

REGULATING FOR RESULTS



Consultation Paper 2: Consultation Outcomes and Reform Directions

May 2025





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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



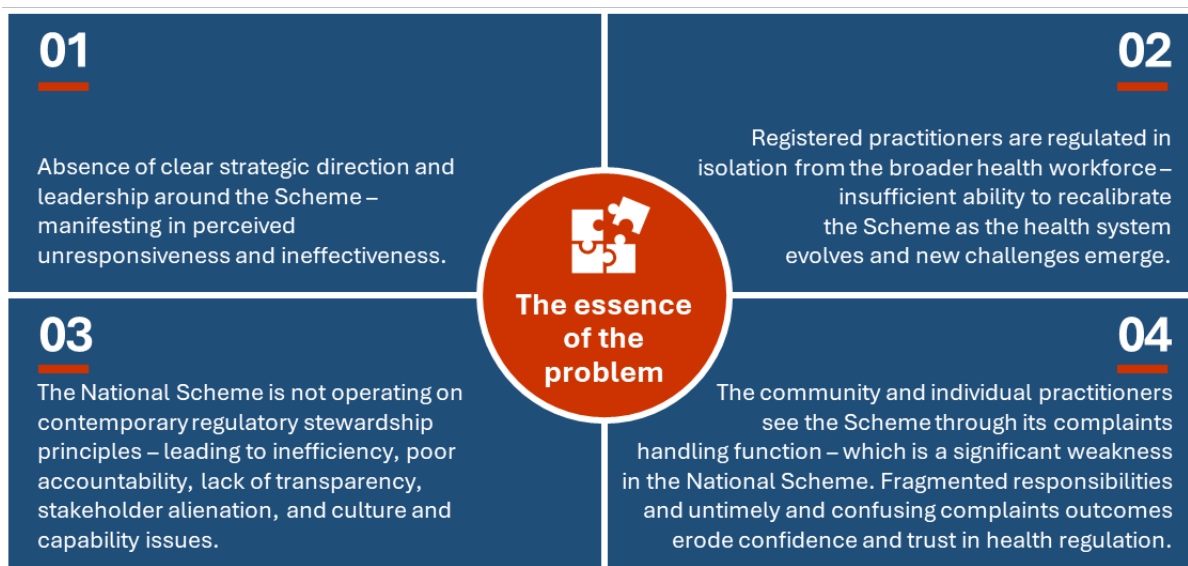
Health practitioner regulation has the foundational objectives of patient safety and ethical standards, as well as a central role to play in advancing broader goals of strengthening the capacity, efficiency and growth of health services in Australia. As the health system and public needs and expectations change, there are associated risks and opportunities for regulation.

To succeed in meeting these objectives, a National Registration and Accreditation Scheme needs two speeds. It needs always to maintain excellence and credibility in regulating the higher risk professions. It also needs inbuilt capability to grow and recalibrate to meet new regulatory challenges and health system and workforce priorities. The Review is working towards delivering this.

This Consultation Paper advances reforms to the National Registration and Accreditation Scheme (the National Scheme) to ensure that it maintains its impact in safeguarding public health and safety and supporting the continuous development of a flexible, responsive, and sustainable Australian health workforce. It draws on global best practice in the design of health professions regulation and on the observations and proposals that have been received during the initial consultation phase of this review.

At the heart of complexity of the National Scheme is a lack of clarity and no shared agreement about what is most necessary and important in health professions regulation, at any point in time and over time. There is not an overarching framework for the regulation of health professions. The 16 registered professions within the National Scheme are regulated in isolation from the broader health workforce. There is significant disillusionment with the manner in which these registered professions are regulated and an expectation that the National Scheme be more effective, responsive and fair in instances where expected standards of conduct and performance are not met.

The Review has distilled the complexity problems in the National Scheme down to four key factors.





The Review approach and process to date

The overarching objective of this Review is to identify areas of unproductive and unnecessary complexity within the National Scheme.

It strives for greater clarity about what is needed from health practitioner regulation (noting that this will change over time), who needs to be involved and in which regulatory functions, and how risk and principles-based decision-making should work to deliver the objectives of the National Scheme.

The Review is being undertaken in four phases.



The initial scoping phase was undertaken during May – June 2024 and this informed preparation of Consultation Paper 1, which was released in September 2024.

From September to October 2024, phase 3 provided stakeholders the opportunity to comment on the issues and themes raised in Consultation Paper 1.

- The review received 83 written submissions. All have been registered and analysed, and those where approval was received to publish are available on the [NRAS Review website](#).
- 35 policy design forums and meetings were held. Forums were held in every State and Territory, with some forums covering the full spectrum of themes being considered by the review, while others delved into specific themes and possible solutions in more detail. Over 400 individuals participated in these sessions.

Consultation Paper 2

Consultation Paper 2 takes the Review into its fourth and final phase. This phase presents more detailed policy development and will culminate in recommendations to Health Ministers for changes to improve regulatory outcomes for the community and health practitioners.

It should be read in conjunction with Consultation Paper 1,¹ which sets out the background to the review, the evidence and issues emerging from initial discussions and research, and some initial reform directions and concepts to guide input from stakeholders.

Consultation Paper 2 is structured around four themes. These have been distilled and refined from feedback and deliberations to date. It also considers the relevant findings and recommendations of the Scope of Practice Review Final Report² which was delivered during the consultation period.

Within each of the 4 themes, the key points from Consultation Paper 1 and the feedback and ideas from the submissions and policy design forums are summarised. The Consultation Paper then takes the reform agenda to a deeper level. There is more granular exploration of the purpose, nature, and features of a suite of potential reforms, with tangible actions that could be taken to progress them.

¹ S Dawson (2024). *Consultation Paper 1: Independent Review of Complexity in the National Registration and Accreditation Scheme*. Available at: <https://www.health.gov.au/resources/publications/consultation-paper-1-review-of-complexity-in-the-national-registration-and-accreditation-scheme?language=en>.

² Professor M Cormack (2024). *Unleashing the potential of our health workforce: Scope of Practice Review Final Report*. Available at: https://www.health.gov.au/sites/default/files/2024-11/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report_0.pdf.



Overview of Preferred Reforms and Actions

The Review presents a set of systemic reforms and discrete measures to ensure that the National Scheme is fit for the future. The four proposed reform themes and associated implementation actions are summarised below. The supporting analysis and additional detail of the actions within each theme are presented in the body of the Consultation Paper.

REFORM 01

Apply a regulatory stewardship model to set direction, context and accountability for the National Scheme.



ACTION 1.1

A *Ministerial Council Statement of Expectations of the National Scheme* to be developed and renewed every 2 years (through a Strategy Assembly process proposed under action 1.3) and be issued to the Ahpra Board.

ACTION 1.4

Health Ministers request HCEF to formalise the composition and reporting line for an *Australian Health Regulators Network*, to provide a recognised structure for collaboration between all health-related regulators.

ACTION 1.2

Confirm the Health Workforce Taskforce (HWT) as an ongoing Advisory Committee to Health Ministers with the primary role of advancing national workforce projects and initiatives, including overseeing and contributing to processes for aligning workforce planning and health practitioner regulation.

ACTION 1.5

Health Ministers request that within a health workforce strategy schedule to the National Health Reform Agreement, HCEF ensures that there is provision to advance actions 1.1 – 1.4 above (as the preferred alternative to reviewing the existing 2008 Intergovernmental Agreement for the National Scheme or other administrative instruments).

ACTION 1.3

HWT and Health Chief Executives Forum (HCEF) to establish and co-chair a Strategy Assembly on Health Practitioner Regulation to be held every two years, covering the entire Australian health workforce (not limited to registered practitioners).



REFORM 02

Establish an Integrated Health Professions Regulation Framework, to inform decisions about regulating occupations across the entire Australian Health Workforce.



ACTION 2.1

Endorse in principle an Integrated Health Professions Regulation Framework, which stratifies the intensity of regulation according to risk and ultimately delivers three models of regulation:

- National Board regulation of registered professions that pose the most significant risk to public health and safety.
- A new Approved Professions Registration model, through an Ahpra approval and auditing process within the National Scheme, to provide a more cost effective additional avenue for regulation of lower risk allied health professions.
- Non-registered Practitioner National Code of Conduct to provide minimum protective standards for all professions, enforced by Health Complaints Entities (HCEs) of the States and Territories.

ACTION 2.2

HWT to review and revise the risk assessment method and the process for assessing professions for entry to the Scheme and produce a new Guidance Document for Ministerial endorsement.

ACTION 2.3

HWT to prioritise further detailed design and costing of an Approved Professions Registration Model, which should involve close consultation with the self-regulated professions, allied health peak bodies and Ahpra, and be presented to Ministers within 18 months.

ACTION 2.4

No decision on inclusion of audiology in the National Scheme should be taken at this time. If Health Ministers determine that inclusion of this profession should remain under consideration, the sponsoring jurisdiction has the opportunity to resubmit the proposal for inclusion once it is known whether and when a new pathway into the National Scheme will be established, following completion of Action 2.3 above.

ACTION 2.5

Health Ministers commit to complete implementation of the National Code of Conduct for Non-Registered Practitioners by all jurisdictions within 12 months and reaffirm the 2015 decision to establish a National Register of Prohibition Orders.

ACTION 2.6

Ahpra Board to take three specific data and analysis initiatives to support more proactive health practitioner regulation and health workforce planning and strategy (covering both NRAS registered and approved professions).



REFORM 03

Realign functions and structures within the National Scheme to strengthen performance, accountability, and transparency.



ACTION 3.1

Transition the Ahpra Agency Board to become the National Scheme Board and request HWT and the Ahpra Board to commence specific administrative and strategic adjustments within the existing National Law.

ACTION 3.2

Ahpra Board to make specific structural governance adjustments within the existing National Law, including the establishment of a Scheme Delivery and Development Leadership Group and a Professions Liaison Group.

ACTION 3.3

Ahpra Board to commission an independent Organisational Capability Review of Ahpra Agency with specific actions and an implementation plan to be communicated to Health Ministers within 12 months.

ACTION 3.4

Ahpra Board to provide an undertaking to Ministers to pursue immediate strategic priorities identified in this review and report to Ministers on progress in each future Quarterly Performance Report until the priority actions are completed.

ACTION 3.5

Ahpra Board to strengthen focus and accountability for accreditation functions with specific actions to achieve this.

ACTION 3.6

HWT Policy and Legislation Committee to further consider and advise on any further administrative, policy or legislative actions required to strengthen accreditation functions within 12 months.

ACTION 3.7

Health Ministers agree to maintain the current voluntary approach to amalgamation of existing National Boards, conditional upon the Ahpra and National Boards establishing a transparent governance process for maintaining efficient and effective board structures and driving enhanced cross profession decision making, including specific immediate actions.



REFORM 04

Progress implementation of a unified national approach to health complaints and require immediate focus on improved management of high-risk matters with the National Scheme, to ensure best practice complaint management.



ACTION 4.1

HWT to establish a time limited National Health Complaints System Implementation Group to undertake a 3-year project to deliver a unified national approach to health complaints handling, including driving finalisation of the implementation of the National Code of Conduct for Non-registered Practitioners (in accordance with Action 2.5 under Reform Theme 2).

ACTION 4.2

Ahpra to take immediate steps to improve the understanding and experiences of notifications processes for the public, complainants and practitioners by:

- Establishing a Complaints Navigator Service.
- Ensuring implementation of National Health Practitioner Ombudsman recommendations for improving management of vexatious complaints.
- Instituting a formal national communications protocol with HCEs to ensure cross jurisdictional liaison on new serious and sensitive complaints, clear roles and responsibilities, timely action, and agreed public communication messages.
- Ensuring that notification management systems and practices identify and examine patterns in notifications, and drive proactive consideration of systemic improvements to the National Scheme.
- Considering if there are sufficient avenues for ensuring that practitioners are aware of and educated about professional standards and obligations on an ongoing basis.

ACTION 4.3

Ahpra Board to immediately improve timeliness and quality of investigation processes and decision making and the availability of clinical advice across all regulatory functions, with specific actions to achieve this.

ACTION 4.4

Health Ministers request HWT to task the Policy and Legislation Committee to:

- Prioritise National Law amendments to: (i) establish a statutory right of review of notification decisions under the National Scheme; and, (ii) section 199 of the National Law to put beyond doubt that a practitioner may appeal a Board decision not to revoke an earlier imposed suspension.
- Consider and advise on other possible legislative amendments: (i) to make referral to panels a more practical and effective alternative to referral to tribunals; and, (ii) the option of an independent Director of Proceedings in the National Scheme.

ACTION 4.5

Health Ministers seek the agreement of the Attorneys General to establish a process to ensure joint consideration of actions that may be taken to harmonise tribunal rules and practices when deliberating on health professions matters.

ACTION 4.6

Ahpra to research and report on outcomes of tribunal decisions about health professionals for the period 2020-2025 and advise of any inconsistencies in outcomes that may require action.



Benefits Snapshot



Ministers will be able to set priorities linked to broader health system challenges and risks.



There will be a single entity accountable to ministers for performance of the Scheme with better performance monitoring and reporting to maintain confidence in the Scheme.



Health regulation will be evidence driven and based on expert advice and quality data from jurisdictions, the professions, the regulators and the community.



Ahpra will work alongside complementary health regulators to deliver collaborative solutions to emerging risks – such as the use of AI in health services.



There will be a transparent framework for making health regulation policy decisions that covers the whole health workforce and supports scope of practice reforms.



Regulation can be at different levels based on risk (as a new lighter touch registration pathway will be available).



Complaints handling bodies will work together and the roles and responsibilities of the jurisdictional Health Complaints Entities and Ahpra will be clearer and stronger.



There will be a clear picture of how all health professions are regulated in Australia to build consumer confidence and trust in the quality of health services in Australia.



Possible complaints outcomes will always include consideration of restorative solutions as well as disciplinary options – applied appropriately.



New risks to public health and safety will be addressed more proactively and effectively.



The public will be better protected as high-risk complaints will get timely and effective attention.



Delays and frustrations when they make a complaint will be addressed – over time all health care complaints will be taken to one place and actioned in a more timely and customer centric way.



The community will see clearly how their voice is heard in the National Scheme and what opportunities they have to contribute to regulatory decision making if they so choose.



The National Scheme will have clear directions and priorities, so regulatory actions will align with workforce strategy.



Ahpra leaders will have a seat at the workforce strategy table and recognition of their contribution to workforce data and development.



The Ahpra board will be empowered to steward the Scheme to meet ministerial expectations and statutory objectives.



Structured connection between the Ahpra Board and National Boards will add to coherence and agility across the Scheme.



Ahpra capability building will deliver Scheme leaders a clear roadmap for actions to support the reforms, including a focus on customer-centrism, workforce development and wellbeing.



The National Scheme Leaders and Ahpra



Strong professions-based regulation will be maintained and there will be new structures for collaboration with professions.



Additional settings for embedding community voice will be in place.



Accreditation functions will be more closely aligned with Scheme objectives.



Decisions about adding professions will be more structured and have regard to alternative options for regulation and Scheme sustainability.



Ahpra will have a formal structure for working alongside other regulators and taking a leadership role in regulatory policy, including through further activating its regulatory intelligence function.



A seat at the table to inform health practitioner regulation policy and priorities.



HCEs will be a recognised partner in the National Scheme with a clearly defined role in all complaints.



Avenues to collaborate to strengthen complaints handling nationwide.



Health Complaints Entities



The expertise of HCEs in complaints resolution and restorative solutions will be available to all complainants and practitioners.



Reduced confusion and inefficiency in working with Ahpra.



Supported implementation of the National Code of Conduct for Non-registered Practitioners.



Better understanding and use of the HCE functions in regulating non-registered practitioners and health organisations.



Professions-based regulation will remain a cornerstone of health practitioner regulation in Australia, with initiatives to promote cross professions work carefully planned and targeted.



Clinical advice to inform notification decisions will be strengthened.



Fee-setting and budgeting processes will become more transparent, so that there is accountability to registrants and consideration of the sustainability of the Scheme.



There will be a National Scheme commitment to strong and authentic engagement methods and structures for ongoing collaboration to inform Scheme strategy and policy.

Registered Professions, Colleges and Practitioners



A unified national model of complaints handling means that complaints that do not require consideration of disciplinary action will not be handled by Ahpra.



Professions will have a stronger voice in setting priorities and directions for health workforce and regulation.



Reducing delays in investigations and prosecutions will be acted on as a priority, emphasising the need to alleviate practitioner impacts.

Allied Health Professions



The options for regulation will be more flexible and enable allied health professions to become a part of the National Scheme, based on risk.



Coherent whole of health workforce approach to making health regulation policy decisions.



Accredited Profession Registration model of regulation will recognise and build on the work of National Alliance of Self Regulating Health Professions and drive an uplift in standards in the interests of public protection.



Next Steps in the Review Process

Consultation Paper 2 supports more targeted consultation with key organisations and individuals across the range of stakeholder groups interested in and affected by this Review – including governments, the National Scheme and Health Complaints Entities (HCEs) leadership, professional memberships bodies (both within and outside the Scheme), consumer representatives, accreditation entities and organisations, and academics.

The targeted consultation will occur during May and June 2025.

While there is not a further open submissions process being conducted, comments on Consultation Paper 2 may be provided through organisational representatives involved in the targeted stakeholder deliberations (who will be free to consult with their members and colleagues) or directly to the Review team via NRASComplexityReview@health.gov.au.

Through this targeted consultation, formal recommendations (including implementation actions, potential timeframes and accountabilities) will be finalised and presented to Health Ministers in July 2025.



THEME 1:

Setting strategic context and direction for the National Scheme



What the Consultation Paper said

Consultation Paper 1 examined the National Scheme against contemporary principles of regulatory stewardship, which requires: a system wide view of regulation in the context of changing needs; a direct strategic connection with the expectations of governments and the community; risk and data driven regulation which balances consideration of workforce supply and demand and quality of care; strong lines of accountability; and, effective collaboration to meet the objectives and priorities set for the Scheme.

Consultation Paper 1 identified aspects of the current design and operation of the Scheme that are not aligned with these principles and which warranted consideration in the Review. These are summarised below.

Summary of issues from Consultation Paper 1: Governance and Stewardship (around the National Scheme)

ABSENCE OF STRATEGIC CONNECTION

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.

TENTATIVE REFORM CONCEPT

The reform concept proposed in [Consultation Paper 1](#) was to strengthen strategic connection:

- Between national workforce strategy and the National Scheme.
- Between the National Scheme regulators and other relevant health regulators.

The concept presented in Consultation Paper 1 was a National Health Workforce Strategy and Stewardship Forum, convened on a regular cycle. The purpose would be 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. A designated Coordinator-General style role, reporting to the Health Workforce Taskforce (HWT) and Health Chief Executives Forum (HCEF), was mooted as being required to coordinate this work.

It was envisaged that other health regulators and standard setting bodies would contribute to designing and delivering more holistic solutions to support broader health workforce and systems reform, through more formalised collaborations processes and a connection to the proposed National Health Workforce Strategy and Stewardship Forum.



What we heard from you

More explicit linkages to workforce strategy

There was widespread acknowledgement from stakeholders that there is an inextricable link between workforce supply and service access goals and the protective purpose of the National Scheme, with the need to actively balance these considerations.

This reflects the objectives for the Scheme set down in section 3(2) of the National Law, including:

- **Objective 3(2)(e)** – to facilitate access to services provided by health practitioners in accordance with the public interest.
- **Objective 3(2)(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.

The Review noted too the evolving international discourse on health practitioner regulation. The World Health Organisation recently released Guidance on the purpose and design of health regulation, in the context of ensuring access to health care and building adaptive health care systems. This Guidance observed that:

“Regulatory frameworks and appropriate regulation of health professionals were identified as critical elements of this stewardship agenda; with huge potential to promote broader health system goals, health systems strengthening and efficiency alongside the traditional roles of patient safety and ethical standards. In adopting the Global Strategy, Member States called upon regulatory bodies to engage in this agenda and contribute towards ensuring the education, employment, retention and enhanced performance of multi-disciplinary teams that would be responsive to population health needs.”³

The broad picture from the consultation was that the workforce and service access objectives were not currently well supported by the Scheme.

However, there are differing views about the reasons for this and the desired response.

PERSPECTIVES ON WORKFORCE STRATEGY AND HEALTH PROFESSIONS REGULATION



The RANZCP affirms that the national scheme is not sufficiently responsive to health system pressures and workforce challenges.

Submission 16 – The Royal Australian and New Zealand College of Psychiatrists



It seems apparent that many entities within the Scheme see their remit and responsibility as relating singularly to public safety, without consideration of workforce strategy or health service access. We strongly support re-alignment to the broader remit envisioned in the statutory objectives.

Submission 35 – Optometry Australia



The balance in considering the statutory workforce, health service access, and public safety objectives in the National Scheme may vary depending on the National Scheme function, context or circumstances.

Submission 75 – Australian Medical Council



The National Scheme has failed to provide the appropriate mechanism to support the workforce reform agenda by providing a robust forum for scrutinising the need and evidence for, and public debate of, changes to the roles and responsibilities of health professionals.

Submission 65 – Australian Medical Association

³ WHO (2024). *Health practitioner regulation: Design, reform and implementation guidance*, p1. Available at: <https://www.who.int/publications/i/item/9789240095014>.



We welcome the opportunity this review provides for greater stewardship over the development of the Australian health workforce. We also welcome greater clarity from Health Ministers and jurisdictions on their priorities for the health workforce and how the National Scheme can help meet these priorities.

Submission 63 – Ahpra, p6

The absence of a comprehensive national health workforce strategy was commonly observed to be a significant obstacle to setting a clear and complementary health practitioner regulation direction and priorities.

Where views differed was whether this gap was a matter to be addressed within the National Scheme or outside of it, and whether the mechanism for this ought to be through structural change or by improved collaboration.

For some professional bodies, greater emphasis on health workforce and service access issues within the National Scheme was seen to pose the risk of departing from the paramount purpose of the Scheme to protect public health and safety. The Australian Medical Association (AMA) presented its argument as follows:

The National Scheme is not an avenue... to drive workforce reform. The National Scheme enables a health workforce and it should contribute to the development of workforce policy, development and reform through the provision of data and guidance. It is not a workforce scheme.

We sympathise with the desires... to address our current workforce shortages. The solution is not to change the fundamental purpose of the National Scheme which is to ensure patients are cared for by practitioners who are trained to the highest possible standards.⁴

Building on their perspective that workforce issues could not be satisfactorily addressed within the National Scheme, and specifically expressing concern about accreditation processes and standards, some saw that the decommissioned Health Workforce Australia as a lost opportunity. Consistent with this, the AMA suggested that workforce pressures should be addressed by a separate independent body.

The National Scheme has a role in guiding workforce policies, but these policies need to be developed outside the scheme with independent, evidence-based input. Independence is crucial because political priorities often emphasise access over maintaining standards.

Analysing the healthcare workforce must be independent from the National Scheme. Robust workforce data and analysis must drive health workforce policy, planning, and decision making. The AMA advocates for a separate agency that is data driven to advise the health ministers on how the National Scheme can support a growing workforce.

The best solution to address Australia's current and future health workforce demands is an appropriately funded Independent Health Workforce Planning and Analysis Agency.⁵

Similarly, the recommendations of the Scope of Practice Review envisaged a solution outside of the National Scheme and beyond existing workforce planning arrangements.

Establish an independent mechanism to provide evidence based advice and recommendations in relation to significant workforce innovation, emerging health care roles, and workforce models that involve significant change to scope.⁶

⁴ Submission 65 – Australian Medical Association.

⁵ Submission 65 – Australian Medical Association.

⁶ Professor M Cormack (2024). *Unleashing the potential of our health workforce: Scope of Practice Review Final Report*, Recommendation 9, p34. Available at: https://www.health.gov.au/sites/default/files/2024-11/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report_0.pdf.



There was also discussion about the former Australian Health Workforce Advisory Council (AHWAC)⁷ and whether, if this still existed or was reinstated, it would be able to address the need for strategic collaboration on workforce issues. However, it was observed that AHWAC did not ever become fully operational (which is why it was disbanded in 2022).⁸ It was also noted that its remit was a broader advisory role in relation to operation of the National Scheme, as opposed to having a workforce strategy focus, which is the dominant consideration for stakeholders and this Review.

Contrasting with this support for a new and separate organisation or structure was a view that there is a plethora of entities and processes already addressing aspects of workforce supply and distribution both within and beyond the health sector. This includes (but is not limited to) the Medical Workforce Advisory Collaboration, the National Aboriginal and Torres Strait Islander Health Collaboration Forum, the Allied Health Workforce Strategy, the National Medical Workforce Strategy, the National Nursing Workforce Strategy, and the National Mental Health Workforce Strategy.

The concern was that reverting to a separate organisation would add further complexity and significant cost, while diverting focus and resources away from these immediately important workforce planning measures.

The preferred alternative for those with this view was to explore non-structural approaches to bringing together jurisdictional, regulator, and broad stakeholder expertise.

Bridging these two perspectives was widespread support for increased collaboration, consultation and transparency, as central features of any solution to the challenge of calibrating workforce strategy to health professions regulation.

Within this, a range of possible actions were raised.

- i. Some sought fuller consideration of the operation and roles of the current workforce policy setting structures and arrangements.
 - The broad interest in consolidating and supporting current and future role of HWT was noteworthy.
 - This included suggestions for a simplified and strengthened approach to advising Ministers on health professions regulation.
 - It was noted that Ministers currently receive advice through both HWT and the Jurisdictional Advisory Committee of Ahpra, with the membership of the committees and their respective Sub-committees having significant overlap and some uncertainty about roles and responsibilities.
 - The Jurisdictional Advisory Committee is recognised as being a “clearing house” for Scheme- related policies and standards for consideration by Ministers, but is not considered to have the necessary business processes, role clarity, and membership level required to support prioritisation of operational policy work and the objective of aligning the Scheme with broader strategic objectives.

⁷ Established in The National Law until 2022, under section 19:

The function of the Advisory Council is to provide independent advice to the Ministerial Council about the following—

(a) any matter relating to the national registration and accreditation scheme that is referred to it by the Ministerial Council;

(b) if asked by the Ministerial Council, any matter relating to the national registration and accreditation scheme on which the Ministerial Council has been unable to reach a decision;

⁸ Frew D, et al (2017). *Review of the Governance of the National registration and Accreditation Scheme (NRAS)*, p9. Available at: <https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31801&dbid=AP&checksum=A4JqDhY5QFSzdi3+dfMbmg==>.



PERSPECTIVES ON THE ROLE OF THE HEALTH WORKFORCE TASKFORCE

- It is evident that the work of HWT is valued. While its Taskforce tag suggests a temporary, project-driven role, it is apparent that there is a general expectation that it have an ongoing role and that it is an important mechanism for cross jurisdictional collaboration on workforce development.⁹
- Some favoured adapting HWT to have a broader health workforce strategy focus, rather than creating any new structure or process.
- Ahpra presented the argument that the HWT should be repurposed and reconfigured to include representation from Ahpra, so that it could assume responsibility for workforce stewardship and strategy and align it with health practitioner regulation.¹⁰
- Others had a more complex view, supporting the HWT but observing that it has a very specific, full and important agenda of work to deliver reforms already agreed by Ministers, and that a broader workforce strategy focus likely requires a differently constituted body, with different inputs, provided through different avenues.
- A further suggestion was that there would be merit in exploring how a national approach to health workforce strategy and planning could be established through an intergovernmental agreement.¹¹

- ii. Mechanisms for strengthening the accountability of the National Scheme for delivering results and maintaining transparency earned more than a passing mention as a key part of the solution, in line with contemporary regulatory stewardship principles.
 - Most noteworthy was the observation that, while Ahpra is not a Commonwealth agency, it is appropriate and necessary to apply the governance model that applies to Commonwealth regulators.¹²
 - This stewardship-oriented model is set out in Resource Management Guide (RMG) 128 issued by the Australian Government Department of Finance.¹³ RMG 128 centres on the governance mechanism of a Ministerial Statement of Expectations for ensuring that there is a regular and clear articulation of what is required of a regulator to meet expectations and obligations, as extracted below.

⁹ For instance Submission 76 – Not for Publication.

A general observation is that this particular function (workforce planning/strategy/future state) is not consistently applied or resourced, and historical attempts to deliver planning forecasts have attracted political debate and criticism. More recent efforts including refinement of methodologies, sharing of crucial data, and establishment of authorised collaborative groups are improving the situation.

¹⁰ Submission 63 – Ahpra.

¹¹ Submission 76 – Not for Publication.

¹² Including: Submission 55 – Health Professions Accreditation Collaborative Forum; Submission 63 – Ahpra.

¹³ Commonwealth Department of Finance (2023) Regulator Performance (RMG 128). Available at: <https://www.finance.gov.au/government/managing-commonwealth-resources/regulator-performance-rmg-128>.



DEPARTMENT OF FINANCE GUIDANCE NOTE – RMG 128

Statement of Expectations – Summary

Guidance Note

Ministerial Statements of Expectations are issued by the responsible Minister to a regulator to provide greater clarity about government policies and objectives relevant to the regulator in line with its statutory objectives, and the priorities the Minister expects it to observe in conducting its operations.

In line with a stewardship approach to regulatory reform, ministers, secretaries and heads of regulators are responsible for identifying and settling what are the regulatory functions within their portfolios.

Definition of regulator and regulatory functions

The government expects Statements of Expectations to apply equally to standalone regulators as well as regulatory functions being undertaken within departments.

Ministerial Statements of Expectations

Ministerial Statements of Expectations are issued by the responsible Minister to a regulator to provide greater clarity about government policies and objectives relevant to the regulator in line with its statutory objectives, and the priorities the Minister expects it to observe in conducting its operations.

Statements of Expectations should be refreshed with every change in Minister, change in regulator leadership, change in Commonwealth policy or every two years.

Statements of Expectations should:

- Consider the economic and social environment in which the regulator operates, and the Government's policy objectives and priorities, including the regulatory reform agenda.
- Provide strategic direction (to the extent allowed by legislation) on the conduct of the regulator, its role, and how the regulator should engage with business, the community, other regulators and policy departments including the States and Territories.
- Reference any major projects, reforms, and key developments (for example, cost recovery, implementation of reviews) the regulator will be progressing over the next 2 years and the Minister's expectations for these, including considering whether the Statement of Expectations needs to be delayed until a review is finalised.
- Expect regulators to act in accordance with best practice, embedding the Government's principles of regulator best practice, striving for continuous improvement against these principles and considering international best practice, as relevant.
- Propose how the responsible Minister will engage with the regulator, including undertakings on how the Minister will help provide an enabling environment for the regulator to consistently implement best practice.
- Request the regulator responds via a Regulator Statement of Intent, outlining how it will deliver on the Minister's expectations and both the Statement of Expectation and Statement of Intent be made publicly available on the regulator's website.
- Request that the Statement of Expectation be incorporated into PGPA Act processes (that is, corporate plan and annual report).



- iii. A universal message was that there must be improved opportunities for stakeholder engagement in setting workforce strategy and identifying and prioritising complementary regulatory actions.

PREFERENCE FOR COLLABORATION TO INFORM WORKFORCE STRATEGY



Open dialogue between regulatory bodies, health providers, and workforce planners would further enhance transparency and consistency.

Submission 22 – Australian Podiatry Association



[I]ncorporating feedback from health practitioners, regulatory bodies, patients, and advocacy groups to ensure that standards reflect both workforce realities and public safety needs...

Submission 21 – Australian Association of Psychologists



The design of flexible standards must be approached through a collaborative process, to ensure that practitioners can realise the actual benefits of reforms. Regular review of Ahpra's priorities with input from professional bodies, such as the APS, would ensure alignment with workforce and service access needs.

Submission 57 – Australian Psychological Society



Profession-by-profession leadership and regulation are important to ensure safety, but collaboration led by the HPACF and Ahpra Accreditation committee can ensure responsiveness to workforce needs and technology's impacts.

Submission 25 – The Australian Psychology Accreditation Council



It is essential to ensure that a diverse range of perspectives is represented among stakeholder groups, professions, and health paradigms...More flexible care models are required.

Submission 12 – The Australian Register of Naturopaths and Herbalists



ASAR strongly recommends engagement with the professional bodies and associations for each healthcare profession...

Submission 20 – Australian Sonographer Accreditation Registry



Taking an organisational, tri/quadripartite approach where consumer peaks, First Nations groups, provider peaks and unions are represented would ensure greater consistency and quality of advice – not just across the different Boards – but also between AHPRA and different agencies. This would also reflect the government's focus on an integrated approach to workforce between higher education and VET as reflected by the Universities Accord.

Submission 60 – Health Services Union



There is always more than can be done to promote better awareness of the NRAS priorities and strategic direction, including with clinicians and patients. Better use of the various representative organisations is key to improving awareness. Clinician and patient groups need to be more involved in the strategic planning as well as communicating and implementing priorities.

Submission 64 – The Pharmacy Guild of Australia



- iv. Other stakeholders focussed more on the scope of workforce planning, concerned about both the lack of data about the health workforce as a whole and the perceived tendency for decision making about which professions should be regulated under the National scheme to occur in isolation.

Multiple stakeholders suggested that there is a skewed emphasis on the regulated health professions in workforce planning and strategy. They urged broader regulatory stewardship and workforce strategy initiatives to include consideration of the full range of health workforce categories (including the allied health professions,¹⁴ self-regulated and unregistered health professions,¹⁵ and workforces in aged care and disability sectors¹⁶). The following is reflective of this position:



Annual planning involving the National Scheme, employers, education bodies, Medicare and private health insurance organisations should occur to scan the future and agree tangible remediations and actions for each stakeholder. Importantly this should not just focus on the larger professions such as medicine and nursing & midwifery as is often the case...this must go to granular level, look at actual data and not sweep smaller professions under the high level health practitioner, or allied health as it won't resolve the problem.

Submission 4 – Individual

Data deficiencies recurred as a as a theme in this context.

- There is recognition that the National Scheme holds a deep reservoir of data, with the potential to gather or analyse it further to inform decision making across the health systems and in health regulation.

- There is also recognition of rich data held across the health service system.
- The key issue seems to be the perceived absence of well-developed avenues to bring the existing data together and to ensure that there is appropriate access to or analysis of it to support pipeline review and workforce decision making.

The associated desire for a broader workforce dataset data beyond the registered practitioner cohorts and including allied health professions is a significant concern – and is further considered in Reform Theme 2 of this Consultation Paper.

HIGHLIGHTING THE NEED FOR DATA-INFORMED STRATEGY



[T]here should be consideration of a data strategy. Ideally, given proposals outlined for greater inter-regulatory engagement, a national data approach across regulators, accreditation agencies, plus health consumer data would provide a national lens to system evolution. Consideration needs to be given to how data can be captured from existing systems without additional burden. Areas that may benefit include colleges to target their education, guidance and support for practitioners, risk management, research, quality improvement, identify any issues arising from workforce strategies and even predictive modelling. This is key to serving both practitioners and the public better.

Submission 76 – Not for Publication

¹⁴ Including Submission 4 – Individual; Submission 12 – Australian College of Nurse Practitioners; Submission 32 – Osteopathy Australia; Submission 35 – Optometry Australia; Submission 36 – Dietitians Australia; Submission 38 – Community Advisory Council; Submission 39 – Office of the Chief Allied Health Officer; Submission 42 – HealthWork International; Submission 43 – Audiology Australia; Submission 60 – Health Services Union; Submission 64 – The Pharmacy Guild of Australia; Note for instance Submission 36 – Dietitians Australia:

“Dietitians Australia is very supportive of improved workforce planning however this more difficult for self-regulating professions given the lack of access to the same workforce data collection platforms and processes as the registered professions”.

¹⁵ Submission 7 – National Alliance of Self Regulating Health Professions.

¹⁶ Submission 21 – Australian Association of Psychologists. For instance, “...collaborative regulation across sectors such as aged care, the NDIS, and the broader health system could promote consistency in care standards, ensuring public safety without overly burdening the workforce or limiting access to services”.



Integrated workforce planning that aligns regulatory processes with health service demand would be crucial. This includes using data-driven insights to anticipate workforce shortages and adapt accreditation standards accordingly.

Submission 21 – Australian Association of Psychologists



Development of the National Allied Health Workforce Strategy has quickly highlighted the limited (or complete lack of) resources, data or understanding, in both State or Federal jurisdictions or their departments, have in regard to the broader allied health workforce, data or planning beyond hospitals. This review must consider what is a responsibility or objective of Ahpra and equally what should remain a planning responsibility for or funded by Government(s)

Submission 32 – Osteopathy Australia



Clearly defined objectives and measurable outcomes for each of these areas would ensure a structured approach, allowing the National Scheme to balance workforce needs while safeguarding public safety.

Submission 22 – Australian Podiatry Association

In summary, the consultation confirmed the importance of additional measures to strengthen the alignment between national workforce strategy and health practitioner regulation, illuminating the desire of stakeholders to participate and contribute. There was a broad preference for non-structural means of achieving this, with a need to consider how existing entities would contribute and be augmented to this end.

Collaboration across related regulatory organisations

The Review recorded strong agreement that success in addressing current and emerging risks to public health and safety requires that regulation of registered health practitioners occur alongside the actions of other health related regulators.

Stakeholders pointed to the different and distinct mandates, powers and expertise of the various health regulators, and the associated benefits of ‘joined up’ consideration of issues that often require complementary regulation – in relation to health products or premises, consumer protection, sector specific regulation (e.g. aged care and disability services).

The relatively fragmented and delayed regulatory response to cosmetic service risks was identified as a clear demonstration of the need for this collaboration. In that instance, it was observed that there was a missed opportunity for early mobilisation of collaborative regulation. Had this occurred, it would have delivered a more powerful and effective response to the problem, given its multiple dimensions, including exploitative business models to the detriment of consumers, importation and use of non-TGA approved products, use of prescribed medicines without authorisation, delivery of services in non-licensed settings, and non-registered practitioners breaching the *Code of Conduct*,¹⁷ alongside serious instances of poor cosmetic surgery practices.

The rapid evolution of technology and health service delivery models was identified as another domain in which agile and integrated regulatory responses will be essential, both to manage risks and to seize opportunities.

¹⁷ Code of Conduct for Non-Registered Practitioners as in place in the following jurisdictions; NSW, VIC, QLD, SA, WA, and the ACT.



Collaborative regulation of technology related risks



We need Ahpra as the professional regulatory body to be better prepared for emerging trends in clinical care for a proactive approach to maintain the professional integrity of clinical services... Telehealth is one example, but we can also expect that Artificial Intelligence (AI) will be another area of evolution in...most if not all professions. There are risks that increasing corporatising of health care providers will see clinical practice pushing the boundaries, with a greater focus on corporate profits than safe patient care. It is critical that Ahpra works together with other regulatory bodies and professional organisations to pre-emptively identify and manage any risks with emerging clinical practices.

Submission 64 – The Pharmacy Guild of Australia



We also recognise that rapid changes in technology and provision of health services, such as the use of artificial intelligence and telehealth models, require greater regulatory responsiveness to ensure we anticipate and respond to emerging safety and quality issues in healthcare. These challenges require both leadership from the National Scheme and partnership with other regulators and health departments.

Submission 63 – Ahpra, p7

Submission 78 pointed to tangible opportunities for complementary effort to align digital health reform with health practitioner regulation reform, to reduce complexity and drive significant innovation in health service delivery.

This included:

- Pursuing a connection between the processes and timing of allocating national PBS prescriber numbers and individual health care practitioner identifiers under the national Scheme, such that registration of a professional delivers more immediate access to national digital infrastructure.
- Optimising arrangements for provision of practitioner information from Ahpra to support the design and implementation of the national Health Information Exchange under the Intergovernmental Agreement on National Digital Health 2023-27.
- The potential for the National Scheme to facilitate digital capabilities across the health workforce. Implementation of the digital Clinical Learning Australia tool, to support the National Framework for Pre-Vocational Medical Training, has the potential to evolve into a core part of national infrastructure, and in addition to supporting interoperability and connected care, could assist in design and delivery of continuing professional development requirements.

The consultations also reflected an aspiration for improved connection between regulation of health and social care sectors (recognising the significant movement of workers across those sectors).¹⁸ Specifically, opportunities for simplification and improved efficiency in worker screening and standard setting across sectors were identified.

¹⁸ For instance, Submission 21 – Australian Association of Psychologists: “[C]ollaborative regulation across sectors such as aged care, the NDIS, and the broader health system could promote consistency in care standards, ensuring public safety without overly burdening the workforce or limiting access to services”.



Scope for increased regulatory collaboration across health and social care

- There is now mutual recognition of Ahpra registration in workforce screening in the aged care sector, but mutual recognition is not currently supported in the NDIS sector. There was seen to be great benefit in Ahpra registration moving beyond static criminal record checks and including ongoing monitoring of health professionals. This would be consistent with recommendations of the NDIS provider and Worker Screening Taskforce, which would benefit from more Ahpra inclusion.
- Timely sharing of information has been seen as a barrier to risk assessment... and enforcement activities, including in the context of the NDIS Worker Screening Check.
- Another example is the perceived benefit of Ahpra involvement in the Care and Support Economy Reform work of Department of Prime Minister and Cabinet, in relation to which it has been observed that a common set of standards for self-regulated professions could be leveraged for decisions around competency for care sector registration purposes.

Ahpra's steps towards regulatory collaboration were noted as being through bilateral MOUs between Ahpra and a number of other regulatory bodies (including the Aged Care Quality and Safety Commission, the NDIS Quality and Safeguards Commission, and the NDIA). Ahpra has also established regulatory insights capability, within which regulatory intelligence is clearly recognised as *"a conduit for collaboration, enabling regulators to exchange information, coordinate response efforts, and harmonise regulatory approaches"*.¹⁹ There is both enthusiasm and a need to build on this.

The Review noted the recent formation of the informal Australian Health Regulators Network in 2022, which is seen to be a very important step towards increased collaboration.²⁰ The consensus was that further development and formalisation of a network of this kind is necessary and timely, especially in relation to information and data sharing, streamlining and integrating workforce screening and regulation across the health and social care sectors, and connection with health digital reforms.

¹⁹ Martin Fletcher, Samantha Stark, Nikola Balvin, David Greenfield (2025). 'Holding up the crystal ball: using regulatory intelligence insights to support quality in healthcare', *International Journal for Quality in Health Care*, Volume 37, Issue 1, 2025. Available at: <https://academic.oup.com/intqhc/article/37/1/mzaf001/7951762>.

²⁰ Currently chaired by Professional Services Review Director, A/Prof Antonio Di Dio, with flexible representation typically including Professional Services Review, Ahpra, Therapeutic Goods Administration, Commonwealth Department of Health and Aged Care, Digital Health Agency, National Disability Insurance Scheme Quality and Safeguards Commission, and Aged Care Safety and Quality Commission.



Preferred Reforms and Actions

Conclusions from the consultation

The National Scheme will be more effective, relevant and understood if it is purposefully and transparently connected to workforce strategy.

A “WORKFORCE WRAPAROUND”

The review proposes a “workforce wraparound” for the National Scheme. This concept reflects broad support for existing entities to work together more effectively, with a higher level of stakeholder engagement and consideration of the wider health workforce in strategy and decision making. It acknowledges concerns about the duplication, further complexity and cost that could arise from the alternative of establishing a separate health workforce organisation.

Implementation of a “workforce wraparound” would require several administrative and structural actions.

To strengthen the nexus between workforce initiatives and health practitioner regulation, the vehicle of a Ministerial Statement of Expectations would reflect a contemporary approach. It would provide the ability to reset priorities and expectations for the National Scheme as circumstances and health service delivery models change. It is recognised that this would present the challenge of achieving the agreement of all jurisdictional Health Ministers, such that there is effectively a Ministerial Council Statement of Expectations. However, it is also noted that a practice of collective thinking and direction setting by Ministers is already a feature of the National Scheme. This is applied when there is a decision to issue a Ministerial Council Policy Direction under the National Law. If it is ultimately considered necessary for the proposed Statement of Expectations to have statutory force, it could be issued in the form of a section 11 Ministerial Power of Policy Direction under the National Law.

To inform the development of the Statement of Expectations, a process would be required to bring together data and a strategic picture, from which shared interests and objectives could be identified and priority directions for health practitioner regulation agreed. This requirement is the genesis of the recommendation for a biennial Strategy Assembly on Health Practitioner Regulation, with inputs including curated national workforce data

analysis. This analysis would become an essential building block for workforce pipeline planning within and across jurisdictions, to address supply, growth and distribution challenges.

The HWT should remain as the engine room for health workforce strategy and mechanism for achieving more effective integration of health workforce strategy and regulation. The terms of reference for HWT would need to be revised. The changes should embed HWT in the architecture of national health policy and delivery arrangements, and support ongoing progress on elements of national workforce strategy. They should establish a clear structure and process for confirming the annual work program and resourcing that program.

The Review also proposes simplifying and strengthening the reporting lines to Ministers on health practitioner regulation policy matters.

Regulatory policy advice should be rationalised into one line of advice, through HWT and with Ahpra having ‘supplementary membership’ of HWT for this purpose. It is anticipated that HWT have a designated section of each meeting to address health practitioner regulation matters with the “supplementary” Ahpra members in attendance.

Under this structure, there would no longer be a Jurisdictional Advisory Committee of Ahpra and its Jurisdictional Advisory Sub-committee. Instead, there would be a Health Practitioner Regulation Committee to work alongside the Policy and Legislation Committee of HWT. This meeting could be chaired by Ahpra, to support development and implementation of changes in regulatory practice where this is either sought by the Scheme or by Ministers and as a source of advice to the Policy and Legislation Committee of HWT, on possible regulatory policy or legislation (proactively or on request). HWT would thus be advised of the nature and implications of proposed changes to legislation, standards, policies, guidelines for the Scheme, and in turn be advising Ministers on the nature and impact of proposed changes.

The National Scheme would continue to provide operational performance reporting directly to Ministers. Where Health Ministers request Ahpra to attend their meeting to discuss the operational performance report or health regulation policy issues presented through HWT, the Ahpra Board Chair would be the relevant spokesperson (supported by the CEO).



The proposed “workforce wrap-around” should deliver:

- Certainty and clarity around the role and function of HWT as the driver of national health workforce initiatives.
- A sharper focus on identifying and managing the interdependencies between workforce and service access strategies and health practitioner regulation.
- Formal Ahpra involvement in the work of HWT.
- Stronger regulatory intelligence, proactively identifying risks to public health and safety, to inform health workforce strategy and practitioner regulation.
- Structured assembly and consideration of workforce data, building from but expanding the National Health Workforce Dataset and ensuring that all jurisdictions have access to the data and associated analysis for workforce planning and decision making.
- Inclusion of professions, colleges and community voice in setting health regulation priorities that align with workforce strategy.
- An evolving collaborative regulation agenda, to deliver mutually reinforcing initiatives, wherever risks and reforms require regulation of for consumer protection, product safety, and worker regulation and support.
- Accountability to Ministers for delivering health regulation outcomes.

A revised Intergovernmental Agreement for the National Scheme would be the traditional instrument for establishing this “workforce wrap around”.²¹ While this may ultimately prove to be necessary, it is arguably an unnecessarily cumbersome and inflexible mechanism.

The preferred approach is to take immediate steps to adjust and add to existing administrative arrangements as outlined above, and formally recognised them as a coherent governance package within a Health Workforce Schedule to the National Health Reform Agreement.

CONNECTING THE NATIONAL SCHEME WITH BROADER HEALTH REGULATION

The consultation reinforced that tangible and immediate benefits could arise from strengthening collaboration across health-related regulatory bodies. Realising these benefits requires building upon the current informally constituted *Australian Health Regulators Network (the Network)*, with the objective of adding breadth, structure and impact to its deliberations.

In terms of the composition of this Network, its current informality results in relatively fluid engagement and involvement, although there is a good argument for establishing core membership, with the capacity to add others as interests and opportunities require.

In addition to the national health-related regulators, this core membership should include representation from the Health Complaints Entities (HCEs) of the jurisdictions, in the context of the proposed unified national complaints handling systems and in recognition of the need for Commonwealth and State health related regulators to work in concert.

The Review has also identified the appetite for the work of the Ahpra Regulatory Insights Unit to be more visible, to give life to the need for a more proactive, evidence driven approach to health professions regulation in Australia. A structured connection between the work program of the Regulatory Insights Unit and that of the proposed Australian Health Regulators Network will assist to strengthen the relevance and impact of the Unit.

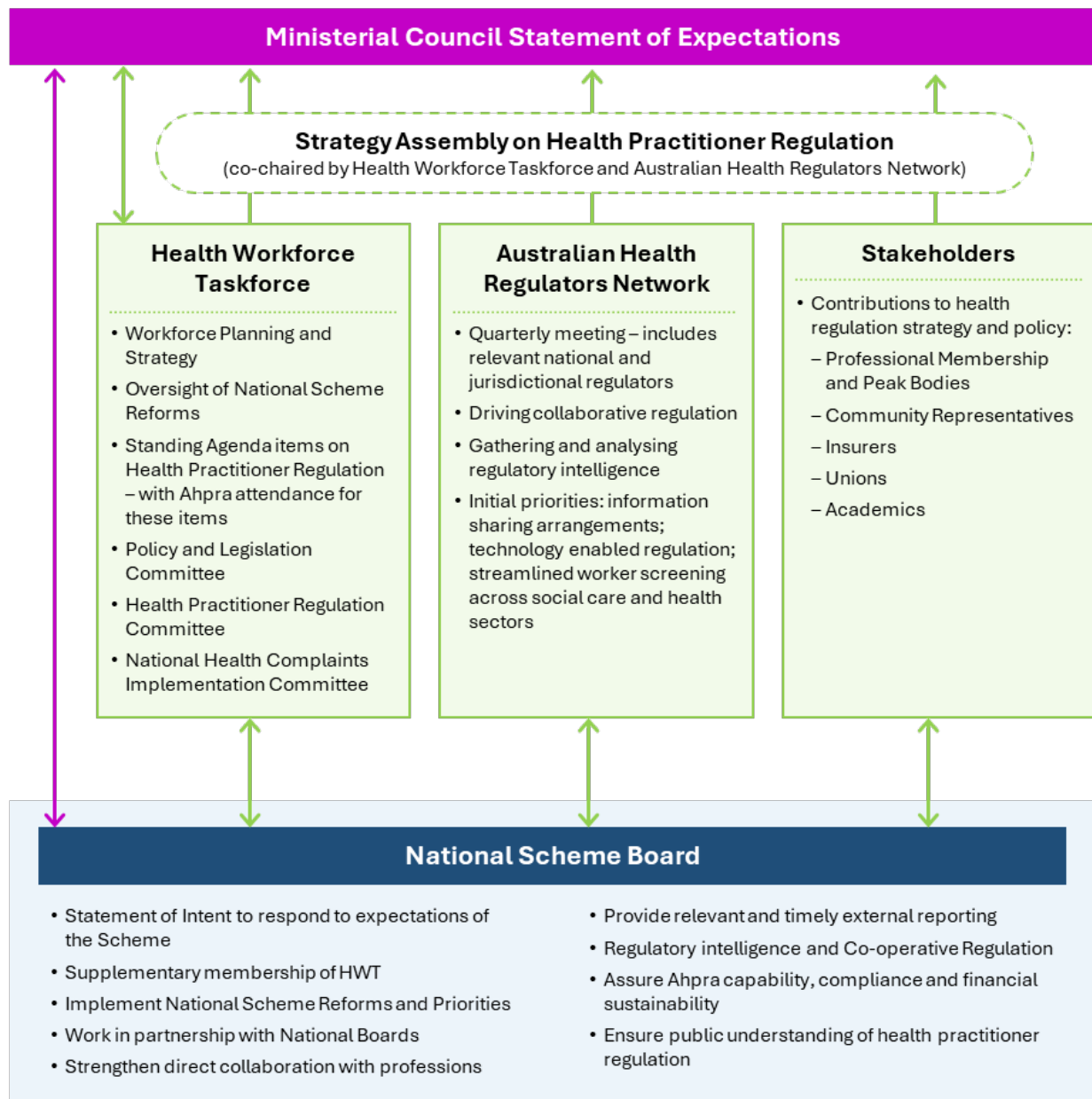
The Terms of Reference for this Network could articulate a line of reporting to the proposed Health Practitioner Regulation Strategy Assembly, with the capacity to provide advice to HWT on request if required.

²¹ Note that the National Scheme was initially established via an Intergovernmental Agreement in 2008. Available at: <https://www.ahpra.gov.au/documents/default.aspx?record=WD10/36&dbid=AP&checksum=NwgooGtzxb6JjNBIEP9Lhg==>.



FIGURE 1: STEWARDSHIP MODEL SUPPORTING THE NATIONAL SCHEME

Stewardship Model supporting the National Scheme





An overview of our proposed reform actions



REFORM DIRECTION 1

The review recommends that the Health Ministers Meeting agree to apply a regulatory stewardship model to set direction, context and accountability for the National Scheme.

- | | |
|-------------------|---|
| ACTION 1.1 | A Ministerial Council Statement of Expectations of the National Scheme to be developed and renewed every 2 years (through a Strategy Assembly process as proposed under action 1.3) and be issued to the Ahpra Board. |
| ACTION 1.2 | <p>Confirm the HWT as an ongoing Advisory Committee to Health Ministers with the primary role of advancing national workforce projects and initiatives, including overseeing and contributing to processes for aligning workforce planning and health practitioner regulation.</p> <p>1.2.1 Revise HWT Terms of Reference and representation, to include.</p> <ul style="list-style-type: none"> a. Requirement for a designated standing item on Health Practitioner Regulation at each HWT meeting and supplementary membership for Ahpra for this standing item. b. An annual program of work and associated budget to be submitted for HCEF consideration. <p>1.2.2 Disband the Jurisdictional Advisory Committee and its Jurisdictional Lead Officials Committee, to be replaced by a Health Practitioner Regulation Committee of HWT.</p> |
| ACTION 1.3 | <p>HWT and Health Chief Executives Forum (HCEF) to establish and co-chair a Strategy Assembly on Health Practitioner Regulation to be held every two years, covering the entire Australian health workforce (not limited to registered practitioners).</p> <p>1.3.1 The primary purpose of the Strategy Assembly would be to inform development of the proposed Ministerial Council Statement of Expectations.</p> <p>1.3.2 The Strategy Assembly could have representative participation drawn from:</p> <ul style="list-style-type: none"> a. All jurisdictions b. Health Regulation Leadership – Ahpra Board/Ahpra CEO; HCEs c. National Professions – Board Chairs; professional membership bodies; peak bodies d. Allied health – peak bodies and professional bodies e. Accreditation entities f. Consumer peak bodies g. Insurers h. Unions <p>1.3.3 The Strategy Assembly should receive:</p> <ul style="list-style-type: none"> a. Status reports on implementation of previously agreed reforms arising from ministerial directions or recommendations accepted by Ministers. b. Workforce data and analysis from Ahpra, jurisdictions, professional bodies, unions and insurers, curated by the Australian Government Department of Health and Aged Care, Health Workforce Division. c. A regulatory intelligence report on issues and risks to public health and safety from the Australian Health Regulators Network (relates to Action 2.6.1) – including but not limited to opportunities for improved integration in workforce screening, standard setting and complaints handling between health and social care sectors. |



- d. Community feedback and input on risks and the operation of the Scheme.
 - e. Practitioner feedback on operation of the Scheme.
 - f. National Health Practitioner Ombudsman advice on issues and opportunities to improve the Scheme, based on its oversight data and evidence.
 - g. A draft of the *National Strategy for the Scheme* from the Ahpra Board.
 - h. Advice from the Ahpra Board on any potential reforms that are not within the accepted suite of registrant funded activities of the Scheme and which may warrant consideration of government funding (links to Reform Direction 3: *Realign functions and structures within the National Scheme to strengthen accountability and transparency*).
 - i. Proposals for legislative reform to improve the effectiveness of health practitioner regulation from the Policy and Legislation Committee of HWT.
- 1.3.4 The Strategy Assembly would result in a biennial report to Ministers confirming action on existing expectations and proposing possible priorities and expectations going forward. The report could include but would not be limited to:
- a. Actions still required of the National Scheme to implement ministerial directions/agreed recommendations and timeframes for those.
 - b. Specific adjustments or enhancements to regulation processes to support workforce or service access reforms.
 - c. Any performance concerns that potentially require a Ministerial Direction.
 - d. Emerging risks to public health and safety – the regulatory strategy for those and the specific role of the National Scheme and other health regulators.
 - e. Outlining Scheme development/improvement opportunities that are in the broader public interest.
 - f. Proposing funding of any potential reforms that are not within the accepted suite of registrant funded activities of the Scheme.
 - g. A revised National Scheme Strategy for the upcoming 2 years for ministerial endorsement.

ACTION 1.4 Health Ministers request HCEF to formalise the composition and reporting line for an *Australian Health Regulators Network*, to provide a recognised structure for collaboration between all health-related regulators.

- 1.4.1 Membership of the Network could include:
- a. All Commonwealth regulators relating to the health workforce and related risks, with core membership to include Therapeutic Goods Administration, Professional Services Review, Ahpra, Australian Commission on Safety and Quality in Health Care, National Disability Insurance Scheme Quality and Safeguards Commission, Aged Care Safety and Quality Commission, Digital Health Australia and Australian Competition and Consumer Commission, as well as HCE representation and flexibility to include others as required.
- 1.4.2 The Network could focus on three early priorities, for instance:
- a. Information sharing agreements between regulators.
 - b. Technology enabled or technology supporting regulation reforms.
 - c. Streamlining and integration of health and social care worker screening and regulation, in support of the Care and Support Economy Reform work of Department of Prime Minister and Cabinet.

ACTION 1.5 Health Ministers request that within a health workforce strategy schedule to the National Health Reform Agreement, HCEF ensures that there is provision to advance actions 1.1 – 1.4 above (as the preferred alternative to reviewing the existing 2008 Intergovernmental Agreement for the National Scheme or other administrative instruments).

THEME 2:

Regulating occupations across the entire health workforce



What the Consultation Paper said

Consultation Paper 1 acknowledged that continuous adaptation and growth of the National Scheme is essential, so that it can meet the challenges and risks of an ever-evolving health system.

It considered the current processes for entry into the Scheme and the registration of specific professions within the broader context of health workforce regulation. It noted the need for more comprehensive and integrated consideration of the full range of occupations delivering health services in Australia, with more systematic decision making for regulation of them, having regard to the differences in the nature and risks across occupations.

The issues identified and the associated reform concepts proposed in Consultation Paper 1 are summarised below.

Summary of issues from Consultation Paper 1: Scope and Expansion of the National Scheme

ARRANGEMENTS FOR EXPANDING THE OCCUPATIONS REGISTERED WITHIN NRAS

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

The argument in favour of registering more occupations within the National Scheme is generally framed in terms of risk, but wider considerations include 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.

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

Whether there should be the option to remove registered professions from the Scheme where it is established that there is insufficient risk, and to make way for adding higher risk professions, was raised.

OTHER MODELS OF HEALTH PRACTITIONER REGULATION

The National Scheme currently includes only one type of occupational regulation, being statutory registration. This is a costly and complex model. There is a genuine prospect that expanding through this model will soon reach a point of unsustainability for the National Scheme.

There are other models operating overseas that are less cumbersome but effective and which could be considered for inclusion in the National Scheme.

If there were other registration pathways within the National Scheme these could be available for lower risk professions seeking to join the National Scheme.



REGULATION OF NON-REGISTERED PRACTITIONERS

Australia already has a ‘negative licensing’ system of regulation – a National Code of Conduct that applies to the non-registered health workforce and which is implemented by jurisdictional Health Complaints Entities (HCEs). However, the Code and associated prohibition order powers are not yet fully implemented in every State and Territory.

These powers are also not well understood by consumers or stakeholders. They tend to be skated over or even overlooked by occupations making a case for inclusion of their profession in the National Scheme.

If these ‘negative licensing’ arrangements were operating to optimal potential they would provide:

- A cost-effective means of setting and enforcing minimum standards of safety and quality, across the entire non-registered health workforce.
- 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.
- A safety net for consumers to build confidence in comprehensive health practitioner regulation.

TENTATIVE REFORM CONCEPT

The reform concept proposed in Consultation Paper 1 was for a “whole of system” view of health workforce regulation, through a framework for applying different levels of intensity of regulation depending on the risk posed by the practitioners across the diverse workforce occupations. It proposed a fully integrated 3 tier Health Practitioner Regulation Framework for occupational regulation of health practitioners in Australia as follows:

- **Ahpra Registration** – risk and benefit-based entry to the National Scheme.
- Introduce a **second alternative model** of registration through **Accreditation of Professional Bodies** to set up Voluntary Practitioner Registers.
- Complete the implementation and strengthen transparency of **Code of Conduct for non-registered health care workers**.

To ensure the effectiveness of this Framework, Consultation Paper 1 also envisaged:

- Clearer processes for managing profession-based applications to enter the National Scheme.
- Building professions and community awareness and understanding of the tiers of regulation.

What we heard from you

Coherence and sustainability of the Scheme

A dominant observation was that health professions regulation and regulatory policy is skewed towards the 16 currently registered professions. There is the firm impression of an ‘inbuilt resistance’ to recognising the allied health workforce (much of which is not within the National Scheme) and considering the risks posed by the broader health workforce, with limited ability to adjust the scope of regulation accordingly. The current approach is perceived to create a somewhat of a caste system of health workforce regulation, with differences in regulatory practices and health system integration for those within and outside the Scheme.

Specific concerns included:

- Lack of understanding and recognition of self-regulated professions and the quality and standards-oriented role of the NASRHP.
- Some allied health occupations are registered within in the Scheme and others outside it-creating confusion and complexity in allied health practitioner regulation.
- Insufficient data about the significant number of professions and practitioners outside the National Scheme and poor awareness of risks relating to those professions or occupations.
- Inadequate risk assessment processes for entry to the Scheme.



- Criticism of incomplete and inconsistent implementation of the regulation of non-registered professions, which in turn heightens the advocacy for including more occupations as registered professions within the National Scheme.

URGING A BROADER APPROACH TO HEALTH PRACTITIONER REGULATION



At present Australia's regulation system could be considered as a two-tier model with registered professions in one camp and non-registered professions in another.

Submission 7 – National Alliance of Self Regulating Health Professions



This current 2 Tier system ...elicits confusion and frustration from consumers, practitioners and the public. Our practitioners are regularly challenged by employers, funding bodies and consumers on their registration status, and have at times been excluded from employment or career pathways as that are not registered practitioners, despite meeting the certification requirements set out by National Alliance of Self Regulating Health Professions (NASRHP)...

Submission 6 – Australian Orthotic Prosthetic Association



Statutory objectives of the scheme should apply to all health professions. Acknowledging that there are multiple ways and levels of regulation that can achieve objective (a) – public protection, the remaining objectives of the National Law are not only relevant to the current NRAS professions and need to apply to all health professions. For example, non-voluntary registration of a broader range of health professionals would provide invaluable insights and data to inform responsive and strategic decision making to meet the needs of the public and help improve the sustainability of the health workforce beyond the current NRAS registered professions.

Submission 39 – Queensland Chief Health Officer

The consultations revealed that sustainability of the Scheme is a complicating factor, particularly if a 'one size fits all' model for regulation of each profession applies and economies of scale cannot be realised through multi-profession structures. Observations in that regard included that:

- Lower regulatory load professions have the option of forming a multi-profession board to deliver a more cost effective and simplified approach to their regulation, but this has not been pursued.
- The process for adding new professions does not address the perceived problem of the current 'set and forget' approach, whereby some professions initially included in the Scheme may no longer be seen to require regulation based on risk.

This highlighted the importance of well managed growth in and around the Scheme and the need to consider whether other models of health regulation need to be introduced to complement the current approach of intensive regulation of a selection of registered professions. The Allied Health Professions Australia put this argument strongly on behalf of the 27 national allied health associations and 165,000 allied health professionals that it represents.



A HOLISTIC APPROACH TO HEALTH REGULATION – THE AHPA SUBMISSION



We welcome the increased focus on regulation of the unregistered allied health and other health professions. We strongly argue in favour of greater regulatory consistency between registered and unregistered professions, as well as across different jurisdictions and health settings. Greater national consistency is a crucial way to ensure that we are meeting the needs of health consumers, practitioners and the broader health and social care systems.

AHPA and our self-regulating health profession members strongly support the need for a system-level approach that considers the scope and purpose of regulation of allied health and other professions with a view to considering the intersection with the National Scheme and potential new models with the National Scheme.

It is our view that a far more comprehensive and systematic review of the negative licensing, self-regulation and co-regulation models in place for allied health professions are required.

[T]here has been little to no focus on the current structures that underpin self-regulation of allied health professions or the function of the NASRHP in setting and accrediting independent standards for some self-regulating health professions.

Submission 37 – Allied Health Professions
Australia

Processes for assessing inclusion of registered professions

While the National Scheme has a mechanism to consider the inclusion and registration of new professions, the consultation indicates extremely limited confidence in this two-staged process and a preference for fuller consideration of the public benefits of including a profession.²²

The risk criteria for inclusion in the Scheme (that are applied as stage 1 of the assessment) are considered outdated and the process as a whole (including the Regulatory Impact Analysis stage) are seen to be unduly cumbersome and lacking in transparency.

There two main criticisms levelled.

- i. **The first concern is that the criteria and risk assessment processes overemphasise “significant harm”, arguably overlooking both the potential harm of non-registered professions and the potential benefits of regulation.**

Many stakeholders make the case that the Scheme takes an unhelpfully narrow and literal view of risk. They observe that this leads to the unreasonable exclusion of professions that are considered to pose a risk to public health and safety of a similar or higher magnitude than some of the 16 registered professions.

Stakeholders are mostly critical of the wording of Regulatory Assessment Criteria 2 (and the description of this criteria in the supporting Australian Health Ministers Advisory Council (AHMAC) Guidance document).²³ Criteria 2 asks: *Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?*

²² The two stages of applying six risk-based criteria in a preliminary assessment, after which a Regulatory Impact Analysis is required is set out in Consultation Paper 1, pp71-72.

²³ Australian Health Practitioner Regulation Agency (2018). *AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions*. Available at: <https://www.ahpra.gov.au/Search.aspx?q=AHMAC%20criteria%201995>.



Many observe that the Guidance and explanatory material emphasises the nature and severity of the risk, requiring that the profession seeking entry to demonstrate that: there is a “serious threat to public health and safety”, “a serious or life-threatening danger”, use of “dangerous chemical or radioactive substances” or “significant potential to cause damage to the environment or substantial risk to public health and safety. This is seen to overshadow broader and equally serious risks to public health and safety (including harm that may materialise over a longer period or which has not yet materialised).

OBJECTIONS TO HOW RISK IS ASSESSED



We note that the current criteria, particularly those criteria associated with risk, do not sufficiently consider the implications of professionals operating outside of regulatory processes due to the voluntary nature of self-regulatory approaches. They also fail to address the potential implications associated with the quality and safety of health services where there is no legislative title protection mechanism to ensure consumers are clear that those providing services have the necessary training and qualifications and are subject to ongoing requirements associated with maintaining clinical knowledge and expertise.

Submission 37 – Allied Health Professions Australia



Criterion 2...could be strengthened to require a stronger focus on emerging risks and trends within healthcare and its impacts upon the practice of the profession in question... There is a need to develop a common understanding of public risk and public interest.

Submission 63 – Ahpra



NASRHP acknowledge the two staged assessment process does currently align with the core purpose of the national scheme – to target professions whose practise pose a risk to public health and safety. However, we challenge the National Scheme’s definition and lack of transparency of what poses risk to public health and safety...we would argue all allied health services pose a risk to public health and safety. We encourage The Review and the National Scheme to publish transparent key indicators of the level of risk that The National Scheme would consider.

Submission 7 – National Alliance of Self Regulating Health Professions



It is not clear that the current assessment process for inclusion in the National Scheme is able to quantify and measure this risk, particularly given the absence or poor quality of data about those health professionals that are not registered and the even greater lack of data about professionals that do not participate in their self-regulating program.

Submission 37 – Allied Health Professions Australia



In rejecting risk-based arguments for inclusion by allied health professions within the National Scheme and referencing professional recognition and opportunity, there has been only minimal consideration of self-regulation from the perspective of regulatory coverage, potential gaps in regulatory responses arising from the voluntary nature of self-regulation and the poorly aligned nature of co-regulation between individual professions and HCEs...

Submission 37 – Allied Health Professions Australia



There is associated criticism that the overriding emphasis on serious risk also excludes due consideration of the potential benefits of regulation. Consultation Paper 1 identified that the two staged assessment process for entry to the Scheme does include an assessment of public benefits at the Regulatory Impact Assessment (RIA) stage.²⁴ However it remains the firm impression of stakeholders that the assessment processes do not sufficiently factor in the public interest benefits.



The current two staged process for adding professions to the National Scheme is focused solely on the level of regulation required to protect the public from harm and does not consider any of the other objectives of the Scheme.

Submission 39 – Queensland Chief
Allied Health Officer

The broader benefits that advocates seek to have recognised are variously described as:

- Recognition of allied health professions and practitioners.
- Assisting access to programs.
- Research grant schemes and practice opportunities that are available to registered practitioners.
- Overcoming the shortcomings of the voluntary nature of self-regulation.
- Consumer protection.
- Assisting the ability of practitioners to work to their full scope of practice.
- Potential to achieve efficiencies in the regulation of workers across the National Disability Insurance Scheme and aged care workforces.

The perceived absence of awareness of what should be expected in terms of the standards of care and conduct for any health professional is also called out as an issue. The self-regulated professions point out that the standards of care that are in place for their professions and their required skills and qualifications are not formally or widely recognised across the health systems or by consumers.

Some argue that the first NRAS criteria for entry to the Scheme is applied to unnecessarily exclude consideration of professions that operate outside of health care settings. This first entry criteria asks:

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?²⁵

The unsuccessful efforts to seek inclusion of social work in NRAS are held up as an example.

Put at its highest, this line of argument is that the National Scheme should be more about the profession than the setting within which they work. This leads to advocacy for the proposition that the National Scheme be expanded beyond regulation of professions delivering health services, to include professions that may deliver health services but also (and potentially primarily) deliver services in a much wider range of settings – such as child protection, corrections facilities, schools or social services agencies.²⁶

²⁴ The RIA considers and compares a range of feasible options for regulating a profession, one of which may be inclusion in the NRAS – this is an important distinction. The RIA does apply a ‘public interest test’ – it is called ‘net public benefit’ and includes assessment and comparison of a range of benefits of each option, including benefits arising from greater efficiencies in assuring qualification and practice standards.

²⁵ Australian Health Practitioner Regulation Agency (2018). *AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions*. Available at: <https://www.ahpra.gov.au/Search.aspx?q=AHMAC%20criteria%201995>.

²⁶ Submission 44 – Not for Publication.



REGULATION FOR PROFESSIONS WORKING OUTSIDE OF HEALTH CARE SETTINGS



One of the challenges regulators and governments appear to have when considering allied health professions is that potentially significant proportions of a profession might work outside of traditional health settings while still providing services that draw on their clinical and professional expertise.

Submission 37 – Allied Health Professions
Australia



[A]pplication of the six criteria has seen professions that arguably should be included in the scheme, such as Social Work... excluded from the Scheme as a result of the narrow interpretation of “risk”... which was not tested for Social Work nationally through the development of a regulatory assessment process.

Submission 39 – Queensland Health
Chief Allied Health



The complexity review should consider the development of a pathway for care professions into the NRAS in lieu of other solutions...[It is appropriate for Health Ministers to regulate the profession as there is no other Ministerial portfolio which takes primary responsibility for the social work workforce. While medical workforces more neatly fall into the purview of the Health portfolio, professions such as social work are more complex.

Submission 44 – Not for Publication

- ii. **The second stakeholder concern is a perceived lack of transparency and objectivity of the assessment process, the complexity of the two staged assessment, and the burden on professions to make their case for inclusion.**

There is a perception that extraneous factors may influence decisions to include a profession in the National Scheme, even where there is the potential for that profession to be more effectively regulated by other methods. Where regulation has been extended to an additional occupation it has been argued that there has not always been robust evidence driven case presented. Where there has been a decision not to include a profession, the reasons have not always been clear. This is regarded as a sign of lack of rigour in applying the current two staged test for inclusion in the National Scheme.

SUBMISSIONS ABOUT LACK OF STRUCTURE AND TRANSPARENCY IN ASSESSING PROFESSIONS



Trying to navigate this process is a minefield with a lack of a standardised process, with no clear direction of how to move forward, nor of who is directly responsible.

The NRAS application guidelines give the impression that they provide an ‘open door’ and ‘no wrong door’ process with the flexibility for professions to make an application at any time to any jurisdiction.

The experience ...is that shared responsibility with no central decision-making or strategic stewardship has led to a ‘hot potato’ dynamic.... This lack of integration or clear pathway for NRAS applications has led to a policy “chasm” and leaves applicants with no way to move forward, and without a fair and reasonable assessment process.

Submission 44 – Not for Publication



A call for statutory regulation of naturopathy and Western Herbal Medicine spans over two decades. A 2005 report commissioned by the Victorian State Government examined the need for statutory registration...Sixteen years ago, in 2008, this report was presented to the Council of Australian Governments, but action was delayed as the NRAS was still being developed...There have been no further developments to date.

Submission 12 – Australian Register of Naturopaths and Herbalists



While we are not opposed to registration under the NRAS, this process was not completed in the way that is outlined in the NRAS IGA, the RIA guide, the AHMAC guidance or the general guidance and best practice consultation principles... [We] advise reviewing the criteria and processes to ensure there is less ambiguity and room for varied interpretation and that any application to join is made in full consultation with the health profession/sector in question.

Submission 43 – Audiology Australia



The current two-stage assessment process is overly complex and inefficient for evaluating health professions seeking inclusion in the National Scheme to protect the public from risk...Relying solely on the health workforce to initiate the need for registration to safeguard public safety is not an effective approach.

Submission 40 – Complementary Medicine Association



On paper the current two-staged assessment process may be appropriate, but it is severely lacking in its implementation. Currently the process appears to serve to avoid the addition of further professions rather than support it and is open to social and political influences being more impactful on decisions than regulatory need. Formalising the processes, with regular reviews of the regulatory needs of professions would help to make the public health aims of the National Scheme more effectively applied.

Submission 47 – Southern Cross University

The Scope of Practice Review

The approach to the assessment of risks and benefits of a profession to determine entry into the National Scheme has also been questioned in the recently released Scope of Practice Review.²⁷

The Scope of Practice Review acknowledged that the current RIA process theoretically takes scope of practice benefits into account, however:

“the overarching threshold criteria stipulate that professions which do not meet the significant harm criteria remain ineligible, regardless of whether there are demonstrable scope of practice benefits to registration [for self-regulating professions]”.²⁸

The Scope of Practice Review recommendations therefore opposed the pre-eminence of a risk-based approach to assessing whether a profession should be added to the National Scheme. Instead, it proposes an alternate “public interest” criterion, which if met would enable the profession to progress to the RIA stage of assessment.

²⁷ Professor M Cormack (2024). *Unleashing the potential of our health workforce: Scope of Practice Review Final Report*. Op cit.

²⁸ Ibid. p125.



That Scope of Practice Review recommendation reflects the perspective that higher emphasis on recognition of allied health professions and the contribution that they make to ensuring high quality primary health care is required and should be enabled by the National Scheme.

Alongside the option for inclusion of an equally weighted “public interest” test for inclusion in the National Scheme, the Scope of Practice Review presented two other reform options to support recognition of allied health professions. Those were to name and include specific professions in the National Scheme (Option B) or accreditation of self-regulated professions by the National Scheme (Option C).²⁹ The recommendation that these options be subject to a “rapid impact assessment” reflected a strong sense of urgency in the need to consider and resolve this issue.

SCOPE OF PRACTICE REVIEW – RECOMMENDATION 8

The Health Ministers’ Meeting (HMM) agree to strengthen and standardise the regulatory model for health professions currently operating outside of the National Registration and Accreditation Scheme (NRAS) to:

- enable the community to access and benefit from all health professionals working to their full scope of practice in multidisciplinary teams in primary care.
- ensure safety and quality of care delivered by the self-regulated health professions.

8.1 HMM agree to commission a rapid impact analysis of the three reform options to determine which option/s meet the criteria defined above and are cost effective:

Option A – targeted legislative amendments to introduce a pathway into the NRAS by introducing an additional criterion, such as a ‘public interest’ criterion, to the NRAS criteria for regulatory assessment of the need for statutory registration of a health profession.

Option B – amended definition of a ‘health profession’ by amending the National Law to include additional specified professions in the definition of a ‘health profession’.

Option C – accreditation by the Australia Health Practitioner Regulation Agency (Ahpra) (or another body) of relevant professional bodies to perform consistent, quality self regulation functions for professions which are not.³⁰

Limited potential for removing professions

Discussion of the arrangements for inclusion of additional professions in the Scheme was rounded out by discussion of the option of establishing an avenue to move professions out of the NRAS registered professions cohort, if the data showed that there were few complaints and signs of low risk. There was only cautious support for this in the context of a risk-based model of registration.³¹

The weight of opinion tended in the opposite direction. The counter argument was that low complaints may in fact be showing that the existing level of regulation works. Practical considerations were also seen to weigh heavily against this proposition. It was argued that introducing an ability to remove a profession from the National Scheme would require legislative change, be administratively difficult, and potentially add to community and practitioner confusion about the Scheme.³²

Consideration of a co-regulatory pathway into the National Scheme

Ultimately, the vast majority stakeholders were deeply critical of the rigidity and limitations of the current two-tiered regulation of health practitioners, the exclusion of many allied health professions from the National Scheme (with unsupported and unrecognised self-regulation of these), and the incomplete implementation of non-registered practitioner regulation are significant problems that cannot be brushed aside or worked around.

²⁹ Ibid. p32.

³⁰ Ibid. p32.

³¹ Submission 75 – Australian Medical Council.

³² For instance Submission 43 – Audiology Australia.



The proposal for a new co-regulatory pathway in the National Scheme attracted extensive discussion, with strong but mixed opinions, ranging from conditional support to significant reticence.

For those not yet supporting the proposal they indicated that there is not a clear case for this, voicing a concern that introducing an additional pathway would be incongruent with the Scheme's primary purpose of focussing regulation on highest risk professions and with the Review's objectives to simplify the NRAS and remove complexity.³³

Weighing against this was a generally widespread and strong support for an alternative pathway into the Scheme from the allied health sector, (although with some caveats regarding the need to further understand and shape the design of such a pathway). Driving this perspective was the concern to redress a sense of historical arbitrariness in selection of the professions included in the Scheme, not just as a matter of principle but as a matter of public protection and the effectiveness of the Scheme.

There is an expected acknowledgement that some allied health professions outside of the Scheme present a level of risk equivalent to some within the Scheme, or if not equivalent at least requiring an additional level of oversight to maintain public safety.

Professions expanding and developing their Scope of Practice were top of mind in this regard. Occupations cannot and do not stand still. They grow and change, which in some cases may elevate risks to public health and safety such as to warrant additional regulation. For instance, we see sonographers conducting transvaginal ultrasounds and we see benefits to speech pathologists assisting with the care of tracheostomy patients, but there may nevertheless be a heightened risk to patients where there is more intensive clinical engagement.

There is also a quest for recognition that self-regulation across these professions has assisted to achieve an uplift in standards of care, but there is more to do to build on this.

[T]here has been little to no focus on the current structures that underpin self-regulation of allied health professions or the function of the NASRHP in setting and accrediting independent standards for some self-regulating health professions.³⁴

Under a self-regulation model, standards can and have been developed by professions. However, absent a formal regulatory framework, there is no process for bringing standards across professions into alignment nor for addressing common professional conduct issues consistently. Where there are profession-generated standards in place, there is no imperative for practitioners in that profession to meet those standards, there is limited health system wide recognition of the standards, and there is no regime to drive continuous learning and awareness of changes in practice over time.

For consumers, the regulatory patchwork is incoherent and inadequate. They do not have the means to determine what qualifications many practitioners hold or whether they have the skills and experience to deliver the care required, even if that care involves risks to them. They do not have a means of understanding potential limitations on the care or advice provided to them. This is particularly the case where allied health occupations (such as sonography), have some practitioners who are registered and others who are not and a consumer may wrongly assume a level of skills and qualifications of an individual practitioner.

For policy makers, the absence of any regulatory framework beyond the 16 Board registered Professions of the National Scheme means that there is no lever to capture and analyse data on the wider health workforce and allied health professions within that. This in turn means that there are significant and largely insurmountable impediments to workforce planning (including lack of visibility of pipeline shortages and workforce maldistribution) and to innovation in care delivery models.

³³ Submission 53 – Royal Australian College of General Practitioners.

³⁴ Submission 37 – Allied Health Professions Australia.



Stakeholders in support of an additional pathway viewed the option as a significant step towards simplification for consumers and for those practitioners in self-regulated professions who continue to incur the costs of lifting standards but without the benefits of doing so.

The dominant tone of the feedback received by the Review is best summarised as more one of how and when (rather than if) an additional pathway should be introduced. This led to a focus on questions regarding the potential design and implementation of an additional co-regulatory pathway.

Importantly, there was firm rejection of some key features of the UK accredited register approach (on which Consultation Paper 1 initially suggested it might be modelled). There was an equally widely held declaration that any new model of regulation within the National Scheme have the features that are required to deliver tangible benefits to practitioners and health consumers and support the overall objective of protecting public health and safety.³⁵

i. The voluntary features of the UK accreditation pathway

Under the UK model, it is currently voluntary for a profession to seek accreditation for a register, and it is also voluntary for an individual practitioner to be on any such register.

Stakeholders saw very limited utility in a model where registration was optional for practitioners, noting also that this held little logic if a decision has been made to establish a register for the profession based on a risk assessment.

The universal view was that once an accredited register is established, the benefits to consumers and employers could only be realised if it is mandatory for any person practising that profession to be on that register.

SUBMISSIONS ON VOLUNTARY REGISTRATION FOR PRACTITIONERS



Voluntary registration is a half-measure and will continue to leave gaps in the regulatory net while offering a false sense of security to consumers and stakeholders.

Submission 49 – Independent Audiologists Australia



By remaining a voluntary scheme with no additional benefits that would increase the proportion of practitioners participating, the proposed model does not increase the proportion of practitioners covered by the model, missing an opportunity to create a nationally consistent regulatory model that incorporates a broader quality and safety focus alongside the most serious misconduct.

Submission 37 – Allied Health Professions Australia



[I]t is currently unclear how having such registration being voluntary would have benefit (for example, in terms of supporting public protection and collection of meaningful data to support health workforce planning).

Submission 74 – the Hon Jacquie Petrusma, Minister for Health, Tasmania

³⁵ Professional Standards Authority (2021). *Consultation on the future shape of the Accredited Registers programme*. Available at: <https://www.professionalstandards.org.uk/sites/default/files/attachments/Consultation%20on%20the%20future%20shape%20of%20the%20Accredited%20Registers%20programme.pdf>.



The Review also considered more fully the 2021 evaluation of the UK model, which supports these concerns about voluntarism:³⁶

- Review of voluntary assurance schemes in other sectors shows that to be effective, they must have high levels of coverage, robust requirements, high levels of awareness and be recognised and used by the broader systems in which they operate.
- The UK programme has not achieved the levels of employer recognition originally envisaged, and this has diminished the benefit for those voluntarily registering and affected the sustainability of the model.
- Success requires that “accreditation becomes a routine requirement for employers and is a greater driver of the choices of patients and the public”.
- The voluntary nature of the programme currently cannot prevent an individual from practising independently in an occupation which is not regulated by law. This can undermine confidence by employers and may fall short of what patients and the public would expect from a system of assurance.
- Employers’ concerns that unsuitable practitioners can continue to provide services to the public even if they are no longer on an Accredited Register, and cannot be prevented from doing so within the current legislative remit for the programme.

ii. Title protection

Both professions and health service employers stressed that this model would only work if there was title protection for the approved professions. Absent this, there would be nothing to prevent a person from representing themselves to consumers or employers using the same title as a person on the register, even if they were not trained in that profession. The Queensland Chief Allied Health Officer observed:

The lack of registration and title protection remains the most significant barrier for the ability to ensure that self-regulated professionals are appropriately qualified and practices safely, competently, and ethically.³⁷

Title protection is supported by Ahpra, albeit with some qualification in relation to cost/benefit assessment as part of any process for further developing the model:

Title protection, linked to a requirement to registration, raises the value of the register to the public by providing a level of assurance about the qualifications of practitioners who are legitimately using the title. It is a well-established and proven regulatory lever within the National Scheme.

However, title protection is a resource intensive requirement for regulators, particularly in enforcing the protection of title and the potential prosecution of offences.³⁸

iii. Standards recognised and common across professions

An important recognised benefit of inclusion of currently self-regulated professions and occupations is the potential for system wide recognition and application of standards that have been (or will need to be) developed for those professions.

The opportunity for harmonisation of standards across the health and social care workforces was highlighted, noting for instance that common standards for self-regulated professions could be leveraged for decisions around competency for registration purposes.

Many sought recognition of the work undertaken by the National Alliance of Self Regulating Health Practitioners, with a solution that builds from this and does not start from scratch.

³⁶ Professional Standards Authority (2021). *Consultation on the future shape of the Accredited Registers programme*. Available at: <https://www.professionalstandards.org.uk/sites/default/files/attachments/Consultation%20on%20the%20future%20shape%20of%20the%20Accredited%20Registers%20programme.pdf>.

³⁷ Submission 39 – Office of the Chief Allied Officer Queensland.

³⁸ Ahpra communication, 11 December 2024.



RECOGNITION AND REINFORCEMENT OF PROFESSIONAL STANDARDS



NASRHP is now the national peak body for self-regulating allied health professions and sets benchmark standards for regulation and accreditation of practitioners within professions. The 11 NASRHP Standards have been developed referencing the Ahpra Standards, Health Care and Professions Council (UK) standards and New Zealand Boards. Peak organisations wishing to join NAHSRP must demonstrate they meet NASRHP standards.

Submission 7 – National Alliance of Self Regulating Health Professions



Self-regulating health professions lack mandated, formal structures that support the setting of consistent standards. While the NASRHP was established with the intention of filling this gap, and is doing so effectively, it is based on voluntary participation and is not supported by government legislation, ongoing government funding, or formal recognition in government policy and programs...

...We note that the absence of a recognised structure or body does not mean that individual professions do not have rigorous and safe regulatory structures based on appropriate standards, where practitioners are subject to those regulatory requirements.

The NASRHP standards have just undergone an independent review ensuring that they are up to date and align with current standards and contemporary practice. The updated standards will come into force from June 2024.

Submission 37 – Allied Health Professions Australia

iv. Complaints

In the UK voluntary accredited register model, a complaint or concern about practitioner who is registered with an Accredited Register is received and managed by the professional body responsible for the register. Standard 5 of the Standards for Accredited Registers requires that registers have “*robust processes in place for ensuring that complaints about registrants are dealt with in a transparent, timely, and fair way*”. This includes the processes for dealing with complaints and concerns, the transparency of decisions and outcomes, training for staff, quality assurance for processes and outcomes, clear communication to all parties, requirements for lay involvement (community voice), and cooperation with other regulators or agencies.

A number of submissions raised the need for fuller consideration of the relationship between complaints handling within the professional association and complaints handling by the Health Complaints Entities (HCEs) and Ahpra.

Most self-regulated allied health professions have their own complaints management processes that operate in addition to the jurisdictional Health Complaint Entities. There is a need for greater consistency and transparency of how the professional practice bodies manage these complaints as there is currently no public visibility on the volume, severity and resolution of the complaints, no external oversight over whether the responses are appropriate and if persistent issues or systemic patterns are being identified and addressed.³⁹

³⁹ Submission 39 – Queensland Chief Allied Health Officer.



The consultation forums drilled into this further. Many suggested that there would be improved public benefit through a new registration pathway if it delivered objective arms-length complaint handling for the approved profession. The following factors were raised:

- Complaints handling in the self-regulated professions is a significant cost to the professional body and cannot be undertaken at scale.
- Specialised skills and resources are required to conduct investigations of serious breaches of standards, which may result in deregistration.
- The need to avoid further complexity in complaints handling, highlighting the desirability of utilising current statutory complaints handling processes.
- The imperative to avoid inconsistencies in disciplinary decision making (depending on whether the practitioner is registered by a professional body, an NRAS registered practitioner, or a non-registered practitioner subject to the Code of Conduct).
- The importance of common types of sanctions across professions, set out in a transparent risk-based disciplinary framework.

It was further noted that if “arms-length” complaints handling is ultimately preferred there would be two options for doing so and these need to be considered in light of any broader recommendations about future distribution of complaint handling functions.

- The first option (raised in Consultation Paper 1) is that complaints handling could be undertaken by the HCEs. This would ensure that there is ready access to resolution and restorative justice pathways for complainants as well as consistency in the manner in which risks are considered and standards are applied across the non-registered professions and the accredited register professions. However, it would require HCE understanding of the allied health professions, their professional standards and clinical or therapeutic guidelines, and linkages with the professional bodies to be strengthened.

- The alternative is that complaints be managed through the Ahpra notifications process. The perceived disadvantage of this was that it would further divert Ahpra from its primary focus on addressing significant breaches of standards across the highest risk professions.

v. Governance of the new pathway

Two models emerged in discussions.

NASRHP advocated it undertake this function:



Recognition of NASRHP’s role and potential future leadership, may work to bridge the gap between regulated and self-regulated professions. If the Review wish to pursue a voluntary register model, we would encourage utilising NASRHP. [It] is a self-regulating model that already exists, is recognised and has received significant resourcing and support from Government. With a small amount of further resourcing, NASRHP could be implemented in a way that mirrors the voluntary register model i.e. publicly publish a register of practitioners. Our experience, policies, processes and knowledge of self-regulating professions, provide NASRHP with multiple advantages over an Ahpra body for this role.

Submission 7 – National Alliance of Self Regulating Health Professions

The broader support was for Ahpra to be the governing entity, consistent with the proposal in Consultation Paper 1. This was on the basis that the benefits of public protection arise from independent regulation, and that complexity is reduced if an additional stream of regulation occurs under the National Scheme, not under a separate governance body. This was also seen to be the most cost effective approach.

Ahpra confirmed in its submission that it has the expertise (subject to funding and legislation) to:

- accredit voluntary-based registers.
- advise or support the establishment and maintenance of practitioner registers.
- undertake enforcement activity.



Data and reporting requirements and actions for additional professions entering the Scheme were stressed as being a key design feature of any new regulatory pathway. In fact, some saw the ability to gather data for a wider spectrum of professions as one of the most compelling arguments in favour of an additional pathway into the Scheme.⁴⁰

It is noted that capturing this benefit would require regulatory specification of the data sought for each profession within the Scheme, with the expectation that the National Health Workforce Dataset should be a minimum requirement. It would also require a method and cycle of reporting to deliver this data, to Ahpra, so that there would be a single point for determining the status on any registered practitioner (including those on the profession accredited register) and to enable collation and analysis for workforce planning purposes. This would need to be fully considered and addressed Accreditation Standards and governance settings for the proposed new pathway.

In terms of ongoing operations, structures and resources for auditing accredited registers, the management of complaints, and reporting on performance are all costs that would need to be examined and accommodated.

It is apparent that detailed assessment of the quantum and distribution of costs and benefits will be required, to inform funding principles and agreements that would be required to implement such a model.

vi. Funding for regulation

Funding for a new co-regulation path was raised.

As with the NRAS registered professions, registrant funding was acknowledged as being the most logical and appropriate funding source for operation of the registration scheme.

However, establishment funding, cost recovery for delivery of services through HCEs or Ahpra, and impacts on the professional organisations were all noted as issues requiring fuller consideration.

There would be costs to establish the framework of co-regulation – including setting the accreditation standards, developing audit protocols, establishing complaints handling processes, fee setting arrangements, and informing the public, professional bodies and practitioners of the details of the new accredited register provisions.

⁴⁰ Including Submission 39 – Queensland Health, Chief Allied Health Officer; Submission 32 – Osteopathy Australia.



SUBMISSIONS ON COST AND FUNDING FOR A CO-REGULATORY MODEL



The proposed model will draw funding out of self-regulating health profession bodies in order to fund new infrastructure and services developed under Ahpra and the management of complaints by HCEs.

Similarly, the new approach adds new costs and structures but does not appear to meaningfully reduce the costs associated with the regulatory functions performed by professional bodies such as the development and management of clinical standards and guidelines, codes of conduct, accreditation of courses and management of issues or complaints that are not addressed by HCEs.

It is also likely that responsibility for negotiating requirements with co-regulators, for example the requirements for self-regulating health professionals seeking registration by the NDIS Commission or Aged Care Regulator, will remain with the professional body rather than a new body under Ahpra. Given this, the most likely outcome is that the overall cost of providing self-regulation increases while reducing the overall resources available to professional bodies.

Submission 37 – Allied Health Professions Australia



[W]e support the need for a national framework for health workforce regulation. However, this is contingent on how the three-tiered system proposed in this review, including the model of voluntary registers, is funded and how it would be implemented.

Submission 63 – Ahpra



Ahpra is well placed to oversee a program of accreditation of these registers. Any such arrangements should not be funded by health practitioners registered in the National Scheme. Responsibility for managing the register should sit with the relevant profession.

Submission 63 – Ahpra

Non-registered practitioner regulation

The Review recorded a high level of support for more explicit and formal regulation of non-registered practitioners within an integrated framework of health practitioner regulation.

The lack of visibility and valued placed on the National Code of Conduct for Non-Registered Practitioners (the Code) was uniformly seen as a handbrake on effective health workforce regulation.

The Code is seen to be important for setting minimum standards of conduct and practice applying to all non-registered health practitioners and protects the public where practitioners are not meeting the Code, through the ability to issue prohibition orders.⁴¹

Notwithstanding this potential, many also confirmed their view that it is currently manifestly inadequate as a part of health regulation in Australia, mainly due to incomplete implementation of the Code. It is not yet operational in the Northern Territory or Tasmania. There are significant differences in the scope and functions of non-registered practitioner regulation in States and Territories where it has been implemented.

There is not a good understanding of how the National Code works with the self regulating certifying entities'/professional association's own Codes of Conduct. There are no procedural frameworks for application of the Code to drive consistent implementation across jurisdictions and to assist HCEs to work with the allied health professions in an effective and efficient manner. This has meant that it is yet to reach the level of maturity to deliver what is required of it.

⁴¹ Note for instance Submission 45 – Not for Publication.



There was also strong emphasis on the need to finalise all implementation steps that would be required to deliver the intended benefits to consumers. The most notable gap was absence of a National Register of Prohibition Orders, as was agreed by Health Ministers in 2015. Several respondents echoed the sentiment that *“if nothing else, establishment of a National Register of prohibition orders issued about health practitioners is essential”*.⁴² Potential for a National Register to cover prohibition orders issued by other regulators in relation to workers in the aged care and disability sectors was also identified.

Consultations nevertheless pointed to the difficulty of resolving problems with incomplete and inconsistent implementation of the Code in the context of jurisdictional legislative and funding responsibility for implementing the Code.

SUBMISSIONS ON NATIONAL CODE OF CONDUCT FOR NON-REGISTERED PRACTITIONERS



Having a National Code of Conduct being enforced by State and Territory entities creates a challenge for standardisation. Focus should be put on how State and Territory health complaint entities are going to manage implementing the National Code of Conduct consistently.

Submission 18 – Hunter New England and Central Coast Primary Health Network



We also support a national register of prohibited unregistered practitioners. This may provide greater protection for consumers in some of the clinical settings, such as disability and aged care, where practitioners who lose their National Scheme registration may seek to continue practising, posing a risk to some of the frailest patients.

Submission 63 – Ahpra



The ASA considers that the National Code of Conduct and its negative licensing approach provides a good baseline. It helps to ensure that – for most health professions – patients have a standard against which to measure health practitioner behaviour and that patients have a complaint mechanism which to use. However, in practice, the inconsistent approaches as to how the Code is implemented and the extent of its application undermines its effectiveness.

Submission 72 – Australasian Sonographers Association



The developments in NSW with a new code of conduct for organisations is an important development. We need better data about how the National Code of Conduct is working.

Submission 42 – HealthWork International

The imperative to address this issue appears to be building. Media and public attention is frequently trained on the issue and typically paints a picture of ongoing confusion about who regulates non-registered practitioners. Most recently this has included commentary in relation to the regulation of non-registered sonographers and private ultrasound clinics, cosmetic injectables, and massage therapists. In the example of massage therapists, a recent media campaign followed the case of a South Australian massage therapist who was found to have assaulted several clients and who had been reported to police and the relevant industry body, but not by police to the SA Health and Community Services Complaints Commissioner (HCSCC) as would be expected and intended. The HCSCC, had the power to impose a prohibition order which would have protected the public, and ultimately did so but only some years after the first report to police.

⁴² Submission 39 – Office of the Chief Allied Health Officer, Queensland, supported by Submission 26 – Speech Pathology Australia; Submission 40 – Complementary Medicine Association; Submission 63 – Ahpra; Submission 72 – Australasian Sonographers Association; Submission 73 – Not for Publication.



EXTRACT FROM MEDIA COVERAGE ON REGULATION OF MASSAGE THERAPY⁴³

Unlike other health professionals, such as doctors and dentists, massage therapists are not regulated by the Australian Health Practitioner Regulation Agency (AHPRA).

There are several industry bodies, including Massage and Myotherapy Australia (MMA) and the Association of Massage Therapists (AMT), but it is voluntary to join these groups.

There is a National Code of Conduct, which covers unregistered and self-registered health professionals not covered by AHPRA, but it is up to States and Territories to implement.

New South Wales, Victoria, South Australia, Western Australia, Queensland and the ACT have implemented the code and can put bans in place on those professionals.

Tasmania and the Northern Territory are yet to implement the code.

The NT Health and Community Services Complaints Commission said the National Code required an amendment of a law to be implemented in the territory and said that had not occurred.

“As the National Code has not been implemented in the NT, prohibition orders made in other Australian jurisdictions are unable to be enforced in the NT,” they said.

That means a banned massage therapist could operate within that jurisdiction.

A Department of Justice Tasmania spokesperson said the National Code of Conduct had not yet commenced within the State.

They said changes to the Act were proclaimed on December 31 last year, and the government would consult with stakeholders.

It is expected to be operating by the middle of the year.

The ACT Health Services Commissioner spokesperson said its code of conduct was only implemented 12 months ago and no prohibition orders had been issued publicly yet.

Publicly available data from New South Wales, Victoria, South Australia, Western Australia and Queensland collated by the ABC found at least 31 massage therapists under either an interim or permanent ban in 2024.

In some of those cases the reasons for a ban are not displayed, and not all are related to alleged sexual offences.

⁴³ ABC News, Briana Fiore (2025). *Is this self-regulated industry a breeding ground for predators*. published online, Saturday 25 January 2025. Available at: https://www.abc.net.au/news/2025-01-25/massage-therapy-regulation-in-australia/104702040?utm_source=abc_news_app&utm_medium=content_shared&utm_campaign=abc_news_app&utm_content=mail.



Preferred Reforms and Actions

Conclusions from the consultation

The case for ensuring that decisions about regulating professions within the National Scheme are risk-based and not made in isolation from the overall approach to health practitioner regulation in Australia seems clearer than ever.

- On the one hand there are professions not currently within the Scheme that may warrant additional regulation over and above any current self-regulation.
- On the other, there are occupations that are never likely to warrant regulation within the Scheme, but which require a baseline level of regulation in the interests of public health and safety.

Decisions about which professions require regulation under the full registration model within the National Scheme must be made in a structured way. They should be based on: a clear evidence of the nature of risks to public health and safety; the need for proportionate regulation; workforce accessibility and quality aspirations; and, health systems goals.

This speaks to the need for data and context driven health regulation policy making, that considers the entire health workforce in a coherent and systematic manner and with an eye to avoiding over-regulation, as is advocated in the WHO Guidance on health workforce regulation.⁴⁴

AN INTEGRATED HEALTH PROFESSIONS REGULATION FRAMEWORK

The Review has concluded that an Integrated Health Practitioner Regulation Framework (first flagged in Consultation Paper 1) has merit. In its ideal conceptualisation (reflected in Figure 2) it should incorporate three types of regulation in a non-hierarchical schema:

- **By National Boards/Ahpra under the National Scheme.**
- **Through Approved Profession Registers under the National Scheme.**
- **By jurisdictions using negative licensing.**

The recognised benefit of a whole of health workforce regulation framework is that it avoids taking decisions about regulation of specific professions in isolation and in an ad hoc manner.

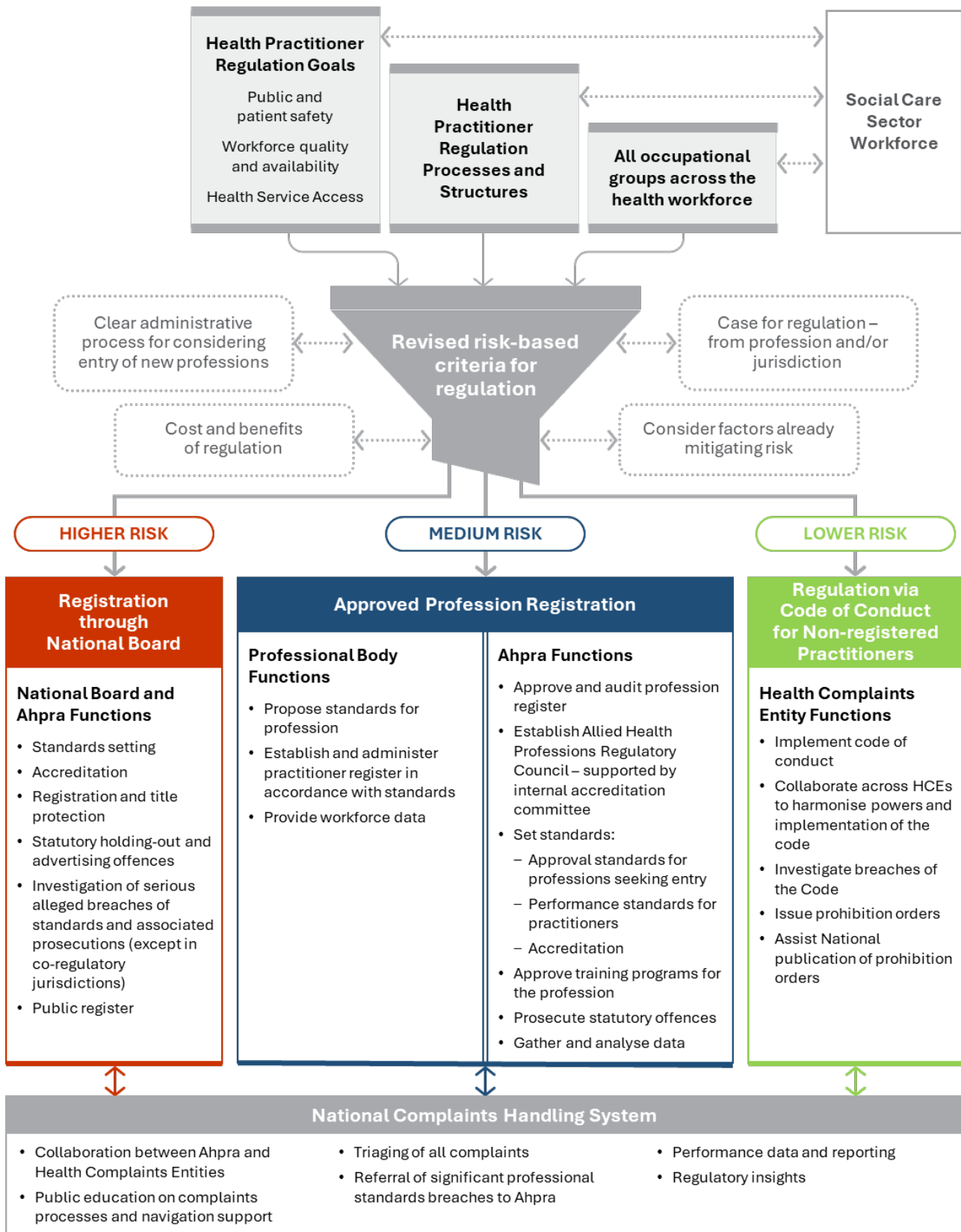
Especially if there are improved risk-based entry criteria and a more transparent assessment process, there will be a means of identifying and analysing the most appropriate model of regulation for a given profession, without the constraints of applying only the most intensive model of registration governed by National Boards. Levels of regulation would be proportionate to the risk presented by different health occupations.

⁴⁴ World Health Organization (2024). *Health Practitioner Regulation: Design, Reform and Implementation Guidance*, Geneva. Available at: <https://iris.who.int/bitstream/handle/10665/378775/9789240095014-eng.pdf?sequence=1>.



FIGURE 2: INTEGRATED HEALTH PROFESSIONS REGULATION FRAMEWORK

Integrated Health Professions Regulation Framework





DETERMINING ENTRY TO THE NATIONAL SCHEME

The capacity to make and explain regulatory decisions based on stratified risk-based regulation of all health practitioner cohorts will build understanding and confidence in health regulation in Australia.

To reiterate, entry into the Scheme must continue to be risk-based. Ultimately, given the costs and the impacts on providers and the grounding purpose of protecting public health and safety, intensive regulation must be necessary, not merely desirable.

This is not to say that consideration should not be given to the benefits of additional regulation of a profession, but it is important to be clear the benefits considered should relate to benefits to the public and consideration of these benefits cannot be separate from risk assessment. This is important because entry to the National Scheme does not and should not automatically confer benefits such as access to Medicare, program funding and research grants and the National Scheme does not have professions recognition benefits as an objective.

In relation to the reform options for entry to the Scheme presented in Recommendation 8 of the Scope of Practice Review, the following observations and conclusions are made.

- Option A proposed an equally weighted and separate public interest entry criteria. As this would enable a profession to be considered for entry to the Scheme irrespective of its risk profile, this Option is not favoured by the Review.
- Option B envisaged that a selected set of professions be included in the Scheme by legislation.⁴⁵ Those defined professions would not be subject to full regulation under the National Scheme, but would be treated the same as those professions wherever there is a statutory reference to those specified professions outside of the National law. As this Option is primarily related to entry considerations other than the risks posed by that profession and also does not grant the full benefits of regulation to these professions, it is not further considered within this Review.

- Option C maintained a risk-based assessment approach, consistent with the direction favoured. It is therefore further developed in this Review.

This Review has concluded that the current risk criteria and associated guidance are focussed too narrowly and should be revised.

Revisions to the administrative instruments for assessing risk should adopt a broader and more evolved approach to risk management. They should assist in considering risks beyond immediate and serious threats of harm or actual harm. They should assess and classify risks as more or less serious based not just on recorded impacts and harms, but also aspects such as lifelong harms and in full consideration of broader risk factors. These may include:

- Typical context and settings in which services are delivered.
- Likely presence of other protective features such as clinical oversight/governance, peer support and review, formalised policies, procedures and training and other relevant associated regulation of facilities, devices or products.
- Likely predominance of patient vulnerabilities.

Fuller consideration of public benefits should also be part of the first stage of assessment for entry to the Scheme. At present, criteria 6 in the current AHMAC Guidance is that Ministers consider whether the public benefits of regulation clearly outweigh the potential negative impacts) the benefits. However, the Guidance is explicit that this is only an optional criteria to be addressed in a submission to enter the Scheme, and rather is subject to independent assessment upon receipt of the submission. Better practice would be that a submission to enter the National Scheme present evidence on both the risks and benefits of regulation to the public, so that these can be weighed in a transparent manner from the outset.

It is also necessary that the processes for presenting and assessing applications for entry to the Scheme be more structured and transparent, noting too the significant costs of the two staged assessment process.

⁴⁵ Professor M Cormack (2024). *Unleashing the potential of our health workforce: Scope of Practice Review Final Report*. Op cit, p129 suggested the indicative priority self-regulated professions be: dietitians, Sonographers, Audiologists, Exercise physiologists, Speech pathologists, Social workers and Counsellors.



The Review proposes that applications to enter the National Scheme be received and examined through a formally defined administrative assessment and review process, as a precursor to being presented to Ministers for determination. The process is summarised in Figure 3, and should include:

- An EOI cycle (every two years),
- An EOI could emanate from either jurisdictionally initiated nominations or profession-generated requests to enter the Scheme.
- Panel(s) of relevant experts assembled by Health Workforce Taskforce (HWT) to advise on EOIs, within 3 months of the EOI.
- Advice to Ministers would inform their decision as to whether the profession should be added to the Scheme and if so, whether this should occur with a full formal Regulatory Impact Analysis with Office of Impact Analysis oversight or with a modified Regulatory Impact Analysis.⁴⁶
- Notification to the profession of a preliminary decision for inclusion in the Scheme (or not) and reasons for that decision and the proposed next steps in process.
- Regulatory Impact Analysis to more fully consider costs and benefits of regulatory options would occur, with the option of a full or modified RIA.
- The funding options for conducting the RIA process would also be considered at this point.
- HWT visibility of the scope and progression of the RIA process and its timing and cost.
- Ministers to determine if a profession is to be added to the Scheme – and if the proposed Approved Professions Register pathway developed whether that profession is to be regulated by a National Board or by an accredited professional entity.

The Review notes that there has been ongoing consideration of the inclusion of the audiology profession in the National Scheme and that further cost benefit assessment is underway.⁴⁷ However, in the absence of the ability to consider any recommendations about the future scope and direction of the Scheme arising from this as yet incomplete Review, that further assessment is unavoidably limited as a decision-making tool for jurisdictions and Health Ministers. This will remain the case until a determination is made as to whether there will be a new pathway for allied health professions into the Scheme.

This will not be an issue if the further assessment leads to a ministerial decision that further regulation of audiology is not necessary.

However, if (based on consideration of the supplementary cost benefit analysis) Health Ministers remain of the view that additional regulation of audiology is warranted, it will be an issue requiring resolution.

In this latter scenario, the Review suggests that a decision on its inclusion in the National Scheme not be taken at this time. Rather, the sponsoring jurisdiction could be requested to withdraw the recommendation for inclusion at this time, with the opportunity to seek further consideration of the matter once it is known whether and when a new pathway into the National Scheme will be established. This would enable consideration of the option of piloting an Approved Professions Register pathway into the Scheme, as an alternative to National Board registration.

⁴⁶ 2023 Whole of Government Impact Analysis – National Cabinet has refocused Impact Analysis requirements for decisions of Ministerial Councils, Proposals coming forward in these fora are no longer required to be finalised with the Office of Impact Analysis unless an Impact Analysis is requested by the relevant decision maker(s).

⁴⁷ Queensland Health (2025). *Audiology Regulatory Impact Statement*. Available at: <https://www.health.qld.gov.au/clinical-practice/engagement/clinical-engagement-projects-and-consultations/audiology-regulatory-impact-statement>.



FIGURE 3: RISK-BASED HEALTH PRACTITIONER REGULATION UNDER THE NATIONAL SCHEME

Risk-Based Health Practitioner Regulation under the National Scheme

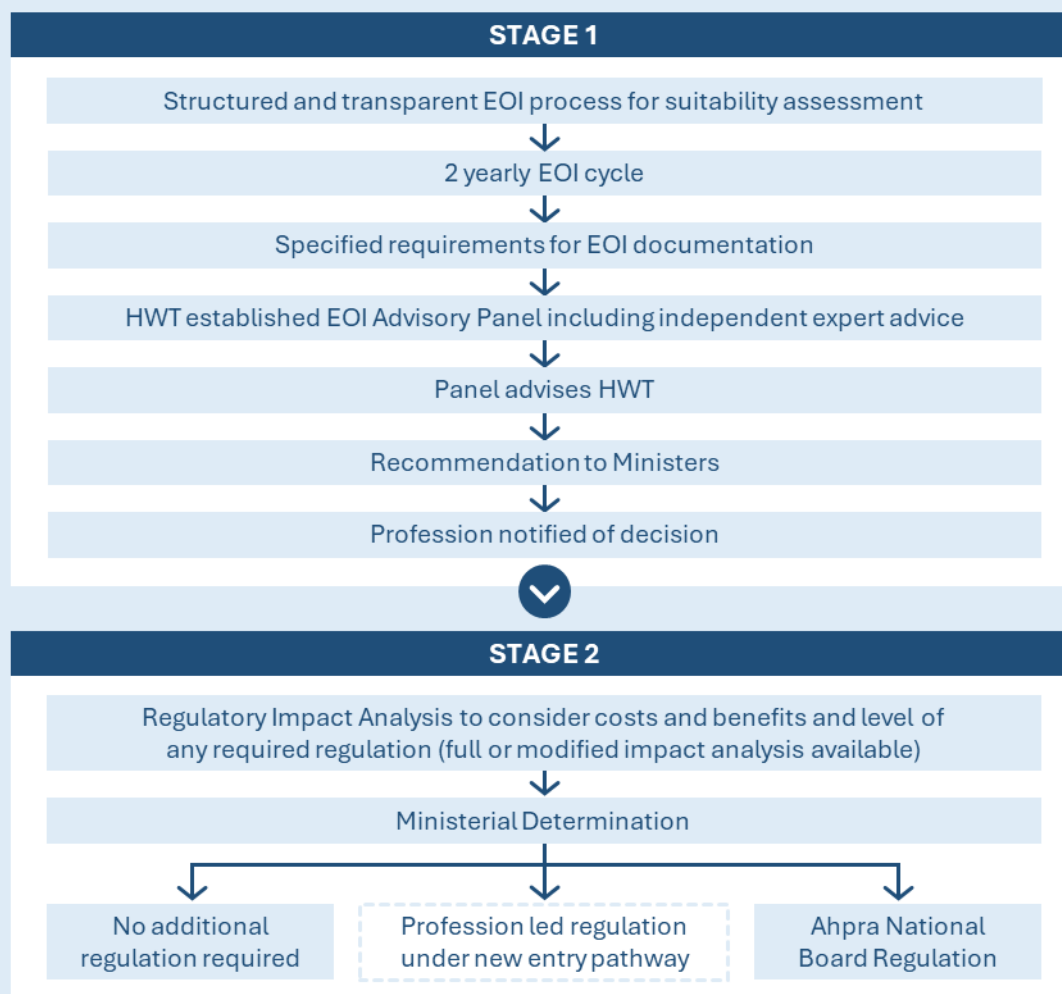
Purpose of Regulation

Ensure public confidence that risks posed by health occupations will be addressed effectively and proportionately.

Risk Assessment Method

- Retain 2 staged assessment process
 - Initial consideration of suitability
 - Regulatory impact analysis – full or modified as required by Ministers
- Revised initial suitability criteria and guidance – wider definition of risk, earlier and structured consideration of benefits.
- Distinguishing between higher or lower risks and more structured consideration of risk mitigation factors
 - Actual or potential harm
 - Factors that may amplify harm (e.g. inherent nature of the services delivered, likely predominance of vulnerable patients, typical practice setting)
 - Any risk mitigation already in place (e.g. clinical governance, peer support and review, formal policies, training, other relevant regulation of facilities, devices, products and business practices).

Risk Assessment Process





THE BENEFITS AND POSSIBLE DESIGN AND GOVERNANCE OF A NEW PROFESSIONS REGISTRATION MODEL

It is appreciated that there is divided opinion on progressing a new Approved Professions Registration model within this Framework. The Review has concluded that this new pathway is an essential element of National Scheme Reform, for the following reasons.

- Health occupations and health systems grow and change, which in some cases may elevate risks to public health and safety such as to warrant additional regulation.
- As an enabler of public safety and health workforce the National Scheme therefore cannot stand still, stymied by narrow risk criteria limiting entry. It must adapt and grow.
- Fragmented regulation of professions inside and outside the Scheme is incoherent and regulatory gaps (with risks to the quality and safety of care) are potentially unchecked. Coherence matters – the National Scheme must be as clear about why professions are not in the Scheme as it is about why they are included.
- Equally, the Scheme cannot grow unbounded. The Scheme has grown to regulate close to 1 million registered practitioners, at an annual cost of \$313 million per year – with critical sustainability questions. The current one size fits all, intensive model of regulation is costly and inflexible. Even if efficiencies can be improved by process and systems changes, adding any new profession is lengthy, costly and potentially disproportionate action for many professions.
- A lighter touch regulation pathway provides a new and more cost-effective tool for regulating professions that may pose lower (but still some) risk, and for which an uplift in standards across that profession would improve the quality and safety of care across the health system.
- There are signs of confused policy thinking. Those opposed are concerned that proposed expansion of the Scheme is based primarily on equity arguments not risk (for instance that more professions should have access to incidental profession-facing benefits of registration (such as billing access under Medicare and ability to administer or prescribe medicines) and would distort the purpose of the Scheme. While the incidental benefits of registration are recognised. It is both possible and necessary to expand the Scheme without distorting its grounding purpose of identifying and addressing risks to health and safety. The argument for inclusion of a new profession can and should continue to rest on an assessment of risk.
- The current model of self-regulation cannot deliver necessary improvements in the care delivered by the broader range of professions across the health system. There is no imperative for non-registered professions to develop standards specific to the risks of that profession or in line with standards for other professions. Where they do so, those standards are not required to be adopted or applied to all practitioners in the profession or to be improved over time to respond to cross profession issues. There is a need for levers to drive uplift and compliance with those professional standards that have been developed, for harmonising standards across professions and for recognition of those standards across the health system.
- The public expects more consistent and equitable complaints handling across all professions. At present, complaints in the self-regulated professions are generally dealt with by professional membership bodies, without the necessary independence or consistency of processes and outcomes across the professions currently falling outside the national Scheme.
- Effective workforce planning requires a more complete picture of the existing and projected health workforce. A significant secondary benefit of an additional class of registered profession is the ability to gather workforce data about these professions to expand the National Health Workforce Dataset. In the absence of any tool for gathering data about professions outside of the 16 registered professions, workforce planning and strategy will always be hampered.



The proposed Approved Professions Registration pathway would need to differ materially from the UK approach. This additional registration model must deliver the desired benefits (including title protection, mandatory practitioner participation in a register, robust accreditation standards, and independent complaints handling) and the costs will need to be clearly identified and appropriately distributed.

For occupations entering the Scheme through the proposed new Approved Professions Registration pathway, governance also requires close consideration.

DESIGN OF THE NEW APPROVED PROFESSIONS REGISTRATION PATHWAY

Role of Ahpra and the proposed Approved Professions Regulatory Council

The Review does not intend that each profession entering the Scheme under the Approved Professions Registration pathway would have a separate governing board or a separate approval, standard setting and auditing entity.

The Review instead proposes a more flexible and streamlined governance structure, with all occupations entering under this pathway being governed by a single Approved Professions Regulatory Council (except where the profession is determined to be more appropriately governed by an existing National Board).

The members of the Council would be appointed by Ministers and subject to Ministerial Directions under section 11 of the National Law.

The role of the Regulatory Council would include setting **standards** for:

- a. **The professional body to operate the register:** The standards for register operation would address features that would assure the integrity of the register and its utility as part of the National Scheme. This would include requirements such as:
 - The register for each of the approved professions to be designed and stored in a form that supports the objective of a centralised and searchable consolidated register. The aim will be for a register curated by Ahpra that provides access to information for both National Board and Profession Registered practitioners through one search.
 - Maintaining a clear separation between registration and membership functions (whether this be by legal or structural construct).
 - Capacity and processes to conduct appropriate probity and qualifications checks for practitioners seeking registration.
 - Data and performance reporting.
 - A transparent and accountable process for setting and reviewing registrant fees.
- b. **Practitioners to be registered by that profession:** Registration standards for practitioners applying to the Approved Professions Register would cover the range of actions required of practitioners seeking registration. This would include aspects such as:
 - checks on qualifications
 - criminal and professional history
 - re-registration intervals,
 - recency of practice
 - insurances
 - CPD undertaken).

As far as possible, registration standards for practitioners should build on those already developed by self-regulated professions, also seeking to lift towards the standards applying to registered professions, particularly for cross-profession issues such as English Language Standards, cultural safety, and sexual misconduct.



c. **Accreditation for training to be provided to practitioners.**

Accreditation standards for the occupations would be performed Approved Professions Regulatory Council (potentially advised by an internal Approved Professions Accreditation Committee of the Council). There would not be an external accreditation authority for allied health professions. This will ensure that accreditation functions are appropriately aligned with workforce and service access considerations and not straining against the objectives of efficient and effective regulation.

All standards within the Approved Professions Registration model (i.e. for register operation, registration and accreditation) would be subject to Ministerial approval.

Ahpra would perform compliance functions and establish a process for audit of the Approved Professions Registers, to ensure adherence to and appropriate application of all relevant standards.

Costs and fees

The costs of all Ahpra/Regulatory Council functions would be met from registrant fees under a formal agreement, set at the time of approval for inclusion of the occupation to join the Scheme.

Registrant Fees would be proposed by the Approved Profession and be approved by the Regulatory Council.

The Role of the Professional Bodies

The relevant profession would need to identify one professional entity to be the Responsible Professional Body at the point of assessment for entry to the National Scheme to facilitate consideration of suitability for registration through the Approved Professions Registration model. It is not considered appropriate that there be more than one professional body for an approved profession. The representativeness and suitability of the body, relative to any others for the represented profession, would be key considerations.

Where a profession is agreed by Ministers as entering the Scheme via the Approved Progression Register Pathway, the profession would need to demonstrate how it complies with standards for the operation of an approved profession register and it would then be formally established under the governance of the Approved Professions Regulatory Council.

The profession would also have the opportunity to make submissions to the Regulatory Council on proposed registration standards for practitioners and accreditation standards for training provision for the profession.

Practitioners in the Approved Profession

Registration via the Approved Profession Register would be mandatory for practitioners seeking to deliver services in the approved profession. They would apply to the responsible professional body to be registered. They would only be registered (and subsequently reregistered) if the Responsible Professional Body determines that they meet the registration standards.

Complaints handling

There is a need for an independent complaint handling process. Approved Professions would be expected to refer complaints relating to conduct and departure from professional standards to the jurisdictional HCEs, as should occur currently, but often does not.

HCEs already assess and manage complaints about non-registered practitioners, so this would not be a new function for them. What would differ is that the standards set under the National Scheme pathway would be clearer and in addition to the *de minimus* provisions of the existing Codes of Conduct.

This would require the approved professional body to propose and maintain procedures by which the HCEs can access profession-specific advice where this is necessary to determine complaints and investigation outcomes.



REGULATION OF THE SOCIAL CARE PROFESSIONS

The question of whether the scope of the National Scheme ought to be expanded to include any professions that work in the broader social care as well as health settings is a difficult one. There is powerful ongoing advocacy for this, particularly from the social work profession.

The Review notes that the existing formal Guidance for adding professions already allows for inclusion of professions that also work in social care settings, where it is appropriate and consistent with the purpose of the Scheme. That Guidance is as follows:

Some professions provide services across a range of portfolios for example, education, justice and community services. Where services cross a range of portfolios, the need for registration standards regarding services other than health should be considered. If the profession mainly provides services outside of the health portfolio, Health Ministers may not be the most appropriate body to approve registration standards. Another form of regulation, other than health professional regulation under the NRAS, may be more appropriate.

Professions should address the contexts in which their members provide services, for example, in the health sector, education sector, child protection or community services sector.⁴⁸

Ultimately, these are not black and white decisions, and judgement will always be required in making fine distinctions across occupations.

The Review has concluded that the existing Guidance provides sufficient scope for inclusion of a social care profession in the Scheme where that is appropriate. It is both relevant and necessary to pose the question of whether a profession primarily delivers services in a health setting and the nature of those services when assessing the appropriateness of its inclusion in the National Scheme. This

acknowledges and supports the principle that, if the dominant service delivery context is other than health settings, the expertise and accountability for setting and enforcing standards may be most appropriately undertaken by those overseeing and governing those settings.

Blanket expansion of the National Scheme – to enable any social care profession to be included, irrespective of the setting within which they work and notwithstanding the nature of the services provided – would not be consistent with the purpose of the Scheme. It would introduce even more complexity across the standard setting, accreditation, complaints and prosecution functions.

Of course, where a profession is working across separately regulated sectors including aged care and disability, there is a very strong case for aligning and streamlining regulation approaches. The Review advocates more active pursuit of initiatives to achieve this.

COMPLETE IMPLEMENTATION OF THE NATIONAL CODE OF CONDUCT FOR NON-REGISTERED PRACTITIONERS

Irrespective of what happens in relation to the models for expanding and refining the pathways to registration within the National Scheme, there is an immediate imperative to complete the rollout of the National Code of Conduct for non-registered health practitioners.

This is necessary to provide baseline regulation across the entire Australian health workforce, in the interests of public health and safety.

This should be followed by strengthening the effectiveness and consistency of regulation of non-registered practitioners across the States and Territories.

The commitment to completing implementation of the Code of Conduct for Non-Registered Practitioners and then harmonising this across jurisdictions should occur within the broader context of the proposed development of a unified complaints handling system, which is outlined more fully in Reform Theme 4.

⁴⁸ Australian Health Practitioner Regulation Agency (2018). *AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions*, p15. Available at: <https://www.ahpra.gov.au/Search.aspx?q=AHMAC%20criteria%201995>.



An overview of our proposed reform actions



REFORM DIRECTION 2

The review recommends that the Health Ministers Meeting agree to establish an Integrated Health Professions Regulation Framework, to inform decisions about regulating occupations across the entire Australian Health Workforce.

ACTION 2.1

Endorse in principle an Integrated Health Professions Regulation Framework, which stratifies the intensity of regulation according to risk and ultimately delivers three models of regulation:

- National Board regulation of registered professions that pose the most significant risk to public health and safety.
- A new Approved Professions Registration model through an Ahpra approval and auditing process within the National Scheme, to provide a more cost-effective additional avenue for regulation of lower risk allied health professions.
- Non-registered Practitioner National Code of Conduct to provide minimum protective standards for all professions, enforced by Health Complaints Entities of the States and Territories.

ACTION 2.2

HWT to review and revise the risk assessment method and the process for assessing professions for entry to the Scheme and produce a new Guidance Document for Ministerial endorsement.

2.2.1 The Guidance Document should include:

- a. A revised definition of risk, which differentiates high and lower risks. In addition to consideration of the actual or potential risk of serious harm, the criteria and assessment should consider the broader range of risk factors, including : potential lifelong harms; typical service settings for the profession (e.g. sole practitioner, group practitioner, institutional service setting); existence of other regulatory or non-regulatory protective measures (such as clinical governance structures, peer supervision or support, formal policies and training, regulation of devices, products or facilities); and the likely predominance of vulnerable patients.
- b. Early consideration of the benefits of regulation at the preliminary assessment stage to inform decision making on the appropriate regulatory model.
- c. Retaining consideration of whether a profession primarily delivers services in a health setting, with greater clarity about assessing risk for professions that straddle the health and social care settings and determining complementary regulatory solutions.
- d. A defined administrative expressions of interest cycle, whereby professions can submit a case for regulation (for either NRAS registration or when established accredited registration) or jurisdictions can invite a submission from a profession at defined intervals.
- e. A formalised cross-jurisdictional preliminary assessment process, with recommendations to Ministers about expressions of interest.
- f. Formal ministerial determinations on expressions of interest and even if there is a decision not to proceed with further action to enable the profession to enter the Scheme, the profession should be notified of the reasons for that determination.

**ACTION 2.3**

HWT to prioritise further detailed design and costing of an Approved Professions Registration Model which should involve close consultation with the self-regulated professions, allied health peak bodies and Ahpra, and be presented to Ministers within 18 months.

2.3.2 The cost and impacts analysis could be based on the following potential features of the new Model:

- a. Be consistent with the evolving Allied Health Workforce Strategy.
- b. Be for medium/lower risk occupations – with clear risk and benefits assessment criteria to inform decision making.
- c. Be registrant funded once operational.
- d. Provide title protection for the approved profession.
- e. Require individual practitioners in the approved profession to be on the register.
- f. Independent complaints and disciplinary processes by HCEs, with protocols for cross referral of complaints from professional bodies to the HCEs and clinical input to decision making on matters of a clinical nature.
- g. Formal practice standards for the profession and harmonise these across professions as far as possible.
- h. A streamlined governance model, with multi-profession governance of professions, whereby:
 - There could be a newly established Approved Professions Regulatory Council.
 - An occupation approved for inclusion through this pathway could be governed by this new Council (or by an appropriate existing Board if this is more appropriate and practical).
 - There would be no separate independent accreditation body for new allied health professions – standards would be set by the Council and an internal accreditation committee would support the Council.
- i. Support the collection and provision of data relating to the approved profession, for inclusion in the National Health Workforce Dataset.
- j. Ahpra to be responsible for establishing and managing a Health Workforce Practitioners Register which captures practitioners registered by either the National Board or through the Approved Professions Registration Model.

ACTION 2.4

No decision on inclusion of audiology in the National Scheme should be taken at this time. If Health Ministers determine that inclusion of this profession should remain under consideration, the sponsoring jurisdiction has the opportunity to resubmit the proposal for inclusion once it is known whether and when a new pathway into the National Scheme will be established, following completion of Action 2.3 above.

**ACTION 2.5**

Health Ministers commit to complete implementation of the National Code of Conduct for Non-Registered Practitioners in all jurisdictions within 12 months and reaffirm the 2015 decision to establish a National Register of Prohibition Orders.

- 2.5.1 HWT to request the National Complaints Handling Implementation Group (proposed at Action 4.1 of Reform Theme 4) to establish a cross jurisdictional Working Group to develop and progress a program of work to strengthen the effectiveness of the implementation of the National Code across the jurisdictions, including but not limited to:
- a. Developing input to the proposed national complaints handling information campaign (see Action 4.1.4) information campaign to enable HCEs to explain the Code and its application in an accessible and consistent way- which would include clarity around jurisdictional regulation of consistently contentious services such as massage therapy and social work.
 - b. Collaborating with Ahpra, National Disability and Insurance Scheme Quality and Safeguards Commission and the Aged Care Safety and Quality Commission to propose a solution to funding and implementing a National Register of Prohibition Orders imposed on non-registered practitioners – including reconsideration of the potential for sponsorship of this register by Ahpra to sit alongside the National Register for Health Practitioners.
 - c. Identifying inconsistencies in the scope and operation of the National Code across jurisdictions and proposing actions that may be taken to forge a more consistent approach.

ACTION 2.6

Ahpra Board to take three specific data and analysis initiatives to support more proactive health practitioner regulation and health workforce planning and strategy (covering both NRAS registered and approved professions).

- 2.6.1 Task the Ahpra Regulatory Insights Unit to work with the Australian Health Regulators Network, to continue development of the regulatory intelligence function and lead development of a regular Health Professions Regulatory Intelligence Report highlighting current or emerging regulatory risks, to present through HCEF and to the Strategy Assembly on Health Practitioner Regulation.
- 2.6.2 Investigate and advise HWT on the ability to collect workforce survey information for the pre-vocational provisionally registered trainee workforces.
- 2.6.3 Consider and advise HWT on options to achieve a single health practitioner regulation identifier, such that student registration numbers carry forward upon transition to registered practitioner status.

THEME 3:

Strengthening performance, accountability and transparency within the National Scheme



What the Consultation Paper said

Consultation Paper 1 examined the National Scheme against principles of regulatory stewardship, including whether all structures, processes and functions delivered within the Scheme are designed to achieve the appropriate standards of performance and align with statutory objectives and strategic priorities.

The issues identified and the associated reform concept proposed in Consultation Paper 1 are summarised below.

Summary of issues from Consultation Paper 1: Governance and Stewardship (within the National Scheme)

WEAK GOVERNANCE WITHIN THE SCHEME

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.

FRAGMENTED ACCOUNTABILITY WITHIN THE SCHEME

The National Scheme has distributed powers and responsibilities across multiple statutory entities and no single line of accountability.

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.

- Recommendations from earlier reviews for merging National Boards were noted but also the view that this strains against the core value of profession-specific expertise as a foundational feature of the National Scheme.
- Nevertheless, the complexity and unsustainability of the plethora of existing decision-making structures was a problem requiring resolution, especially as more streamlined and flexible arrangements might work just as well.



ACCREDITATION FUNCTIONS REQUIRE STRENGTHENING

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.

INSUFFICIENT COMMUNITY VOICE AT ALL LEVELS OF THE SCHEME

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.

At the operational level, the community voice was not considered to be sufficiently embedded.

Tentative reform concept

The reform concept was to reset structures and accountabilities within the National Scheme.

To meet the need for a single accountable entity the concept envisaged:

- The Ahpra Board should ultimately be responsible for aligning the National Scheme priorities and programs with the objectives of the legislation and broader health workforce priorities and directions – in accordance with Ministerial Directions or requests – and for reporting on these in an impactful way.
- A reconfigured and formally constituted NRAS Forum of Chairs together with the Ahpra Board may be an avenue for progressing this Scheme-wide direction setting.

To meet the need for structures that support greater responsiveness, performance orientation and cross profession action across the Scheme, the concept presented an alternative to rationalising National boards. This was to retain the existing separate National Boards, but reassign the functions between the Boards and 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.
- This could be achieved by removing day to day notification decision making from the National Boards and placing these to Ahpra, (for defined classes of notifications or more generally).

In relation to community voice: Strengthening this at both the direction setting strategic level and at the point of regulatory decision making was envisaged.

To strengthen accreditation functions the concept proposed:

- The Independent Accreditation Committee of the Ahpra Board potentially re-mandated to drive alignment of accreditation functions with workforce strategy.
- The power of direction from Health Ministers to be expanded but would need to be carefully formulated.



What we heard from you

Governance and accountability within the Scheme

The consultation heard the expectation that measures will be taken to increase the confidence of decision makers, registrants, professions and the community that the Scheme is delivering its statutory functions in an effective and efficient way.

The consultation fostered rich discussion on how this could be achieved and the way structures should or should not be changed to meet this need.

Reforms that would confirm and communicate strategic priorities for the Scheme as a whole and drive improved accountability for delivering these were widely supported.



Different entities have differing goals which impacts on the strategic direction of the National Scheme. In order to overcome this, setting priorities and strategic direction needs to be done collectively between all entities and driven by government. Currently Ahpra's guiding principles do not align with the National Scheme. There is no mention in the Ahpra Regulatory Principles that addresses how the National Scheme operationalises the National Law objectives of facilitating service access and a flexible, responsive and sustainable health workforce.

Submission 18 – Hunter New England and Central Coast Primary Health Network

Perspectives on clarity of purpose and accountability



[T]he priorities and strategic direction of the National Scheme are not clear to all the entities within the Scheme, and further, that there may not be appropriate processes and structures to ensure that actions and decisions taken by entities align with the strategy direction and priorities for the Scheme. Reform options would need to address both issues.

Submission 57 – Australian Psychological Society



Neither the priorities nor the strategies are truly clear, or more accurately, they may be clearly stated but it is difficult to understand how they are operationalised...

Submission 32 – Osteopathy Australia

The role of the Ahpra Board

Ahpra presented a consolidated submission from the Ahpra Board and National Boards. This submission advocated that the Ahpra Board has ultimate stewardship and accountability for the National Scheme, ensuring that the entities in the Scheme are collectively meeting its objectives and the expectations of Ministers and the community. It suggested that the Ahpra Board should be transitioned to a National Scheme Board. The submission advised the majority position (9 of the 15 National Boards) in support of this.⁴⁹

⁴⁹ Submission 63 – Ahpra – pages 7-8 and 21-22, noting only partial support from 5 Boards and 1 Board opposed.



A POSSIBLE STEWARDSHIP AGENDA FOR THE AHPRA BOARD – THE AHPRA VIEW

As the National Scheme steward, the National Scheme Board should:

- Oversee the various Scheme parts to ensure they are working effectively together to serve the paramountcy of public protection and align with other Scheme strategic priorities.
- Be responsible for the Scheme's care, leadership, and management, without holding ownership of all parts of the Scheme (such as Health Complaints Entities (HCEs) and tribunals)
- Display leadership in anticipating and responding to emerging risks and changes in the regulatory landscape, working with all parts of the Scheme to future-proof the Scheme and enhance its resilience.
- Be empowered to ensure cross-professional regulatory approaches where this is necessary to support the National Scheme's objectives.

Submission 63 – Ahpra

There was also more broadly based stakeholder support for the Ahpra Board to be reset to a Scheme wide leadership role, but with firm expectations that:

- Priorities and reforms within the Scheme would be guided by strategic directions and priorities (as set down in any relevant Ministerial Direction and any proposed Statement of Ministerial Expectations).
- There would be increased consultation and co-design with stakeholders in setting and implementing the National Scheme Strategy.
- There would be additional structures for communicating priorities.
- Profession-based expertise should remain a central design feature, with steps towards increased cross profession regulation regulatory actions being carefully designed.
- There would be clearer lead performance indicators and enhanced performance reporting, to strengthen accountability and transparency for delivering to expectations.

BROADER PERSPECTIVES ON SCHEME LEADERSHIP



There is a need for clearer articulation of how health practitioner regulation actions and priorities align with health workforce and service access imperatives...There is a need for Health Ministers and Health Chief Executives to be provided with clear data and performance reporting that demonstrates this alignment....

Submission 74 – the Hon Jacquie Petrusma,
Minister for Health, Tasmania



[M]ore efforts should be made to ensure that all involved entities – including medical colleges – are aware of and aligned with the strategic directions of the Scheme, through improved cross-organisational communication and greater transparency.

While it is logical that the NRAS should support broad government workforce strategic objectives, a clear alignment with the scheme and the [National Medical Workforce Strategy] has not been articulated. Indeed, the National Scheme Strategy 2020-25, available on the Ahpra website, is silent on health workforce as a strategic priority.

[T]here currently appears to be a high operational focus leading to a lack of open communication streams with accrediting bodies and down chain entities. A greater emphasis on high-level policy and risks may allow the Boards to more effectively contribute to longer term goals within healthcare.

Submission 17 – The Australasian
College of Dermatologists



Strengthening communication pathways could improve understanding and operational clarity for all entities involved. Consistency in how these priorities are communicated and executed would help reduce any misalignment between entities. Creating uniform messaging and providing practical, operational guidelines to implement strategic priorities would ensure that all stakeholders remain aligned with the broader objectives of the Scheme.

Submission 22 – Australian Podiatry Association



[In relation to an additional cross profession focus for the Scheme]... There are a range of risks including the prospect of professional dilution, cultural degradation, potential erosion of nuanced (clinically specific) regulatory decision making, which could all be mitigated by a comprehensive planned change management program and strengthened governance.

Submission 76 – Not for Publication

Connection with National Boards

In the context of a strong and common view that the Scheme ought to maintain a profession-led character, if the Ahpra Board has an overarching Scheme wide stewardship function the nature and strength of the connection between the Ahpra Board and the National Boards is a critical issue.

- The experience of the National Boards is that they do not have sufficient scope to provide input into Scheme-wide decisions.
- The experience of the Ahpra Board members is that there is not a sufficient opportunity for Ahpra Board members to develop a deeper understanding of profession-specific concerns and imperatives that are in play.

Currently there is a NRAS Forum of Chairs. Through this Forum the National Board Chairs, the Chair of the Community Advisory Council, the Ahpra Board Chair, and Ahpra Executive come together on a regular basis. In its current role and configuration, stakeholders do not see this Forum as a sufficient or functional element of the governance architecture of the Scheme.

Observations about the NRAS Forum of Chairs included that:

- The role and function is unclear. It is not a decision making body but rather an information sharing session. This is not to say that information sharing was considered unimportant, but there is a desire for more efficient and effective ways of achieving this. The Forum should be reoriented towards action and decision making.
- The composition of the Forum is not conducive to meeting a strategic or Scheme leadership purpose. It is too large to foster the Board-to-Board dialogue and debate that is necessary to make progress on issues requiring robust discussion, collective consideration and decision making. Over-representation of agency staff is an issue for some.
- There is no supporting structure of broader consultation with professional membership bodies, accreditation entities and colleges.
- Similarly, the community voice is not sufficiently accessed, noting that the only avenue for this voice is through an invitation to the Chair of the Community Advisory Council to “participate” in the Forum.

These issues are recognised in the Ahpra submission, which supports a “re-mandated” Forum of NRAS Chairs to advise the Ahpra Board on stewardship of the Scheme.⁵⁰

⁵⁰ Submission 63 – Ahpra – page 11 of 20.



Performance reporting and transparency

Overwhelmingly, performance reporting from the Scheme is seen to lack focus and impact. This is not a trivial problem.

The Review heard that the Scheme is replete with data and performance information, but it does not meet the needs of those receiving it.

- Ministers, the Ahpra Board and other stakeholders require a succinct regular (quarterly) high level report on the performance of the Scheme, progress on delivery of agreed reforms (including actions on ministerial directions) including any barriers to implementation, and identification of emerging regulatory risks and action proposed to address those.
- Both the Ahpra Board and its Regulatory Performance Committee and the National Boards require operational reporting, in a form that enables them to identify operational blockages and high risk issues, and to consider resourcing, business process or systems improvements that may be required to maintain an appropriate level of performance.
- The professions are looking for KPIs to be outcomes focussed (ie longer term, strategic impacts in areas such as workforce supply and regulatory efficiency) rather than merely measuring operational performance.⁵¹
- Ahpra staff need real time reporting, designed to support effective and timely case management.

PERFORMANCE REPORTING – A JURISDICTIONAL PERSPECTIVE



Ahpra provides regular quarterly updates to Health Chief Executives and Health Ministers, and a detailed annual report on the operation and performance of the National Scheme, usually through out-of-session processes.

However...there would be value in considering opportunities to strengthen such reporting. This could include, for example, establishing key performance indicators (KPIs) for the National Scheme that are set (or at least reviewed) annually and reflect Health Ministers' priorities and expectations for operation of the National Scheme. Such KPIs could then be reported on regularly (e.g. quarterly) to Health Chief Executives and Health Ministers, in an easily accessible and digestible format. Noting the current strong investment in improvement of data through implementation of the Kruk Review recommendations, these KPIs must be consistent, measurable and collectable, and supported by modern IT systems and reporting tools.

Submission 74 – the Hon Jacqui Petrusma,
Minister for Health, Tasmania

Aligning Accreditation functions

The consultation featured significant differences in perspective about governance and delivery of accreditation functions. These differences are occurring against a backdrop of extensive reform in the accreditation domain, with tensions that have occurred around accreditation of specialist medical training sites (resulting in Ministerial Council Policy Direction 2023-01)⁵² and the establishment of expedited pathways for International Medical Graduates.

The Ahpra submission reflects the experience of working with the current long chain of accountability and responsibility, in circumstances where the training and accreditation functions are pivotal to achieving workforce and service access objectives.

⁵¹ See for instance Submission, 17 – Australasian College of Dermatologists.

⁵² Health Ministers' Meeting (2023). *Ministerial Policy Direction 2023-1: Medical college accreditation of training sites*. Available at: <https://www.ahpra.gov.au/documents/default.aspx?record=WD23%2f33130&dbid=AP&checksum=TNtCS9D56alnMsqd3id3JA%3d%3d>.



This experience suggests that “strong and clear signals are needed to direct and accelerate change, and relying on persuasion and influence is obviously much slower”.⁵³

Alongside this, there is a clear perspective from professional bodies that measures to strengthen oversight of accreditation and align this function more strongly to broader workforce strategy, risks undermining the principle of a Scheme built on the expertise and knowledge of the professions. It is also argued to be inconsistent with maintaining the Scheme’s primary purpose of protecting public health and safety.

This manifests in strident opposition from professional membership and accreditation bodies to the proposal for a Ministerial Council power of direction in relation to accreditation, notwithstanding that this policy option remains under active consideration following the recommendation in support of establishing such a power in the recently completed Scope of Practice Review. The Scope of Practice Review observed that current constraints on the ability to issue a direction could “*result in circumstances where the full range of objectives of the national law may not be translated efficiently or effectively...which is inconsistent with the extensive authority of HMM over registration functions*”.⁵⁴

The broader question of the operation of accreditation structures and entities within the Scheme also remains a live issue. Previous reform proposals to rationalise these structures (including to establish a single national accreditation body or to amalgamate existing accreditation entities) were again raised in the consultation.

The dominant opinion from the professional membership and accreditation entities was to retain the current institutional arrangements – that is, the multiple separately constituted, profession-specific external accreditation authorities. Generally, these respondents do not see the current structures for delivering accreditation functions as overly complex. They consider the Accreditation Authorities to be well connected with and responsive to important stakeholders both locally and internationally.

PERSPECTIVES ON ACCREDITATION FUNCTIONS WITHIN THE NATIONAL SCHEME



We do not support the view that the collective of our organisations are more complex than other parts of NRAS. There are significant benefits given the complexity of health service delivery in Australia and the foundational and necessary differences across the regulated health professions, for profession specific knowledge and expertise driving accreditation policy and decision-making. External Accreditation Authorities also support agility and the ability to respond to the specific profession/s specific accreditation related needs, for example Accreditation Authorities with National Boards responses over the recent pandemic, the Australian Medical Council’s ability to respond to the recent issues related to the assessment of internationally qualified medical practitioners.

Submission 55 – Health Professions Accreditation
Collaborative Forum



While the review seeks to identify opportunities for improvement through changes in the NRAS, we would urge a precautionary approach that also recognises what could be lost. The benefits from professional organisations are more than the sum of their parts, and divesting key functions from them may fundamentally undermine their role and contribution.

Submission 77 – Australian College of Rural
and Remote Medicine

⁵³ Submission 63 – Ahpra – p11.

⁵⁴ Professor M Cormack (2024). *Unleashing the potential of our health workforce: Scope of Practice Review Final Report*. Available at: https://www.health.gov.au/sites/default/files/2024-11/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report_0.pdf. Recommendation 3, p24.



While workforce supply is a crucial consideration, it must not overshadow the importance of maintaining high standards in patient safety and clinical training. Accreditation must remain focused on these core objectives, and any attempts to align it more closely with workforce strategy must be carefully managed to ensure that quality is not compromised in favour of quantity.

Submission 61 – Royal Australian and New Zealand College of Radiologists



...[T]here are currently sufficient measures within the National Scheme that ensure accreditation functions continue to contribute to addressing workforce strategy and needs.

Submission 15 – Australian Physiotherapy Council



...while RANZCR supports the idea of a more coordinated approach between workforce planning and accreditation, this must not come at the expense of patient safety or the welfare of trainees. Any changes to the accreditation system must be accompanied by appropriate resourcing and long-term planning to ensure that the balance between workforce needs and quality healthcare is maintained.

Submission 61 – Royal Australian and New Zealand College of Radiologists



Accreditation authorities are currently implementing recommendations of various reviews including Kruk and that of the National Health Practitioner Ombudsman in relation to accreditation processes, as well as advice from the Independent Accreditation Committee in areas such as development of professional capabilities; consumer involvement; outcome-based approaches; good practice in clinical education; cultural safety; and interprofessional collaborative practice.

Submission 15 – Australian Physiotherapy Council

Many professional membership and accreditation stakeholders argue that the better alternative to amalgamated accreditation entities is to strengthen existing collaboration and governance arrangements.

There is some convergence of opinion in relation to the role and function of the Independent Accreditation Committee of the Ahpra Board (IAC) and also the role of the Health Professions Accreditation Collaborative Forum (HPACF) going forward.

In relation to IAC, there is reasonable consensus that, with some adjustments to its remit, operating practices and membership, it has an important role to play. Both the Australian Medical Association (AMA) and Australian Medical Council (AMC) submissions strongly support this, as does the Ahpra submission.

STRENGTHENING THE ROLE OF THE INDEPENDENT ACCREDITATION COMMITTEE (IAC)



There is no clear mechanism for a single accreditation authority to raise an issue with the accreditation committee or to contribute to the work of Ahpra staff in shaping the agenda. Responses to the committee's work takes the form of responses to consultation documents or guidance, and there is limited opportunity for deeper discussion or capacity for codesign of responses. This under-utilises the knowledge, skills and connections of the accreditation authorities.

The AMC supports the independently chaired accreditation committee, which brings together a wider group of accreditation stakeholders, but it sees significantly less engagement of the accreditation authorities in this work and believes any review of the committee needs to enable this engagement. How agendas are set, and limitations on what items and discussions can be shared means that the committee can be remote to the accreditation authorities.

Submission 75 – Australian Medical Council



[W]ould like to see a strengthening of the Accreditation Committee, with the AMC and other accreditation bodies brought onto the committee to engage directly. This body currently acts more as a think tank, but it could act as an arms-length body to work through concerns with accreditation processes.

Submission 65 – Australian Medical Association



HPACF recommends: That the Independent Accreditation Committee (subcommittee of the Ahpra Board) terms of reference (ToR) and membership are reviewed to more align and reflect the ‘functional, continuous improvement and strategic’ work of accreditation in the NRAS. The changes the membership and ToR build stronger connections with the Accreditation Authorities to improve outcomes and deliver on the (above) agreed strategic direction This would also enable Accreditation Authorities to more directly contribute to improvement of the National Scheme.

Submission 55 – Health Professions Accreditation Collaborative Forum



The Ahpra Board’s Independent Accreditation Committee (IAC) provides a legitimate option to further address this need. It is worth noting that the IAC is the only body with a current ministerial mandate to progress whole-of-Scheme accreditation issues. Its current work plan is mostly the issues referred by Ministers following the outcomes of the Woods review. The IAC could adopt a stronger and clearer focus on:

- reducing duplication between the accreditation bodies in the scheme
- reducing duplication between accreditation bodies in the National Scheme and other regulators such as the Tertiary Education Quality and Standards Agency (TEQSA), migration skills assessment and registration assessments
- developing consistent approaches in assessing qualifications and overseas qualified practitioners.

Submission 63 – Ahpra

The HPACF has presented the collective preference of its member entities that, in addition to resetting the IAC, there is a need to formalise, elevate and resource the role of the HPACF as it is well placed to make a strong strategic contribution.

PROPOSING A MORE PROMINENT AND ACTIVE ROLE FOR HPACF



The Accreditation Authorities are very collaborative..., despite being independent organisations. The HPACF have recently agreed to formalising a dedicated Executive Officer and administrative support roles to support the HPACF. These roles will result in greater connection and collaboration across the HPACF members and also support the delivery of key areas of strategy, standardisation and consistency, as relevant, across accreditation services.

Submission 55 – Health Professions Accreditation Collaborative Forum



The ADC considers the consultation paper has not sufficiently recognised the importance of the HPAC Forum to the success of the accreditation functions with the scheme. HPAC Forum has shown consistent leadership and support for several key reforms under the Scheme including interprofessional collaborative practice and the introduction of cultural safety training for assessors on collaboration with ABSTARR Consulting.

Submission 24 – Australian Dental Council



ANMAC supports that the strategic direction of the NRAS related to accreditation is developed together with the Accreditation Authorities and more aligned with the National Law objectives and guiding principles. This will ensure improved synergies and linkages to the Accreditation Authorities strategies and that the consideration of workforce, health service access, and public safety are more effectively addressed.

Submission 56 – Australian Nursing and Midwifery Accreditation Council



Importantly, consultations also emphasised other additional or adjusted governance and accountability settings that could contribute to increased alignment between accreditation and the strategic agenda for the National Scheme.

It is noteworthy that the current approach to analysis and review of the impacts of proposed amendments to accreditation standards was questioned. As Consultation Paper 1 noted, Ministers do have a power of direction in accreditation but it is limited. Specifically, under section 11 of the National Law, Ministers may give a direction to a National Board or Ahpra in relation to a proposed accreditation standard only if “*in the Council’s opinion the proposed accreditation standard or amendment will have substantive and negative impact on the recruitment or supply of health practitioners*”.

Those consulted gave examples of standards that have been introduced notwithstanding significant workforce service access impacts. The Review heard from health service providers the example of psychology standards pushing towards higher level post graduate clinical learning and away from clinical learning at an undergraduate level, with significant impacts on the ability to attract and retain clinical psychologists in rural and regional areas during a time of increasing demand for mental healthcare services. The issues and impacts were explained as follows:

- The traditional ‘4+2’ training pathway to professional psychology practice was based on an entry-level psychology Bachelors degree (that incorporated clinical experience) with two further years of internship in supervised clinical practice working as a provisional registrant.
- The ‘4+2’ model worked well for rural and regional locations: it aligned with employer expectations, accommodated a variety of service settings and connected provisionally registered psychologist interns with employers, professional networks and the communities in which they lived and worked.
- Through changes to standards in 2019, the ‘4+2’ internship pathway to registration was removed. In its place are longer 5-year university Masters degrees and a one-year internship based primarily in larger population centres.

- A 2019 decision to limit supervision in an endorsed area of practice training to only those holding that endorsement further restricted opportunities for Masters and internship supervision in rural and remote areas.

Such examples highlighted the need to consider more closely how workforce impact assessment in setting accreditation standards, including examination of when and how Ministers receive advice from the National Boards about these impacts, the nature of that advice, and how it informs Ministerial consideration of any potential Directions to the Board.

Examination of the 2023 Ahpra procedures for development of accreditation standards confirms that accreditation authorities are “expected” to consider the objectives and principles of the National Law, which includes workforce sustainability and service access when developing standards.⁵⁵ However, the detailed specifications within the body of the procedure of what an accreditation authority must include in a submission to the Board for new or revised standards do not require an explanation of how workforce impacts have been considered or the nature and extent of any potential impacts.

Ahpra has advised that their procedures require Boards to consider the advice of the accreditation authorities and/or undertake their own analysis to determine if there are negative workforce impacts warranting notification to Ministers.

While a Board has the option to undertake its own workforce impact analysis, the Review has been unable to locate information about whether Boards do undertake their own workforce analysis, how frequently advice on negative impacts has been provided to Ministers, what such advice entails, or the outcomes of those situations.

On this basis it does not appear that there are adequate procedures and processes to ensure effective consideration and mitigation of the workforce impacts of accreditation standards. This effectively means that the existing Ministerial Power of Direction in relation to accreditation standards under Section 11 of the National Law is not currently able to be applied as intended.

⁵⁵ Ahpra and National Boards (2023). *Procedures for the development of accreditation standards*, published online. Available at: <https://www.ahpra.gov.au/documents/default.aspx?record=WD20%2f30479&dbid=AP&checksum=70Su42ntfnsZN%2bFOeEWKQg%3d%3d>



On the question of the potential for an expanded Power of Direction, the Review heard that this issue requires more careful, thorough analysis and consideration in light of the extensive body of accreditation reform currently underway and having regard to complex drafting questions. Key policy questions include whether such a power could/should:

- Be able to be directed only to accreditation training site standards or be more extensive with potential to relate to a decision of a college about an accreditation site. The limitation to a direction on standards would be consistent with the usual concept of ministerial direction over policy rather than operational decisions, and also with the direction powers that apply to other functions in the Scheme under section 11.
- Be able to be made in reference only to specialist medical colleges, or to any relevant education provider. Unintended consequences for other education providers need to be avoided.
- Include the ability to issue a direction to implement a recommendation of the National Health Practitioner Ombudsman following an administrative process within a specialist medical training college. The risk of this may be that there is a sound reason why a recommendation is unable to be implemented by a college.
- Be made only to Ahpra or the National Board, or able to be made directly to the colleges. The former would be consistent with the formulation for other functions but may be seen to frustrate the ultimate policy objective. It is noted that it is the indirectness of the current power of direction that is at least part of the policy concern in the accreditation space. The legal ability to direct colleges may be open to question.

- Be constrained in the same way as the current direction power for standards developed by accreditation authorities, whereby policy directions can only issue *if Health Ministers believe these standards may have a substantial or negative impact on the recruitment or supply of health practitioners and they have first considered impacts to the quality and safety of health care.*⁵⁶

The performance monitoring and accountability arrangements for accreditation governance functions also attracted stakeholder comment. While recognising that the existing *Quality Framework for the Accreditation Function* has been subject to some useful recent work to strengthen KPIs, it nevertheless lacks focus and impact. Further development to build cross profession connection and performance and to drive delivery of key reforms was advocated. The National Health Practitioner Ombudsman (NHPO) Submission addresses this issue.⁵⁷

NHPO SUBMISSION ON THE QUALITY FRAMEWORK FOR ACCREDITATION

On the basis of its review of complaints and appeals processes of accreditation authorities and specialist medical colleges and procedural aspects of accreditation processes to ensure fairness and transparency, NHPO has found:

- There is not one central resource which provides a clear picture of the various forms of accreditation across the whole of the National Scheme.
- The Independent Accreditation Committee has no formal delegated powers (from National Boards).
- KPIs for accreditation authorities outlined in the accreditation agreements and terms of reference are not well defined by the Boards.
- There are no formally documented procedures for identifying and responding to possible non-compliance or poor performance.
- There is very little publicly available information about the performance of accreditation authorities.

⁵⁶ Queensland Government (2024). *Health Practitioner Regulation National Law Act 2009*, s11 (4). Available at: <https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2009-hprnlq>.

⁵⁷ Submission 51 – National Health Practitioner Ombudsman.



- There is no meaningful cross-comparison of the performance of the various accreditation authorities or monitoring for systemic problems in accreditation activities across the National Scheme
- The Quality Framework does not articulate how accreditation authorities should report on concerns raised by stakeholders about their performance and whether Ahpra and the Boards hold any responsibility for responding to systemic issues.

The NHPO therefore advocates a range of administrative reforms which include:

- Improved documentation of the National Scheme Accreditation Framework to clearly present the roles, responsibilities and accountabilities of all bodies delivering accreditation functions.
- Clearer and more specific KPIs for accreditation organisations.
- Formal procedures for management of performance concerns about accreditation organisations
- Standardise data collection on programs of study, training sites and assessment of overseas qualified practitioners.

Structure and composition of National Boards

The submissions and consultations did resurface some advocacy for amalgamation of National Boards, pointing out the desirability of improved efficiency and consistency in decision making, and also raising the significant underlying concern of the inability of the Scheme to adapt and respond to emerging challenges in an agile way.

The difficulty of working across 15 National Boards to pursue important and necessary change and innovation was commonly characterised as one of the most significant and unrelenting challenges of the National Scheme.

There was particular concern about the difficulty of meeting the requirement to secure agreement from all 15 National Boards in relation to Scheme-wide issues such as responding to new models of care, harmonising registration standards, and cross profession decision making. This difficulty was identified as a significant factor in protracted timeframes for making adjustments to standards

and processes, even where these were explicitly identified government priorities. The timeframes and processes for harmonising English Language Standards in registration standards across professions was a frequently cited example of this.

Many stakeholders expressed frustration that matters of significant public concern, such as sexual boundary violations were not receiving prioritised cross-profession consideration when this was considered necessary.

Essentially, the Scheme is seen to have limited responsiveness, which is impacting the reputation of the Scheme and confidence in it. This has a direct link with the urge of some stakeholders to press an amalgamation agenda.

Notwithstanding, there was not a strong push for mandatory amalgamation of the existing professions and their 15 Boards. The significant concern across professions was that any such initiative would unacceptably erode the foundations of profession based decision making, which continues to be regarded as an integral design feature of the National Scheme. There was strong urging for a measured and selective approach to advancing cross-profession regulation.

EMPHASIS ON EXPERTISE OF THE PROFESSIONS AND MEASURED IMPLEMENTATION OF CROSS PROFESSION DECISION MAKING



If the reforms are perceived as reducing the profession-specific input or not adequately addressing transparency and fairness, there could be further fracturing of trust in the regulatory system. The public and practitioners may worry that their interests are not sufficiently represented or that regulatory decisions are being made by individuals who lack clinical expertise in specific areas...

Submission 65 – Australian Medical Association



For health profession regulation to work well, the professions and the people regulated need confidence in the system of regulation. How the national Scheme, Ahpra and the National Boards continue to demonstrate accountability, including relevance and responsiveness to the regulated professions requires thought. There is a tension in focussing on multiprofessional and interprofessional regulation and maintaining the trust of individuals in the regulation that affects them building on profession specific knowledge and expertise. Individual boards do need to retain the capacity for profession specific approaches, and to be responsive to the needs of the profession.

Submission 75 – Australian Medical Council



It is acknowledged that the opportunities that the National law and the NRAS provide is a multi-profession standardised approach to policy and processes. However, given the complexity of health service delivery in Australia and the foundational and necessary differences across the regulated health professions there must be profession specific knowledge and expertise driven policy and decision making where relevant.

Submission 55 – Health Professions Accreditation Collaborative Forum



Knowledge and expertise driven processes are essential to appropriate regulation. The nature of the variance between disciplines, knowledge and expertise is unique to each individual professions represented by the relevant Board. Reducing the number of Boards, risks dilution of essential and necessary professional knowledge and expertise, and poorer outcomes for the public they are supposed to protect.

Submission 57 – Australian Psychological Society



Profession-by-profession National Boards are necessary to ensure safety and contemporary regulation. A key value of profession-by-profession boards is that Boards and accreditation councils have well-developed relationships with individual and representative groups of professionals and providers with discipline knowledge.

Submission 25 – The Australian Psychology Accreditation Council Ltd

Stewardship reforms that ultimately authorise the Ahpra Board to lead and drive the delivery of strategically important reforms and create a stronger impetus for professions to work to common purpose were generally seen as preferable to amalgamation.

Beyond the issue of mandatory amalgamation of existing boards, there was wider support for two actions in relation to multi-profession boards.

- i. The option of ongoing encouragement at Scheme level for boards with a low level of regulatory activity and increasing registration fees to consider voluntary amalgamation as an efficiency measure.
- ii. Where new professions are entering the Scheme – they could be expected to either by join with an existing board or agree to join with other entering professions.

In relation to the operations of individual Boards, the need to retain State level boards under the Medical and Nursing and Midwifery Boards was questioned.



With many National Boards, committees and subcommittees in place, there are concerns over lack of efficiency due to multiple layers of bureaucracy with inherent duplication as well as a lack of accountability. It is unclear what functions each of these national Boards, committees and subcommittees at the State and National levels perform and what they are responsible for...Common functions performed at individual State level should be able to be amalgamated at a national level.

Submission 30 – Royal Australian and New Zealand College of Ophthalmologists



It was acknowledged that the continued existence of these State level boards most likely relates to the higher volume of notifications. However, it was also suggested that there are other models for managing notifications at national level that could reduce complexity and increase efficiency.

It is fair to say that there is a common expectation that there will be more active and early consideration of removing the residual State level layer of decision making within the medical and nursing and midwifery professions of the National Scheme.

Ahpra regulatory capability

While increased delegation of regulatory decision making to Ahpra was acknowledged as a logical and practical measure in the context of a complexity review, it did not earn ready support.

A frequent concern was capability, with a widely held impression that Ahpra is overly bureaucratic and too wedded to existing operational practices, lacking in responsiveness to the requirements of the Boards and external stakeholder needs, and insensitive to impacts on individual registrants and notifiers.

Many highlighted a desire for better Ahpra systems and process design, clearer role delineation, additional training and capability building, clearer mission-critical performance reporting and culture change to provide the confidence that a more delegated model of decision making could work.

- Boards had a cautious and mixed view about increased operational delegations as a measure to streamline decision making and improve efficiency.
 - Some National Boards expressed support for increased delegation of regulatory decision making by Ahpra staff, but with reluctance to achieve this through legislative amendment, an expectation of uplift in skills and governance, and largely limited to low risk matters.



The MBA is prepared to consider delegation of low risk matters...to appropriately qualified staff, such as clinical advisors with appropriate governance as they are making notification decisions in the name of the board.

Submission 63 – Ahpra, Appendix 3

- Other Boards (particularly those for the smaller professions) did not support delegation of regulatory decision making to Ahpra. They favoured retaining profession-based handling of notifications, primarily due to the specific knowledge and expertise required to manage those matters fairly and effectively and with some concern about Ahpra processes and capability.⁵⁸
- Noting that effective delegation needs to be supported by strong and relevant performance reporting, a practical impediment to increased delegation was seen to be the absence of relevant and accessible operational performance reporting, profession by profession or Scheme wide. Commentators again pointed to the paradox of a significant (and almost overwhelming) amount of detailed operational reporting, without this being in a form or frequency to assist them to understand how processes are working within Ahpra, what factors are impacting operational performance, what high risk matters remain active, or what actions could be taken to drive excellence in regulatory decision making. This is a significant frustration for Boards who seek to deliver optimal regulatory performance and outcomes.
- The quality of advice and agenda papers to support regulatory decisions of Boards attracted some criticism.

⁵⁸ These Boards are listed in the Submission 63 – Ahpra as Physiotherapy, Medical Radiation, Chiropractic, Chinese Medicine, with 3 other boards also only partially supporting.



- The role of Executive Officers to the Boards was raised. These roles are seen to occupy a potentially pivotal position at the intersection of Boards and Ahpra, but many are unclear to whom they are ultimately accountable, their focus, and how they contribute to strengthening the links between operational and strategic objectives.
- The National Health Practitioner Ombudsman also points to issues with the Ahpra decision making tools, systems and processes, training and policies and procedures within the Ahpra notifications process, as well as siloed structures across accreditation notifications and registration functions.

SOME NHPO OBSERVATIONS ON AHPRA REGULATORY PERFORMANCE AND CAPABILITY

Complaints to our office about the management of notifications and matters relating to practitioner registration have increased from last financial year. Most notably, complaints about Ahpra's process for receiving and managing concerns about a registered health practitioner (a 'notification') increased from 309 in 2021–22 to 430 in 2022–23.⁵⁹ HPO 2022-23 Annual report p9.

While we welcome the general reduction in the time taken to manage notifications, our office finds it troubling there has been a significant increase in the number of issues raised with us regarding concerns that a decision made about a notification was unfair or unreasonable (from 153 issues in 2021–22 to 227 issues in 2022–23) and that the notifications process was unfair (from 46 issues in 2021–22 to 88 issues in 2022–23). We continue to explore the causes of these increases. [I]t is important that Ahpra's attempts to reduce the length of time taken to manage notifications does not lead to negative results downstream.⁶⁰

Ahpra does not have a comprehensive policy and procedure for identifying and responding to unreasonable notifier conduct.⁶¹

The NHPO submission makes the following relevant observations:



[T]he current approach to delivering registration and accreditation standards is generally siloed, despite their interconnectivity.

The NHPO...suggests that further consideration should be given to what is driving notifier dissatisfaction with no further action decisions, and whether there is the potential to better set expectations and provide greater transparency regarding this outcome.

While increased delegation may assist in reducing delay to finalise some notifications, the NHPO considers that appropriate steps would have to be implemented to ensure consistency across decisions.

The NHPO agrees...that the current clinical advice model is underdeveloped.... [T]here is a need to better clarify how and when clinical input is used in a notifications context, and the importance of impartiality and conflict of interest mechanisms in these circumstances. ...This includes issues relating to inconsistencies in how clinical input is used to inform an assessment, limited availability of practitioners, notifications being made about clinical advisors and independent clinical opinion providers, and a lack of appropriate record keeping regarding clinical advice.

Submission 51 – National Health
Practitioner Ombudsman

⁵⁹ National Health Practitioner Ombudsman (2023). *Annual Report 2022-2023*, p9. Available at: <https://www.nhpo.gov.au/sites/default/files/2023-11/NHPO%20Annual%20Report%202022-23.pdf>.

⁶⁰ Ibid, p16.

⁶¹ National Health Practitioner Ombudsman (2024). *Review of Ahpra's Framework for identifying and managing vexatious notifications*, August 2024, p13. Available at: <https://www.nhpo.gov.au/sites/default/files/2024-12/NHPO%27s%20Review%20of%20Ahpra%E2%80%99s%20Framework%20for%20identifying%20and%20managing%20vexatious%20notifications%20-%20August%202024.pdf>.



- Broader stakeholders tended not to favour additional delegation to Ahpra, citing limited confidence in Ahpra processes and systems.
- There was scepticism that delegation to Ahpra and additional clinical advice would reduce notification assessment timeframes.



We would support “additional clinical advice embedded at the operational level [that] could facilitate increased delegation of decision making from National Boards to Ahpra” if this enabled faster processing of notifications, which as we have previously mentioned is currently unacceptably slow and significantly affects practitioner mental health (unnecessarily in 75% of cases).

Submission 35 – Optometry Australia

- There was a concern that increased delegation would reduce community involvement in regulatory decision making.
- Again, clearer KPIs for timeframes and performance reporting were seen to be an essential precondition for increasing delegation as was additional clinical advice, to ensure that the National Boards and the Ahpra Board have confidence that operational performance is at the required level and that risks are being identified and addressed.

In summary, a proposal that the day-to-day regulatory decision making of boards should be substantially devolved to Ahpra (either through an activated regime of operational delegations to Ahpra officers or legislative amendment) was not widely embraced at this time.

The consultation highlighted the need for a concerted focus on capability building at leadership and senior operational level, supported by a clear business process and systems improvements and strategy-relevant performance reporting, which could ultimately support a shift towards increased operational delegations to Ahpra.

Community voice

There is widespread acknowledgement that community voice is currently not embedded firmly enough at all levels of the Scheme. There were diverse opinions about what would be appropriate in this regard.

In terms of Scheme stewardship, the Community Advisory Council noted that the National Scheme Engagement Strategy 2020-25 is at too high a level in terms of its settings for community contribution. While it is broadly consistent with the framework of the IAP2 Public Participation Spectrum, it is considered to be inadequate in that it does not articulate what engagement will occur, with who and when. The Council also observed that neither the Strategy nor the IAP framework are overtly or widely used in Ahpra’s community engagement, strategic deliberations, or decision making.

Community stakeholders identified, with favour, the work of the Independent Accreditation Committee of the Ahpra Board in its document “*Principles to Strengthen the involvement of consumers in accreditation*” as a model of how the consumer perspective ought to be considered in all functions of the Scheme.⁶²

In practice it appears that the Community Advisory Council carries a significant burden of projecting the community voice across the Scheme and with limited avenues for doing so. There is an opportunity for the Community Advisory Council to present to the Board on progress with its annual workplan and to hold an annual forum with the Ahpra Board and for the Council Chair to participate in the NRAS forum of Chairs. This is regarded by community advocacy groups as insufficient.

It was of concern that there is not a designated community voice on the Ahpra Board and no clear structured, planned and funded program to support the work of the Community Advisory Council, even though the Council holds responsibility for reviewing all standards and policies proposed by the Boards from a community impact and interest perspective, and seeks to interact more widely with consumer peak bodies to enable it to perform this function.

⁶² Submission 38 – Community Advisory Council.



In seeking further consideration of community voice in strategy processes, the Community Advisory Council has highlighted that Ahpra has two bodies for identifying and responding to emerging health regulatory issues and risks (the Regulatory Intelligence Insights Group and the Rapid Response Working Group) but neither includes a community member, which it believes is a lost opportunity for additional insights into community experiences of risks.⁶³

At the level of operational regulatory decision making the issue of community membership of the National Boards and their positions on a Board drew diverse opinions.

A case for strengthened community membership on National Boards was put stridently and clearly in the Community Advisory Council Submission, referencing:

- i. The Guiding Principles of the National Law which refer to the paramountcy of maintaining public confidence in the safety of service provided.
- ii. Ministerial Direction 2019-01 which requires consideration of public impacts of practitioner's actions and how regulation can build public confidence.
- iii. The fact that some existing Board committees are chaired by community members and/or have community membership parity, and these are operating effectively.

The Community Advisory Council summarised the benefits as follows:

“Community members bring a perspective, unique outlook and set of experiences to the National Scheme and National Boards, that differ from health professional working in the system. This adds strength, balance and value.... And brings the public voice and understanding of health literacy, system literacy, service literacy, disease literacy and quality improvement processes, to support changing expectation of the community. Knowing that there are community voices in decision making roles enhances confidence in the health regulator”.⁶⁴

Ahpra offered support in this direction, including recommending that National Board Chairs be appointed on their merits, regardless of whether they are a practitioner or community member.⁶⁵ It is noted that this would require a change to the National Law, as section 33(9) currently requires the Chairperson of a Board to be a practitioner member.

There was also support from many medical colleges for increased community representation on Boards.⁶⁶

However, some submissions from professional bodies conveyed a contrary view, that embedding the community voice through formal requirement for parity between community and profession membership and enabling community members to chair board runs counter to the imperative for the National Boards to be profession-led. The Australian Medical Association (AMA) put the issue thus:

“The AMA is supportive of consumer involvement in the regulatory process, but it is absolutely essential that National Boards remain professions led, with the majority being clinicians and always chaired by a member of the profession.”⁶⁷

⁶³ Ibid.

⁶⁴ Ibid.

⁶⁵ Submission 63 – Ahpra.

⁶⁶ For instance: Submission 16 – Royal Australian and New Zealand College of Psychiatrists, Submission 17 – Australasian College of Dermatologists, Submission 53 – Royal Australian College of General Practitioners.

⁶⁷ Submission 65 – Australian Medical Association.



Connection with the professions

There is a general picture of reasonably well-established operational level connections between most professional membership bodies and their respective National Boards.

However, a recurring theme in the consultations was the perceived weakness of the links and opportunities for professional organisations to influence the direction, priorities and regulatory policy at a Scheme-wide level.

It was noted that there is a Professions Reference Group (PRG) with a representative from the professional association of each registered profession and a representative of the Health Professions Accreditation Collaborative Forum, which is chaired on 12 month rotation by a profession representative. It is attended by Ahpra Executive members and supported by an Ahpra Secretariat. The Group meets about 5-6 times per year.

The purpose of the Group as stated in the Terms of Reference is to engage on:

- Developments in the implementation and operation of the National Scheme.
- Issues affecting the professions in the administration of the National Scheme.
- Experience with the implementation and operation of the National Scheme.
- Professional and environmental issues that impact, or potentially impact, on the National Scheme.

There is a PRG communique produced, but it is unclear what is done with this and whether there is any link between the deliberations of the PRG and policy and strategy collaborations that would be occurring at National board and Ahpra Board levels.

The general experience of the professional organisations is that PRG is not operating or constituted in a way that meets its intended purpose. It is an information sharing forum that brings the professions together with Ahpra officers, whereas the professional bodies are seeking regular high-level strategy and policy dialogue between the professions and the Scheme leadership and the opportunity to consider significant profession specific or Scheme wide challenges to be addressed collaboratively, to drive innovation and shared commitment.

A CALL FOR MORE STRATEGIC DIALOGUE WITH THE PROFESSIONS



The key to the success of the stewardship model lies in ensuring that dialogue between government entities, regulators, and professional colleges is not only regular but also genuine. It is vital that the perspectives of all stakeholders, including specialist medical colleges such as RANZCR, are meaningfully considered during discussions...The effectiveness of the model hinges on transparent communication and decision-making processes that safeguard the interests of both trainees and patients. Colleges must have a seat at the table to ensure that their input, especially concerning trainee education and patient safety, is taken seriously.

Submission 61 – Royal Australian and New Zealand College of Radiologists



It is the ACA's view that the consultation paper does not adequately address or consider broader direct input from the profession and stakeholders in relation to governance and stewardship. The role of the professional boards is limited in its ability to provide specific professional input. Within the context of the wider health services environment there is a lack of access to a suitable feedback or contributory mechanism to support overall stakeholder connection and scheme proactivity. Harnessing the reach of professional/peak/membership representative bodies is key.

As an example, ACA represent over 45% of the profession and through its major partners and stakeholders can easily access up to 80% or more. [This] allows the Association to identify contemporaneous issues that impact on behaviour of registrants and performance of accredited educational courses. Having a consistent and robust two-way feedback mechanism could allow for proactive discussions...before these issues become complaints or larger professional body issues.

Submission 54 – The Australian Chiropractors Association



The AMC agrees with the Health Professions Accreditation Collaborative Forum that the strategic direction would be improved if the accreditation authorities were more engaged in its development”.

Submission 75 – Australian Medical Council

Engagement with professions on the development and implementation of registration standards was suggested as a particularly low watermark in terms of effective connection at the policy making level.

While it is usual to expect tension in relation to the standards that are set for registration and unrealistic to expect that the standards will meet with universal approval, it is difficult to overlook the consistent message of concern about the manner in which registration standards are reviewed and the apparent lack of progress on addressing some features of registration that are seen to directly affect workforce supply.

The issues raised included:

- It is unclear to stakeholders how the cycle and program of revision to standards is set and by whom – in terms of the priorities, timeframes and sequence for revisions.
- Lack of clarity in relation to the roles and responsibilities of Ahpra, the Ahpra Board and the National Boards in relation to review and approval of draft and finalised standards to be submitted to Ministers.
- Concerns about timeframes, with a complex picture in that regard.
 - On the one hand, the time taken to review and revise standards – referenced to the experience of timeframes for reviews of the CPD and Recency of Practice Standards for professions – has raised significant frustrations. The lengthy process for delivering policy adjustments in response to concerns about inequities in the health practitioner fee structure for health practitioners who take periods of parental leave was also mentioned.

- On the other hand, the experiences included “consultation overload”, with a perception of “insincere and perfunctory consultations”, with feedback either disregarded or only minimally addressed.⁶⁸

- Stakeholders identified specific standards they considered to be urgently in need of closer consideration in the context of workforce/regulatory reform.⁶⁹ These include standards for return to work, recency of practice and the unworkability of arrangements for moving from non-practising to practising registration, which attracted significant comment.



The AMA would also like to see improvements to the process for moving from non-practising registration back to practising, as this is a complicated process which could be simplified without compromising safety.

Submission 65 – Australian Medical Association

- The perceived absence of evidence bases or impact assessment for foundational settings and changes to registration standards – including in recency of practice policy and the elapsed time of practice, which triggers a competency-based assessment.



[W]hile there are generally cyclical reviews of relevant standards, guidelines and policies, there appears to be little proactive monitoring or performance reporting on their impact. Ahpra and the National Boards are undertaking more proactive monitoring following the implementation of the revised shared English language skills registration standard. However, this does not appear to be the case for all standards.

Submission 51 – National Health Practitioner Ombudsman

⁶⁸ Note for instance Submission 61 – Royal Australian and New Zealand College of Radiologists.

⁶⁹ Including: Submission 32 – Osteopathy Australia; Submission 53 – Royal Australian College of General Practitioners, and Submission 6 – Australian Medical Association; and, strong policy forum inputs from professional membership bodies.



- There was also a view that there was insufficient due consideration of actions already underway across the entities of the Scheme, including in accreditation standards. An example was the significant investment of some Councils and colleges in fostering cultural awareness within their work and how this would be recognised and acknowledged by the Ahpra-led strategy.⁷⁰

It is noted that the Ahpra submission to the Review advocated that approval of registration standards (which currently rests with Ministers) should be given to the Ahpra Board. It was apparent that this recommendation could only be considered in the context of broader initiatives to improve the adequacy and robustness of processes for development of, and consultation on, registration standards.

Scheme finance and fees

The submissions and forums raised a range of issues about financial arrangements for the Scheme that were not mentioned in Consultation Paper 1. These addressed aspects such as sustainability, unbalanced funding distribution, lack of transparency and complexity in fee-setting and budget processes, all of which are ultimately interrelated.

As this is a registrant funded Scheme, the overall cost of the Scheme (now at \$313 million per annum) and the burden on registrants is of concern. This is reflected not only in objections to increases in registration fees, but also deeper questions about what functions ought reasonably be registrant funded and what functions could and should be funded by other means.

Ahpra has explained the fee setting process as follows:

Under the National Law, Ahpra is required to ensure its operations are carried out efficiently, effectively, and economically, that there are effective procedures in place for prudent financial management (including audit) and to prepare accurate financial statements in its annual report. National

Boards are also required to ensure that their operations are carried out efficiently, effectively, and economically, and ensure that Ahpra can comply with its financial requirements as the National Agency.

There is an annual fee setting process. This includes entering into an agreement with each National Board (known as a health profession agreement) that makes provision for fees payable by registrants and the annual budget of the Board.⁷¹

However, it is apparent that neither the professions nor Ahpra are satisfied with that process.

The concerns of Ahpra seem to be ones of efficiency and consistency, which is a driver for their specific recommendations about reform of financial processes in its submission.

A VIEW FROM AHPRA – SCHEME FEES AND BUDGETS



All 15 National Boards work with Ahpra to undertake individual budgeting and regulatory fee setting. This approach is burdensome, and results in inconsistencies and complexity, due to all 15 National Boards at times duplicating the Ahpra Board's corporate governance actions and management.

For example, there can be different approaches to issues of fee relief for financial hardship or other financial policies such as the management of equity and reserves.

[T]he Ahpra Board should have overall financial accountability for the national scheme financial performance and positions, including budget fee setting, and maintenance of a single equity account within the Ahpra balance sheet.

Submission 63 – Ahpra

⁷⁰ For instance: the AMC initiative for inclusion of the Aboriginal and Torres Strait Islander and Māori Committee in the standards of accreditation for primary medical programs facilitated a shared sovereignty approach to development of the standards; The Royal Australian College of General Practitioners launch of its Aboriginal and Torres Strait Islander cultural and health training framework in November 2024.

⁷¹ Submission 63 – Ahpra.



Professional organisations are more fundamentally concerned with transparency and sustainability. Their issues include the nature of the costs that are expected to be covered by registrants, the significant recent escalations in fees, the potential inadequacy of expenditure on some core functions, and the need to consider alternative sources of funding for functions that are broader and related to the development and credibility of the Scheme, and for which registrant funding should not be considered.

The National Health Practitioner Ombudsman shares some of these concerns, noting also that effective growth and development of the public interest dimensions of the scheme may require consideration of broader sources of funding (beyond registrant fees).

PERSPECTIVES ABOUT FEES AND EXPENDITURES



The consultation paper does not adequately discuss ...registration fees and transparency of funding.

We would like to see clearer reporting on how Ahpra fees are used. [T]here is insufficient accountability...within the National Scheme, and this is one of the major aspects that must be improved.

Submission 65 – Australian Medical Association



The transparency of the funding model for accreditation activities, and the associated charging model is central to building trust in the National Scheme.

The need for increased transparency regarding the existing funding model is not ...solely related to accreditation activities, but also to registration activities. The NHPO's recent own motion investigation into the current charging model for health practitioner registration fees uncovered the need for greater transparency...and how it relates to cost recovery principles. The investigation has found, for example, that there are different approaches to charging application and registration fees across the professions..., particularly for certain registration types (such as provisional or limited registration, or practitioners transitioning to or from non-practising registration).

As the regulatory landscape shifts and if...Ahpra and the National Boards are to focus more on proactively addressing emerging issues, one part of the complex puzzle that should be considered is how this work should be funded. Complaints to the NHPO about the National Scheme's fees, including how they are set and charged, have been recurrently common. It is necessary to consider how and whether the current funding approach is fair, reasonable and practicable in this changing environment...

Submission 51 – National Health Practitioner Ombudsman



A stronger strategic connection would be enabled by dedicated resources to support whole of scheme communication, engagement, research and analysis, and the capacity for all National Scheme entities to engage. Opportunities to access a pool of funding to take forward strategic priorities would allow organisations to dedicate time and effort to embedding reforms.

Submission 75 – Australian Medical Council



[T]he current funding model (and National Law functions) has precluded a proactive risk management focus that looks beyond notifications received. Public trust requires a robust and proactive risk management process. Together with co-regulators (National and international), Ahpra must be a contemporary and agile regulator and accordingly must take a forward-looking broader view to identify, manage, and respond to risks that may impact public safety. To do this comprehensively Ahpra needs funding avenues, in addition to registrants' fees, to undertake a proactive program of work around emerging issues, independent of the National Boards.

Submission 38 – Community Advisory Council



Preferred Reforms and Actions

Conclusions from the consultation

Establishing a clear single line of accountability for performance and development within the National Scheme is essential to reducing complexity and improving its effectiveness and ability to respond to the challenges of health service delivery in Australia.

The defining strategic direction must be to steer regulation toward supporting broader health workforce and systems objectives, balanced with the enduring obligation of protecting public health and safety, consistent with the statutory objectives of the National Law.

In terms of who ought to be responsible for stewardship and accountability of the Scheme, many hold a firm belief that the Scheme ought to always first and foremost be built around the skills, knowledge and experience of the professions, and therefore be profession led. Initiatives which seek to adopt a ‘whole of Scheme view’ and to align regulation with broader objectives can tend to be cast as risks to the profession-oriented design of the Scheme and its grounding purpose of protecting public health and safety.

The Review does not agree that promoting fuller consideration of the overall functioning and effectiveness of the National Scheme and fostering its broader strategic contribution amounts to a view that professions do not have a central role to play. This is not a case of one or the other.

To the contrary. A Scheme which is unified by clear common purpose and led to deliver to that purpose in all its functions and parts, built on the bedrock of expertise and skills within and across professions, is more certain to retain the confidence of governments, the community, health practitioners and the health system.

The fact of this Review and what we have learned in the consultations is that there is widespread appetite and need for improvement for the Scheme to reach its full potential. Business as usual is not an option.

To evolve and adapt and to meet the expectations, requires a broader lens referenced to the overall purpose of the Scheme and ensuring regular consideration of:

- How well it functions in the interests of public health and safety and in support of the health system in Australia.
- How well the regulatory function is designed and performed to maintain trust with those who are regulated and those who rely on effective regulation.
- How it addresses issues that are common to all professions whilst also ensuring that regulatory decision making is robust and evidence driven.
- How prudential responsibility is exercised transparently and in the interests of the practitioners who fund the Scheme.

Contemporary regulatory stewardship principles need to be applied, and these require structures and processes based on a systems approach, featuring proactivity, collaboration, and a continuous improvement mindset, through which the regulatory regime is monitored, evaluated, maintained and improved over time. The proposed structures and accountabilities are stepped out in detail below and brought together in summary form in *Figure 4: Governance Model for the National Scheme*.

THE AHPRA BOARD AS SCHEME STEWARD

The essence of the stewardship obligation is to ensure that health practitioner regulation is both in line with the statutory objectives and adapting to the challenges of an evolving and changing health service system and community expectations.

This obligation should rest unambiguously with the AHPRA Board, consistent with its core responsibility to ensure that the National Agency performs in a proper and effective manner and in accordance with Ministerial directions.

Any proposed Ministerial Statement of Expectation or Policy Direction would be the responsibility of the Board to action, supported by a Statement of Intent from the Board to Ministers. The Board would be accountable for overseeing implementation and reporting to the Ministers on progress, in addition to its core responsibilities of reporting on the operational performance of the Scheme.



Success will require building on the current skills-based Board, noting that the National Law may be sufficiently flexible to enable this to occur without legislative change, at least in the short term. The National Law:

- Sets a minimum of 5 members for the Board, but no maximum (section 29(2)).
- Provides that the Chair should not be a registered practitioner (section 29(3)).
- Provides that at least 2 members must have business or administrative experience and must not be a registered health practitioner.
- Provides that at least 2 members have expertise in health, education and training or both, and who may or may not be a registered health practitioner.
- Includes in the functions of the Board (at section 30(1)) actions to decide the policies of the National Agency, ensure that the National Agency performs its functions in a proper and effective way, and any other function given to the Board by or under this Law.

More specific Board membership skill requirements (within or in addition to the current statutory membership specifications) could include:

- Financial Literacy – this is a high value Scheme and the Board has an obligation to ensure that registrant and any received government funds are expended in a prudent manner. The review also notes the converging agendas for more transparent and efficient financial across the Scheme in the context of significant growth in expenditure and fees.
- Stakeholder engagement expertise – a complex stakeholder picture is an inherent and unavoidable feature of this Scheme. It needs to balance consideration National and State interests across jurisdictions and professions, the spectrum of health service and systems, impacts on practitioners and a high level of community expectation. Credibility depends on being effective and trusted in this regard.
- Governance and risk – this will support the required governance uplift to meet contemporary stewardship expectations.
- Policy and Analysis – data driven solutioning is necessary to inform the strategy for the Scheme and to achieve effective collaboration with regulatory partners.

The Review has a preliminary view that this reset of the Ahpra Board is consistent with and achievable within the existing legislation. It proposes that implementation could and should begin through administrative measures as far as possible.

Nevertheless, and for abundance of clarity and transparency, it may ultimately be prudent to consider amending the legislation. This would include relabelling the Ahpra Board “the National Scheme Board” and articulating more precisely what skills the Board members should have. The need for and nature of legislative change to implement this approach should be subject to early legal advice.

A FORMALISED ROLE FOR NATIONAL BOARDS IN SCHEME LEADERSHIP

There are not adequate arrangements for the Ahpra Board and the National Boards to work together to optimise both the performance of the Scheme as a whole and the delivery of profession specific regulatory functions within this.

The expectation should be that the reset Ahpra/National Scheme Board builds a strong leadership structure (through a mechanism such as a Scheme Delivery and Development Leadership Group – which would effectively be a Sub-Committee of the National Scheme Board). This would provide a formally recognised connection between the National Scheme Board, the National Boards (including any newly constituted Approved Professions Regulatory Council and the Community Advisory Committee, to highlight their respective roles and responsibilities.

The contribution of the National Board Chairs to stewardship should see them advising on the directions and priorities for the Scheme, with avenues for identifying emerging risks in service delivery and supporting innovation in regulatory approaches. It may also be helpful to be as explicit as possible in the role definition for Board Chairs to highlight the requirements for a commitment to the mission and objectives of the national Scheme, alongside profession related skills, knowledge and experience.

The National Board Chairs also need to be empowered and accountable for taking forward formally established Scheme priorities and working with other National Board Chairs to advance those priorities both within and across professions.



AN IMMEDIATE STRATEGIC AGENDA FOR THE NATIONAL SCHEME BOARD

Over time, the proposal for a Strategy Assembly to inform a Ministerial Statement of Expectations (see Reform Theme 1, action 1.1) would provide a mechanism for setting out priorities to guide the strengthened stewardship function of the Ahpra/National Scheme Board.

However, there are immediate priorities for action that have been identified by the Review and these should not be delayed. They include:

- Establish a Scheme-wide performance monitoring and reporting framework.
- Review of the National Board selection criteria and process to build in explicit requirements for application of a Scheme wide approach in performing regulatory functions
- Review of budget and fee setting processes.
- Review the Scheme stakeholder engagement strategy and structures.
- Review processes for development and approval of registration and accreditation standards and Codes of Conduct, to deliver a structured and transparent cycle for and process of review, to ensure that these policy setting tools align with policy objectives and priorities.

These matters are all within the existing remit of the Ahpra Management Board and could be captured in a proactive undertaking from the Ahpra Board (and incorporated into the Boards current work program and/or the 2025-30 National Scheme Strategy that is now under development). They could alternatively be the subject of an early initial Ministerial Statement of Expectations, or at its most formal a Ministerial Policy Direction, if this was considered necessary.

THE FOCUS ON ACCREDITATION

Ensuring alignment between accreditation functions and the National Scheme Strategy is foremost in current regulatory challenges.

Ministers have sought consideration of a Ministerial Power of Policy Direction for accreditation functions and progressing introduction of such a power has been recommended in the Scope of Practice Review.

The potential of this extended power is recognised. However, in the context of the complex dispersed arrangements for delivery of accreditation in the National Scheme (as between the National Boards, the Accreditation authorities and the specialist medical colleges), it is very important for the potential scope and reach of any such direction power to be carefully considered, and precise drafting would be required to avoid any unintended consequences and to be effective.

An important initial consideration is how any proposed power of direction sits alongside the accreditation reform currently underway, and the potential for other legislative reform proposals to arise from that work.

- This Review is occurring in the midst of substantial work following the recommendations of the National Health Practitioner Ombudsman inquiry into accreditation in 2023.⁷²
- It is intended but not yet clear whether this work will deliver the effect of improving accountability and alignment with workforce objectives.
- Further, Recommendation 23 of that report envisaged consideration of legislative reform in the event that implementation did not satisfactorily address the concerns. The proposed evaluation is not yet completed.
- Any associated legislative reform would likely include to the question of whether there is a need to recognise the role of colleges in accreditation training sites under the National Law. This may have the potential to deliver a higher level of transparency, stronger oversight and harmonised decision making, with clear expectations for providers. However, there are also practical and legal dimensions to this approach that would need to be fully examined, to avoid unintended consequences and to establish whether it would achieve the desired outcomes.

⁷² National Health Practitioner Ombudsman (2023). *Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation*. 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>.



- Such National Law reform may also involve consideration of other actions, such as formalised arrangements requiring specialist medical colleges to advise the AMC or the Medical Board of Australia of certain accreditation issues which may impact workforce planning, such as prospective workforce impacts if a college believes a training site is at risk of having its accreditation revoked.
- The question would then become whether potential legislative change arising from this accreditation reform work would be in addition or as an alternative to introducing a Power of Direction.

The second consideration would be understanding and navigating the complexity of current arrangements in drafting the detail of any proposed Ministerial Power of Direction in relation to accreditation.

Importantly, a general power of direction covering accreditation functions (such as already applies to registration or notification functions under the National Law) would not deliver the capability to direct specialist medical college in relation to accreditation procedures and practices at training sites. This is because training site arrangements are managed outside of the National Law between a health service and the relevant college.

A more specific power of direction in relation to specialist medical training college sites would therefore be required.

The legislative reform considerations associated with both the existing accreditation reforms and a potential additional ministerial power of direction are not insubstantial and need to be progressed in concert.

Further, consideration of the need for legislative reform should not be divorced from analysis and implementation of available administrative actions to strengthen the chain of accountability within the Scheme.

Even if a new Ministerial Power of Direction for accreditation functions is established, the policy ideal is that such a power is not required to be exercised. The firm expectation should be that current accreditation reforms would be successfully progressed and augmented by strengthened oversight and collaboration measures that should arise from this Review. These should include:

- Accreditation directions and priorities to be set by the Ahpra/National Scheme Board, with a mandate for the Independent Accreditation Committee (IAC) to oversee and report to the Board implementation of those priorities. This will require a review of the IAC's terms of reference, and potentially membership. Priorities for the Board, and by extension the IAC, could include:
 - Review the 2023 Ahpra Board Procedures for development of accreditation standards, with a view to making explicit provision for analysis of workforce impacts throughout the process and for advising Ministers on these impacts (in support of ensuring the effective application of the existing Ministerial Power of Direction under section 11 of the National Law).
 - Identifying and progressing cross profession priorities in accreditation and driving innovation.
 - Overseeing further development of the Performance Framework for Accreditation – striving for performance measures and reporting arrangements that assist change and alignment with Scheme wide priorities.
 - Actions to reduce duplication and improve efficiency in accreditation processes for health and tertiary education purposes.
- Strengthening the role of HPACF, with a requirement for IAC to establish and maintain a structured link to that Forum, to promote a partnership approach to accreditation reform and to ensure a direct avenue for the professions to influence strategic deliberations on accreditation matters.

NATIONAL BOARD STRUCTURES

The Review did not find a strong case for pursuing mandatory amalgamation of the existing National Boards. It concluded that amalgamation of the existing National Boards may have superficial appeal but is unlikely to deliver the benefits that are anticipated and hoped for.

- Ultimately, profession specific knowledge will always be important for settling standards for entry and training for a profession – even if there are common elements that can be harmonised or standardised, there will be specificities to be considered.



- This is equally so in managing complaints, where some notifications may relate to conduct not specific to the profession, whilst other matters may raise clinical concerns or require a deeper understanding of the practice context of a profession, thus requiring profession specific expertise.
- If professions were merged into a multi-profession Board, there would therefore still need to be the ability to access profession specific advice for that Board to exercise many of their functions. The need for this would arguably add a new layer of complexity.

Nevertheless, it is not possible to ignore the significant concerns about the impracticality and difficulty of working through 15 National Boards (in addition to the Ahpra Board) to ensure that regulatory effort remains efficient, effective and responsive.

The stewardship reforms proposed above are the primary mechanism to address this issue in the first instance – they are designed to empower the Ahpra Board to lead and drive the delivery of strategically important reforms and create a stronger impetus for professions to work to common purpose.

For existing professions within the Scheme, there should be active consideration of voluntary amalgamation to form Multi-Profession Boards, as is currently available under the National Law. If the National Scheme Board forms the view that more active consideration should be given to this option, this could be discussed with the relevant National Boards and be the subject of advice to Ministers.

For professions seeking to enter the Scheme, the expectation should be that the profession seeking entry be required to be part of a multi-profession board. The proposed revised Risk Assessment process and Guidance should ensure assessment of the costs and benefits of the alternatives of establishing a new Board relative to forming or joining a Multi-Profession Board.

In terms of concerns about inconsistencies in regulatory policy and decision making across professions, settings for the stewardship role of the Ahpra Board should also address this.

- For instance, where there is a matter related to Scheme wide policy direction or strategy and decisions of an individual Board are inconsistent with this, there should be a transparent account of this in Ahpra Board advice and reporting to Ministers. This would foster open discussion and consideration of whether a profession specific difference is appropriate and necessary.
- In relation to the current structures under National Boards, two areas require action.
 - Establishing a Sexual Boundary Violation Notifications Committee. This was recommended in 2020 and broadly welcomed as a necessary improvement in managing these sensitive complaints in a consistent way.⁷³ There have not been signs of progress since then.
 - The case for retaining State level boards under the Medical and Nursing and Midwifery Boards does not appear to be strong. They open the way to inconsistency in disciplinary decision making with in these professions, and add an additional hurdle to implementing changes to business processes. They are a significant cost to the registrants. To the extent that the volume of notifications is a driver for these additional structures, there are other models of national decision making that could address that aspect. These Boards should be requested to provide advice on options for establishing notification decision making at a national level to the Ahpra Board, with a view to retiring these structures within a 12–18 month time horizon.

⁷³ R Paterson (2020). *Three years on: changes in regulatory practice since the independent review of the use of chaperones to protect patients in Australia*, p27. Available at: <https://www.ahpra.gov.au/documents/default.aspx?record=WD20%2f30454&dbid=AP&chksum=YE1XW9tLtpZFD7LUE0IGGg%3d%3d>.



COMMUNITY VOICE AT SCHEME LEADERSHIP LEVEL AND ON NATIONAL BOARDS

For a Scheme that is designed to deliver results in the public interest and in line with community expectations of safe health care, the voice of community must be present.

At the very least, representation from the Community Advisory Committee should formally sit alongside the professional council chairs in a Scheme leadership capacity. To achieve this the Chair of the Community Advisory Committee should be a formal member of the proposed Scheme Development Leadership Group.

Understanding of the community facing purpose of the Scheme should also be a formal consideration in the Board selection process. Representation of the Community Advisory Council on Board selection panels is a positive means of achieving this and should be maintained.

There are polarised views about the arrangements for community membership of national boards, including in relation to the ability of a community member to chair a national board and membership parity.

The Review has concluded that it is most appropriate and consistent with wider contemporary practice for there to be merit selection of Board members, such that they are appointed on the basis of skills, experience and attributes. This would enable the Chair to be either a practitioner or community member. This will require legislative change to remove the requirement for a Board to be Chaired by a practitioner member in section 33(9) of the National Law.

The Review notes that there is currently scope within the National Law to achieve parity of community and practitioner on Boards and the move in this direction should continue to be pursued within the context of a merit-based selection model.

THE VOICE OF PROFESSIONAL MEMBERSHIP BODIES

As professions are at the heart of the Scheme, a clearer structure and pathway for input from the professional membership bodies in setting Scheme wide strategy and priorities and assessing risks is warranted.

The Review proposes that the Ahpra Board require the Scheme Development Leadership Group, to establish a Professions Liaison Group, to replace the current Professions Reference Group. This Group should be jointly chaired by a representative of the Scheme Development Leadership Group and a nominated professional association representative, with membership including a representative of each professional associations of each registered profession and of the Health Professions Accreditation Collaborative Forum. The cycle of meetings could be twice a year, supported by the Leadership Group Secretariat.

The role of the Professions Liaison Group would be to provide profession-based input on issues that are the subject of advice to the Ahpra/National Scheme Board on request or proactively, and to plan and collaborate on profession specific and/or Scheme-wide development projects being led by the National Boards.

ENSURING AHPRA CAPABILITY

Regulating a rapidly growing and changing health sector, ensuring continuous improvement, and delivering best practice regulation is challenging.

The Review concludes that an independent capability review is required to consider whether Ahpra has what it needs to regulate health practitioners effectively (now and into the future) and to support the reforms that are envisaged in this Review. The independent capability review should be a short outcomes-oriented capability review and help to build confidence and trust in the ability of the Scheme to meet its objectives.



The review should draw on best practice principles and the Regulatory Performance Guide of the Australian Government (RMG128), and the key requirements to be a high performing, risk-based regulator can be identified across the two key domains of organisational and regulatory enablers, as follows.⁷⁴

- **Organisational enablers:**

- Clear purpose and clarity of role
- Strategic and visible leadership, appropriate supporting structure and culture
- Good internal governance
- Accountability and transparency
- Capable people
- ICT and data systems
- Trust and Reputation, and a focus on organisational continuous improvement
- Resourcing

- **Regulatory enablers:**

- Regulatory strategy and operating model
- Risk based and data-driven
- Cultural capability, and ability to deliver for diverse groups
- Effective engagement and communication

In terms of what stakeholders are seeking, the Review sees an opportunity through the independent capability review to provide necessary assurances that the National Scheme will be supported through:

- A proactive and preventative regulatory posture alongside a focus on regulatory performance and outcomes.
- Strong and effective connections with health policy makers, jurisdictions, the Ahpra Board, and the National Boards – so that operational effort and performance follows strategy.
- Customer-centred and compassionate regulation as core values.
- Responsiveness to stakeholder inputs and requests.

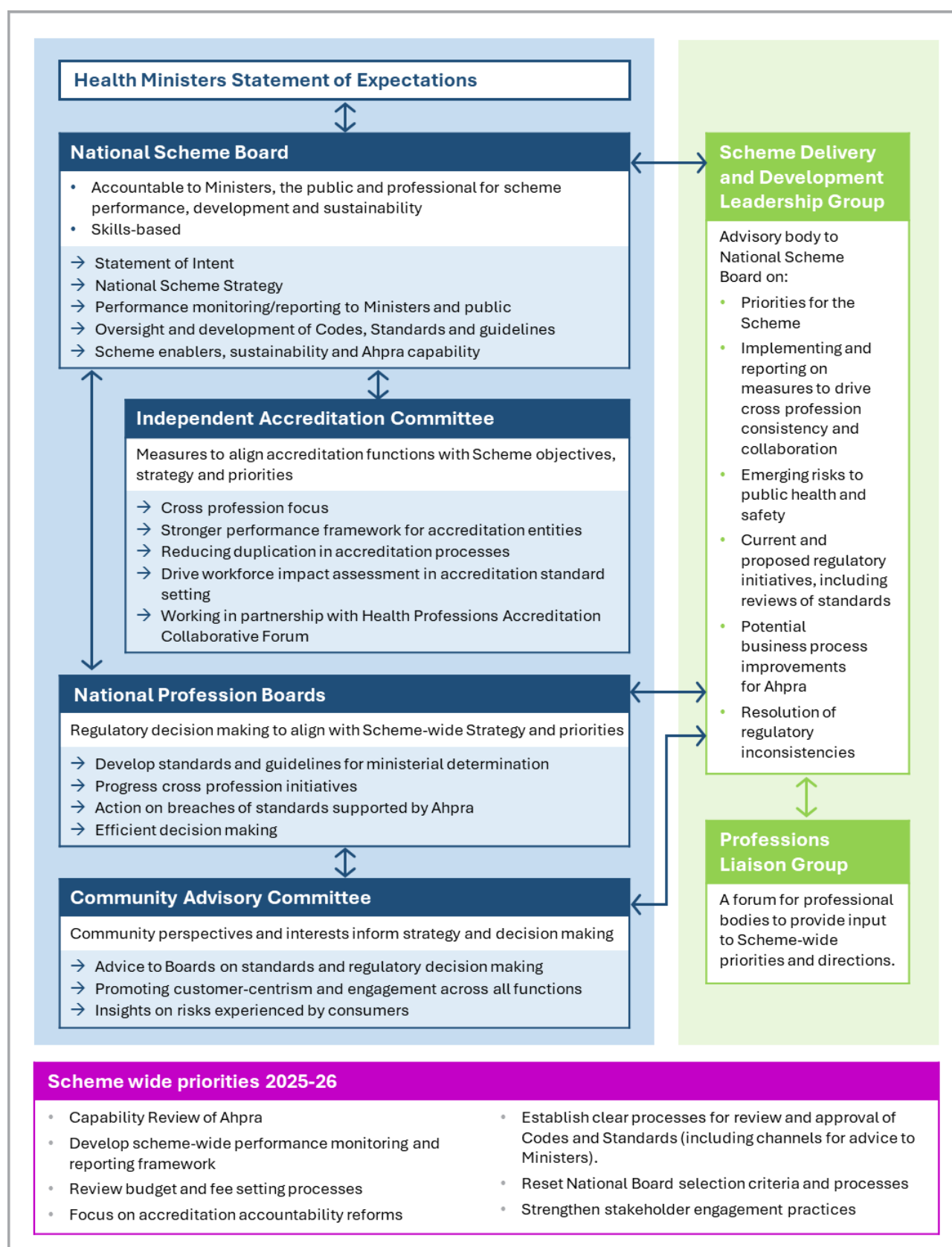
- Workforce skills, expertise and structures aligned to the desired focus on professional standards regulation- particularly to maintain strength in clinical advice and investigation and prosecution capabilities.
- An embedded and enduring ethos of working in collaboration with professional membership and peak bodies.
- A commitment and capacity to collaborate with State and Territory jurisdictional health regulators and other national health regulators to deliver comprehensive and efficient regulation.
- A continuous improvement and learning culture.

⁷⁴ See for instance Tune, D (2023) *Report of the Independent Capability Review of the Aged Care Quality and Safety Commission*, at p 28 available at: <https://www.health.gov.au/resources/publications/final-report-independent-capability-review-of-the-aged-care-quality-and-safety-commission?language=en>



FIGURE 4: GOVERNANCE AND STEWARDSHIP WITHIN THE NATIONAL SCHEME

Governance and Stewardship within the National Scheme





An overview of our proposed reform actions



REFORM DIRECTION 3

The review recommends that Health Ministers agree to realign functions and structures within the National Scheme to strengthen performance, accountability, and transparency.

ACTION 3.1

Transition the Ahpra Agency Board to become the National Scheme Board and request Health Workforce Taskforce (HWT) and the Ahpra Board to commence specific administrative and strategic adjustments within the existing National Law.

- 3.1.1 Revise the Ahpra Board Charter to reflect the Board's responsibility for stewardship of the National Scheme.
- 3.1.2 Review Ahpra Board appointment processes to support the intention that the proposed National Scheme Board remains skills-based and that as Board vacancies arise the following skills are prioritised: financial literacy; stakeholder engagement expertise; health regulation knowledge and experience; risk and governance; and, policy and analysis.
- 3.1.3 Request the Policy and Legislation Committee to advise the Health Chief Executives Forum and Ministers as to whether there is a need for, or benefit in, legislative change to put beyond doubt the Scheme stewardship role of the Ahpra Board and/or to formalise its role relative to the National Boards.
- 3.1.4 Policy and Legislation Sub-committee of HWT to progress amendment of section 33(9) of the National Law to advance merit selection of National Board Chairs, enabling the Chair to be either a profession member or a community member.

ACTION 3.2

Ahpra Board to make specific structural governance adjustments within the existing National Law, including the establishment of a Scheme Delivery and Development Leadership Group and a Professions Liaison Group.

- 3.2.1 Board to establish a Scheme Delivery and Development Leadership Group:
 - a. Comprising all National Board Chairs, the Chair of the Community Advisory Committee, the Ahpra Board Chair and CEO.
 - b. To be chaired by an annually nominated National Board Chair or the Chair of the Community Advisory Council.
 - c. To meet quarterly.
 - d. To be supported by a secretariat.
- 3.2.2 Board to require the Scheme Delivery and Development Leadership Group to establish a Professions Liaison Group to replace the Professions Reference Group and to ensure direct dialogue between the professions and the Boards on key strategic issues and priorities.
 - a. Comprising professional membership bodies for each registered profession.
 - b. To meet twice yearly.
 - c. Chair to formally report to the Ahpra Board following each meeting.



ACTION 3.3

Ahpra Board to commission an independent Organisational Capability Review of Ahpra Agency with specific actions and implementation plan to be communicated to Health Ministers within 12 months.

3.3.1 The Capability Review should focus on:

- **Purpose, vision and strategy:** Strategic documents and priorities aligned and communicated externally and internally; processes for responding to changes in environment and government and community expectations.
- **Leadership structures and culture:** Structure and resource allocation matching strategy; clear delegations; effective connection between State offices; strong relationships and timely and objective advice to Ministers and boards; risk management; performance reporting and accountability tools and processes; communication.
- **Collaboration and engagement:** Strong connections internally and externally, including with Ministers and jurisdictions, Ahpra Board and National Boards, other regulators, community, professions and academia.
- **Delivery:** A customer centric approach to all functions and a commitment to co-design of processes; clear delineation of roles and responsibilities in structures and policies; active use of data and evidence; effective change management; active use of review and evaluation to drive continuous improvement.
- **Workforce:** Current and future operating and workforce requirements – identifying critical roles and skills gaps (including attention to clinical advice capacity and capability and investigation skills); investment in learning and development; diversity profile; leveraging recruitment and other workforce instruments to address needs; wellbeing and resilience.
- **Enabling functions:** Resource allocation matched to strategy and priorities; IT system implementation and change management (including AI-enabled regulation); strengthening data analytics; corporate operations.

ACTION 3.4

Ahpra Board to provide an undertaking to Ministers to pursue immediate strategic priorities identified in this Review and report to Ministers on progress in each future Quarterly Performance Report until the priority actions are completed.

3.4.1 Examine the status and content of the current review of revised *National Scheme Strategy (2025-28)* to ensure that the review process and timing considers the issues and priorities raised in this Review, with the revised strategy to be presented to HWT and Ministers (and able to inform a Statement of Intent to respond to a Ministerial Statement of Expectations as and when one issues) within 6 months.

3.4.2 Establish major projects to deliver the following:

- a. Establish and implement a Scheme-wide Performance Monitoring and Reporting Framework, including performance measures at high level as well as operational level to measure output, timeliness and quality of all regulatory functions performed by the Scheme, supported by reporting that is in a proposed form and frequency that meets the needs of Ministers, the Scheme entities, the professions and the public.
- b. Examine the annual budget and regulatory fee setting processes within the Scheme, with a view to reducing the administrative complexity of current arrangements, improving transparency in cost allocation and fee setting for professions, and providing a framework for assuring the financial sustainability of the Scheme.



- c. Reset the National Board appointment selection criteria and process, to formalise representation of the Community Advisory Council on Board selection panels and include explicit requirements for members to adopt a Scheme-wide approach to performing regulatory functions.
- d. Drive strengthened Ahpra stakeholder engagement policy, roles and practices – to build authentic collaboration and partnership with stakeholders and improve channels for regulatory gauging and responding to consumer and practitioner perspectives on the Scheme.
- e. Establish and oversee a more structured and transparent processes for review and revisions to accreditation and registration standards and Codes of Conduct, with clarity about the role of the Ahpra Board relative to National Boards, a strategic approach to the cycles and sequence of review, identification of issues to be addressed across professions, clearer protocols and practices for stakeholder engagement, and arrangements for advice to Ministers.

ACTION 3.5

Ahpra Board to strengthen focus and accountability for accreditation functions with specific actions to achieve this.

- 3.5.1 Ahpra Board to re-mandate and potentially reconstitute the Independent Accreditation Committee as the entity to oversee and guide delivery of accreditation reforms within the Scheme and set immediate priorities and timeframes for its work program, which should include:
 - a. Prioritising development and implementation of more specific workforce impact analysis requirements for accreditation standards, to support effective operation of the current section 11 Ministerial Power of Direction on accreditation functions.
 - b. Reviewing and strengthening the Quality Framework.
 - c. Reducing duplication between the accreditation bodies in the Scheme.
 - d. Reducing duplication between accreditation bodies in the National Scheme and other regulators such as the Tertiary Education Quality and Standards Agency, migration skills assessment and registration assessments.
 - e. Developing consistent approaches in assessing qualifications and overseas qualified practitioners.
- 3.5.2 Require the Independent Accreditation Committee to establish a formal connection with the Health Professions Accreditation Collaboration Forum to ensure wider professions input to direction setting, supporting collaborative solutions to progressing reforms.
- 3.5.3 Ahpra Board to request the Independent Accreditation Committee to advise within 9 months:
 - a. Its program of administrative actions to improve accreditation accountability.
 - b. The nature and potential benefits of National Law amendments relating to specialist medical training sites including the option of a Ministerial Power of Direction.



ACTION 3.6

HWT Policy and Legislation Committee to further consider and advise on any further administrative, policy or legislative actions required to strengthen accreditation functions, within 12 months.

- 3.6.1 Monitor and report on implementation of recommendations from the 2023 National Healthy Practitioner Ombudsman inquiry into accreditation and actions taken by Ahpra based on this Review.
- 3.6.2 Consider the need for legislative reform, including receiving advice from the Ahpra Board and the Independent Accreditation Advisory Committee on the potential scope, application and benefits of a less constrained Ministerial Council Power of Direction on Accreditation.

ACTION 3.7

Health Ministers agree to maintain the current voluntary approach to amalgamation of existing National Boards, conditional upon the Ahpra and National Boards establishing a transparent governance process for maintaining efficient and effective board structures and driving enhanced cross profession decision making, including specific immediate actions.

- 3.7.1 Prioritise establishment of a multi-profession Sexual Boundary Violation Notifications Committee.
- 3.7.2 Monitor regulatory volume and costs for professions where voluntary amalgamation may be necessary to deliver cost effective regulation.
- 3.7.3 Operationalise the principle that new professions entering the Scheme should be expected to be part of a multi-profession board.
- 3.7.4 Progress a planned transition from State and Territory Boards to national decision making for Medical and Nursing and Midwifery professions, within a 12-18 month timeframe.

THEME 4:

Delivering best practice health complaints handling nationally



What the Consultation Paper said

Consultation Paper 1 recorded the deep frustration and confusion of consumers, practitioners and health service providers about the processes for managing complaints. It highlighted the universal view that there is a need for a significant uplift in performance in this area for there to be confidence in the integrity of health practitioner regulation.

The issues identified and the associated reform concepts proposed in Consultation Paper 1 are summarised below.

Summary of issues from Consultation Paper 1: Deliver Coherent and Effective Complaints Handling

LOW LEVEL OF CONFIDENCE IN COMPLAINTS HANDLING

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.

Both consumers and practitioners seek improved timeliness, transparency and natural justice.

Ahpra and Health Complaints Entity (HCE) processes are not well aligned to mitigate this frustration about how health care complaints and notifications are managed.

INCONSISTENCY AND DELAY IN NOTIFICATION DECISION MAKING

Complex decision making structures, absence of cross-profession decision making and lack of delegation 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 more timely and effective way.

The community voice in decision making is limited.

Operational performance monitoring and accountability within the National Scheme does not focus on effective management of serious complaints.

INADEQUATE CLINICAL ADVICE TO INFORM REGULATORY DECISIONS

Clinical advice is central to effective regulatory decision-making, but the current clinical advice model within the National Scheme appears underdeveloped. Additional clinical advice embedded at the operational level could facilitate increased delegation of decision-making.

INCONSISTENT TRIBUNAL PROCESSES AND DECISIONS

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 guide full consideration of possible solutions.



TENTATIVE REFORM CONCEPT

The reform concept proposed in Consultation Paper 1 was to simplify complaints handling structures and processes. It envisaged redefining the roles and responsibilities between State and Territory HCEs and Ahpra, to provide a single front door in each jurisdiction for consumer complaints with clear guidance and information for consumers and practitioners.

Consultation Paper 1 proposed a sharper focus on management of serious complaints within the National Scheme and improved timeframes and consistency by:

- Resetting the regulatory decision-making responsibilities and delegations between Ahpra and the National Boards.
- Expanding clinical expert input at the operational level.
- Measures to strengthen community voice in regulatory decision making.
- Strengthening risk-based tools for identifying and progressing high risk complaints.
- Research on consistency in Tribunal outcomes for disciplinary matters.

What we heard from you

A dysfunctional model of complaints handling

It would be hard to overstate the breadth and depth of dissatisfaction with the current complaint handling and notification processes. These processes are not meeting the basic expectations of health practitioner regulation in Australia. This is an equally acute concern for practitioners, consumers and policy makers.

The picture for consumers is summed up as an overwhelming choice of where to take a complaint, alongside an underwhelming lack of support for how and where to do so.



The burden should not be on the consumer to locate the most appropriate organisation to lodge their complaint. From the consumer's perspective, making a complaint should be easy. The consumer should not be expected to understand or navigate a complex complaints system.

Submission 52 – Western Australia Health and Disability Services Complaints Office

Consultation confirmed that many consumers believe that they can and should make any type of health complaint to Ahpra. They are frustrated to learn, frequently after a significant period, that this is not the case – as Ahpra can only manage notifications about registered health practitioners. They are also frustrated to learn that Ahpra will only progress the complaint about a registered practitioner (known as a notification in the context of the National Scheme) if the matter is a significant breach of standards of conduct or performance or a question of practitioner impairment. If a concern is ultimately less serious, but still requiring further explanation and resolution, it must be raised again with a HCE or other regulator. The consequent delay and process confusion is at the centre of their dissatisfaction.

Professions also confirm a deeply unsatisfactory experience for practitioners, highlighting the protracted and stressful processes on matters that often could be easily addressed or dismissed at an earlier stage.⁷⁵ This is significant, noting that well over 85% of notifications to Ahpra ultimately result in no jurisdiction to consider the matter or no further action required by Ahpra.⁷⁶ It is even more significant

⁷⁵ Refer for instance to Submission 68 – Not for Publication; Submission 67 – Avant Mutual.

⁷⁶ Ahpra (2024). *Annual Report 2023-2024*, Page 70, Available at: <https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-2024.aspx#:~:text=The%20Australian%20Health%20Practitioner%20Regulation%20Agency%20and%20the,report%20is%20E2%80%98Leadership%20and%20collaboration%20for%20safer%20healthcare%20E2%80%99.>



when considered in the context of recorded instances of practitioner suicides coinciding with investigation processes and potential disciplinary action.

The quality and content of communication remains a major issue for both consumers and practitioners. The overwhelming view is that communication from Ahpra is inadequate and bureaucratic. There is a clear desire for early contact with complainants and provision of information to practitioners, with plain language customer centric explanations of processes, possible outcomes, and the reasons for decisions as core practices in managing a notification.

In relation to communicating the reasons for decisions, the National Health Practitioner Ombudsman has drawn from consumer experiences to call out the confused accountability for providing information about a national board decision.



This generally appears to stem from a view that it is not Ahpra's role to speak for a National Board and that it is not an appropriate use of resources to seek clarification from a National Board on its reasoning when Ahpra cannot further describe it. This situation points to a disconnect between Ahpra in administering the Boards decisions and the National boards as decision makers.

Submission 51 – National Health Practitioner Ombudsman, p11

The absence of a right of review for notifiers within the National Scheme compounds the problem. It is seen as a lack of fairness, ill-befitting of a Scheme that requires integrity and public confidence, and an unacceptable departure from contemporary practise. The consultation pointed to the options of either a formal internal merit review or ideally a statutory right of review as applies in some jurisdictions for matters dealt with by HCEs.⁷⁷

It is also concerning and confusing for complainants and practitioners that Ahpra does not have powers that allow a notification to be dealt with by conciliation, mediation or other less formal restorative means. While the National Law does enable Ahpra to refer such matters to the HCEs and to health services, who do have restorative justice functions and powers, there are not adequately developed mechanisms to ensure that such referrals occur in a timely and effective way.

This deficiency affects complainants who are seeking closure in a way that acknowledges their experiences when the matter may not warrant disciplinary action.

It is equally concerning for practitioners, who feel too frequently confronted with the prospect of disciplinary oriented process, even when this is not proportionate or appropriate to the issues that have been raised and they would be very willing to apologise or engage in alternative resolution processes to address concerns that have arisen.



The punitive lengthy and taxing nature of the current system means that even in cases where a complaint was not deemed substantive, practitioners experience significant and avoidable distress.

Submission 46 – College of Intensive Medicine of Australia and New Zealand

The State and Territory HCEs also find the absence of effective referral pathways problematic. The Review heard that the new triaging processes adopted by Ahpra to take no further action on complaints where they have no jurisdiction have been important to reducing triaging timeframes. However, this change has also reduced the level of consultation with the HCEs. As a result, HCEs may never receive a referral from Ahpra of a matter that they would be able to assist with, as it is closed by Ahpra at triaging on the basis that it is not regarded by them as a notification. There are other circumstances where a HCE may receive a complaint that has been initially made as a notification to Ahpra, but only after a significant time within the Ahpra processes prior to referring it or redirecting the complainant to them.

⁷⁷ Ibid, p11. See also for instance section 28(9) of the *NSW Health Care Complaints Act 1993*. Available at: <https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-1993-105>.



To the extent that the HCEs are consulted on the outcomes for notifications accepted by Ahpra, they were concerned about the lack of knowledge of Ahpra officials regarding relevant jurisdiction-specific health service delivery issues and context that may be relevant to a regulatory decision.

At a minimum, there is a plea for Ahpra and HCEs to clarify ownership and accountability for communication about joint decisions and referrals. Complainants and practitioners are rightfully baffled when a matter is raised with one entity and communication is received from another.⁷⁸

The option of a national complaints handling body

The Review noted the view of some stakeholders that optimal simplification might occur through the cut-through option of replacing State and Territory HCEs and Ahpra notification functions with a national Complaints Handling Body, to provide only one front door for all health service complaints as opposed to one in each jurisdiction. This approach attracted considerable discussion through policy design forums.

There was little doubt that this solution had some intuitive appeal, with the suggestion that such a national body could:

- Receive all types of complaints – about registered or non-registered practitioners and/or health organisations.
- Have the full range of complaints handling functions – including the complaints resolution as well as disciplinary determinations, through to prosecutions.
- Co-design processes and systems with complainants and providers with no passing of complaints from one organisation to another.
- Potentially contribute to more consistency in disciplinary outcomes.

That said, significant obstacles to adopting and implementing a national complaint handling body were identified.

In essence, given our federated system, radical policy, legislative, funding and administrative reforms would be required across all nine Australian jurisdictions, with the following considerations.

- A national complaints handling body would need to be established by national law.
 - As the body would be undertaking functions beyond the management of complaints about registered practitioners, the options would be to:
 - Establish a new body separate to Ahpra under separate legislation
 - Dramatically overhaul the National Law to reflect a shift to a much broader notification function within Ahpra.
 - Either solution would add complexity.
 - If Ahpra were to be envisaged as the single complaints handling body, its powers would extend well beyond the current scope which applies only to registered practitioners and disciplinary matters. It would be reset to consider complaints about non-registered practitioners and health organisations, and with a restorative justice capability.
 - The alternative of a separate complaints handling body would fragment the coherence of regulation for registered practitioners, fracturing the nexus between standard setting, registration, practitioner management and complaints handling that is necessary for best practice regulation for the registered professions.
 - Any new national body complaints handling body would sit alongside the National Scheme, with ongoing interface issues (just of a different nature to those that currently exist between HCEs and Ahpra). This would include where matters need to be referred for action by a National Board for either immediate action or management of performance or impairment concerns.

⁷⁸ Submission 51 – National Health Practitioner Ombudsman, p18.



- Whichever solution was adopted, there would need to be a new funding model. This would include consideration of a relevant contribution from the National Scheme for management of complaints about registered practitioners if there was a new separate body. It may also require consideration of a contribution from governments to the National Scheme if the complaints handling function of the Scheme was expanded to covered non-registered practitioners and health organisations.
- The HCEs in each jurisdiction would need to be either dismantled or operate with a significantly reduced statutory responsibility, and this would require a policy decision from each State and Territory to cede all complaints handling functions and powers to a newly established national entity, with commensurate legislative change.
 - The HCEs have explained the significant complexity that the scope of functions performed by each State and Territory HCE varies, and in many HCEs extends beyond health complaints. For instance:
 - In Victoria the HCE manages health privacy complaints in addition to care complaints.
 - In SA and WA the remit of the HCE includes community services complaints.
 - In WA, the remit also includes management of complaints about disability services and mental health service providers.
 - In the ACT the health complaint function is embedded within the Human Rights Commissioners functions, to ensure that the health complaints processes reflect application of human rights principles. That role also extends to complaints about health records and mental health in addition.
 - These “residual statutory functions” would need to be either reassigned within the relevant jurisdiction or retained by a reconfigured and probably renamed entity.
- The appropriateness and practicality of a national complaints handling body managing complaints about health organisations (in addition to individual practitioners) was questioned.
 - It was noted that HCEs have well developed direct connections and detailed systems-knowledge at jurisdictional level. This enables them to perform health organisation inquiries and investigation functions, across public and private health service providers.
 - Under a national complaint handling regime there would be challenges in establishing and maintaining the necessary ongoing systems and jurisdictional level connections and capabilities that are essential to supporting health organisation investigation functions.

In summary, the consultation highlighted that comprehensive reconstruction of the complaints handling and disciplinary architecture in Australia would at least be a lengthy, elaborate and costly process, requiring a series of policy, legislative and administrative changes. It would be hampered by uncertain outcome and inevitably there would be little or no focus on substantive improvements in the interim.

Single Front Door for complaints handling in each State and Territory

The consultations leaned towards a more realistic and achievable solution of refashioning the roles and responsibilities of the existing complaints/notifications handling entities, to deliver seamless complaints management. Consideration focussed on the concept of a single front door for health care complaints located within each State and Territory (through each of the jurisdictional HCEs), as presented in Consultation Paper 1.

In concept, this single front door was positively viewed by the majority of stakeholder groups. They observed the particular benefit of a solution that enables consumers to present any health care complaint, whether it be about a registered or non-registered practitioner or a health organisation (or a combination of these), to one place, and being able to rely on that complaint being managed in the most appropriate way.



The full spectrum of resolution through to disciplinary outcomes would be available to address their concerns.

It was stressed that under the “single front door” concept the hard work of navigating the complexities of the complaints handling system must be done by the regulators – not by the complainant or notifier. It should therefore embed triaging and referral protocols which ensure that if submitted complaint belongs elsewhere (with Ahpra, or another State or Territory HCE, or indeed another regulator such as the Aged Care Quality and Safety Commission), it will not be sent back to the complainant to resubmit. The complaint would be forwarded for consideration by that appropriate entity and this will be transparent to the complainant. In short, a single front door must also incorporate a “no wrong door” principle.

For both complainants and practitioners, a key potential benefit from any solution was reduction in administrative delays and frustration, with alternative ways of managing the 85-90% of notifications that currently go to Ahpra but are finalised with “No Further Action”. The more effective management of vexatious complaints was also a particular objective of professional bodies and medical colleges, with many contributors stressing that the impact of these notification cannot be underestimated.⁷⁹

It was noted that these benefits could occur if complaints are first considered by the HCEs (who have wider powers and the ability to channel them quickly into resolution pathways if appropriate, thus minimising trauma to the practitioner and optimising potential for resolution). Only those matters meeting the threshold for consideration of a breach of professional standards would then progress to Ahpra.⁸⁰

Notwithstanding the broad appeal of single front door model, support of most stakeholders was appropriately conditional upon the need for a very high level of confidence about there being improved timeliness, transparency and appropriate natural justice for both complainants and providers in any new arrangements.

Some material risks and challenges to successful implementation were identified.

Notably, Ahpra holds significant reservations. Their concern is whether the existing HCEs are at a sufficient and consistent level of performance, capability, coverage and systems maturity to meet the clear expectation that serious complaints will be referred to Ahpra in a timely or consistent way. Ahpra is also concerned about the costs that may be sought from the National Scheme for the transfer of triaging responsibility to HCEs.⁸¹

For this reason, Ahpra prefers to retain its triaging and assessment functions rather than passing these over to the HCEs. Their alternative proposal for addressing the problem of the extremely high proportion of notifications resulting in “No Further Action” is to amend the National law to narrow the scope of matters that can be the subject of notification to Ahpra and making the acceptance of a notification an administrative determination for Ahpra, rather than the National Board.⁸²

The National Health Practitioner Ombudsman also expressed only qualified support, highlighting that such a model would rely on a common risk assessment tool and effective referral pathways.⁸³

The challenges and risks are also recognised by the HCEs, but they showed a high level of support for the proposal and general enthusiasm to implement it.

⁷⁹ Submission 53 – Royal Australian College of General Practitioners.

⁸⁰ Ibid.

⁸¹ Submission 63 – Ahpra, p13-14.

⁸² Ibid, p4.

Recommendation 3.4: Amend section 144 of the National Law to clarify that notifications can be accepted on the basis of substantial departure from standards or the practitioner Code of Conduct to signpost our role as the professional standards regulator and what matters we can deal with in that role.

Recommendation 3.7: Amend the National Law so that Ahpra (as distinct from the National Board) determines whether a matter is sufficiently serious to warrant it being accepted for consideration for regulatory action.

⁸³ Submission 51 – National Health Practitioner Ombudsman.



Importantly, there are only two HCEs which currently operate a single front door model of complaints handling – Queensland and NSW. The Review heard that other jurisdictions would need to adjust the scope and processes for their work. This would be easier for some than others, depending on the expected volume of notifications that would be redirected to them.

The adjustments required would not necessarily be minor, depending on the volume of additional complaints that would be received, the resourcing arrangements, and whether any of the current legislative settings in that jurisdiction impede the ability to receive the full spectrum of complaints.

The potential volume distribution was examined from the 2023-24 notifications data, noting that all notifications currently going to Ahpra would go to the relevant HCE for triaging and assessment under the “single front door” model. Generally, the volume of complaints that would need to be triaged by jurisdictions was not seen to be unmanageable.

2023-2024 Notifications Received by Ahpra

Jurisdiction	#notifications
ACT	285
NT	182
SA	1,293
TAS	389
WA	1,717
NSW	135
QLD	2,162
VIC	4,509

The Review noted that the scope of activity, capabilities and outcomes available do vary across each of the eight HCEs in Australia. Areas of difference to consider and address include:

- How complaints are received and processed.
- Who can complain.
- What matters can be considered in assessing a complaint.
- What outcomes are available.
- Information sharing limitations.
- How complaints data is captured.
- Statutory performance indicators.

In some cases, HCEs confirmed that change was readily achievable. In others, the change would be more substantial, requiring process and/or legislative change.

- For instance, the ACT would receive around 300 additional complaints to triage. It already has all the powers that would be required to triage and consult on matters under a single front door approach. Process refinements to triage and assess the additional matters have been described as insubstantial and easily delivered.
- In contrast, Victoria would receive 4,509 additional complaints. It would also need to establish stronger processes and capabilities for triaging written complaints within the Health Complaint Entity – noting that its current model prioritises receiving and handling most complaints verbally.
- In the case of Western Australia, there is also a larger volume and they have legislative settings that are narrower than the National Scheme in terms of who can lodge a complaint – only a patient can lodge a complaint. This would appear to mean that that mandatory reports could not be provided straight to the Health and Disability Services Complaints Office for triaging as they have no function or power to triage them.

At the heart of the perceived challenges in achieving a single front door model were also resourcing and capability aspects.

- Funding remains a complex issue.
 - There is a funding model in place in the Queensland co-regulatory arrangement, whereby the Queensland Health Ombudsman receives funding for the National Scheme to deliver notification and prosecution functions that would otherwise be performed by Ahpra.
 - HCEs noted that a funding allocation model which is activity-based would need to apply if they were receiving and triaging complaints currently triaged by Ahpra.
 - While funding from the National Scheme would be required, it is nevertheless expected that the savings to the Scheme would far outweigh the costs noting the substantial volume of matters that would no longer require triaging and assessment by Ahpra.



- The potential need for front end investment in harmonising systems and processes and establishing common business tools to set up the single front door model also requires consideration.
- The varied capacity of many HCEs must also be recognised, with a number having a small number of staff to support their operations. This limits immediate reform considerations, with any significant projects likely requiring resourcing.
- Alongside this is the challenge of HCEs building the expertise that would be required to apply a common risk assessment tool and deliver fully integrated complaints handling.

In summary, a jurisdictionally based single front door model is seen to have significant potential to address the problems that consumers and practitioners experience with the current complaints and notifications regime. However, additional steps must be taken to unify the systems and processes to deliver consistency in their experience and to harmonise the timeframes, decision making processes and outcomes across jurisdictions.

This is by no means an unachievable reform goal, particularly if there is active application of AI-enabled triaging and risk assessment to drive efficiency and consistency. However, it would need to be delivered in stages and over time.

Resetting the relationship between Ahpra and the HCEs

Success in any reform to complaints handling and notification processes will require a significant uplift in the strength of the relationship and collaboration between Ahpra and the HCEs, with formal tools to achieve this.

While the HCEs report that they generally experience constructive and collegiate working relationships at day to day operational level, at the governance and partnership level the interface is not well structured or formalised. As a result, there is not the required level of mutual trust and there is not a shared mindset towards process and systems integration.

There is an MOU in place between Ahpra and each HCE. This was established in 2010 at the commencement of the Scheme.

The Review heard that in 2022 Ahpra formulated a new MOU, seeking to amend the complaints handling roles and responsibilities, largely to accommodate a new Ahpra triaging model that was designed to deliver improved timeframes in managing new notifications. The review noted that this revised MOU was not able to be negotiated to completion with any of the HCEs.

The fundamental obstacle in setting a contemporary MOU appears to have been the absence of a clear and shared objective for the revisions and no structure or process for collaboration in scoping and developing it. The HCEs felt that the draft MOU cast their role in incorrect, uncertain or contested terms, with potentially significant operation impacts. The original (and inadequate) 2010 MOU therefore stands.

There is a biannual conference of HCEs. However, this is not a formal decision making or priority setting body, it does not have a defined and or resourced work program, and it does not include Ahpra in the core membership. Ahpra provides information and updates to this Conference by invitation.

Changes to the National Law, which potentially impact the work of the HCEs are progressed through the Health Workforce Taskforce (HWT) Policy and Legislation Committee with input from Ahpra, but it has been noted that consultation with the HCEs on the nature or impacts of legislative change (through Ahpra or the jurisdictional representatives) does not always occur.

In all of these respects, the current arrangements fall well short of what would be expected to deliver efficient and coherent integrated health practitioner regulation.

Consumer support

Even in circumstances where complaints handling is potentially simplified and the process is understood, health consumers may be particularly vulnerable and in need of support to assist them to present their issues to the right place and in the most effective way. There is typically an imbalance in power and the fact of a complaint can be traumatising for consumers, especially in cases alleging severe or potentially severe harm in terms of clinical outcomes or the personal impacts of more extreme professional conduct departures.



The National Health Practitioner Ombudsman has expressed the view that success could require establishment of a navigator service (potentially through a navigator website) as a point of contact for all consumers, no matter their jurisdiction.⁸⁴

Ahpra also recognises the importance of support for consumers and points to its Navigator Service as a potential building block for this.

AHPRA PERSPECTIVE ON CONSUMER DIRECTED NAVIGATION SERVICES



Ahpra should do more to support the inevitable proportion of consumer complainants whose complaints will be inappropriate for management by Ahpra and National Boards and HCEs. Ahpra should ensure that it has specialist resources available to help support the complainant's understanding of the decision, and where appropriate, provide assistance to refer the complaint to an appropriate service or government/regulatory agency.

Ahpra and HCEs should undertake mapping of other consumer protection legislation and agencies and use its employed navigators to warm transfer complaints to these entities (including Commonwealth entities such as the Aged Care Quality and Safety Commission, NDIS Quality and Safeguards Commission and other State and Territory agencies) where appropriate.

The power to refer complaints to other entities exists in the recently established section 150A of the National Law. However, if there was an intention for the navigator service to also support complainants whose complaint did not meet the statutory requirements for the complaint to be a notification under section 149 of the National Law (about a person registered in the Scheme and about a matter that is a ground for a notification), some minor amendments might be required.

Submission 63 – Ahpra

The role of Boards and Ahpra in determining notification outcomes

The dominant stakeholder perspective that regulatory decisions about practitioners should be considered and determined by those with profession specific knowledge and expertise is particularly evident in opinions about notification decision making.

Support from the Boards for additional operational delegations to Ahpra in determining the outcome of notifications is best described as mixed.

The Ahpra submission puts the case for amendment of the National Law to statutorily transfer functions or for Boards to do this by delegation.



National Law amendment would transfer some of the regulatory decision-making functions to Ahpra staff. Another option could be National Boards agree to consistently delegate some of this decision making to Ahpra staff...

This would:

- reduce timeframes in the complaints process, as matters could be decided directly by Ahpra and referral to National Board's decision-making committee would not be required.
- improve consistency in decision making between professions, as Ahpra would be the decision-making entity.
- enable National Boards and their decision-making committees to focus on more serious matters.

Submission 63 – Ahpra, p13

The obstacles to this include the National Boards' reservations about capability and transparency across notification processes, but also a strongly held view that determinations on more serious matters (including those with significant clinical concerns and significant misconduct allegations), should remain for Board determination.

⁸⁴ Submission 51 – National Health Practitioner Ombudsman, p23.



...profession specific knowledge and expertise is critical to for effective regulatory policy development and decision-making processes.

Submission 56 – Australian Nursing and Midwifery Accreditation Council

These concerns seem to be acknowledged and understood by Ahpra, whose submission notes that *“this will require further investment in the capability of Ahpra and strengthened profession-specific clinical input.”*⁸⁵

Across the National Boards there appears to be tentative recognition of the potential for increased cross profession decision making. In relation to issues such as sexual misconduct and cultural safety, the logic that notifications should be subject to consistent considerations and judgement is broadly acknowledged.



Recognising the changing nature of healthcare, there should be greater emphasis on cross- professional and inter-professional approaches, while appropriately recognising the unique risk profile and professional features of each regulated profession.

Submission 63 – Ahpra.

However, the Review did not identify any clear plan or pathway across the Scheme as a whole to progress the expected structures or processes to support a stronger cross profession focus in regulatory decision making.

Clinical advice

The need for quality clinical input to regulation decisions, no matter the ultimate decision maker, was mentioned in many submissions. It is seen a foundational feature of a Scheme that is designed to draw from professional expertise and knowledge. The consistent refrain on this topic was that current clinical advice arrangements are not adequate and reform should drive and uplift this capability.

SUMMARY OF PERSPECTIVES ON CLINICAL INPUT TO REGULATORY DECISIONS

Perceive inadequacies included

- Delays associated with the time it takes to secure the necessary clinical input (Submission 21 – Australian Association of Psychologists; Submission 47 – Southern Cross University)
- Inconsistencies or lack of transparency in how clinical input is integrated into decision-making... can lead to variability in outcomes and a lack of clarity for both practitioners and complainants (Submission 21 – Australian Association of Psychologists)
- Clinical input may not always be from professionals with the most relevant expertise for specific cases (Submission 21 – Australian Association of Psychologists)
- The depth of clinical input varies, and decisions in high-risk cases may not always reflect the full scope of expertise required (Submission – Australian Podiatry Association)
- Clinical input could be expanded to include a broader range of health professions. Without proper integration of clinical input from each profession, decisions could overlook important nuances that affect practitioner competency and patient safety (Submission 22– Australian Podiatry Association)
- Sometimes documents are not provided to advisors in a timely fashion creating urgency in reporting (Submission 54 – Australian Chiropractors Association)
- Suitable remuneration remains an issue, particularly given the sometimes-tight turnaround of advice being required. A clinical advisor providing the same service to a State based complaints entity can be remunerated at a higher rate than Ahpra. This can disincentivise experienced practitioners from taking on these roles (Submission 54 – Australian Chiropractors Association)

⁸⁵ Submission 63 – Ahpra.



- At times it can be limited by the fact it is an opinion provided by a single practitioner... Reviewers should not provide opinions outside their own expertise (Submission 67 – Avant Mutual)
- It has been a criticism levelled by practitioners that there is no disclosure of who the Medical Board decision-makers are in their matter. This is born of a desire from practitioners to have their matter and conduct considered by like for like peers (Submission 68 – Not for Publication)

A range of suggestions were made to enhance the timeliness and usefulness of clinical input:

- Develop clear guidelines for selecting and involving clinical experts in the decision-making process (Submission 21 – Australian Association of Psychologists)
- Ensure that clinical input is timely and relevant to the specific context of each case (Submission 21 – Australian Association of Psychologists)
- Increase transparency about how clinical input influences decisions (Submission 21 – Australian Association of Psychologists)
- Provide training and support for those involved in providing clinical input to ensure consistency and quality (Submission 21 – Australian Association of Psychologists)
- Practitioner selection and appointment structures additionally should be reviewed (Submission 54 – Australian Chiropractors Association)
- Include professional body input about candidates could be beneficial when assessing impartiality, professional objectivity and activity (Submission 54 – Australian Chiropractors Association)
- It is not appropriate for these roles to ever replace decisions being made by boards and committees with a majority of practitioner members (Submission 54 – Australian Chiropractors Association)

Management of investigations

The unwavering stakeholder expectation is that serious matters that require deeper investigation will be identified quickly and managed in focussed and timely manner. Too frequently this expectation is not met.



The timeframe for getting a serious misconduct matter from Ahpra investigation to tribunal hearing is presently excessive. It is typical that a practitioner, if not suspended, has some form of conditions placed on their registration because of an immediate action process pending investigation. It is not uncommon for Ahpra investigations to span years. This is profoundly unfair on practitioners generally, let alone those found to have no case to answer at the matter's conclusion.

Submission 68 – Not for Publication

In terms of the identification of serious matters, the Review noted a significant decline in the number and proportion of notifications that have been assessed for investigation over the past 2 years. Whereas in 2021/22, there was an outcome of investigation for 2,275 of the 10,804 notifications received (21%), which reflected the trend over the previous years, by 2022/23 this outcome had reduced to 1,427 of 9,706 notifications (15%). The Review was not able to establish the cause of this shift. While one driver of this may have been the important and welcome adjustment in policy to address concerns about practitioners with health issues outside of the disciplinary pathways, the number of such notifications fell from 192 in 2021/22 to 91 in 2022/23 and cannot therefore explain more than a small portion of the change in investigation numbers.

The question that has therefore arisen, and which does require further consideration, is whether the changes in triaging processes during this same period impacted identification of serious conduct and performance matters requiring further investigation.

The data received also showed continuing issues with the timeliness of finalising professional standards cases, notwithstanding the decline in the number of such investigation matters.



Between 2018/18 and 2022/23 the average number of days to complete an investigation increased by 52%. The increase between 2021-22 alone was from 367 days to 436 days. The evidence showed that 25% of investigations and 21% of Tribunal referrals are open for more than 24 months.⁸⁶ There was also evidence of cases that had been in the process for more than three years, but not yet brought before a tribunal.⁸⁷

Poor timeliness is an understandably deep concern when a practitioner is subject to immediate action and either prevented from practising or subject to significant limitations on practising. Procedural fairness is at the heart of this matter, in the context of the significant personal and economic impact on practitioners.



While we understand and support the reasoning behind the immediate action process, we would also recognise that there needs to be consideration of the impact of conditions to hasten Ahpra's investigation to conclude in a timely manner. Tribunals have pointed out in the past that the impact of immediate action conditions do not weigh on their consideration of sanction or term of suspension. As such, drawn out investigations can have additional punitive effect in circumstances where guilt or innocents is yet to be determined.

Submission 68 – Not for Publication

Recognising that the issue of delay has a serious human impact, the importance on the work that Ahpra has commenced on alleviating practitioner distress cannot be underestimated.⁸⁸ There is wide support for progressing this work, to ensure that practical arrangements for supporting practitioners are in place. This initiative is considered necessary but not sufficient.

The greatest alleviation will occur from reducing investigation timeframes to the fullest extent possible and more must be done in this regard, both in the interests of practitioners and to avoid erosion of public confidence if cases that are serious are not managed effectively.

The National Law does have a requirement that a National Board must ensure that an investigation is conducted “as quickly as practicable, having regard to the nature of the matter to be investigated.”⁸⁹ However, it does not specify a time limit for an investigation or on the duration of any associated immediate action (which has effect until the decision is set aside on appeal by the relevant Tribunal or the suspension is revoked or the conditions removed by the National Board or an undertaking is agreed upon).⁹⁰

The National Law does set out certain procedural safeguards in relation to a National Board's ability to take immediate action. These include:

- A ‘show cause’ requirement whereby a practitioner must receive notice of a proposal to take immediate action and can make a submission.⁹¹ The National Board must consider submissions before taking immediate action.
- Decisions to restrict a practitioner's practice (such as by suspending or imposing, changing or refusing to change or revoke a registration condition) are appellable.⁹²

These safeguards are seen to be manifestly inadequate.

⁸⁶ Ahpra (2024). *Annual Report 2023-2024*, Page 69, Available at: <https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-2024.aspx#:~:text=The%20Australian%20Health%20Practitioner%20Regulation%20Agency%20and%20the,report%20is%20%E2%80%98Leadership%20and%20collaboration%20for%20safer%20healthcare%E2%80%99>.

⁸⁷ *Peers v Medical Board of Australia* (2024). VSC 630 (15 October 2024), is a recent example. Available at: <https://aucc.sirsidynix.net.au/Judgments/VSC/2024/T0630.pdf>.

⁸⁸ 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>.

⁸⁹ See National Law, s 162.

⁹⁰ See National Law, s 159.

⁹¹ See National Law, s 157.

⁹² See National Law, s 199.



It is acknowledged and accepted that delays may arise from the need to pause an investigation where there is parallel law enforcement activity or criminal proceedings. However, the consultation noted that this is only a proportion of all investigations. The delays in investigations also relate to matters being 'on hold' for a much broader range of reasons and also to matters that are not 'on hold' but are nevertheless subject to extended investigation timeframes.

In relation to matters placed 'on hold', the Ahpra Policy and Procedure identifies at least 11 scenarios that could be expected to lead to this action.⁹³ This includes cases paused due to parallel coronial, family law or civil litigation processes or other factors, but the policy justification for placing many of these sorts of matters 'on hold' is unclear. The Review noted that during 2023/24 one third of all investigations were on hold.

The recent findings of the Victoria Supreme Court in *Wilks v Psychology Board of Australia*⁹⁴ are more than thought provoking in this context. In that case, Justice Harris found that a Board does have power to place an investigation 'on hold'. However, in that matter the investigation was put 'on hold' due to ongoing defamation proceedings and this was found to be unreasonable for several reasons.

- The obligation in the National Law is for expeditious completion of investigations.
- The investigator and Board cited impediments to gathering information during the defamation proceedings, but this would have been evident from the outset of the investigation.
- The investigation had been underway for almost 18 months, and the view that a fulsome investigation could not be conducted while these proceedings were underway could (and should) have been made earlier.

- The period for which the investigation would be on hold could not be determined, as it was unknowable whether the key witness would co-operate with the investigation following the civil proceedings.
- The Board had information about the personal and financial impacts on the practitioner and should have given clear consideration to that.

These findings give rise to important questions about regulatory decision making and case management practices for delayed investigations. The questions include:

- The factors that should be considered when placing investigations 'on hold'.
- The practice of moving investigations to an 'on-hold' team (as opposed to leaving the case with a Regulatory Advisor as an investigation to be actively progressed whenever this becomes possible).
- Responsibility and accountability for the review of 'on hold' matters, including when information on practitioner impacts is to hand.
- The role of the National Boards in management of 'on-hold' matters.

The Review notes that in June 2024 the National Health Practitioner Ombudsman commenced an own motion inquiry into delay and procedural safeguards for practitioners who are subject to immediate action.⁹⁵ The concerns raised by the NHPO are consistent with those heard by the Review. The stated genesis of this NHPO investigation included practitioners being subject to immediate action restrictions on their registration over many years, in circumstances where the action may ultimately be found to have been unnecessary.

⁹³ Ahpra Guide, Managing on Hold Notifications, December 2021

⁹⁴ *Wilks v Psychology Board of Australia* (2024). VSC 2, 12 January 2024. Available at: <https://aucc.sirsidynix.net.au/Judgments/VSC/2024/T0002.pdf>.

⁹⁵ National Health Practitioner Ombudsman (2024). *Consultation Paper: National Health Practitioner Ombudsman's investigation into delay and procedural safeguards for health practitioners subject to immediate action*. Available at: <https://www.nhpo.gov.au/sites/default/files/2025-02/Consultation%20paper%20-%20Investigation%20into%20delay%20and%20procedural%20fairness%20for%20practitioners%20subject%20to%20immediate%20action%20%28PDF%29.pdf>.



“Practitioners have voiced their concern that a National Board’s immediate action decision has had an unfair impact on them and their livelihood. Given a National Board often makes a decision to take immediate action based on limited information, it is possible that after gaining further information about the matter, it may decide that the immediate action decision (which based on the limited information was reasonable), is now not necessary.⁹⁶ In other circumstances, the restrictive action taken may be changed due to the National Board’s consideration of the full information. For example, a National Board may decide not to take further action in relation to the matter which originally led to the decision to take immediate action. These circumstances give rise to risks of unfairness to practitioners, particularly given the concerns regarding psychological distress and financial and career implications outlined above.”

NHPO Consultation Documents

COMMENCEMENT OF NATIONAL HEALTH PRACTITIONER OMBUDSMAN INQUIRY INTO INVESTIGATION DELAYS⁹⁷

The Ombudsman’s routine complaint monitoring activities found that practitioners had increasingly raised issues about immediate action being taken. In 2023–24 the office recorded 84 issues related to immediate action being taken across complaints about the notifications process, compared to 51 issues in 2022–23, 45 issues in 2021–22 and 24 issues in 2020–21.

Health practitioner complainants have raised a range of concerns with the Ombudsman related to immediate action processes. A common theme is practitioners expressing frustration with the time taken to receive an outcome for the matter that led to immediate action being taken, and a lack of communication about its progress.

Practitioners who have been suspended, or had significant conditions placed on their registration, often raise concerns with the Ombudsman about the impact this has on their career, livelihood and wellbeing.

The Ombudsman is investigating:

- whether Ahpra’s current policies and procedures allow for the timely:
 - use of immediate action
 - investigation of health practitioners subject to immediate action.
- whether there are sufficient procedural safeguards for health practitioners subject to immediate action.

⁹⁶ *Kozanoglu v Pharmacy Board of Australia* (2012). VSCA 295, 12 December 2012. Available at: <https://aucc.sirsidynix.net.au/Judgments/VSC/2024/T0630.pdf>.

⁹⁷ National Health Practitioner Ombudsman (2024). *Investigation into delay and procedural safeguards for practitioners who are subject to immediate action*. Available at: <https://www.nhpo.gov.au/investigation-into-delay-and-procedural-safeguards-for-practitioners-who-are-subject-to-immediate-action>.



While noting and supporting the inquiry that has been commenced by the NHPO, the timing of completion of this is unclear.

The Review notes a strong and reasonable expectation of urgency to address the already evident issues. Opinion is that there could and should be actions that deliver more immediate improvements, with due consideration of investigation capability and resourcing, investigation policies, and business process.

The Review has heard from Ahpra that it has briefed the National Boards on the Wilks Case and made some adjustments to investigations and briefing practices as a result of the case. Specifically, it has set in place a process for briefing Boards that an investigation is finalised, prior to the next step of presenting and investigation report. However, the more significant issue from that case is the regime for managing notifications that are 'on hold'. In this regard Ahpra has advised that it is "commencing updating the relevant guidance, but is awaiting 'an external process' to complete this work. It is assumed that the "external process" referred to is the NHPO inquiry, but it is unclear why the necessary action needs to be paused for this reason.

On the question of capability and resourcing, Ahpra advises that it now has in place a generalist model of notifications management, within which assessments and investigations functions are fully integrated, having moved away from having specialist or designated investigators. There is a Notifications Directorate, with five notification streams. Regulatory Advisors both assess and investigate matters allocated to them. Where a matter is determined for investigation, the regulatory officer who has assessed it will then prepare the investigation plan and it will generally be signed off by a Senior Regulatory Advisor.

While there are pros and cons to generalist versus specialist models, in a professional standards setting whatever the model, the skills required to ensure that the most serious matters are addressed in an effective way must always be assured. In the current arrangements, there are signs that the current resourcing and skills model may be insufficient to support the required level of investigation performance.

From the information available to the Review it has not been possible to distinguish what proportion of effort and time is directed to investigations versus notifications functions, by each regulatory officer or each team. Nor is it clear what skills and expertise is available across the notifications function and how this aligns with the profile of notifications. These inputs would be necessary to consider and determine whether investigation delays may relate to resourcing distribution across teams, difficulties in distributing effort across assessment versus investigation functions within teams, skills gaps within either assessment or notification functions, or other factors.

In relation to business processes for investigations, ultimately, effective case management requires suitable mechanisms for classifying or distinguishing urgent, sensitive or high risk investigations (for instance those where immediate action is in place, a credible and serious mandatory report, and/or significant community concern). It appears that there is some capacity to attach a risk category to cases in the new and recently commenced case management system, but the Review could not identify a process for how these labels will be applied consistently and linked to case management practices -including prioritising and monitoring progress of the highest risk matters.

As the Wilks decision underscores, investigation policies also play a part in driving efficient and effective regulatory decision making.

There is emerging advocacy for a change in policy to impose a maximum timeframe on investigations. This will no doubt be considered more fully in the NHPO Inquiry, as it would require legislative change and close consideration of undesirable consequences such as the potential of premature closure of investigations where there are serious criminal proceedings which may later result in conviction, or unintended compromise to an ongoing criminal investigation as a result of action taken in the professional standards space.

This should not however prevent consideration and action on other measures that can be taken in the meantime without the need for legislative change.



The Wilks decisions highlights for instance the importance of considering the personal and financial impacts on the practitioner when an investigation is placed 'on hold' matters. In that case the Court noted that that Ahpra had information of this kind and should have been obliged to consider that information, as a matter of policy. The current Ahpra policy does not require such impacts to be considered.

More immediate administrative action is also possible and necessary in the absence of a statutory timeframe for completion of investigations. It would be expected that there would be clear KPIs, with systems and processes for monitoring and driving progress in accordance with these.

The review could not locate a formal and embedded KPI set that drives investigation case management. Ahpra advised that the key KPI for investigations is that: a briefing paper for higher risk practitioners must be submitted to a Board within 21 days of a matter being progressed beyond the notification assessment and into notification. It further advised that a Regulatory Advisor should aim to finalise an investigation:

- Within six (6) months for non-complex notifications in strengthening practice.
- Within nine (9) months for complex strengthening practice matters
- Within twelve (12) months for matters likely to result in a decision of Professional Misconduct.

In relation to monitoring and reporting Ahpra advised:

- A further briefing paper can be provided to the Board at any time during the life of the notification
- Boards regularly receive a report listing all notifications and reports on aged matters regularly.

Ahpra further indicated that investigation case management and case review regimes are in place and that there is already work underway to more regularly report to the Boards on progress and identify barriers to completion of complex, high risk investigations, with recognition that further involvement of Boards in developing and monitoring investigation strategies may improve outcomes, experiences and timeliness.⁹⁸

Advice of further work in this area is welcomed. However, it is not clear whether this will go to the heart of the issues and have the required impact on investigations performance.

In terms of what is in place, the Review inquired further as to how monitoring and reporting operates in practice and whether it is considered sufficient to ensure effective oversight of investigations.

- It heard from Boards that they receive detailed operational reports on the age of investigations, but not in a form or a manner that enables them to identify the reasons for delay and the potential to expedite or re-prioritise matters.
- Similarly, the Ahpra Board Regulatory Performance Committee receives quarterly updates on notification functions, but that reporting seeks to address the total pool of open notifications, arguably detracting from the ability to focus on the most important and significant operational performance concerns (such as significant changes in the volume and timeliness of investigations).
- The Review was unable to identify a report on performance against the informally set timeframes for non-complex, complex and professional standards investigations.
- Briefing to Boards on significant notifications moving to assessment is at the discretion of Ahpra officers. For instance, a live investigation which is delayed or "on hold" may or may not be the subject to a briefing to the Board. It is not a sufficiently or consistent arrangement for identification of matters of concern and interest to Boards and the Scheme as a whole.

Ultimately, the Review heard a consistent perspective that the nature and utility of operational performance monitoring and reporting is a shortcoming that requires systematic attention.

⁹⁸ Submission 63 – Ahpra.



Absent this, investigation timeframes are likely to continue to fall below expectations.

Another part of the solution to delays in investigations appears to rest with strengthening the operational interface with police in all jurisdictions, and stakeholders advocated additional focus on this connection. Again this need not await the completion of the NHPO inquiry.

The Review noted that Ahpra and/or the State or Territory HCEs have MOUs with police in some but not all jurisdictions. Where these are in place, they facilitate the exchange of information and support joint investigation planning if both bodies are considering or investigating a matter. The Queensland Health Ombudsman model is the most evolved and effective of these arrangements. This model includes funding of a liaison officer to work across Policy and the Office of the Health Ombudsman to operational an MOU which facilitates information sharing.



A significant feature of the joint work between OHO, the Queensland Police Service and Ahpra in the Queensland system is the MOU regarding criminal offences. This MOU allows for real-time monitoring of criminal charges involving regulated professions, ensuring timely notifications. It ensures regulators are in possession of details of charges and convictions, which enables prompt assessment of the need for regulatory action. This approach has been beneficial and is something that should be rolled out nationally across all jurisdictions.

Submission 63 – Ahpra

Lessons from significant health regulation events

Frequently, situations will lead to both National and State regulatory functions being in play, involving multiple entities at each level. Such scenarios raise questions about the clarity of roles and responsibilities and the adequacy of joint issues-management and communication between Ahpra and relevant states and territory regulators.

The recent situation of the Bankstown nurses expressing anti-Semitic sentiments is an illustration. In that case:

- The immediate frontline response was appropriately from the health service, in terms of the employment status of the practitioners.
- The regulatory response rested firstly with the NSW Nursing and Midwifery Council and resulted in suspension.
- The outcome of the immediate regulatory response required Ahpra action, in terms of adjusting the National register to ensure that the suspension in NSW took effect in all jurisdictions in Australia.
- In parallel with the immediate action by the Nursing and Midwifery Council of NSW, the NSW Health Care Complaints Commission (HCCC) assessed the complaint, with referral for investigation.
- While the suspension of the practitioners provided public protection pending the outcome of the HCCC investigation in that it prevented them from working as registered nurses, questions ultimately arose about whether they may work as unregistered practitioners either in health services or in other sectors.
- There was therefore a need to ensure visibility of the fact of the suspension of registration for the aged care and disability regulators. It is unclear who had responsibility for this aspect and it is not clear that any steps were taken to address this.
- This mobility across sectors and the ability of a health worker to work in either registered or non-registered capacity in turn raised questions about the role of the regulation of non-registered practitioners.
- The systemic issue of the adequacy of Codes of Conduct for registered professions in setting clear and consistent expectations of practitioner conduct and behaviour also arose and this was an issue warranting consideration by the National Scheme.

Ahpra has explained that in situations where the registered practitioner is in a jurisdiction where the notifications and investigations function is not performed by Ahpra, its practice is to redirect all inquiries to the relevant jurisdiction. Similarly, Ahpra has confirmed that its approach to situations involving a non-registered profession is to redirect inquiries to States and Territories.



While the basis for this response is understood (in that Ahpra does not have jurisdiction in relation to the management of complaints in these scenarios), it is not the full picture. To ensure public understanding and confidence in the regulatory response to specific incidents, there is an expectation that more can and should be done to examine any potential patterns across notifications, to determine if regulatory intervention is timely and consistent across jurisdictions, and to consider if relevant Codes and Standards for professions require adjustment to prevent ongoing issues.

In the Bankstown nurse scenario, an early joint statement of regulatory action would have been beneficial demonstrating accountability and leadership, and clarity for the public regarding which entities are involved, how and when. Such a single statement could have covered:

- How the actions of the health service and state regulators address the immediate risk.
- How notification of a practitioner suspension on the Ahpra register means that this action applies nation-wide.
- How advice to the ageing and disability sector regulators could assist them to be aware of a practitioner suspension to protect against the suspended employee crossing sectors worked with Ahpra responsibilities.
- How Ahpra sets the Codes of Conduct for professions (including to counter racism) and whether there is a process for review of the Code to determine if the obligations and responsibilities are sufficient and clear.

In essence, in instances where there is significant sensitivity or risk and a pressing need to ensure confidence in a comprehensive regulatory response there is potential utility in a protocol or practice of joint communication which addresses both the individual case and any relevant systemic issues and the relative roles and responsibilities of each entity.

In the context of a general perspective that Ahpra tends towards reactive regulation, this case also highlights the opportunities for a more preventative and proactive regulatory posture for the National Scheme, particularly through case review practices, standard setting and practitioner education functions.

In terms of aspirations for more proactivity and consistency, stakeholders questioned whether there is a sufficiently structured case review process or mindset where high risk or high sensitivity matters arise. They were seeking a higher degree of confidence that, in addition to undertaking the routine operational decisions on the individual triggering case, is targeted identification and assessment of similar or related open or closed matters. This was considered important to provide the opportunity to consider the effectiveness and consistency of the regulatory response across matters and also the need for any systemic response – such as changes to a code or standards to signal clear conduct expectations going forward.

A stronger appreciation of the regulatory significance and impact of the standard setting role and education was also advocated. Benchmarks for performance and behaviour to which all practitioners will be held, and aligning these with contemporary public expectations and risks, was stressed as a cornerstone of effective health practitioner regulation. Similarly, ensuring that these obligations are well understood by all practitioners.

Processes for developing, reviewing and communicating the Codes therefore become important strategic considerations impacting public confidence in the safety and quality of our health systems.

The review has learned that there are 4 Codes of Conduct for the registered professions, one each for Nursing and Midwifery, Medical and Psychology and one for all of the remaining 12 Boards. Generally, the Codes are regarded as principles-based documents which set enduring core standards. Under current processes, new or revised Codes are approved by the relevant National Board. It is intended that they be reviewed from time to time (every 3-5 years). They are scheduled for review in 2025 (with the exception of the Psychology Code which will only commence in December 2025). These reviews are yet to commence.

To the extent that important conduct related issues arise between reviews (such as the use of social media, telehealth and use of AI), they are addressed by supplementary guidance which may (but not always) be developed with stakeholder consultation.



In terms of communication of obligations within the codes and supplementary guidelines to practitioners, systems and the public, Ahpra advises that it has a multi-pronged approach through its website, stakeholder collaboration and registration complaint measures. Less well developed it appears is student facing education across the professions, which is now rolling out for medical students but not yet beyond this.

Prosecutions and tribunals

The consultation sought to explore more fully stakeholder concerns in relation to prosecution functions of Ahpra and the processes and determinations of the tribunals.

- On the one hand there were concerns arising from the National Scheme regarding the operation of tribunals.
- On the other tribunals raised concern in relation to the functioning of the National Scheme.

Mirroring the concern we heard about investigation delays (outlined above), the tribunals also pointed to significant delay between the time of Ahpra receiving a notification and ultimately lodging the matter with the relevant tribunal, (particularly where the practitioner has been subject to significant interim action pending the outcome of the matter).⁹⁹

This criticism is not new or minor and it is not limited to tribunal level.

It has also been the subject of judicial comment, notably by the Court of Appeal of the Supreme Court of Victoria as far back as 2012,¹⁰⁰ and again more recently in *Peers v Medical Board of Australia* [2024] VSC 630 (15 October 2024).¹⁰¹

PEERS V MEDICAL BOARD OF AUSTRALIA [2024] VSC 630 (15 OCTOBER 2024) – THE RISK OF UNFAIRNESS TO PRACTITIONERS

35. It is apparent that the regulatory regime may operate unfairly from the perspective of medical practitioners by suspending them for prolonged periods of time – and potentially destroying their livelihoods – before any findings of actual wrongdoing have been made. This may arise if the Board has decided to impose a suspension and to commence an investigation but has not made a referral because it has not formed a view on reasonable grounds that a practitioner has behaved in a way that constitutes professional misconduct...
36. There are some protections. A practitioner may not be suspended unless the Board forms the views referred to and the suspension must not be made without having given the practitioner an opportunity first to make submissions following a ‘show cause’ process.^[38] A practitioner may also apply to VCAT to have the immediate action reviewed on the merits and, if that fails, apply for leave to appeal to this Court on a question of law.^[39] That, however, is not a complete solution because the practitioner will not know at that stage how long the immediate action will last. This case is a good example. The real problem, or at least a very significant problem, is that the investigation into Dr Peers’ conduct took almost three years.... [T]here was no evidence before me as to why the investigation into Dr Peers’ conduct took that long. Unless Dr Peers in some way contributed to or caused delays, it seems to me that the fact that the investigation took almost three years has been unfortunate to say the least.

⁹⁹ Correspondence from the Council of Administrative Tribunals, 1 October 2024. See also National Health Practitioner Ombudsman citation of Nursing and Midwifery Board of Australia v Bronstring (Review and Regulation) [2024] VCAT 1040 (30 October 2024) in <https://www.nhpo.gov.au/investigation-into-delay-and-procedural-safeguards-for-practitioners-who-are-subject-to-immediate-action>.

¹⁰⁰ *Kozanoglu v Pharmacy Board of Australia* (2012). VSCA 295, 12 December 2012. Available at: <https://aucc.sirsidynix.net.au/Judgments/VSC/2024/T0630.pdf>.

¹⁰¹ *Peers v Medical Board of Australia* (2024). VSC 630 15 October 2024. Available at: <https://aucc.sirsidynix.net.au/Judgments/VSC/2024/T0630.pdf>.



37. The regulatory scheme requires an investigation to be undertaken ‘as quickly as practicable, having regard to the nature of the matter to be investigated’. For the regulatory regime to operate fairly, the obligation to undertake investigations as quickly as practicable must be complied with. But the regulatory regime does not expressly provide any protections for a practitioner if an investigation is taking what seems to be an excessively long time or for any consequences in the event that the obligation is not being complied with....

38. It is not clear whether a practitioner would be able to seek merits review at VCAT of a decision made by the Board not to revoke a suspension earlier imposed as immediate action. If not, it may be that it would be a decision that would be amenable to judicial review, and it may that one of the factors the Board would have to consider was the extent of any delay.

In addition to the earlier raised question of the need to review policies and procedures off the back of judicial criticism, the Review considered questions of the mechanism by which potential legislative change is considered.

Under current arrangements, there is a report on such decisions now provided to National Boards and the Regulatory Performance Committee of the Board, but the descriptive nature of the Litigation Report may not be sufficient to identify and analyse issues relating to potential legislative shortcomings.

Ahpra has also explained that due to the difficulty of legislative change, it generally prefers administrative and policy solutions where such issues arise. While this issue is fully understood and acknowledged, there may merit in a process by which Scheme leadership can selectively consider and identify potential legislative changes that may assist to improve the coherence and operation of the Scheme.

In the example of *Peers v Medical Board*, the sufficiency of the appeal arrangements under section 199 of the National Law was raised but not the subject of advice in the Litigation Report.¹⁰² It

may ultimately be the position of Ahpra that the availability of judicial review is sufficient in such scenarios and/or that a decision to maintain a suspension could be regarded as a new decision to suspend (which is an appellable decision). However, formal consideration of the potential benefits of seeking legislative clarification could also be useful.

The quest of stakeholders for a reduction in timeframes and consciously minimising practitioner impacts also shone a light on current practices and arrangements in relation to the discretion to determine the optimal forum in which to progress disciplinary action.

It was noted that the National Law provides the option of referral of a disciplinary matter to a panel (as opposed to a tribunal). This offers the prospect of a more informal process, potentially faster determination of the matter and the prospect of reduced distress to the practitioner and relevant witnesses. However, this avenue currently has relatively and increasingly limited use within the Scheme.

In 2023-24, whereas 235 matters were referred to Tribunals, 8 were referred to panels (a reduction from the 13 in 2022-23). Ahpra has advised that there are two reasons for this.¹⁰³

- i. The National Law requires (in section 193) that, if there is a breach of the National Law, even if that breach is minor, technical or of no material consequence in terms of public health and safety, the Board must refer the matter to a Tribunal.

The only exception to this (set down in a relatively recent legislative amendment to section 193A) is if the Board forms the view that there is no public interest in pursuing the matter.

- This is a very narrow exception to the requirement in section 193. We have formed that view firstly because it requires the National Board to decide that there is “no public interest” in the Tribunal hearing the matter. This is different (and narrower) than the normal reference to public interest where a balancing of competing public interest factors is undertaken, to determine

¹⁰² *Peers v Medical Board of Australia* (2024). VSC 630 15 October 2024. Available at: <https://aucc.sirsidynix.net.au/Judgments/VSC/2024/T0630.pdf>.

¹⁰³ Correspondence from J. Orchard, General Counsel, Ahpra, 1 August 2024.



whether on balance a decision is in the public interest. Here, there must simply be no public interest in referring the matter.

- Section 193A(3) requires information about each instance of reliance upon section 193A to be published in the annual report. Clearly, it is expected that section 193A will be sparingly used. It is most likely used when the relevant practitioner is at the end of their professional career, no longer practising and unlikely to ever be able to return to practice.

It follows that the amendment to section 193A has not had a significant influence on the number of matters referred to Tribunals.

- ii. The National Law offers only one sanction that a panel can impose that a Board cannot – that being a reprimand. Given that all other actions available to a panel can also be imposed by a Board, the Boards have tended to prefer the use of Board powers (primarily the use of powers to impose conditions under section 178).



While panels do offer another method of decision making, their constitution under the National Law tends to add more complexity than reduce it. Panels are constrained by the same limitation that National Boards are, that is, they must refer a matter to tribunal where it involves professional misconduct. Panels are not time efficient because they can only consider one matter, whereas the Board's RNC can consider multiple matters for both registration and notifications in the one sitting.

Submission 69 – Not for Publication

The key policy question seems to be whether increasing the utility of panels would assist to deliver the protective benefit of the Scheme and perhaps more consistent decision making while avoiding the significant time delays and costs arising from the need to progress every possible case through a tribunal. This was the subject of a specific recommendation from Ahpra.



Ensure tribunals focus on the most serious matters by strengthening the role of performance and professional standards panels to deal with lower-level professional misconduct matters that currently require referral to a tribunal (e.g. those where cancellation or disqualification are unlikely to be required).

Submission 63 – Ahpra, Recommendation 3.10

It was noted that greater discretion for the Boards to refer to Panel rather than to refer to a tribunal would require statutory amendment.

- This could involve removing the requirement to refer to a tribunal in every instance of a reasonable belief of professional misconduct.
- Another policy alternative is amendment of s193 under the National Law, to change the consideration for Boards in determining a tribunal referral, so that it is limited to cases where there is a reasonable belief that cancellation, disqualification and/or prohibition is appropriate. This would reduce the need to refer those matters where a lesser form of sanction, typically a short suspension, is fully expected as is the common scenario with cases involving more technical breaches such as failing to renew insurances or failure to completed CPD.
- Also, to give meaning to the Boards having the option of greater consideration of the use of panels, those panels would require access to greater sanctions, such as the right to suspend practitioners based on performance or conduct concerns.

If there is more discretion provided within the Scheme for referral to a panel as an alternative to a tribunal and/or a wider range of sanctions to panels, consideration should be given to safeguards to ensure consistency and transparency. The independent Director of Proceedings model in place in both the Queensland and NSW jurisdictions,¹⁰⁴ was noted as establishing a robust and process for exercising the discretion and setting the criteria on which the discretion should be based.

¹⁰⁴ In NSW for instance, prosecution decisions must be based on considerations that are set down in section 90C of the Health Care Complaints Act 1993: a) the protection of the health and safety of the public b) the seriousness of the alleged conduct the subject of the complaint c) the likelihood of proving the alleged conduct and d) any submissions made under section 40 of the Health Care Complaints Act 1993 by the health practitioner concerned. Available at: <https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-1993-105>.



The Director of Proceedings provides an additional check on the strength of the case by working through the evidence and ensuring there is enough evidence to effectively prosecute the case. In NSW, for example, the Director of Proceedings formulates the complaint for the tribunal. Having one person responsible for making decisions about proceeding to a hearing helps with consistency.

Submission 67 – Avant Mutual

Once matters come before a tribunal, inconsistencies in their processes have been found to be a legitimate concern. The consultation identified experiences of inconsistencies between various jurisdictions in areas that include costs orders, alternative dispute resolution procedures, and the constitution of panels that hear and determine matters. There were particular issues for smaller jurisdictions around access to hearing members with relevant expertise.

A TASMANIAN PERSPECTIVE ON TRIBUNAL PROCESSES¹⁰⁵

Each State has different statutory regimes regulating the hearing and determination of referrals on disciplinary matters regarding health practitioners, and there are considerable variations across these regimes.

[V]ariations may relate to matters such as review panel composition, mediation, and cost provisions, and there may be challenges in seeking to harmonise these due to the inherent differences...their governing legislation. For example, while membership of the Tasmanian Civil and Administrative Tribunal (TASCAT) does not include members of the judiciary, it is noted the governing legislation for the New South Wales Civil and Administrative Tribunal mandates the appointment of judicial officers to certain positions in that tribunal, including the President of the Tribunal. [TASCAT advises] it can be difficult to identify, for example, medical professionals who are willing to sit as professional tribunal members and are suitably experienced in the particular medical field to which the matter relates.

The Council of Administrative Tribunals emphasised similarly, that many inconsistencies are likely to arise because each jurisdiction's tribunal is established by, and is subject to, different legislation. Additionally, each tribunal may be subject to precedent authority from their respective Supreme Courts and Courts of Appeal.

General resourcing issues for tribunals across all their areas of jurisdiction, were also mentioned. An interesting example of how this is managed was raised in NSW, where there is a Health Minister appointed hearings list position within the Tribunal, to support management of hearings regarding registered health practitioners.

The Review identified considerable scope to improve the timeliness of disciplinary outcomes and consistency of process through further consideration of tribunal processes and development of a program of harmonisation improvements. It has been advised that such issues would need to be raised directly with Attorneys General and/or tribunals in each jurisdiction.

The Review found less conclusive information about the inconsistency in tribunal outcomes. The small sample of matters presented did not provide a sufficient basis for determining whether there are inconsistencies in decisions beyond those that would be expected from different fact scenarios and other relevant legal considerations. There was a sense that this is nevertheless an important issue and one that could benefit closer consideration. There was therefore support for the suggestion that further legal research is warranted, including in relation to whether there is a need to seek greater consistency in cases relating to family and domestic violence, where the perception is that this is an area of potentially problematic variation.

¹⁰⁵ Submission 74 – the Hon Jacqui Petrusma, Minister for Health, Tasmania.



Preferred Reforms and Actions

Conclusions from the consultation

It is impossible to ignore the chorus of voices urging significant improvement in the processes and structures for managing health complaints.

It is far more difficult to identify a simple and fast solution. Significant structural reform is arguably beyond reach. Even if formation of a national complaints handling body was within the terms of reference for this review,¹⁰⁶ the consultation has identified that, ultimately, there would be significant and perhaps insurmountable obstacles to achieving that. If this were to be pursued, it is inevitable that new complexities would replace the old.

Nevertheless, the reform imperative remains. Health consumers, practitioners and service providers cannot reasonably be expected to have to continue to navigate between the entities managing complaints or withstand the delays, lack of due process and inconsistencies in decision making that they report as their dominant experience.

A UNIFIED NATIONAL COMPLAINT HANDLING SYSTEM

Across policy, business process, systems development, communication, and data analysis functions, Ahpra and the six HCEs within the National Scheme operate in relative isolation from one another and sometimes to differing ends. The poor experiences of health consumers and the regulated health sector reflect this.

There is a need for a formal mechanism to bring the health regulator entities across Australia together, with the unambiguous objective of progressing a structured joint work program and ensuring collective accountability in working towards a unified national approach to complaints handling.

While it is acknowledged that implementation would take time and require a concerted program of complaints integration work, the Review has concluded that this is an achievable and worthwhile objective, particularly if AI-enabled triaging and risk assessment can be deployed.

The Review is proposing the establishment of a National Health Complaints System Implementation Group (Implementation Group) under the auspices of HWT. Its role would be to develop and implement a 3-year Project to deliver a unified national approach to complaints handling and this would be done through collaboration between Ahpra and all HCEs.

It is recognised that NSW and Queensland regulatory arrangements are out of scope for Terms of Reference 1-3 of this Review and that this proposed action may be seen as inconsistent with this. However, the Review also notes the requirement (under Term of Reference 4)¹⁰⁷ to consider the alignment between the National Scheme and regulatory stewardship principles and the overall efficiency and effectiveness of health practitioner regulation for all jurisdictions, including NSW and Queensland.

Relevantly, the recommended unification Project focusses on the manner in which complaints triaging and assessment decisions are made and communicated, and the favoured single front door approach is already in place in NSW and Queensland. For abundance of clarity, investigation and prosecution processes would not be within the scope of this unification Project and it would have no impact on these functions within Queensland and NSW.

Involvement of Queensland and NSW in this Project would not require material changes to their complaints processes, but it would deliver benefits. It would enable them to share their well-evolved triaging and assessment tools with other jurisdictions and to be a part of the proposed systems integration, information sharing and data capture improvements. This would assist to drive inefficiency within their assessment processes and decision making. This will be particularly appropriate and relevant in relation aspects such as carefully considered adoption of AI tools within regulatory processes and complaints navigation solutions. It would also support the objective of a national complaints data set to improve transparency and proactivity in regulation.

¹⁰⁶ Which it is not, by virtue of the exclusion of NSW and Queensland from Terms of reference 1,2 and 3.

¹⁰⁷ Term of Reference 4 requires: "Review current regulatory principles for the National Schemeand make recommendations on improvements to increase effectiveness and efficiency and promote a stewardship approach, without adding unnecessary complexity..."



In short, involvement of NSW and Queensland in this project would accelerate progress towards bringing to life a nationally unified complaints system.

THE ATTRIBUTES OF A UNIFIED HEALTH COMPLAINTS HANDLING SYSTEM

For both the regulated practitioners and those making complaints, it is important that complaints that do not warrant disciplinary action are not assessed through the disciplinary lens. To do so is unnecessarily time consuming and costly, and distressing to all involved.

Taking the customer centric perspective, the key design principle must be that a person's concern about a health service experience (irrespective of whether it relates to a registered practitioner, a non-registered practitioner, a health organisation or a mix of these) should be able to be made as a complaint to the HCE in the jurisdiction where the service occurred. That complaint should be risk assessed in the same manner, no matter the jurisdiction in which it is lodged, and be directed quickly into to the most appropriate pathway. AI tools have considerable potential to support this.

A resolution pathway should be available for any complaint that is more suited to this approach.

- If a complaint raises a significant question of a breach of professional standards, such that disciplinary action is potentially required, it ought to be referred quickly and transparently for investigation. For those jurisdictions in the National Scheme this would be to Ahpra.
- If it is not a complaint warranting disciplinary action, it never needs to be handled by Ahpra and should instead be determined by the HCE (in consultation with Ahpra) as requiring no further action, or alternatively action to facilitate resolution of the issues.
- The method and process for triaging and referring a complaint should be consistent, irrespective of the jurisdiction.

This is the essence of the single front door approach.

The Terms of Reference for the Implementation Group will also need to be unambiguous about the desired attributes and the outcomes required of the unified approach, as follows:

- Identification and removal of barriers to complaint and practitioner information exchange.
- Real time HCE access to registered practitioner information held by Ahpra, including complaint history.
- Identifying core information required in a complaint and designing a template complaint form, to be used by all health practitioner regulation entities.
- Selecting/distilling from existing risk assessment tools a common risk assessment tool to be used for triaging within all HCEs, with active mobilisation of AI features.
- Agreeing on consultation and referral processes where complaints need to go from the HCE to Ahpra or from Ahpra to the HCE, including decision making escalation for cases where there is not operational level agreement on whether a matter is, or is not, appropriate for referral to Ahpra.
- Developing agreed communication protocols and products relating to all possible outcomes of a complaint – co-designed with health consumer peak bodies.
- Establishing a complaints navigation capability (potentially AI-enabled) to assist consumers to understand and manage the process of making and complaint, the processes and timeframes for management of a complaint, the possible outcomes of the complaint, and address any concerns they may have about the outcome of the complaint.

Setting common KPIs and implementing high level complaints performance reporting to Ministers and the public.

The broad structure and features of the proposed approach are summarised in *Figure 5: Unified National Health Complaints System*.



A FLEXIBLE AND STAGED IMPLEMENTATION APPROACH

The Terms of Reference for the Implementation Group should recognise the need for jurisdictional flexibility to consider and address any necessary adaptations to their current complaints handling processes, systems, legislation or resourcing over the 3 year implementation timeframe.

As noted above, the single front door approach is already in place in NSW and Queensland and the unified approach will be materially consistent with their usual business process improvement agenda and without a requirement for legislative change.

Its application in some other jurisdictions may be achieved without relatively straightforward process or systems adjustment, under existing legislation and organisational arrangements.

In other jurisdictions some administrative and legislative change would likely be required. This can be modelled on the best of the arrangements already in place and would deliver significant benefits, but will take more time.

AN EARLY FOCUS ON COMMUNICATION AND CUSTOMER FACING IMPROVEMENTS

Recognising that unification reforms will take time under this staged implementation approach, the Review has identified several immediate administrative measures that should be taken to address specific concerns about how complaints and notifications are managed.

An early action for the proposed Health Workforce Taskforce National Complaints Handling Implementation Group should be to oversee the development and implementation of a national communication package, to explain the types of regulation applying to the health workforce and how these will operate into the future, as well as identifying some immediate Ahpra-led improvements to the National Scheme notifications processes and practices.

Introducing a statutory right of review for notifiers is also an imperative and should be progressed as a matter of priority by the Policy and Legislation Committee of HWT.

Other immediate Ahpra-led improvements should include:

- Establishing a Complaints Navigator function in collaboration with the Health Complaints Entities.
- Ensuring implementation of National Health Practitioner Ombudsman recommendations for improving management of vexatious complaints.
- Instituting a formal national communications protocol with HCEs to ensure cross jurisdictional liaison on new serious and sensitive complaints, clear roles and responsibilities, timely action, and agreed public communication messages.
- Ensuring that notification analysis practices include proactive consideration of patterns in notifications that may require systemic improvements to the National Scheme, including whether there is a need for Scheme wide amendment of Codes or Practice or Guidance to practitioners to address any significant escalating concerns.
- Consideration of whether measures to assure practitioner awareness and education about their professional standards and obligations are adequate.

STRENGTHENING CLINICAL INPUT TO THE NATIONAL SCHEME

Clinical advisory capability will remain a critical operational question, in the context of maintaining a National Scheme that is grounded in professional expertise and to support potential for increased delegation of notification decision making from the National Boards to Ahpra.

Deeper consideration of current capability and governance of clinical input, with systematic consideration of options for further strengthening should be a specific focus for the proposed independent Capability Review of Ahpra.



FIGURE 5: UNIFIED NATIONAL HEALTH COMPLAINTS SYSTEM

Unified National Health Complaints System





INCREASED OVERSIGHT AND DETERMINATION OF INVESTIGATION OUTCOMES FOR HIGH-RISK MATTERS

Performance of the investigation function and its ability to deliver early, effective and fair regulatory action in cases where there is a substantiated serious risk to public health and safety will always be a litmus test for the effectiveness of the National Scheme, as it should be.

The Review has concluded that there is an urgent need for Ahpra to place greater emphasis on effective case management of the most high risk and highly sensitive investigations, including those where:

- There are serious sexual assault allegations.
- A practitioner has been suspended or had significantly restrictive conditions placed on their practice.
- A mandatory report raises a significant question of potential or actual serious misconduct.

It is especially clear that practices associated with placing investigations ‘on hold’ require more immediate consideration and adjustment than is currently proposed.

The advice of Ahpra that work is underway in these respects was welcome but needs to be supported by a defined and milestone driven program of business improvement so that progress is assured and visible to the Ahpra Board, National Boards and stakeholders.

The Review proposes that several actions to be progressed as a priority and in parallel:

- Confirm the investigative skills required, with assessment and remediation of any capability gaps in this domain, which should be considered in the proposed independent Capability Review of Ahpra.
- Develop and implement KPIs for investigation functions – as distinct from notification assessment functions.
- Make immediate adjustments to the policy and procedures for placing investigations ‘on hold’ having regard to the findings of the Wilks Case. These policy adjustments should include:
 - Sharper definition of when placing an investigation ‘on hold’ is warranted.

- A requirement that all decisions about extending the period that an investigation beyond 12 months be notified to the Board.
- The obligation to consider the personal and financial impacts on a practitioner in any decision to place an investigation ‘on hold’.
- Conduct an audit of existing investigations (not limited to those ‘on hold’) that have been open for more than 12 months, to be completed within 3 months.
- Use the tagging and alert functions of the new Ahpra case management system to implement a system for identifying, monitoring and reporting on notifications that involve serious allegations and ensuring that the fact of the investigation and its progress is visible at National Board, Ahpra Board and executive levels.
- Prioritise establishment of MOUs with each jurisdictional police force to facilitate the reliable exchange of information where misconduct is also of a potentially criminal nature.

These actions must proceed irrespective of the current National Health Practitioner Ombudsman inquiry into delays investigating “immediate action” cases, which may suggest additional actions.

SYSTEMIC ISSUES ARISING FROM COMPLAINTS AND RISKS

A contemporary regulatory posture requires a more proactive and systemic approach to practitioner regulation, and the Review has concluded there is scope to elevate this aspect of the National Scheme.

Most particularly, a more structured approach to review of Codes of Conduct and practitioner guidance would be beneficial. This would ensure that:

- Conduct standards remain contemporary and responsive to emerging issues.
- Conduct issues relevant to all professions are the subject of consistent standards across all professions.
- Practitioners are effectively educated and regularly updated on their obligations.



PROSECUTION DECISION MAKING AND MANAGEMENT

There is a strong case for additional safeguards against undue delays in prosecution decision making. There should be clearer recourse for practitioners where there is potentially unnecessary delay in progressing matters to a tribunal, particularly where a practitioner has already been suspended through immediate action powers.

Having regard to the findings in *Peers v Medical Board of Australia*, the Review observes that it may assist practitioners to be unambiguous that section 199 of the National Law (which identifies the decisions made within the national Scheme that are appealable) allows a merit appeal against a Board's decision not to revoke an earlier imposed suspension (in response to a request from a practitioner)¹⁰⁸.

The Review has also concluded that measures to support the more frequent use of the panel processes, as an alternative to tribunals warrant further consideration. This could have utility for cases involving more minor technical and one-off breaches where the cost, time taken and practitioner impact of a Tribunal process may not be justified.

It is proposed that there be particular attention to possible legislative amendment to introduce a broader the suite of sanctions that a panel can impose under the National Law, so that the effectiveness of this pathway is enhanced, alongside greater discretion to refer a matter for disciplinary action through a panel rather than through a tribunal.

It is appreciated that replacing the obligation of a Board to refer any professional misconduct matter to a tribunal, with a discretion based on defined considerations (such as whether there is a reasonable belief that cancellation, disqualification and/or prohibition is likely or appropriate) gives the regulatory decision more of a legal character. This raises the question of who is best equipped to make such decisions.

The Review therefore concludes that establishment of an independent Director of Proceedings model within the National Scheme, such as is in place in both the Queensland and NSW jurisdictions, warrants serious consideration. This could also have efficiency benefits, assisting with reducing timeframes, as well as ensuring consistency in decision making.

The Review also sees potential to strengthen analysis of tribunal and Court decision-making and obiter on Ahpra processes and decisions. This would help to inform a continuous improvement and decisions on potential process or regulatory changes. The recent initiative of the Litigation Committee to deliver a Quarterly Report on legal decisions is a welcome step in this direction. With the selection of a smaller set of the most significant cases and additional analysis on impacts for regulatory decision making or potential legislative reform, this Report could be of more strategic value.

TRIBUNAL PROJECT

The Review has identified process and scale differences between tribunals, which can result in practitioners having different experiences and potentially different pressures and impacts depending on the jurisdiction in which their matter is prosecuted. This requires discussion through Attorneys General, to establish a process for joint consideration of actions that may be taken to harmonise tribunal processes and improve timeframes for progressing health professions matters.

In relation to the argument that there are inconsistencies in outcomes that amount to a strong case for pressing for a national tribunal, the review did not find a sufficient basis on which to form a conclusion one way or the other.

Noting however that any such inconsistency would raise serious concerns about the integrity of health regulation, initial emphasis ought to be placed on undertaking longitudinal research on Tribunal outcomes, to establish more clearly whether cases of a materially similar nature attract significantly different outcomes depending on which jurisdictional tribunal has heard the matter, such as to warrant further action.

¹⁰⁸ *Peers v Medical Board of Australia* (2024). VSC 630 15 October 2024. Available at: <https://aucc.sirsidynix.net.au/Judgments/VSC/2024/T0630.pdf>.



An overview of our proposed reform actions



REFORM DIRECTION 4

The review recommends that the Health Ministers Meeting agree to progress implementation of a unified national approach to health complaints and require immediate focus on improved management of high-risk matters with the National Scheme, to ensure best practice complaints handling.

ACTION 4.1

HWT to establish a time limited National Health Complaints System Implementation Group to undertake a 3-year project to deliver a unified national approach to health complaints handling, including driving finalisation of the implementation of the National Code of Conduct for Non-registered Practitioners in (accordance with Action 2.5 under Theme 2).

4.1.1 The Group would be constituted as follows.

- a. Chair to be appointed by HWT (with the potential for a jurisdictional or independent Chair).
- b. Commissioners (or nominee) of each jurisdictional HCE.
- c. Ahpra CEO (or nominee).
- d. Health Consumer representative.

4.1.2 The Terms of Reference for the Group would state the objective of each State and Territory HCE becoming the single point of entry for complaints over time, with the discretion to opt in during the 3-year timeframe, as and when jurisdictional considerations allow.

4.1.3 The Terms of Reference would envisage development of a new MOU between Ahpra and the HCEs, to be in place within 6 months and with an agreed program of collaboration that commits each party to:

- a. Actions to complete implementation of the National Code of Conduct for non-registered practitioners and establishing a National Prohibition Order register (links to Reform Theme 2, Action 2.5)
- b. Implementing a single complaints form, with common data fields.
- c. Developing and implementing common processes and tools for risk-based triaging, making optimal use of AI for these purposes.
- d. Common procedures and protocols for identifying and managing vexatious complaints.
- e. Prioritising establishment and maintenance of processes for timely referral to Ahpra of complaints about registered practitioners and which involve significant breaches of professional standards.
- f. Review communication templates for consumers and providers through co-design processes, to promote improved customer centism and consistent style and content.
- g. Reporting against specified Performance Indicators.
- h. Identifying any current barriers to information sharing and refreshing information sharing protocols and ensuring IT systems integration to achieve secure transfer of information



- i. Establishing a complaints navigation approach within their processes to assist consumers and practitioners to understand the processes and timeframes, what is expected of them during the process, and what outcomes may occur.
- j. Development of an activity-based funding model to provide a consistent basis for budget decision making, in relation to complaints triaging functions within and between the National scheme and each HCE.

4.1.4 The Terms of Reference would also require the Implementation Group to oversee development of a national complaint handling information campaign as an immediate priority, to communicate the Integrated Health Professions Regulation Framework (see action 2.1) and present a joint message on proposed reforms to complaints handling as a key element, setting out what consumers and providers can expect now and into the future if they are lodging or are the subject of a complaint.

ACTION 4.2

Ahpra to take immediate steps to improve the understanding and experiences of notifications processes for the public, complainants and practitioners by:

- Establishing a Complaints Navigator Service.
- Ensuring implementation of National Health Practitioner Ombudsman recommendations for improving management of vexatious complaints.
- Instituting a formal national communications protocol with HCEs to ensure cross jurisdictional liaison on new serious and sensitive complaints, clear roles and responsibilities, timely action, and agreed public communication messages.
- Ensuring that notification management systems and practices identify and examine patterns in notifications, and drive proactive consideration of systemic improvements to the National Scheme.
- Considering whether there are sufficient avenues for ensuring that practitioners are aware of and educated about professional standards and obligations on an ongoing basis.

ACTION 4.3

Ahpra Board to immediately improve timeliness and quality of investigation processes and decision making and the availability of clinical advice across all regulatory functions, with specific actions to achieve this.

- 4.3.1 Investigation capability and processes and the nature and quality of clinical input to regulatory decision making to be considered in the proposed Ahpra Capability Review (see Reform Theme 3, action 3.3).
- 4.3.2 Immediate interim actions to improve investigation governance should also be progressed and include:
 - a. Ensuring clear investigation and prosecution KPIs in the Performance Monitoring and Reporting Framework for the Scheme (this links to Reform Theme 3, action 3.4.2).
 - b. An audit of all Ahpra investigations that have been open for more than 12 months and consideration of actions that would ensure timely completion of those matters to be completed within 3 months.
 - c. Review and revise the policy and procedure for placing investigations 'on-hold' and managing those investigations. These policy adjustments should include: tighter definition of circumstances where placing an investigation on hold is available; a requirement that all decisions about extending the period that an investigation beyond 12 months be notified to the Board; and, the obligation to consider the personal and financial impacts on a practitioner in any decision to place and investigation on hold.



- d. Agreeing with the Boards categories of notifications that pose a higher risk or of higher sensitivity (including those where the practitioner has already been suspended or constrained from practising), to which tags and alerts should be applied in the new case management system. This is to support improved monitoring and reporting to the relevant Board, the Ahpra Executive Group, and the Ahpra Board's Regulatory Performance Committee.
- e. Establishing a single cross profession committee to determine the outcome of notifications and investigations on matters alleging serious sexual boundary violations (consistent with Reform Theme 3, action 3.7).

4.3.3 Establish formal MOU arrangements with police in those jurisdictions currently without an MOU, to ensure timely information exchange where registered health practitioners are also the subject of police investigation or criminal prosecution.

ACTION 4.4

Health Ministers request HWT to task the Policy and Legislation Committee to:

- Prioritise National Law amendments to: (i) establish a statutory right of review of notification decisions under the National Scheme; and, (ii) section 199 of the National Law to put beyond doubt that a practitioner may appeal a Board decision not to revoke an earlier imposed suspension.
- Consider and advise on other possible National Law amendments: (i) make referral to panels a more practical and effective alternative to referral to tribunals; and, (ii) the option of an independent Director of Proceedings within the National Scheme.

ACTION 4.5

Health Ministers seek the agreement of the Attorneys General to establish and process for joint consideration of actions that may be taken to harmonise tribunal processes applying to health professions matters.

ACTION 4.6

Ahpra to research and report on outcomes of tribunal decisions about health professionals for the period 2020-2025 and advise on any inconsistencies in outcomes that may require action.