation Scheme (governance review) as it not necessary for the effective governance of the National Scheme.

Who's who in the National Scheme



7

Legislation

Objectives

Under the Health Practitioner Regulation National Law as in force in each state and territory (the National Law), the objectives of the NRAS are set out in as follows:¹¹⁶

National Law Objectives – Section 3 clause (2)

- (a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
- (b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
- (c) to facilitate the provision of high-quality education and training of health practitioners; and
- (ca) to build the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples; and
- (d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
- (e) to facilitate access to services provided by health practitioners in accordance with the public interest; and
- (f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

Guiding principles

The National Law also sets out the guiding principles – including the paramount principle – for administration of the National scheme.

¹¹⁶ Section 3(2)(a) National Law.

Roles and responsibilities of National Scheme Entities

Ministerial Powers

Under the National Law, ministers can:

- Issue ministerial policy directions (section 11)
- Approve registration standards recommended by a National Board/s (section 12)
- Approve specialist registration (and specialist titles) for a profession recommended by a National Board (section 13)
- Approve the endorsement of the registration of health practitioners in relation to scheduled medicines as recommended by a National Board (section 14)¹¹⁷
- Approve an area of practice for a profession as recommended by a National Board (section 15)¹¹⁸

National Board members are appointed by the Ministerial Council. In reaching a decision, the Ministerial Council will consider factors such as the candidate's skills, experience, and communication skills in addition to other eligibility criteria.

Ahpra

Under the National Law (at Section 25) Ahpra has responsibility to:

- Provide administrative assistance and support to boards.
- Establish procedures for the development of accreditation standards, registration standards and codes and guidelines approved by National Boards, for the purpose of ensuring the national registration and accreditation scheme operates in accordance with good regulatory practice.
- Negotiate *Health Professions Agreements* with National Boards to
 - set registration fees
 - allocate the annual budget of the board
 - specify the service to be provided by Ahpra to the Board.
- Establish and administer procedures for receiving and dealing with applications for registration and other matters relating to the registration, including maintaining registers of registered health practitioners and students for each health profession.
- Keep an up-to-date and publicly accessible list of approved programs of study for each health profession.
- Deliver a national process for receiving and dealing with notifications about registered health practitioners in all professions.
- Provide assistance or information to the Ministerial Council in connection with the administration of the National Scheme.

National Boards

National Boards have responsibility for regulatory decision making as follows (section 35):

¹¹⁷ Note that a scheduled medicines endorsement on registration indicates that the practitioner is qualified to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicine. State and territory drugs and poisons legislation set what an endorsed practitioner is authorised for and this rests with individual Health Ministers.

¹¹⁸ Note that an area of practice endorsement indicates that the practitioner has qualifications in addition to the qualification that is needed to become registered. An example is the psychology profession that has 9 areas of practice improved, including for clinical psychology and organisational psychology.

- Registering suitably qualified and competent persons (if necessary, with conditions)
- Decide requirements for registration or endorsement on registration for the profession
- Develop registration standards for approval by the Ministerial Council
- Develop and approve codes and guidelines to provide guidance to health practitioners registered in the profession
- Approve accreditation standards developed and submitted to it by an accreditation authority
- Approve accredited programs of study as providing qualifications for registration or endorsement in the health profession;
- Oversee assessment of the knowledge and clinical skills of overseas trained applicants for registration in the health profession to determine the suitability of the applicants for registration in Australia;
- Oversee the receipt, assessment and investigation of notifications about registered as health practitioners or students;
- Establish panels to conduct hearings about—
 - health and performance and professional standards matters in relation to persons who are or were registered in the health profession under this Law or a corresponding prior Act; and
 - health matters in relation to students registered by the Board;
- Refer matters about registered health practitioners to responsible tribunals for participating jurisdictions;
- Oversee the management of health practitioners and students registered in the health profession, including monitoring conditions, undertakings and suspensions imposed on the registration of the practitioners or students;
- Make recommendations to the Ministerial Council about the operation of specialist recognition in the health profession and the approval of specialties for the profession;
- With Ahpra keep an up to date national register of practitioners and students (shared function);
- Negotiate in good faith with, and attempt to come to an agreement with, Ahpra on the terms of a health profession agreement (shared function)
- A discretion to fund health programs for registered practitioners and students.
- Provide assistance or information to the Ministerial Council in connection with the administration of the national registration and accreditation scheme.

A Board has broad delegation powers and can delegate any of its functions to a Committee or Ahpra (section 36).

A board may also establish a State or territory Board to exercise its functions (section 36). If a state or territory board is established – the relevant state or territory Health Minister appoints members.

Accreditation Authorities

Under section 43 of the National Law National Boards must decide if accreditation functions will be performed by an external accreditation entity (for example the AMC) or a committee of the board.

The relevant entity or committee has responsibility for developing accreditation standards for consideration and approval by the board.

The relevant committee or entity may accredit program of study that are considered to meet the standard, with or without conditions and once a program of study is approved it must be monitored by the entity or committee.

Ahpra may enter into a contract with an external accreditation entity for its performance of an accreditation function if the terms of the contract are in accordance with the health profession agreement between Ahpra and the National Boards.

Key Operational Functions under the National Scheme

Registration

Each application for registration is considered by the National Board (or delegate) and is assessed against eligibility requirements for the relevant profession. Health practitioners renew registration annually and make declarations on renewal which can be audited for compliance. If a practitioner does not renew their registration by the due date, registration will lapse, and the health practitioner's name will be removed from the national register.

Notifications

A complaint made about a health practitioner's health, conduct or performance is a notification. Any person or organisation can make a notification provided there is a belief that the registered health practitioner may be placing the public at risk, practicing in an unsafe manner or the health of the practitioner may impact their ability to make sound judgements in relation to their patients.

Importantly, while anyone may exercise their choice to make a notification, practitioners, employers and education providers have a mandatory duty to report 'notifiable conduct' in line with the National Law, noting the treating practitioner exemption in Western Australia.

Once a notification has been received, there is a risk-based assessment of the notification and a decision as to whether there is breach of professional standards, such as to warrant Board action or referral to a tribunal.

Note that the notifications process varies in NSW and Qld, as these states have a co-regulatory model, whereby all complaints and notification are received by the Health Complaints entity within that jurisdiction. In NSW, complaints are dealt with by the NSW Health Complaints Commission or the health professional councils. In Queensland, they may be retained by the Health Ombudsman or referred to Ahpra and National Boards for action.

National standards, codes, and guidelines

- 1) Registration Standards: These are approved by Health Ministers and set out requirements that must be met by practitioners in order to obtain and hold registration and under the National Law. All National Boards must have standards for:
 - professional indemnity insurance arrangements
 - continuing professional development
 - recency of practice
 - criminal history
 - English language skills

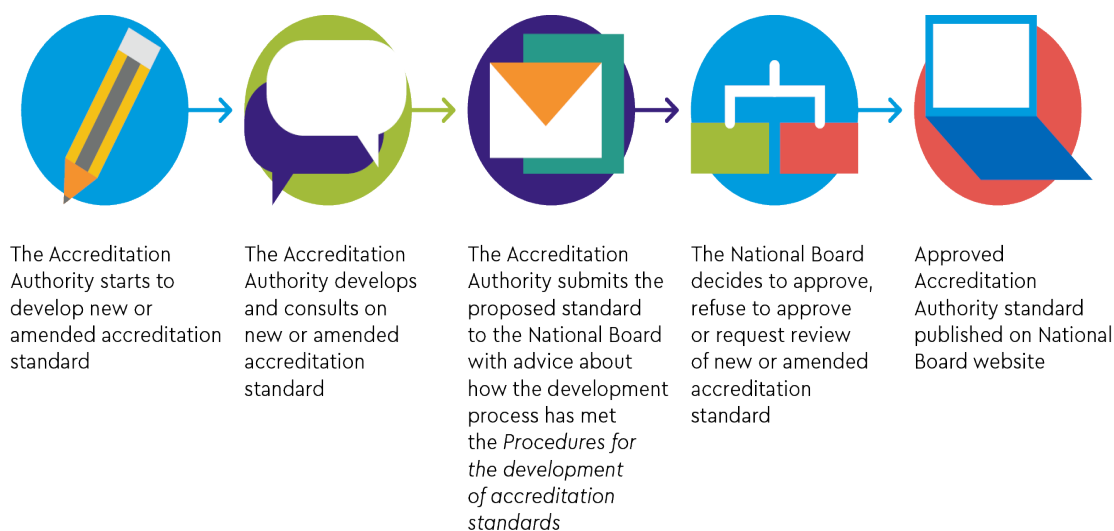
National Boards may also develop other registration standards for approval by Health Ministers. A registration standard cannot be about a matter provided for by an accreditation standard.

- 2) **Accreditation standards:** This is a standard developed by the accreditation authority for approval by the National Boards. Accreditation standards are used to assess whether a program of study, and the education provider that provides the program of study, provides persons who complete the program with the knowledge, skills and professional attributes to practise the profession in Australia. Accreditation authorities also use accreditation standards for monitoring accredited programs of study to ensure the program and its education provider continue to meet the standards.
- 3) **Codes/Guidelines:** Such documents provide guidance to health practitioners and may be factored into deciding whether a course of regulatory action is necessary (for example, all National Boards have an approved Code of Conduct).

National Boards are responsible for developing and recommending registration standards to the Ministerial Council for consideration of approval. Accreditation authorities develop accreditation standards for approval by National Boards. National Boards develop codes and guidelines to assist health practitioners, and this is also approved by the National Board. The National Law requires wide-ranging consultation on all standards, codes and guidelines.

Accreditation

Accreditation Authorities develop accreditation standards for their specific profession. The relevant profession's National Board is responsible for approval of accreditation standards. The key steps are outlined below.



It is a shared function of National Boards and Accreditation authorities under the National Law to oversee the assessment of the knowledge and clinical skills of overseas trained applicants for registration in the health profession whose qualifications are not approved qualifications for the profession, and to determine the suitability of the applicants for registration in Australia (see section 35 and section 42 of the National Law).

Current National Scheme Strategy

Vision and priorities for the National Scheme are articulated in the National Scheme Strategy, extracted below.

National Scheme Strategy 2020-25

Vision: Our communities have trust and confidence in regulated health practitioners

Purpose: Safe and professional health practitioners for Australia

Values:
Integrity
Respect
Collaboration
Achievement



Regulatory effectiveness

- Efficient and effective core regulatory functions
- Responsive accreditation systems
- Strengthened risk-based regulatory practices
- Sustainable financial framework
- Enhanced digital capability



Trust and confidence

- Eliminating racism for Aboriginal and/or Torres Strait Islander Peoples
- Enhanced safety of vulnerable communities
- Supported professional learning and practice
- Enhanced community collaboration, engagement and communication
- Strengthened contribution to accessible and sustainable healthcare



Evidence and innovation

- Consistent and evidence-based standards, codes and guidelines
- Strengthened proactive use of data and intelligence
- Enhanced capability to change and improve our regulatory model



Capability and culture

- Service focus
- Safe and inclusive work culture that fosters diversity
- Capability, learning and development of our people
- Embedding cultural safety

Attachment B: Relationship map – Regulatory change

