REGULATING FOR RESULTS – REVIEW OF COMPLEXITY IN THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME

Transforming health professions regulation in Australia

Independent Review Final Report

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July 2025

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Acknowledgement

We acknowledge 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.

Foreword

It has been a great privilege to conduct the Independent Review of Complexity in the National Registration and Accreditation Scheme for health practitioners. I am pleased to present this Final Report, "*Transforming Health Professions Regulation in Australia*".

The Review was clear affirmation of the central importance of health professions regulation in safeguarding public health and safety. There was recognition of the key achievements of the National Scheme in establishing a national register of health professionals and setting the platform for health workforce mobility. It has embedded strong professional standards across and within professions, pursuing compliance with these standards. The National Scheme now regulates close to 1 million health professionals.

It was also salutary recognition that despite strong foundations the National Scheme has struggled to deliver to its full potential. It has become too inward-looking, too fragmented, and too slow to respond to emerging risks and opportunities.

The Review faced the fundamental question of how health professions regulation can keep pace with the ever-evolving health system. Our health system is subject to challenges associated with shifts in demand, workforce and service distribution, impacts of technological change, and imperatives to adapt models of care.

I was struck during the Review process by the passion and commitment across all stakeholders – policy makers, the community, regulators, professions and practitioners – to recognise and understand the challenges impacting the Scheme. The deep and robust discussions about what solutions might look like and how they could be progressed have resonated with me. The Review has been all the richer for the applied knowledge and wisdom of those who so generously participated. Thank you.

The Review would not have been possible without the support of the Australian Government Department of Health, Disability and Ageing, and I extend my sincere gratitude for the project management and stakeholder relations support that was so critical to its successful completion.

The recommendations of the Review set out 4 key transformation directions, supported by 26 specific actions to advance these. The recommendations embed the principles of regulatory stewardship – taking a system-wide view, being proactive and evidence-driven, and fostering collaboration across sectors. The recommendations apply these principles around and within the National Scheme.

The recommended directions and actions are designed to be practical and achievable. They build on existing structures and relationships, while introducing new mechanisms to drive collaboration, innovation, and accountability. There are both immediate and longer term actions. They are designed to be mutually reinforcing, creating a regulatory system that is coherent, responsive, and trusted.

This is an ambitious transformation program, and rightly so. The health of Australians depends on a regulatory system that responds effectively and proportionately to risks on a day-to-day basis, as well as being agile and forward-thinking. More is required for the National Scheme to achieve this.

I am confident that there is strength of purpose and commitment to deliver this transformation. The early support and commitment of the Ahpra leadership for a new approach and the desire of jurisdictions, professions and community representatives to continue to collaborate in delivering transformation are the best possible signs. All have a role to play in shaping and delivering a regulatory system that is fit for purpose and capable of meeting future challenges.

Sue Dawson
Independent Reviewer

July 2025

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

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

Health Ministers have established this Independent Review to look behind the inherent complexity of health practitioner regulation, to identify areas of unproductive and unnecessary complexity, and propose reforms that will enable the National Scheme to work to its full potential. The ultimate objective is to ensure that the National Scheme remains 'fit for purpose' and meets community expectations.

Executive summary

Health professions regulation has the foundational objectives of patient safety and ethical standards. Alongside this, it has a central role to play in advancing the 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, the National Registration and Accreditation Scheme for health practitioners (the National Scheme) needs two speeds. It must always maintain excellence and credibility in regulating the higher risk professions and practitioners. It also needs inbuilt capability to grow and recalibrate, so that it can meet new regulatory challenges and support health system and workforce priorities.

This Review has highlighted the factors that are preventing the National Scheme from meeting its full potential.

This Final Report proposes new directions and actions to transform the National Scheme, so that it delivers maximum effectiveness in safeguarding public health and safety, including 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 feedback received during research and consultation phases of the Review.

What problems are we trying to solve

At the heart of complexity in the National Scheme is a lack of clarity and no shared agreement about what is most important in health professions regulation, at any point in time and over time. The context is ever-evolving health services, models of care and public needs and expectations.

The fact is that meeting the health needs of Australians requires that health services are accessible, delivered by a range of occupations working to clear clinical and conduct standards, and with individual practitioners who are suitably trained and qualified.

A reflection on the legislation is important here. The seven objectives of the Health Practitioner Regulation National Law (the National Law) are clear. They set out equal goals across public health and safety, training standards and qualifications (including for overseas practitioners), workforce mobility, cultural safety, public access to health services, and workforce development and innovation.[1] There are also guiding principles, which were added to the National Law in 2022. The paramount principles are protection of the public and public confidence in the safety of services.[2]

How the foundational objectives and guiding principles fit together is somewhat unsettled and this is a factor contributing to the lack of clarity about the purpose and practice of health practitioner regulation and what the National Scheme ought to focus on. Policy debate can tend to be reduced to binary propositions – that increased consideration of workforce supply and service access objectives places undue downward pressure on quality and standards, or, in the reverse that the primacy of protection of public health and safety will be a barrier to meeting health service needs.

The Review highlights that it cannot be a case of one or the other. The interdependency is the key. Public safety is the paramount principle and applies equally to all objectives of the Scheme. Expressed otherwise, maintaining health service access and workforce supply and development (pursuant to objectives (e) and (f) of the National Law) is central to public health and safety – the absence of services and/or workers being the ultimate risk.

The policy task will always be to achieve a balance across public safety, workforce and service availability.

The National Scheme has not maintained its impact as an enabler of workforce and health service access. Impediments to success currently run from the strategy and policy level, down to the operational level.

A key problem is that there are inadequate structures and processes in place. There is not a mature mechanism for bringing together the evidence and experience of policy makers, professions, community representatives and regulators, in the service of striking the necessary balance.

There is significant disillusionment with the fragmented regulation of health professions. In the absence of an overarching framework to structure decisions about the regulation of health occupations, the basis on which individual professions have been brought within the National Scheme and others remain outside of it lacks coherence. Many professions outside the Scheme arguably ought to be included, based on the presenting risks.

Of note is that health workers are increasingly part of the broader social care economy, also working in aged care and disability services. However different standards and different regulatory arrangements apply across those sectors. Interdependencies between health and social care workforces are clear and yet workforce regulation occurs in silos.

These are lost opportunities which risk disruptive misalignment between workforce strategy and regulation.

The National Scheme itself seems somewhat frozen in time and its 16 registered professions are not regulated in a sufficiently cohesive, consistent and responsive way.

When expected standards of conduct and performance are not met by individual health practitioners, the wide experience is that the National Scheme is not sufficiently effective, timely or fair. Complaints present opportunities to address risks that have arisen and to learn from them to improve our health system. Dissatisfaction with the way complaints are handled is felt equally deeply by consumers and practitioners, and this is a significant challenge to the integrity of health practitioner regulation.

The National Scheme is inward looking and reactive, lacking proactivity and responsiveness. There are not embedded practices of using data and evidence to anticipate and address risks early or to take a system-wide perspective. There are culture and capability barriers to Ahpra evolving to a higher level of regulatory effectiveness.

The essence of the problem

01

Absence of context and direction around the Scheme-weakens alignment between workforce strategy and professions regulation.

02

Registered practitioners are regulated in isolation from the broader health workforce – insufficient ability to recalibrate the Scheme as the health system evolves and new challenges emerge.

03

The National Scheme is not operating on contemporary regulatory stewardship principles – leading to inefficiency, poor accountability, lack of transparency, stakeholder alienation, and culture and capability issues.

04

The community and individual practitioners see the Scheme through its complaints handling function – which is a significant weakness in the National Scheme. Fragmented responsibilities, with untimely and confusing complaints outcomes, erode confidence and trust in health regulation.

The Review approach

The overarching objective of this Review was to identify areas of unproductive and unnecessary complexity within the National Scheme.[3]

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

The Review was undertaken in four phases.

The initial research and scoping was undertaken during May – June 2024. This enabled the problems to be defined and tested through Consultation Paper 1, which was released in September 2024.[4]

From September to October 2024, stakeholders had the opportunity to comment on the issues and themes raised in Consultation Paper 1 and to inform the development of possible solutions. In that initial consultation:

- 83 written submissions were received 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. Over 400 individuals participated in these sessions.

In May 2025 Consultation Paper 2 was finalised and released.[5] Consultation paper 2 drew on the initial feedback and input received and presented detailed reform options and actions. This supported a second round of more targeted consultation, involving solution-oriented policy forums with selected stakeholders. Written input was received from these stakeholders, as well as other individuals and organisations.

During this final phase of targeted consultation:

- 37 policy design forums were conducted, involving 83 organisations, with more than 250 individuals participating.
- 36 written submissions and comments were received.

Recommended directions and actions

This Final Report distils the conclusions and perspectives arising from the research and consultations and presents both systemic and discrete measures to ensure that the National Scheme is fit for the future.

The four recommended transformation directions aim to break through the complexity, mobilising practical and achievable solutions.

Direction 01: Apply a regulatory stewardship model to set strategic context, priorities and accountability for health professions regulation and the National Scheme.

Direction 02: Establish an Integrated Health Professions Regulation Framework, to inform decisions about regulating occupations across the entire Australian health workforce.

Direction 03: Realign functions and structures within the National Scheme to strengthen performance, accountability, and transparency.

Direction 04: Progress implementation of a unified national approach to health complaints and require immediate focus on improved management of high-risk matters within the National Scheme, to ensure best practice complaints handling.

Within each transformation direction there are top line implementation actions, which are summarised below. The body of this Final Report presents the supporting analysis and additional detail of the elements to be addressed in each of the actions, as well as the expected benefits.

DIRECTION 01

Apply a regulatory stewardship model to set strategic context, priorities and accountability for health professions regulation and the National Scheme.

ACTION 1.1

A *Ministerial Council Statement of Expectations of the National Scheme* to be developed and renewed every 2 years and issued to the Ahpra Board.

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, in collaboration with relevant professional bodies.

ACTION 1.3

Health Chief Executives Forum (HCEF) to consider the option of a Strategy Assembly on Health Workforce and Practitioner Regulation to be held every two years. This would consider whole of health workforce data and evidence, innovation in models of care and emerging risks, that may require policy, program or regulatory action.

ACTION 1.4

Australian Government Department of Health, Disability and Ageing to establish and lead a time limited project to streamline Health, Disability and Aged Care Professions Regulation. The project would involve Aged Care Quality and Safety Commission, the NDIS Quality and Safeguards Commission, and Ahpra and report progress to Health Ministers on an annual basis.

ACTION 1.5

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 1.6

Health Ministers request that the National Health Reform Agreement includes a health workforce strategy schedule, through which 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 1.7

Ahpra Board to take three specified data and analysis initiatives to support more proactive health practitioner regulation and health workforce planning and strategy.

DIRECTION 02

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

ACTION 2.1

Endorse an Integrated Health Professions Regulation Framework, which stratifies the intensity of regulation according to risk and ultimately delivers three models of regulation, as a basis for future decision making on the approach to regulation of all health professions.

- National Board regulation of registered professions that pose the most significant risk to public health and safety.
- Enhanced profession-led regulation – uplift of existing self-regulated profession practices and active consideration of a new Professions Registration Model 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

Health Workforce Taskforce (HWT) to review and revise the risk assessment method and the process for assessing professions for entry to the National Scheme and produce a new Guidance Document for Ministerial endorsement.

ACTION 2.3

HWT to establish a collaborative process to examine the potential features and feasibility of a Professions Registration Model within the National Scheme, involving the self-regulated professions, allied health peak bodies and Ahpra.

ACTION 2.4

Pending completion of actions 2.2 and 2.3, HWT to initiate a selective Expressions of Interest process to extend the National Scheme under the existing risk-based method. Jurisdictions would identify professions where available evidence suggests a current and significant risk to public health and safety, such as to warrant consideration of immediate inclusion in the Scheme.

ACTION 2.5

Health Ministers commit to complete implementation of the National Code of Conduct for Non-Registered Practitioners by all jurisdictions within 24 months (including reaffirming the 2015 decision to establish a National Register of Prohibition Orders and actions to strengthen the effectiveness of the Code).

DIRECTION 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 specified administrative and strategic adjustments within the existing National Law.

ACTION 3.2

Ahpra Board to make specified 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 an implementation plan to be communicated to Health Ministers within 12 months.

ACTION 3.4

Ahpra Board to pursue immediate strategic priorities identified in this Review through its current cycle of review of the *National Scheme Strategy (2025-30)* and present the revised Strategy to HWT and Ministers within 6 months, with a report to Ministers on implementation of the Scheme Strategy in each future Quarterly Performance Report.

ACTION 3.5

Health Ministers to issue a Policy Direction pursuant section 11 of the National Law, requiring the Ahpra Board to strengthen focus and accountability for accreditation functions with specified actions to achieve this over a 2-year period.

ACTION 3.6

HWT Policy and Legislation Committee to consider and advise on any further administrative, policy or legislative actions required to strengthen accreditation functions, within 24 months.

ACTION 3.7

Health Ministers agree to maintain the current voluntary approach to amalgamation of existing National Boards. This must be 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 specified immediate actions.

DIRECTION 04

Progress implementation of a unified national approach to health complaints and require immediate focus on improved management of high-risk matters within 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. This would include finalising implementation of the National Code of Conduct for Non-registered Practitioners (in accordance with Action 2.5 under Direction 02).

ACTION 4.2

Ahpra to take immediate steps to improve the understanding and experiences of notifications processes and to take a more systemic approach to regulation by:

- Establishing a Complaints Navigator Service through a codesign approach with Health Complaints Entities and the Community Advisory Council of Ahpra.
- 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.
- Considering the need for additional 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 specified actions to achieve this.

ACTION 4.4

Ahpra Board to request that the Regulatory Performance Committee identify tribunal cases presenting significant commentary on the adequacy of Ahpra practices and processes, and advise on potential policy or legislative change.

ACTION 4.5

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) 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 4.6

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

ACTION 4.7

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.

Getting it done

The new directions and supporting actions from this Review have been proposed on the basis that they are necessary, practical and achievable. When implemented they will be mutually reinforcing and ensure that the Scheme can meet the challenges before it.

That said, the breadth and depth of the change agenda is undeniable. The recommendations chart what is realistically a 3-5 year change program.

Careful consideration of the sequence and timing of actions is therefore essential.

Consultations have identified three key pressure points which should be prioritised in progressing the change.

Underpinning these priorities there must be a collaborative mindset.

PRIORITY 1

First, success will rely on the leadership of the National Scheme Board in progressing implementation of governance and stewardship actions proposed in Direction 02 with urgency and purpose.

The Review has welcomed advice from the Ahpra Board and the Chief Executive that many of the actions envisaged are already underway or planned, including resetting the leadership structures and undertaking a capability review. Progress reporting is built into the recommended actions, in the interests of transparency and to maintain confidence that change is occurring.

PRIORITY 2

Second, in the context of the reasonable expectation of the community and the regulated professions that complaints handling will be timely, fair and compassionate, the actions envisaged in Direction 04 should also be prioritised.

When implemented, the unified national complaints handling model will ensure that consumer concerns are managed outside of the Ahpra processes as far as possible and with a resolution orientation. Only the more significant alleged breaches of professional standards would be referred to Ahpra.

While this transformation is occurring, there are immediate actions to be taken by Ahpra to expedite investigations. This will result in more timely and proportionate responses to complaints, and avoid the frustration and distress experienced by practitioners and consumers under existing arrangements.

PRIORITY 3

Third, there must be avenues for the Scheme to grow and adapt in a manageable and coherent way and to maintain a focus on emerging risks. This is to be progressed through Direction 02.

An implementation approach which takes immediate steps to expand the Scheme appropriately, while also enabling more detailed assessment of the features and feasibility of a potential new lighter touch registration pathway is favoured.

Irrespective of whether there is a new pathway to registration, strengthening the risk-based criteria and processes for entry to the Scheme and completed implementation of the National Code of Conduct for non-registered practitioners are imperatives.

As with any transformation, success will rely on genuine partnership and collaboration between all those with a role to play in the planning and delivery of safe and high-quality health services. Within and across each of the four transformation directions are actions that work towards ensuring that this collaboration between policy makers, regulators, professions and training providers, and consumers occurs at strategic and operational levels.

How this delivers simpler, smarter regulation

Strategy and context

Priorities and directions for health professions regulation are formal and clear.

Alignment of public safety and workforce objectives.

Single line of health regulation and workforce policy advice to Ministers.

Inclusive strategy setting – defined structures and opportunities for stakeholder input.

All health regulators working together.

Integration of health, ageing and disability professions regulation.

Workforce data and regulatory intelligence inform policy decision making.

Expanding the Scheme via integrated regulation

Risk-based regulation across all health professions.

Immediate action to address emerging health risks within existing board structures.

Co-design process to develop new lighter touch, cost effective registration model.

Complete nationwide implementation of Code of Conduct for non-registered practitioners – including National Register of Prohibition Orders.

New regulatory tools to avoid harm from exploitative business models.

Simpler, smarter regulation

Resetting Ahpra functions and structures

One entity accountable for performance and development – National Scheme Board.

Leadership structures ensure all National Boards work to clear Scheme-wide priorities and on cross-profession solutions.

Profession and consumer voices embedded at strategy and operational levels.

Financial sustainability and transparent fee setting prioritised.

Culture and capability lift to deliver more proactive, effective and compassionate regulation.

Unified national complaints handling

Consumers can make a complaint about any health practitioner or organisation in one place.

Complaints navigator service for consumers now and single front door over time.

Ahpra and state and territory complaints bodies are working together – not in isolation.

Early resolution is taken whenever possible.

Ahpra investigation and disciplinary role reserved for more serious alleged breaches of standards.

Investigation is more timely and procedurally fair.

BENEFITS TO STAKEHOLDERS

HEALTH CONSUMERS AND THE COMMUNITY

- There will be a clear picture of how all health professions are regulated in Australia.
- The community will have a stronger voice to inform the National Scheme.
- Consumer will have confidence and trust in the quality of health services in Australia.
- New risks to public health and safety will be addressed more proactively and effectively.
- Complaints will be addressed in a timely manner and include consideration of restorative solutions.
- A right of review of Ahpra notification decisions.

MINISTERS, GOVERNMENTS AND HEALTH SYSTEM LEADERS

- Ministers will have a systems overview of health challenges, risks and regulatory responses.
- There will be a single entity accountable to Ministers for performance of the Scheme.
- Health regulation will be evidence driven and based on expert advice and quality data.
- Regulators and Ahpra will work in partnership to deliver collaborative solutions to emerging risks – such as the use of AI in health services.
- Policy decisions and regulatory frameworks will cover the whole health workforce and support scope of practice reforms.

REGISTERED PROFESSIONS, COLLEGES AND PRACTITIONERS

- Stronger focus on professions input to workforce strategy and regulatory policy.
- Reducing delays in investigations and prosecutions, minimising practitioners distress.
- A unified model for complaints to ensure improved management and so that lower level matters are not handled by Ahpra.
- Fee setting and budget processes will become more transparent.
- Improved sustainability of the Scheme.

ALLIED HEALTH PROFESSIONS

- Builds on progress made in self-regulation.
- Uplift and recognition of professional standards for allied health professions.
- Opportunity to join the National Scheme.
- Leverage from a more integrated approach to workforce regulation and policy.
- Stronger connection with HCEs to support public health and safety.

HEALTH COMPLAINTS ENTITIES

- Reduced confusion in roles and responsibilities (with Ahpra).
- A seat at the table to inform regulation.
- Partners in the National Scheme.
- Collaboration to improve the national approach to complaints handling.
- Stronger connection with self-regulated professions.

THE NATIONAL SCHEME LEADERS AND AHPRA

- The National Scheme will have clear directions and priorities, so regulatory actions will align with workforce strategy.
- 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.
- Structured connection between the Ahpra Board and National Boards will add to coherence and agility across the Scheme.
- New structures for collaboration with professions.
- Regulatory decision making will be supported by stronger governance and Ahpra capability and culture.

THEME 1:

Setting strategic context, priorities and accountability for health professions regulation and the National Scheme

The problem defined

The Review has examined the National Scheme against contemporary principles of regulatory stewardship. These require: a system-wide view of regulation in the context of changing needs; 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.

Stakeholders have highlighted aspects of the current design and operation of the Scheme that are not aligned with these principles.

THE ELEMENTS OF THE PROBLEM

ABSENCE OF STRATEGIC CONTEXT

The National Scheme for regulation of health practitioners has multiple objectives.

While its grounding purpose is protecting public health and safety, this goal is inextricably linked to meeting health workforce and service needs. Australians must have both and quality and accessible health services. It cannot be a case of one or the other.

To balance these objectives requires strong alignment between workforce strategy and health regulation.

Current arrangements are not sufficient to achieve the necessary balance. The arrangements see workforce policy and strategy occurring without sufficiently broad consideration of the optimal settings within professional standards, registration, training, and complaints handling functions – all of which have a role to play.

Within health practitioner regulation, there is tension triggered by a concern that regulation with consideration of workforce objectives may undermine the paramount purpose of protecting public health and safety. There are not identified structures and opportunities for dialogue to maintain balance between service access, workforce and safety objectives in designing policies and programs.

Ahpra is not a member of the jurisdictional health workforce policy and program structure and has limited influence and impact in that regard. There are not clear structures for consultation with the professions across all aspects of workforce planning and policy.

The ultimate consequence is that health practitioner regulation is occurring in a relatively transactional way and without a unifying purpose.

CROSS SECTORAL WORKFORCE DEPENDENCIES

The health sector increasingly draws on the same workforce as social care sectors of disability and ageing. And yet, the sector each regulates workers and organisations in isolation. This impedes worker mobility and misses the opportunity to put in place consistent standards of conduct and care, which in turn undermines the efficiency and coherence of compliance approaches.

Efforts to address this do not have sufficient reach or momentum. For instance, there is now mutual recognition of Ahpra registration in workforce screening in the aged care sector. However, mutual recognition is not currently supported in the National Disability Insurance Scheme (NDIS), largely because the Ahpra static screening model is not consistent with the emerging models of ongoing monitoring of fitness to practice.

There is not yet an avenue for identifying and removing barriers to integrated regulation between the health and social care sector.

LACK OF COLLABORATIVE HEALTH REGULATION

Health practitioner regulation policy and practice is not only relatively disconnected from workforce strategy, but it also lacks the structures and role clarity required to achieve the necessary co-operative regulation between the regulators of health products, devices, premises and businesses.

There are a range of regulatory levers within the powers of various regulators and enabling agencies that intersect with the work of Ahpra and the Health Complaints Entities of each jurisdiction.

These include:

- Therapeutic Goods Administration (TGA) – responsible for regulation of the supply, import, export. Manufacturing and marketing of medical products and devices.
- The Australian Commission for Quality and Safety in Health Care (ACSQHC) – responsible for national safety and quality standards and oversight of accreditation of health service organisations against the standards.
- The Professional Services Review agency (PSR) – responsible for investigation of potentially inappropriate practices in providing services through Medicare, Child Benefits Dental Schedule, or the Pharmaceutical Benefits Scheme.
- The Australian Competition and Consumer Commission (ACCC) – responsible for consumer protection.
- State and Territory Health Departments regulate access and supply of medicines and poisons.
- The Australian Digital Health Agency (ADHA) – responsible for facilitating adoption and use of innovative digital services and technologies.

We know that emerging risks to public health and safety will often require action across a number of these regulatory domains to have the necessary impact.

Taking the example of medicinal cannabis regulation, more than a million Australians now use medicinal cannabis, amid the growing number and spectrum of prescribers and the evolution of telehealth, online prescribing and direct to consumer dispensing.

Ahpra has recently taken significant steps to strengthen standards for health practitioners and to take enforcement action to address risks to public health and safety in this space. That said, an effective response will ultimately require mutually reinforcing regulatory actions in the approval of medicinal cannabis goods, authority to prescribe, representations to consumers and the manner of dispensing. This is in addition to ongoing effort to ensure appropriate care of those utilising medicinal cannabis for therapeutic purposes. While there has been some discussion of shared regulatory challenges in this space (and similar areas such as regulation of cosmetic services), including through the informally established Australian Health Regulators Network, we are yet to see fast-paced, fully integrated, cooperative regulation strategies.

Effective regulation increasingly requires multi-faceted solutions, often requiring action across the various domains of regulation, but there are not currently adequate arrangements for this.

Analysis of issues and opportunities

A 'WORKFORCE WRAPAROUND'

The National Scheme will be more effective, relevant and understood if its defining objective of protecting public health and safety is purposefully and transparently connected to workforce strategy.

The Review consulted on a proposed 'workforce wraparound' for the National Scheme.

Within a climate of broad agreement that setting strategic context and direction around the National Scheme is necessary and important, the most pressing question for stakeholders was how this would best be achieved.

The Review heard concerns about the potential duplication, further complexity and cost that could arise from the option of establishing a separate health workforce organisation. There was a general preference for the alternative of enhancing existing structures and processes.

There was strong support for existing entities to work together more effectively, with a higher level of stakeholder engagement and consideration of the wider health workforce through strategy and decision making.

The Review has noted that implementation of a 'workforce wraparound' would require several administrative and structural actions.

A revised Intergovernmental Agreement for the National Scheme would be the traditional instrument for establishing this 'workforce wrap around'.[6] While this may ultimately prove to be necessary, it is arguably a cumbersome and inflexible mechanism.

The preferred approach is to take immediate steps to adjust and add to existing administrative arrangements (as outlined below) and to formally recognise these as a coherent governance package within a Health Workforce Schedule to the National Health Reform Agreement. The existing Intergovernmental Agreement would remain in place, as the enhancements proposed here are entirely consistent with the objectives set down in that original Agreement.

To strengthen the nexus between workforce initiatives and health practitioner regulation, the vehicle of a Ministerial Statement of Expectations would reflect a contemporary approach.[7] 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, it was suggested that 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 was the genesis of the recommendation for a biennial Strategy Assembly on Health Workforce and Practitioner Regulation, with inputs including curated national workforce data analysis. This analysis would then become an essential building block for workforce pipeline planning within and across jurisdictions, to address supply, growth and distribution challenges.

Ultimately, there were mixed opinions about the value and workability of the proposed Strategy Assembly on Health Workforce and Practitioner Regulation. Those not supportive of the Strategy Assembly concept generally pointed to uncertainty about its composition and purpose and whether it would create more confusion and unmet expectations, while also being costly and resource intensive to support.

> This forum will be extremely costly and its work program is too big. It is not frequent enough to achieve the stated objectives.
>
> Jurisdictional Input

Those who were more supportive of a Strategy Assembly pointed to the need for a structure or a process to consider workforce issues more broadly and expansively, and in a more inclusive manner. They advocated that profession and consumer voices be more present in setting workforce policies and priorities. They sought workforce planning and strategy practices that look beyond the registered professions. This was seen as an important antidote to the perceived skewing of workforce and regulatory policy towards the existing 16 registered professions, to the exclusion of significant and growing unregistered and self-regulated occupations. There was also a desire for an active approach to managing emergent and expanding scope of practice.

> AHPA and its members recognise the benefit of the proposed Strategy Assembly as a means of expanding the perspective of Health Workforce Taskforce (HWT) Ahpra and HCEs and creating improved opportunities for collaboration and alignment across health professions independent of their regulatory status.
>
> Allied Health Professions Australia

There was an emerging view that, if there was to be a Strategy Assembly, it should be focussing on workforce data and evidence, innovation in models of care, and emerging risks requiring policy or regulatory action. That is, it should not be tied to the separate and specific task setting the Ministerial Council Statement of Expectations for the National Scheme.

There was also common ground that, irrespective of whether the Strategy Assembly concept progresses, there is a need to rework aspects of Health Workforce Taskforce (HWT) operation. While HWT is considered by many to be the most appropriate engine room for health workforce strategy, there is concern that this current structure is jurisdiction-facing and to the exclusion of dialogue with the professions, who seek to be able to directly continue and influence workforce policy.

> AHPA and its members recognise that the role of HWT will need to expand under the proposals and argue that a key component of that expanded focus needs to be a recognition of the need to engage with, and understand, the private sector workforce which now comprises a majority of many allied health professions along with the needs and issues impacting individual jurisdictions.
>
> Allied Health Professions Australia

> ACN strongly supports the establishment of the Health Workforce Taskforce (HWT) as a standing advisory body to health ministers. We believe this will bring greater clarity to national workforce planning and regulatory alignment.
>
> Australian Collage of Nursing

> The proposal to bring stakeholders together through a strategy assembly is a welcome initiative to develop a more formal consultation process to guide the National Scheme. We query the emphasis given to holding an assembly every two years. This leaves a huge gap between where decisions are taken by HWT and others, without an obvious mechanism for engagement or meaningful input.
>
> We know the progress on implementing the National Medical Workforce Strategy is slow… The Medical Workforce Advisory Collaboration has very little influence [with HWT] even though it was meant to guide future medical workforce planning and policy. We need a robust body with strong stakeholder involvement that can provide regular and ongoing advice to health ministers, with access to robust workforce data and mechanisms to encourage greater transparency and accountability.
>
> Australian Medical Association (AMA)

> HWT is made up of representatives from state and federal health departments- perspectives that are primarily focussed on service delivery. Effective health regulation must reflect a broader lens, incorporating education training and clinical expertise.
>
> HWT does not appear to RANZCR to be a vehicle that can offer a whole of sector solution mindset in its current composition.
>
> While we support the concept of a Ministerial Statement of Expectations, we emphasise the need for diverse sectoral input to its development. The voices of medical colleges, educators, practitioners and consumers must inform strategic direction.
>
> The Royal Australian College of Radiologists

The recommended directions and actions proposed by the Review advance the need for greater collaboration between policy makers, regulators, professions and consumer representatives in progressing actions that will meet public safety, workforce development, and service access objectives in a balanced way.

The recommendations carry forward the proposal for a Ministerial Council Statement of Expectations for the Scheme, but as an action that is separated from the Strategy Assembly proposal.

They retain the option of a Strategy Assembly on Health Workforce and Practitioner Regulation, as this is an approach to collaboration that is not profession-specific and which should support the aspiration for a whole of health workforce lens over workforce planning and health regulation on a periodic basis.

There are additional measures proposed to drive increased collaboration on a day to day, profession specific policy and strategy.

The adoption of a more open and inclusive mode of operation for HWT is recommended, to deliver more structured and effective collaboration with the professional associations and colleges in day-to-day workforce policy and planning.

The HWT Terms of Reference 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.

Collaboration must be embedded in the structures and processes of the HWT and this should also be made explicit in the revised Terms of Reference. The Medical Workforce Advisory Collaboration is an important element of this. It is a recent inclusive structure for integrating workforce planning and regulation actions, and valued for this, but more can be done for it to reach its full potential. The Review heard stakeholder advocacy for this to be a stronger and more influential forum, as well as an approach that should be applied across other workforce domains.

Amended Terms of Reference for HWT should also simplify and strengthen the reporting lines to Ministers on health practitioner regulation policy matters, to deliver advice that reflects the active consideration of balance between effective management of risks to public health and safety and workforce strategy.

Regulatory policy advice should be rationalised into one line of advice, through HWT (informed by its collaborative advisory structures and committees). To ensure that advice to Ministers is undergirded by regulatory expertise, Ahpra should have ‘supplementary membership’ of HWT. It is anticipated that HWT will 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 separate Jurisdictional Advisory Committee, nor the Jurisdiction Lead Officials Committee.

Instead, there would be a Health Practitioner Regulation Committee of HWT to work alongside its already established Policy and Legislation Committee. This Committee could be chaired by Ahpra and have the primary purpose of ensuring development and implementation of changes in regulatory practice where this is either sought by the Scheme or by Ministers. Such a Committee should also be 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 quarterly 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).

These proposed 'workforce wrap-around' actions 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.
- Inclusion of professions, colleges and community voice in setting health regulation priorities that align with workforce strategy.
- 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.
- 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.
- Momentum on integration of health and social care workforce regulation.
- Accountability to Ministers for delivering health regulation outcomes.

WORKFORCE MOBILITY AND EFFICIENT REGULATION

Inevitably and increasingly, the health sector is sharing a workforce with the growing aged care and disability services sectors. The situation cries out for integrated regulation to support worker mobility, uplift in professional identity across these sectors and consistent standards.

While it is recognised that there is a broader whole of Australian government productivity project underway to establish a national system for worker screening across the social care economy, this Review also sees the opportunity for immediate and focussed actions to streamline and integrate practitioner regulation.

Consistent with the system-wide orientation of regulatory stewardship, the recommended directions and actions seek to build on the important circumstance of the formation of the Commonwealth Department of Health, Disability and Ageing, to intensify efforts to streamline and reduce red tape and inefficiency in workforce regulation across these sectors.

The proposal is that the Commonwealth Department lead a project which brings the Aged Care Quality and Safety Commission and the NDIS Quality and Safeguards Commission and Ahpra together, to advance practical actions to streamline worker regulation across health, aging and disability sectors. The proposed elements are:

- Harmonisation of worker screening – considering what screening is required at what frequency and removing barriers to mutual recognition of sector specific screening.
- Having common conduct standards.
- Shared access to information about who is registered to provide services within and across these sectors.
- Consistent thresholds for disciplinary action within codes of conduct and risk assessment tools.

- Consideration of model regulatory powers and outcomes that could apply to all these settings.
- Information sharing protocols for high risk individuals and organisations – this element would relate to the other recommendations in this Report for cooperative regulation (including the recommendations for improved information sharing between Commonwealth and jurisdictional health regulators and for a National Register of Prohibition Orders).

CONNECTING THE NATIONAL SCHEME WITH BROADER HEALTH REGULATION AND DIGITISATION

The Review proposes that tangible and immediate benefits could arise from strengthening collaboration across health-related regulators and systems development bodies.

An exemplar is the significant potential for benefits from better alignment of digital health reform with health regulation, noting important opportunities such as:

- Pursuing a connection between the processes and timing of allocating national PBS prescriber numbers and individual Healthcare Provider 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 Health Connect Australia under the Intergovernmental Agreement on National Digital Health 2023-28.
- 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. In addition to supporting interoperability and connected care, this could assist in design and delivery of continuing professional development requirements.

Taking such strategic opportunities and realising these benefits requires a collaborative arrangement, ideally 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. More structure and formality is now warranted.

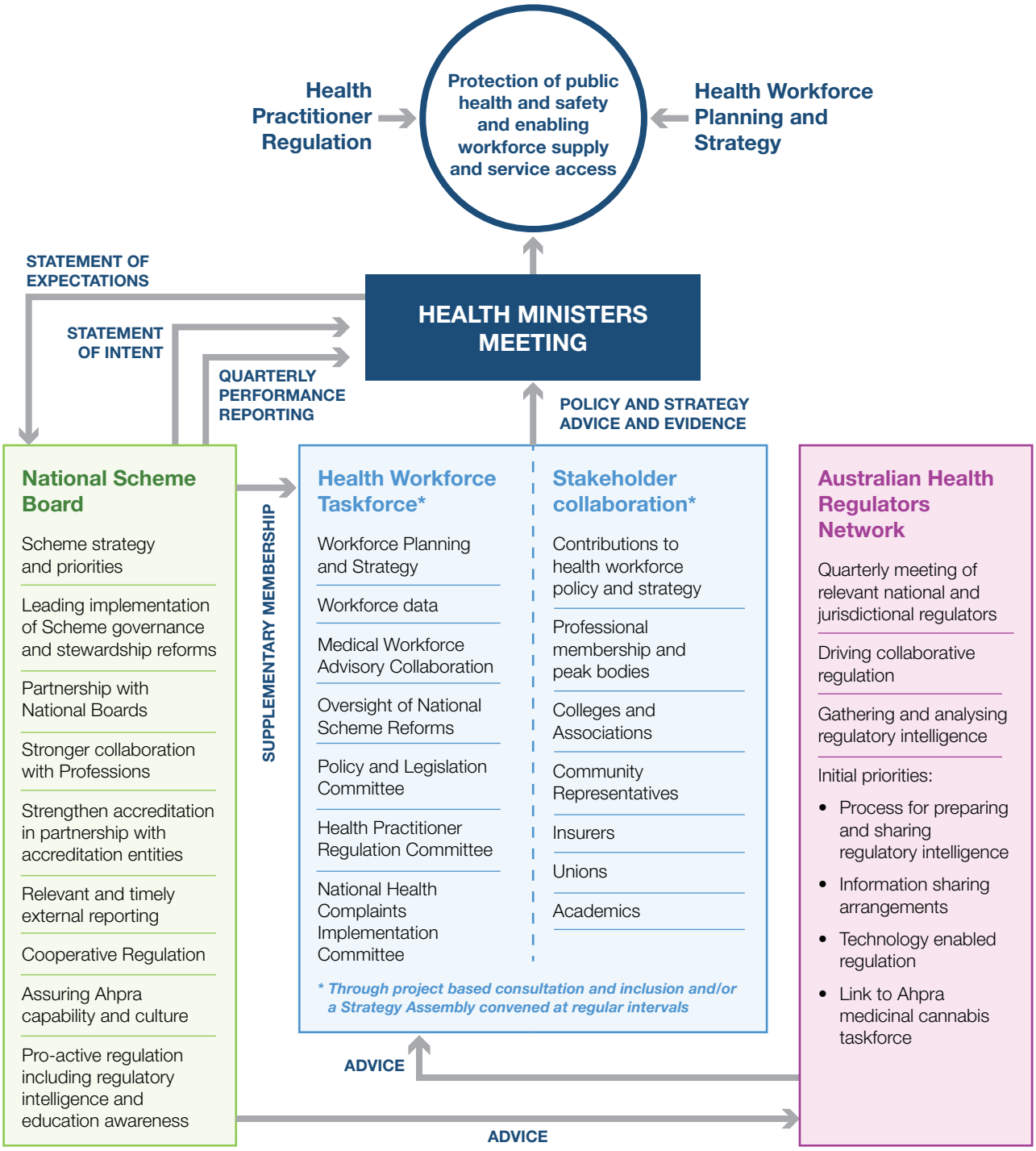
In addition to the national health-related regulators (including Ahpra, TGA, ACSQHC, PSR, ACCC, ADHA) this core membership should include representation from the Health Complaints Entities (HCEs) of the jurisdictions and HWT, in the context of the proposed unified national complaints handling systems and in recognition of the need for Commonwealth and State health 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 and for the data generated through the National Scheme to be in a form that strengthens the National Health Workforce Data Set. This would 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 would also assist to strengthen the relevance and impact of the Unit.

The Terms of Reference for the Australian Health Regulators Network could articulate the capacity to provide advice to HWT on request if required (and potentially a line of reporting to the proposed Health Workforce Practitioner Regulation Strategy Assembly).

The structural elements of the recommended directions and actions are summarised in Figure 1: Stewardship Model Supporting the National Scheme.

FIGURE 1: STEWARDSHIP MODEL SUPPORTING THE NATIONAL SCHEME



Recommended directions and actions

DIRECTION 01

Apply a regulatory stewardship model to set strategic context, priorities and accountability for health professions regulation and the National Scheme.

ACTION 1.1

A *Ministerial Council Statement of Expectations of the National Scheme* to be developed and renewed every 2 years and issued to the Ahpra Board.

ACTION 1.2

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, in collaboration with relevant professional bodies.

1.2.1 Revise HWT Terms of Reference and representation, to include:

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 Health Chief Executive Forum (HCEF) consideration.

c. More structured arrangements for workforce data sharing and analysis to inform decisions about the optimal approaches to addressing health workforce issues.

d. Structures or processes for collaboration and consultation between jurisdictions and professional membership and peak bodies, to support development and implementation of workforce plans and strategies and to inform design and delivery of accreditation and other regulatory functions.

1.2.2 In advancing 1.2.1(d) above, HWT be requested to consider further steps to strengthen the effectiveness and impact of the Medical Workforce Advisory Collaboration and the potential for similar structures to be established to achieve the necessary collaboration in other professions and across professions.

1.2.3 Disband the Jurisdictional Advisory Committee and its Jurisdictional Lead Officials Committee, to be replaced by a Health Practitioner Regulation Committee of HWT.

ACTION 1.3

Health Chief Executives Forum (HCEF) to consider the option of a Strategy Assembly on Health Workforce and Practitioner Regulation to be held every two years. This would consider whole of health workforce data and evidence, innovation in models of care and emerging risks, that may require policy, program or regulatory action.

1.3.1 The Strategy Assembly could have representative participation drawn from:

a. All jurisdictions

b. Health Regulation Leadership – Ahpra Board/Ahpra CEO; HCEs

c. National Professions – Board Chairs; professional membership and peak bodies

d. Colleges and Associations

e. Allied health – peak bodies and professional bodies

f. Accreditation entities

g. Consumer peak bodies

h. Insurers

i. Unions

1.3.2 The Strategy Assembly could receive:

a. Workforce data and analysis from Ahpra, jurisdictions, professional bodies, unions and insurers, curated by the Australian Government Department of Health, Disability and Ageing, Health Workforce Division.

b. A regulatory intelligence report on issues and risks to public health and safety from the Australian Health Regulators Network.

c. Status reports on implementation of previously agreed reforms arising from ministerial directions or recommendations accepted by Ministers.

d. Professions, practitioner and community feedback and input on health service risks and the effectiveness of health practitioner regulation.

ACTION 1.4

Australian Government Department of Health, Disability and Ageing to establish and lead a time limited project to streamline Health, Disability and Aged Care Professions Regulation. The project would involve Aged Care Quality and Safety Commission, the NDIS Quality and Safeguards Commission, and Ahpra and report progress to Health Ministers on an annual basis.

1.4.1 The purpose of this project would be working towards:

a. Harmonising settings for worker screening across the sectors.

b. Harmonising conduct standards across the sectors.

c. Shared access to information about who is registered to provide services within and across these sectors.

d. Consistent thresholds for disciplinary action within codes of conduct and risk assessment tools.

e. Model regulatory powers that should apply in each sector.

f. Information sharing about high-risk individuals and organisations.

ACTION 1.5

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.

1.5.1 Membership of the Network could include:

a. All national 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 Quality and Safety Commission, Australian Digital Health Agency and Australian Competition and Consumer Commission.

b. HCE representation.

c. Flexibility to include others as required.

1.5.2 The Network could focus on four early priorities.

a. Establishing a process for preparation and dissemination of regulatory intelligence.

b. Information sharing agreements to support co-operative regulatory operations.

c. Technology enabled or technology supporting regulation reforms.

d. Input to the Ahpra Taskforce on the regulation of medicinal cannabis.

ACTION 1.6

Health Ministers request that the National Health Reform Agreement includes a health workforce strategy schedule, through which 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 1.7

Ahpra Board to take three specified data and analysis initiatives to support more proactive health practitioner regulation and health workforce planning and strategy.

1.7.1 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. This links to action 3.4.1 vi.

1.7.2 Investigate and advise HWT on the ability to collect workforce survey information for the pre-vocational provisionally registered trainee workforces.

1.7.3 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.

> [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.
>
> Australian Association of Psychologists

Benefits

Strategy and context

Priorities and directions for health professions regulation are formal and clear.

Alignment of public safety and workforce objectives.

Single line of health regulation and workforce policy advice to Ministers.

Inclusive strategy setting – defined structures and opportunities for stakeholder input.

All health regulators working together.

Integration of health, ageing and disability professions regulation.

Workforce data and regulatory intelligence inform policy decision making.

Simpler, smarter regulation

Expanding the Scheme via integrated regulation

Risk-based regulation across all health professions.

Immediate action to address emerging health risks within existing board structures.

Co-design process to develop new lighter touch, cost effective registration model.

Complete nationwide implementation of Code of Conduct for non-registered practitioners – including National Register of Prohibition Orders.

New regulatory tools to avoid harm from exploitative business models.

Resetting Ahpra functions and structures

One entity accountable for performance and development – National Scheme Board.

Leadership structures ensure all National Boards work to clear Scheme-wide priorities and on cross-profession solutions.

Profession and consumer voices embedded at strategy and operational levels.

Financial sustainability and transparent fee setting prioritised.

Culture and capability lift to deliver more proactive, effective and compassionate regulation.

Unified national complaints handling

Consumers can make a complaint about any health practitioner or organisation in one place.

Complaints navigator service for consumers now and single front door over time.

Ahpra and state and territory complaints bodies are working together – not in isolation.

Early resolution is taken whenever possible.

Ahpra investigation and disciplinary role reserved for more serious alleged breaches of standards.

Investigation is more timely and procedurally fair.

THEME 2:

Regulating occupations across the entire health workforce

The problem defined

The Review has identified that continuous adaptation and growth of the National Scheme is essential if it is to meet the challenges of an ever-evolving health system. This must involve structured and risk-based consideration of the broader health workforce and openness to applying new models of regulation.

Stakeholders have highlighted aspects of the current design and operation of the Scheme and broader health regulation policy making that do not meet this test.

ELEMENTS OF THE PROBLEM

LIMITED LENS FOR REGULATION

Health practitioner regulation essentially lacks coherence.

It tends to be reduced to a matter of how we go about regulating the existing 16 registered professions.

While this is not an unimportant consideration, the prior policy questions are whether there are other occupations not currently within the Scheme that should be based on the level of risk, and whether there are new approaches to regulation that could inform its future shape and operation.

The last addition to the professions registered under the National Scheme occurred in 2018, notwithstanding significant shifts in the nature and manner of health services delivery since then and emergent risks. There is fragmented and limited consideration of the full range of occupations delivering health services in Australia

There is a skewed emphasis on the exiting 16 registered professions, relatively closed thinking on the future of the Scheme, and the inability to systematically consider inclusion of professions currently outside of the Scheme.

There is also incomplete implementation of the baseline level of regulation for all health practitioners, which was originally envisaged when Health Ministers determined to implement a National Code of Conduct for non-registered practitioners more than a decade ago.

> 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.
>
> Allied Health Professions Australia

EXPANDING THE OCCUPATIONS REGISTERED WITHIN THE NATIONAL SCHEME

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 are in play and include professional recognition and the expectation of equality of access to opportunities (such as access to Medicare or ability to particulate 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 generally 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. However the risk assessment methodology is too blunt and adds to the challenge of effective consideration of the options for expanding the Scheme.

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, remains an open question.

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 alone would be unsustainable for the National Scheme.

There are other registration models operating overseas that are less cumbersome but potentially effective (especially if adapted to Australian policy settings). If there were other registration pathways within the National Scheme these could be available for lower risk professions seeking to join the National Scheme.

There is active self-regulation of many allied health professions, but limited recognition of the standards applied within these professions across the health system and by the Health Complaints Entities (whose remit for regulation includes the non-registered workers in these professions). Little, if any, consideration is given to building on the existing self-regulation efforts of professional bodies.

There is currently no active policy debate or agenda to drive consideration of alternative models of regulation nor the conceptual framework supporting decisions about professions to be regulated and the manner of their regulation.

REGULATION OF NON-REGISTERED PRACTITIONERS

Australia already has a ‘negative licensing’ system of regulation. A National Code of Conduct applies to the non-registered health workforce. It is implemented by jurisdictional HCEs. However, the Code and prohibition order powers are not yet fully implemented in every State and Territory, and where it is, the approach is not consistent.

The wide powers to investigate and issue prohibition orders for non-registered practitioners within this ‘negative licensing’ system 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.

Analysis of issues and opportunities

AN INTEGRATED HEALTH PROFESSIONS REGULATION FRAMEWORK

The case for ensuring that decisions about regulating professions within the National Scheme are not made in isolation from the overall approach to health workforce 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.

> RANZCR supports the principle of an integrated framework and supports the proposal to create an additional regulatory avenue for lower risk allied health professions. Extending regulatory oversight to more healthcare providers is a positive step toward improving public safety and confidence, system consistency and provides a model that is proportionate and cost-effective.
>
> RANZCR

> At present Australia's regulation system could be considered to be a two-tiered model with registered professions in one camp and non-registered professions in the other.
>
> National Alliance of Self Regulating Health Professions

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: 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 World Health Organisation Guidance on health workforce regulation.[8]

The Review has concluded that an Integrated Health Practitioner Regulation Framework (first flagged in Consultation Paper 1) has merit. The primary benefit is that it avoids taking decisions about regulation of specific professions in an ad hoc manner or in isolation.

In its ideal conceptualisation the Framework should incorporate three types of regulation in a non-hierarchical schema:

- By National Boards/Ahpra under the National Scheme.
- By professions with enhancements that lift and strengthen current self-regulation practices and active pursuit of an additional lighter touch registration model within the National Scheme (potentially through a Professions Registration pathway).
- By jurisdictions using 'negative licensing' and enforcing compliance with the National Code of Conduct for Non-Registered Practitioners.

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. There would not be the constraint 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.

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.

Entry into the National Scheme must continue to be risk-based. Ultimately, given the costs and the impacts on providers and the grounding purpose of the Scheme 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 that 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 three reform options for entry to the Scheme that were presented in Recommendation 8 of the Scope of Practice Review,[9] 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. 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.

> Scope of practice reforms will continue to be at the top of the Government's reform agenda as medical workforce challenges continue. This will see activities of existing and new health workers develop. Better this happens in a quality assured and regulated manner.
>
> RACGP

This Review has concluded that the current risk criteria and associated guidance are focussed too narrowly and should be revised.[10] Irrespective of whether there is a new Professions Registration Pathway into the National Scheme, stakeholders were supportive of proposals strengthening the risk-based entry criteria and processes for managing entry of new professions to the Scheme. This action is carried forward in the final recommendations.

Revisions to the administrative instruments for assessing risk should adopt a broader and more evolved approach to risk management. They should continue to consider immediate and serious threats of harm or actual harm, and also assess and classify risks as more or less serious. The assessment would include not just recorded impacts and harms, but also aspects such as lifelong harms and 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.
- Variation and emergence in scope and complexity of practice.

The Review has also found that fuller consideration of public benefits should also be part of the first stage of assessment for entry to the National Scheme. At present, criteria 6 in the 2018 AHMAC Guidance is that Ministers consider whether the public benefits of regulation clearly outweigh the potential negative impacts. However, the Guidance explicitly states that this is only an optional criterion to be addressed in a submission to enter the Scheme and should be subject to independent assessment upon receipt of the submission. Better practice would be that any submission to enter the National Scheme presents 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. This recognises concerns about the fragmented and ad hoc nature of the current processes, noting too the significant costs of the two staged assessment method.

> 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

> 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 – SCU

The final recommendations of the Review propose 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 proposed process is summarised in Figure 2, and includes:

- An Expression of Interest (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.[11]
- 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 National Scheme – and, if the proposed Professions Register pathway is ultimately established, whether that profession is to be regulated by a National Board or by a professional body.

FIGURE 2: 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.
- Distinguish between higher or lower risks
  - 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)
  - Expanding or emergent scope of practice.

Risk Assessment Process

STAGE 1

Structured and transparent EOI process for suitability assessment

↓

2 yearly EOI cycle

↓

Specified requirements for EOI documentation

↓

HWT established EOI Advisory Panel including independent expert advice

↓

Panel advises HWT

↓

HWT recommendation to Ministers

↓

Ministerial determination

↓

Profession notified of decision

STAGE 2

Regulatory Impact Analysis to consider costs and benefits and level of any required regulation (full or modified impact analysis available)

↓

Ministerial Determination

↓

No additional regulation required

Profession-led regulation under potential new entry pathway

Ahpra National Board Regulation

REGULATION OF THE SOCIAL CARE PROFESSIONS

The question of whether the scope of the National Scheme ought to be expanded to explicitly enable inclusion of any professions that work in the broader social care sector as well as partially in 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.[12]

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 has sufficient flexibility to include a social care profession in the National Scheme where that is appropriate, determined on a case-by-case basis. When assessing the appropriateness of a profession for inclusion in the National Scheme, it is both relevant and necessary to pose the questions of whether a profession primarily delivers services in a health setting, the nature of those services, and whether regulation is best conducted through the health portfolio. This acknowledges and supports the principle that the expertise and accountability for setting and enforcing standards may most appropriately rest with those overseeing and governing those settings if the dominant service delivery context is other than a health setting.

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 and this is the genesis of the earlier recommendations for streamlining health, disability and aged care regulation (through action 1.4).

BENEFITS AND POSSIBLE DESIGN AND GOVERNANCE OF A LIGHTER TOUCH PROFESSIONS REGISTRATION MODEL

It is appreciated that there is divided opinion on progressing a new lighter touch registration model within an integrated regulation framework. The Review has concluded that a new registration pathway should be regarded as 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 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 the option of 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 in the manner envisaged 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). The specific concern is that this 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 through self-regulation. Harmonising standards across professions and recognition of those standards across the health system is necessary.

- 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.
- 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 professions would be 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 Board registered professions, workforce planning and strategy will always be hampered.

While the case for a new registration pathway into the National Scheme is solid, any additional registration model would need to differ materially from the UK approach. The strong stakeholder advice was that it must deliver the desired benefits (including title protection, mandatory practitioner participation in a register, robust accreditation standards, and independent complaints handling). The costs will need to be clearly identified and appropriately distributed. For occupations entering the Scheme through the proposed new Professions Registration pathway, governance also requires close consideration.

Extensive stakeholder discussion on the language to be used in describing any potential new pathway into the Scheme and the status of it relative to the Board registered professions, were but two indications of the general desire for fuller opportunity to understand and examine the details and impacts. This included advocacy against language such as 'Accredited Professions' (to avoid confusion about the nature and function of accreditation within the National Scheme and therefore avoid further complexity), or 'Approved Professions' (which would be seen to suggest that self-regulated professions outside of the National Scheme did not meet with approval). There was support for the use of the working label 'Professions Registration' and to be clear that any such form of registration would be within the National Scheme, not outside of it.

Possible design features of a Professions Registration Pathway were discussed in depth and this initial thinking is summarised below.

POTENTATION DESIGN OF A PROFESSIONS REGISTRATION PATHWAY

This would be a new pathway into the National Scheme, differing from Board registration in terms of the structures and accountabilities and the role of Ahpra in regulating the relevant professions.

ROLE OF AHPRA AND THE PROPOSED PROFESSIONS REGISTRATION COUNCIL

The Review does not intend that each profession entering the National Scheme under the 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 Professions Registration 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. This Council would have the same status and participation in Scheme wide leadership arrangements as each of the National Boards.

The role of the Professions Registration 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 Professions 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 be on a profession based register would cover the range of credentialing and assurance actions required for practitioners seeking registration. This would include aspects such as:
   - Checks on qualifications.
   - Criminal and professional history.
   - Re-registration intervals.
   - Recency of practice.
   - Insurances.
   - Completing Continuing Professional Development.

   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 set by the Professions Regulatory Council (potentially advised by an internal 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 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 Professions Registration functions 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 Professions Registration model. It is not considered appropriate that there be more than one professional body for a profession seeking entry to the Scheme via this pathway. 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 Professions Registration Pathway, the profession would need to demonstrate how it complies with standards for the operation of a profession register and it would then be formally established under the governance of the 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 PROFESSION

Where a profession is added to the Scheme through the Professions Register pathway it would be mandatory for practitioners seeking to deliver services in that profession to be registered. 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. Professions operating registers 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 minimis* provisions of the existing Codes of Conduct.

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

A WAY FORWARD ON PROFESSION-LED REGULATION

Ultimately and importantly, stakeholders shared the view that the National Scheme cannot stand still in the face of continually changing and evolving health services and associated risks. The question is how the necessary growth and adaptation can be achieved in a sustainable and measured way.

Notwithstanding the powerful case for progressing a lighter touch regulation mode and significant pockets of support for this, the Review noted also the dominant preference for a cautious and measured approach, to avoid the possibility that a new Professions Registration Pathway, if not carefully designed, could add complexity, with the risk too that costs could outweigh the benefits.

For the currently self-regulated professions, there was strong support for having a new pathway into the National Scheme, but also a recognition of the need for fuller discussion and assessment of how it would work, the structure and nature of obligations that would be borne by professions and practitioners, and potential cost impacts for the professions and practitioners.

AHPA and its members presented the following summary of their perspectives:

- Strongly support the recommendation to undertake additional work to explore an additional 'profession registered' pathway that sits within the Scheme.
- Additional work will need to consider carefully how roles break down between individual professions and a proposed Council.
- Need to further consider appropriate levels of independence for functions such as accreditation, registration of practitioners etc.
- Full fiscal separation is not necessarily required and any recommendation for fiscal separation should carefully consider if other options provide sufficient protection against bias while also reducing potential cost or viability issues.
- Concern that professions may be required to undertake formal fiscal separation, implement associated constitutional changes, implement new IT systems, and otherwise meet requirements prior to being able to apply for inclusion in the Scheme. It may be more appropriate for the application process to allow professions to specify changes that would be made during a transition period, if they are granted entry.

Similarly, a number of jurisdictions highlighted the importance of taking more time to consider the feasibility of a new registration pathway, and to build a clearer picture of what features would be required to ensure that it is lighter touch, more cost effective for registrants, and coherently connected to the existing streams of health practitioner regulation.

The final proposed directions and actions recommend pursuing an additional registration pathway as a component of an Integrated Health Professions Regulation Framework, recognising that this would be an extension of the existing self-regulation model. They present some potential general design features of this pathway drawing on stakeholder input and as a starting point for further consideration of the feasibility and detail of these features. A collaborative 'co-design' process between the jurisdictions, self-regulated professions and Ahpra is proposed.

However, the Review remains mindful of the need for immediate action to manage apparent or emerging risks to public health and safety, as this further deliberation will take time.

The final recommendations therefore propose an additional action, for an early selective EOI process for professions entry into the National Scheme within its existing structures and risk criteria. This would involve jurisdictions considering existing risk-related data and evidence. Where this suggests attributes of the occupation that pose risks and the potential need for additional regulation, this would lead to invitations to those professions to seek consideration of entry to the National Scheme. Approval for addition of any new professions to the Scheme from an EOI process would continue to rest with Health Ministers.

The recommended directions and actions also include interim actions to uplift the current self-regulation arrangements across allied health professions. This is with an eye to strengthening recognition of the standards applying in and across the self-regulated professions and application of those standards in regulatory decision making for the non-registered professions by each of the jurisdictional health complaints entities.

> AHPA and its members have significant concerns about the potential for ineligible professions to be disadvantaged by the introduction of a new pathway unless there is also a focus on improving recognition of self-regulation, and the role of HCEs and the National Code of Conduct in supporting self regulation.
>
> AHPA and its members recognise that the National Code of Conduct and the HCEs could work much more effectively and that improved effectiveness would strengthen regulation for unregistered and potential profession registered professions. The changes needed include…
>
> - Formalising relationships with self-regulating health professions (such as through MoUs) as the basis for ensuring that HCEs:
>
> i. Can (and do where appropriate) collaborate with health professions at all stages of the complaints process—making complaints, investigating complaints (including access to independent clinical input with appropriate specialist knowledge for the area of practice), and setting conditions as a result of regulatory actions, with support from professions to ensure these are carried out appropriately.
>
> ii. Understand the standards and requirements that apply to health professionals within self-regulating health professions to ensure that HCEs apply appropriate requirements when investigating complaints including competency, recency of practice, and CPD requirements.
>
> iii. Establish mechanisms for cross referring complaints, noting that HCEs will manage complaints requiring regulatory intervention while professional associations manage complaints that sit below that threshold and involve advice and guidance to practitioners.
>
> iv. Understand privacy limitations that may impact referral and collaboration with professions and address these.
>
> v. Understand titles and service offerings associated with particular professions, based on established training requirements and certification, as the basis for being able to protect consumers from service providers misrepresenting what they offer (effectively affording title protection).
>
> - Involvement of self-regulating health professions in a forum with HCEs focused on understanding and identifying trends and issue areas associated with complaints as the basis for supporting collaborative work to educate professionals and address emerging issue areas.
>
> Allied Health Professions Australia Submissions

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

The risks to consumers associated with non-registered practitioners who are delivering health services in areas where there is not a formal training and qualification requirement or accreditation and no protective structures (such as worker screening, qualification checks, supervision, or performance management) are significant.

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 and a National Register of Prohibition Orders across Australia.

> The ASA considers that the National Code of Conduct and its negative licensing approach provides a good baseline. It helps to ensure that patients have a standard against which to measure health practitioner behaviour and that patients have a complaint mechanism. 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

> 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

If the National Code of Conduct was in place in all jurisdictions and operating to optimal potential this would provide:

- Increased awareness of non-registered health practitioner of their professional and ethical obligations.
- A cost-effective means of setting and enforcing minimum standards of safety and quality, across the entire non-registered health workforce.
- A safety net for consumers to build confidence in comprehensive health practitioner regulation.
- Consumer access to information about practitioners who are subject to conditions or prohibitions, irrespective of their registration status.

> This reform acknowledges the issues around complaints about health practitioners who are not registered within the National Scheme. This is important as there needs to be consistency in how complaints are managed, and a consumer should be able to make a complaint about any practitioner, regardless of their registration status.
>
> [C]consumers are often unaware of the regulatory status of practitioners. Most consumers would not be aware of the National Scheme and which sorts of practitioners are covered by the Scheme. We are particularly concerned about consumers who have complaints of a serious nature, such as sexual misconduct, about a practitioner such as an audiologist, massage therapist, nutritionist, dietician or a speech pathologist….
>
> Consumers have every reason to believe that if they have a serious complaint to make about someone who claims to have provided a health service, that there would be a national regulatory body who could not only investigate but could provide a serious sanction as well.
>
> Health Consumer Council WA

Implementation of the National Code by all jurisdictions should be followed by strengthening the effectiveness and consistency of regulation of non-registered practitioners across the States and Territories.

This harmonisation task should include actions to drive consistency in protective features, including the threshold for Prohibition Orders, the ability to publish the reasons for Prohibition Orders (so that consumers are aware of the circumstances of the disciplinary action) and the capacity to issue a public warning during or after investigation to assist in protecting the public. It was noted in that regard that some Acts (such as in Queensland) confine Prohibition Orders to matters where there is a "serious risk" and a general absence of broader tools that can be applied in non-registered practitioner matters.

> A broader suite of regulatory tools should be considered such as findings on breaches of standards, cautions, warnings, education and practice conditions.
>
> Office of the Health Ombudsman (Queensland)

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 the recommended Direction 04 and related actions.

REGULATORY INNOVATION

Just as regulation of registered practitioners should not occur in isolation from regulation of other occupations in the health workforce, so too should regulation of individual practitioners not overlook the importance of regulation of health organisations to address risks to public health and safety.

The management of complaints about health organisations is a well-established feature of the role of all State and Territory HCEs. There is the opportunity to strengthen this stream of regulation.

The Review noted with favour the manner in which the Prohibition Orders are used in a wider fashion in NSW, where the Health Care Complaints Commission can issue a prohibition order against a relevant unlicensed and unaccredited private health organisation, where an investigation shows that that organisation has breached the code of conduct relating to that organisation or been convicted of an offence under public and private health or consumer and completion legislation.[13] This power offers extra regulatory reach in circumstances where the risk to consumers arises from the action and business practices of an organisation rather than an individual. It has been used to good effect in relation to risky practices in organisations such as cosmetic clinics.

The option of extending minimum protective standards to all unlicensed and unaccredited health facilities (such as massage facilities or cosmetic parlours) that often operate on the fringes was welcomed during the targeted consultation. This recognises that risks to consumers can arise not only from the actions of individual practitioners. It will become all the more important in a climate where business models in health service delivery may be more commercially oriented and more consumer demand driven, with less connection to therapeutic purpose and less clinical governance.

The recommended directions and actions therefore include a proposal for adoption of this wider regulatory approach across all jurisdictions.

The elements of the recommended approach to regulation are summarised in Figure 3: Integrated Health Professions Regulation.

FIGURE 3: INTEGRATED HEALTH PROFESSIONS REGULATION.

IN PARTNERSHIP WITH OTHERS

Aged Care and Disability Regulators
Streamlined worker screening and registration to support worker mobility and regulatory coherence

Australian Health Regulators Network
Joined up solutions to common regulatory problems across product, consumer, and integrity regulators (including TGA, Ahpra, HCEs, Borderforce, ACCC, PSR and ACSQHC)

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: 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 by the World Health Organisation.

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.

Recommended directions and actions

DIRECTION 02

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

ACTION 2.1

Endorse an Integrated Health Professions Regulation Framework, which stratifies the intensity of regulation according to risk and ultimately delivers three models of regulation, as a basis for future decision making on the approach to regulation of all health professions.

- **National Board regulation** of registered professions that pose the most significant risk to public health and safety.
- **Enhanced profession-led regulation** – uplift of existing self-regulated profession practices and active consideration of a new Professions Registration Model 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

Health Workforce Taskforce (HWT) to review and revise the risk assessment method and the process for assessing professions for entry to the National 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).
- The likely predominance of vulnerable patients.
- Variation and emergence in scope and complexity of practice.

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 and is most appropriately regulated by the health portfolio. There should be 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 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 – 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.

g. Rules and timeframes applying to re-applications for entry to the Scheme once an application is not approved.

h. Explanation of a modified impact analysis method and when this might be appropriate.

ACTION 2.3

HWT to establish a collaborative process to examine the potential features and feasibility of a Professions Registration Model within the National Scheme, involving the self-regulated professions, allied health peak bodies and Ahpra.

2.3.1 The features and feasibility assessment 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 and 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 relevant registered 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 and align with the NRAS profession standards as far as possible.

h. Support the collection and provision of data relating to the approved profession, for inclusion in the National Health Workforce Dataset.

i. 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.

j. A streamlined governance model, with multi-profession governance of professions, whereby:

   – There could be a newly established 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.

ACTION 2.4

Pending completion of actions 2.2 and 2.3, HWT to initiate a selective Expressions of Interest process to extend the National Scheme under the existing risk-based method. Jurisdictions would identify professions where available evidence suggests a current and significant risk to public health and safety, such as to warrant consideration of immediate inclusion in the Scheme.

2.4.1 This process should include a sustainability consideration – whereby the cost and impact of adding a profession would be minimised by the ability to regulate that profession under an existing Board.

2.4.2 This process should also aim to support further consideration and design of a modified Impact Analysis method for assessment of entry to the Scheme. This links to action 2.2.2(h).

2.4.3 The decision to approve a profession for entry to the Scheme would continue to rest with Health Ministers.

ACTION 2.5

Health Ministers commit to complete implementation of the National Code of Conduct for Non-Registered Practitioners by all jurisdictions within 24 months (including reaffirming the 2015 decision to establish a National Register of Prohibition Orders and actions to strengthen the effectiveness of the Code).

2.5.1 HWT to request the National Complaints Handling Implementation Group (proposed at Action 4.1 of Direction 04) 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 explanatory information (see action 4.1.4) to enable HCEs to explain the Code in an accessible and consistent way, including clarity around regulation of consistently contentious services such as massage therapy and social work.

b. Proposing 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.

d. Ensuring active consideration of the option of strengthening the regulatory powers of State and Territory HCEs to issue Prohibition Orders to relevant unlicensed and unaccredited private health organisations (based on the NSW model).

e. Establishing a structured working relationship with the self-regulated allied health professions (most likely through AHPA and NASRHP) to strengthen regulatory linkages, and with the following specific objectives:

   – Greater mutual recognition of the Code of Conduct and profession specific standards, with consistent and effective application of those in regulatory decision making.

   – Implementation of complaint referral protocols.

   – Accessing clinical advice in support of regulatory decision making.

   – Assembly of regulatory intelligence to support proactive regulation of non-registered practitioners.

   – Education of practitioners on standards and obligations.

   – Explore the potential for profession-based supports (for instance in relation to monitoring, mentoring, training or supervision) to strengthen the options for regulation of non-registered practitioners.

Benefits

Expanding the Scheme via integrated regulation

Risk-based regulation across all health professions.

Immediate action to address emerging health risks within existing board structures.

Co-design process to develop new lighter touch, cost effective registration model.

Complete nationwide implementation of Code of Conduct for non-registered practitioners – including National Register of Prohibition Orders.

New regulatory tools to avoid harm from exploitative business models.

Strategy and context

Priorities and directions for health professions regulation are formal and clear.

Alignment of public safety and workforce objectives.

Single line of health regulation and workforce policy advice to Ministers.

Inclusive strategy setting – defined structures and opportunities for stakeholder input.

All health regulators working together.

Integration of health, ageing and disability professions regulation.

Workforce data and regulatory intelligence inform policy decision making.

Simpler, smarter regulation

Resetting Ahpra functions and structures

One entity accountable for performance and development – National Scheme Board.

Leadership structures ensure all National Boards work to clear Scheme-wide priorities and on cross-profession solutions.

Profession and consumer voices embedded at strategy and operational levels.

Financial sustainability and transparent fee setting prioritised.

Culture and capability lift to deliver more proactive, effective and compassionate regulation.

Unified national complaints handling

Consumers can make a complaint about any health practitioner or organisation in one place.

Complaints navigator service for consumers now and single front door over time.

Ahpra and state and territory complaints bodies are working together – not in isolation.

Early resolution is taken whenever possible.

Ahpra investigation and disciplinary role reserved for more serious alleged breaches of standards.

Investigation is more timely and procedurally fair.

THEME 3:

Strengthening performance, accountability and transparency within the National Scheme

The problem defined

The National Scheme has been looked at through the lens of principles of regulatory stewardship and mainstream governance discipline. The structures, processes and functions of the National Scheme are either not present or not designed to achieve strategic clarity and accountability, alignment of priorities with strategy, or appropriate performance standards.

Stakeholders have highlighted many of the associated issues.

ELEMENTS OF THE PROBLEM

NARROW REGULATORY POSTURE

National scheme does not have a well evolved regulatory posture.

It is predominantly reactive and inward looking, focussing on the mechanics of the separate parts of its operations (registration, accreditation, and notifications). It lacks a clear picture of how together these support the statutory objectives of the scheme and how innovation might drive improved outcomes.

Engagement with health workforce policy makers and the regulated professions is generally at a more operational level and not at the level of setting directions, policies and priorities, which ultimately limits effectiveness and agility.

The 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.

WEAK GOVERNANCE

Missing are the governance and accountability fundamentals.

- Lack of visible alignment between strategy and operational priorities.
- Inadequate performance measurement and reporting.
- Lack of partnership structures with the professions in planning and implementation.
- Poorly resolved stakeholder engagement policies and practices.
- Insufficient clarity around the culture, capability
- Building and change management required to ensure that systems and processes deliver outcomes.

FRAGMENTED ACCOUNTABILITY

The National Scheme has distributed powers and responsibilities across multiple statutory entities. It lacks both a single line of accountability and clearly articulated roles and responsibilities across its decision makers and entities.

Too often individual entities are straining in a different direction to others, or not keeping pace with desired improvements. This is a significant impediment to its ability to adapt to meet new challenges and to maintain strategic alignment across all functions over time.

Major decisions or significant potential change will continue to be required to ensure that regulatory effort across the National Scheme as a whole remains efficient, effective and responsive. It is impractical and difficult (and too frequently unachievable) to work through 15 National Boards (in addition to the Ahpra Board).

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 is a problem requiring resolution, especially as more streamlined and flexible arrangements might work just as well.

ACCREDITATION FUNCTIONS REQUIRE STRENGTHENING

Differing perspectives on accreditation decision making and processes are a significant point of tension. 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 stronger strategic connection between workforce strategy and 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.

SUSTAINABILITY IS AN ISSUE

The National Scheme is almost exclusively registrant funded.

Recent patterns of rising registrant fees have shone a light on the absence of a transparent set of principles for the use of registrant fees.

While the preference is to maintain profession based decision making, challenges to financial viability (particularly for boards of smaller professions), Scheme sustainability, and the need for improved efficiency are nevertheless issues without sufficiently transparent consideration.

Analysis of issues and opportunities

A SINGLE LINE OF ACCOUNTABILITY

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.

In terms of who ought to be responsible for stewardship and accountability of the National Scheme, many hold a firm belief that it ought 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 National Scheme which is unified by clear common purpose and led to deliver to that purpose across all functions, 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.

Contemporary regulatory stewardship principles need to be applied. 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.

To evolve and adapt and to meet the expectations, requires strong and purposeful leadership 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.

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. It is consistent with its current statutory 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 additional to its core responsibilities of reporting on the operational performance of the National Scheme.

Success will require building on the current skills-based Board. 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.

More specific Board membership skill requirements (within or in addition to the current statutory membership specifications) should 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 fee setting and budgeting for Boards and across the Scheme, in the context of significant growth in expenditure and registrant 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 the view that this proposed reset of the Ahpra Board is consistent with and achievable within the existing legislation, at least in the short term.

The National Law 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.

Implementation therefore could and should begin through administrative measures as far as possible.

Nevertheless, and for abundance of clarity and transparency, it may ultimately be considered necessary to amend the legislation. This could 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 the performance of the Scheme as a whole and the delivery of profession-specific regulatory functions within this.

It is important to note that this gap is already recognised by the National Scheme leaders and work is already in progress through collaboration between the Ahpra Board and the National Boards to address it.

The Review is an important opportunity to set the expectation that the reset of the 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 Council), 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 priories both within and across professions.

ENSURING AHPRA CAPABILITY

Regulating a rapidly growing and changing health sector, ensuring continuous improvement, and delivering best practice regulation is challenging. Success will be a strong reflection of culture and capability.

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 short and outcomes-oriented capability with the objective of building confidence and trust in the ability of the Agency to support the Scheme to meet its objectives.

> We support the proposal to improve performance across AHPRA functions but stress that structural change must be accompanied by a cultural shift toward greater collaboration, transparency, and responsiveness.
>
> Royal Australian and New Zealand College of Radiologists

> An independent organisational review would help Ahpra navigate the challenges of a nationwide organisation and rehabilitate its standing with stakeholders.
>
> Health and Community Services Complaints Commissioner (SA)

The Review notes and welcomes the commitment already made by Ahpra to progress this Independent Capability Review.

> The capability review proposed in the Review presents an opportunity to explore what our future needs are to be an agile regulator, capable of responding to changing needs.
>
> Ahpra

The Review is seeking to ensure that it draws on best practice principles and the *Regulatory Performance Guide of the Australian Government* (RMG128). 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.[14]

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

It also seeks to shine a light on capability benchmarks and expectations of stakeholders. The Independent Capability Review should aim to provide necessary assurances that the National Scheme will be supported through:

- A proactive and preventative regulatory posture, underpinned by a strong performance and outcomes orientation.
- 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 stakeholders inputs.
- Workforce skills, expertise and structures aligned to the desired focus on professional standards regulation – particularly to maintain strength in clinical advice, investigation and prosecution capabilities and regulatory intelligence.
- An embedded and enduring ethos of working in collaboration with professions, peak bodies, State and Territory jurisdictional health regulators and other national health regulators.
- Continuous improvement and a learning culture.

AN IMMEDIATE STRATEGIC AGENDA FOR THE NATIONAL SCHEME BOARD

The Ministerial Council Statement of Expectations proposed in Direction 01 will ultimately provide a mechanism for setting priorities to guide the strengthened stewardship function of the Ahpra/National Scheme Board, but this Review has identified immediate priorities for action which should not be delayed.

The Review has identified six immediate priorities which are both necessary and achievable to see early improvement in the performance, governance and accountability.

i. Establish a Scheme-wide performance monitoring and reporting framework.

This is essential to delivering the required level of transparency and accountability- a cornerstone of maintaining confidence in regulation.

The Review heard that the National 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 more detailed operational reporting, but 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.[15]

Ahpra staff need real time reporting designed to support effective case management.

ii. Review of budget and fee setting processes and principles.

The National Scheme is registrant funded, although from time-to-time government funding has been provided to adapt the Scheme to address policy priorities (such as the implementation of the expedited registrations pathways and recently funded research into the training and education of psychologists in Australia).

In the context of increasing registrant fees and in consideration of the likelihood of additional investment requirements to develop a more proactive approach to regulation pathways expand the Scheme, the targeted consultation has highlighted the need for a greater transparency and clarity in how registrant fees are set and what they should be used for.

> 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.
>
> AMA

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

> [T]he current funding model (and National Law functions) has precluded a proactive risk management focus that looks beyond notifications received. 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.
>
> Community Advisory Council

iii. Review of the National Board selection criteria and processes.

There is a widely held view that the current processes for managing board appointments are administratively cumbersome and not sufficiently focussed on the outcomes for key appointments.

The Review has concluded that there is benefit in retaining existing Ministerial approval of Board Chair and Deputy Chair appointments, but significant potential to streamline selection processes for other board positions- including delegation to the Ahpra/National Scheme Board. Ahpra has advised that it is already embarking on improvements to board appointment processes and these additional considerations would add to that work.

iv. Review and strengthen stakeholder engagement strategy and structures.

The consultation uncovered the common experience of stakeholders that, somewhat paradoxically, they feel over consulted and yet unheard. The Review noted that the Scheme has a stakeholder engagement strategy, but that it is at a high level. Essentially it is not seen as a driver for day-to-day practice around what engagement will occur, with whom, and when. There is insufficient stakeholder confidence that their views are well presented or understood when key policy or process decisions are being made.

Measures to rebuild stakeholder relationships and to embed genuine collaboration are required.

v. Review processes for development and approval of registration and accreditation standards and Codes of Conduct.

Within a strategic, proactive and preventative model of regulation, effective and contemporary standards are imperative. Emerging risks, such as lax telehealth practices need to be addressed in a timely way. Issues that are relevant to all professions should be addressed consistently in standards. Standards must reflect evolving community behaviours and ethical mores, including in areas such as cultural safety, family and domestic violence, and anti-discrimination and racism, and assisting transitions back to work.

To achieve this requires structure and co-ordination in the program of development and approval of all codes, standards and guidelines, supported by effective ongoing education of practitioners on the obligations that sit within them. The absence of these features in current processes needs to be corrected.

vi. Embed development and application of regulatory intelligence in the approach taken by the National Scheme.

The current regulatory intelligence function of the scheme is in its formative stages. Further action is required to build it.

The question of what data and analytics capability is required should be a core question for the proposed Independent Capability Review.

Further development should also include setting in place processes for producing a Regulatory Intelligence Report at regular intervals, identifying emerging risks to public health and safety and outlining the regulatory strategy for these risks, the specific role of the National Scheme and the nature of collaboration with other health regulators.

These matters are all within the existing remit of the Ahpra Management Board and could be advanced and/or brought together through the current cycle of review of the *National Scheme Strategy (2025-30)*. This would require a commitment to presenting the revised *National Scheme Strategy* to HWT and Ministers within 6 months. It would also require future Quarterly Performance Reports to Health Ministers to explicitly report on implementation of these elements of Strategy.

If greater formality is considered necessary, these priorities could alternatively or additionally be the subject of an early initial Ministerial Council Statement of Expectations, or at its highest a Ministerial Policy Direction to the Board pursuant to Section 11 of the National Law.

THE FOCUS ON ACCREDITATION

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

Ministers have sought consideration of an additional Ministerial Power of Policy Direction for accreditation functions and progressing introduction of such a power has been recommended in the Scope of Practice Review.[16]

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) and in the current context of significant accreditation reform activity, it is very important for the purpose, potential scope and reach of any such additional Ministerial Power of Direction to be carefully considered.

A first consideration is how any proposed power of direction would sit alongside the accreditation reform already underway. This follows the recommendations of the National Health Practitioner Ombudsman (NHPO) inquiry into accreditation in 2023.[17] Many elements of this are directed at addressing the concerns that gave rise to the suggested consideration of a new Ministerial Power of Policy Direction in this Review.

- 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 consequent legislative reform would likely include to the question of whether there is a need to recognise the role of colleges in accrediting 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.
- In the context of concerns about accreditation decision making at specialist medical training sites, steps to implement recommendation 13 from the NHPO inquiry (requiring a communications protocol to ensure effective routine management of workplace safety and culture) have been taken and actions to ensure that it is fully embedded are still in train.
- The current reforms 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 (for instance prospective workforce impacts if a college believes a training site is at risk of having its accreditation revoked).

The key question, not yet able to be answered, is whether current reform activity and/or potential legislative change arising from this NHPO accreditation reform work would obviate the need to introduce a Power of Direction or have an impact on how such a power would need to be framed.

> 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.
>
> Australian Physiotherapy Council

The second consideration in any decision to progress a new Ministerial Power of Direction in relation to accreditation would be how to draft it in light of the complexity of current arrangements, to avoid any unintended consequences and to be effective.

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.

Furthermore, consideration of the need for a new Ministerial Power of Policy Direction should not be divorced from analysis and implementation of currently available administrative and statutory tools to strengthen the chain of accountability within the Scheme.

Even if a new Ministerial Power of Direction for accreditation functions is considered necessary to complete coverage of accreditation functions, the policy ideal is that such a power is not required to be exercised. The firm expectation should be that current powers are used effectively that accreditation reforms are successfully progressed and augmented by strengthened oversight and collaboration measures that are envisaged from this Review.

In terms of the effectiveness of current accreditation reforms arising from the NHPO 2023 inquiry, oversight of this is within the remit of HWT. The Review sees benefit in formalising the point at which a report to Ministers on the progress and effectiveness of reform implementation will be provided as a precursor to further consideration of the option of a new Ministerial power of Direction. This would assist in addressing questions such as whether the communications framework that has been instituted for managing concerns about bullying, harassment, racism and discrimination at accredited specialist medical training sites is having the expected benefits, or whether additional action is required.

In terms of ensuring optimal use of current Ministerial Direction powers, there is more that can be done.

As Consultation Paper 1 noted, Ministers do have a power of direction in accreditation, albeit 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*". It goes without saying that such a power only has effect if it is supported by strong processes for identifying the "substantial and negative impacts".

Those consulted gave examples of standards that have been introduced notwithstanding significant workforce service access impacts. For instance, 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 the adequacy of workforce impact assessment in setting accreditation standards, including understanding 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 confirmed that accreditation authorities are "expected" to consider the objectives and principles of the National Law, (which include workforce sustainability and service access) when developing standards.[18] However, the detailed procures do not require an explanation of how workforce impacts have been considered or the nature and extent of any potential impacts in a submission from the authority to the Board.
- 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 in fact do this, how frequently advice on negative impacts has been provided to Ministers, what such advice entails, or the outcomes of those situations where adverse impacts are identified.

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.

In terms of strengthened oversight of accreditation functions, there is already an Independent Accreditation Committee established by Ministerial Policy Direction 2020-01, but a need to consider whether its remit and composition is able to deliver the additional focus that is envisaged.

> 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.
>
> Ahpra

> 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 would build stronger connections with the Accreditation Authorities to improve outcomes and deliver on the agreed strategic direction. This would also enable Accreditation Authorities to more directly contribute to improvement of the National Scheme.
>
> HPACF

> [W]ould like to see a strengthening of the Accreditation Committee, with the Australian Medical Council (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.
>
> AMA

> 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.
>
> AMC

> RACMA supports the goal of realigning NRAS structures and clarifying governance roles…[I]n particular, reform of accreditation functions and greater alignment between education standards and workforce needs.
>
> Royal Australian College of Medical Administrators

The consistent stakeholder advice was that the Independent Accreditation Committee should be re-mandated and charged with taking and stronger lead role in overseeing and reporting on reform of accreditation functions across the National Scheme.

This would require review of the IACs Terms of Reference and potentially its membership. While this could be achieved through an Ahpra Board instruction to the Committee, the significance of the issues and the imperative for change is considered such that more formal authorisation through a further Ministerial Direction using the existing powers of direction under the National Law should be considered.

The Review recommendations also recognise that Accreditation Agreements, through which external accreditation functions are procured, are both commercially and strategically important. They go to the heart of what is done within Ahpra and what is done externally in relation to accreditation and how external entities are held to account for delivering their functions. They are done within a Quality Framework for Accreditation, which is therefore a critical tool for setting expectations and achieving accountability.

> The Royal Australian College of General Practitioners is asking that NRAS is fit for purpose by …clearly articulating governance and performance expectations to support more accountable, outcome driven accreditation systems.
>
> Royal Australian College of General Practitioners

Whether by Board instruction or by Ministerial Direction, the priorities for the IAC should include:

- Review the 2023 Ahpra Board Procedures for development of accreditation standards. The purpose would be to make 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 Quality 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.

Collaboration with the professions is also key to the solution.

> 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.
>
> HPACF

> 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.
>
> Australian Dental Council

Specifically, the Review found a strong case for strengthening the role of the Health Professions Accreditation Collaborative Forum (HPACF), including a requirement for IAC to establish and maintain a structured link to that Forum. This will promote a partnership approach to accreditation reform and a direct avenue for the professions to influence strategic deliberations on accreditation matters.

NATIONAL BOARD STRUCTURES

The Review did not find a strong argument 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.

> 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…
>
> AMA

> 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.
>
> AMC

> 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.
>
> 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.
>
> Australian Psychological Society

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.

It is also not possible to look past the difficulties of maintaining viable financial and governance arrangements for some of the smaller profession boards in particular.

The governance and stewardship reset proposed above are the primary mechanism to address these issues 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 National Scheme (and especially those whose financial viability is strained), 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 National Scheme, there was significant support for increased consideration of multi-profession boards, with some flexibility and case by case consideration. The expectation could be that a profession seeking entry be expected to consider becoming part of a multi-profession board and "show cause" as to why they could not be. The revised Risk Assessment process and Guidance proposed under action 2.2 would ensure assessment of the costs and benefits of establishing a new Board relative to joining a Multi-Profession Board.

In terms of concerns about inconsistencies in regulatory policy and decision making across professions, 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.

i. 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.[19] There have not been signs of progress since then.

ii. 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 additional structures, other models of national decision making to address this.

    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.

    This is not an unrealistic objective or timeframe, noting the advice of Ahpra that the National Scheme has a strong track record in successfully managing such transitions for other professions.

> The MBA already has a number of national decision-making committees. The NMBA is currently working through transitioning its state and territory boards to national registration and notifications committees…
>
> We already have substantial experience in successfully managing this transition. In recent years, the Dental Board of Australia and Psychology Board of Australia have transitioned their respective state and territory boards to national decision-making structures. These transition processes included analysis of the regulatory decision-making requirements of these boards, along with engagement and consultation to enable the changes to be made. Each Board now has national registration and notifications committees, which make decisions about matters across the country. We are confident this transition can also be made for the medical, nursing and midwifery professions.
>
> Ahpra

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.

> There is currently a lack of consumer voices involved in decision-making processes and governance, and performance reporting is currently opaque and in need of more transparency.
>
> We again feel this is another opportunity to embrace consumer leadership by ensuring consumer representatives are part of all key governance groups and are part of the decision-making process. Including consumers in governance processes may be a cultural change for some groups and may present a challenge, but the time to do this is now, while these reforms are being implemented, to embed the consumer voice in the process of change.
>
> Health Consumers' Council – Western Australia (HCONC)

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

Understanding the community facing purpose of the National 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 National 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 Delivery and Development Leadership Group to establish a Professions Liaison Group. This would replace the current Professions Reference Group and to give effect to the strong and consistent advocacy for increased professions involvement in shaping and supporting the National Scheme.

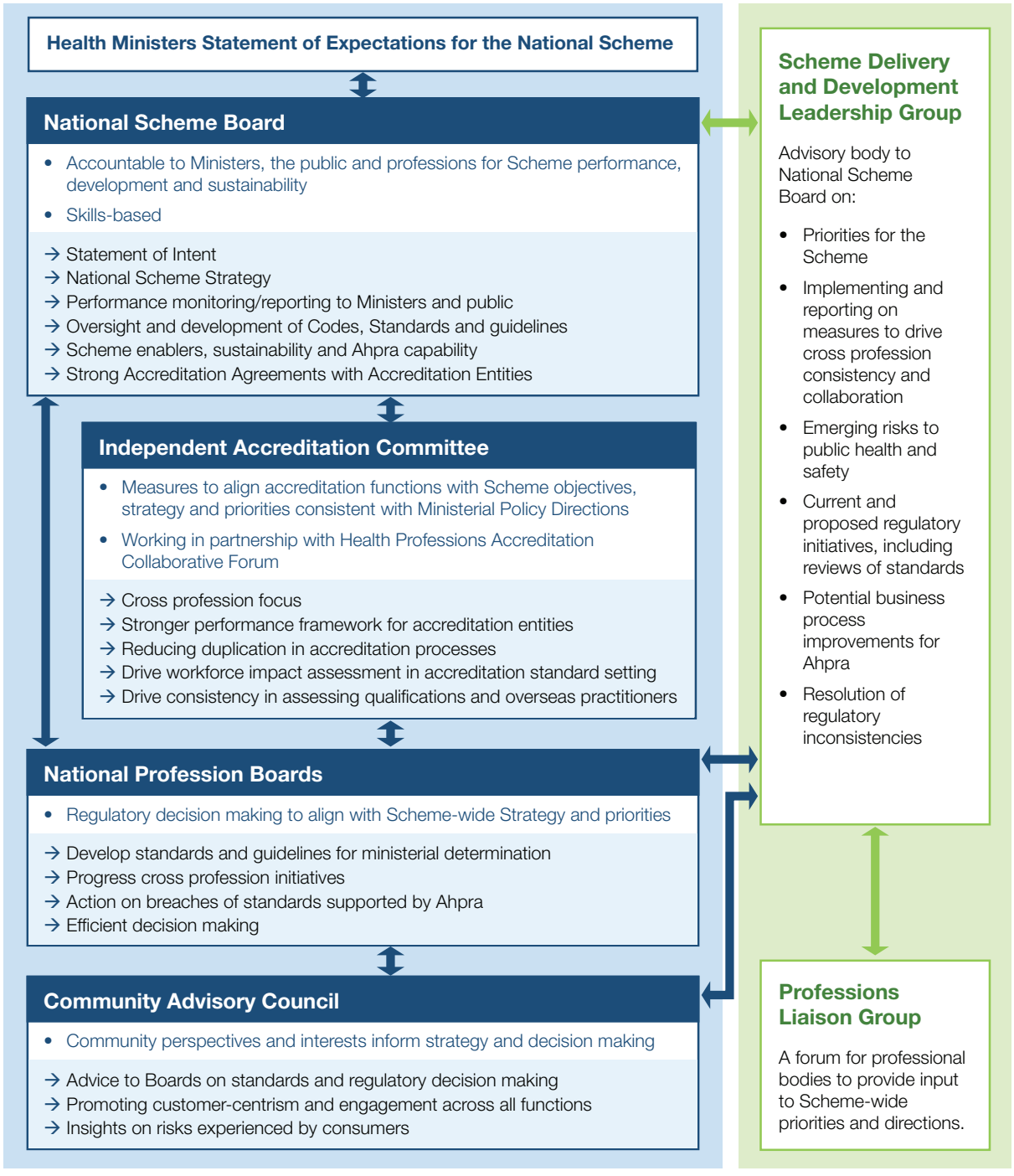
> RANZCR …agrees there is considerable room for improvement in AHPRA's governance and performance. Reforms must be implemented to deliver tangible benefits for both patients and practitioners — not simply internal realignment. We support the establishment of the Professions Liaison Group, provided that its composition is balanced and includes strong representation from medical colleges. Done well, this group could play a meaningful role in improving communication, mutual understanding, and sector engagement.
>
> Royal Australian and New Zealand College of Radiologists

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.

This Professions Liaison Group should be jointly chaired by a representative of the Scheme Delivery and Development Leadership Group and a nominated professional association representative. Membership should include a representative of the professional association of each registered profession (including any profession that may enter the Scheme under the proposed Professions Register pathway) and of the Health Professions Accreditation Collaborative Forum. The cycle of meetings could be twice a year, supported by the Leadership Group Secretariat. The co-chairs would present a report to the Ahpra Board following each meeting.

The proposed structures and accountabilities envisaged in Reform 3 are summarised in Figure 4: Governance and Stewardship within the National Scheme.

FIGURE 4: GOVERNANCE AND STEWARDSHIP WITHIN THE NATIONAL SCHEME



Scheme wide priorities 2025-26 — Built into the *National Scheme Strategy 2025-30*

- Capability Review of Ahpra
- Develop Scheme-wide performance monitoring and reporting framework
- Review budget and fee setting processes – transparent principles for use of registrant funds
- Focus on accreditation accountability reforms
- Establish clear processes for review and approval of Codes and Standards (including channels for advice to Ministers)
- Reset National Board selection criteria and processes
- Strengthen stakeholder engagement practices

Recommended directions and actions

DIRECTION 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 Health Workforce Taskforce (HWT) and the Ahpra Board to commence specified 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 on whether there is a need for, or benefit in, legislative change (to put beyond doubt the Scheme stewardship role of the Ahpra Board, formally rename it as the National Scheme 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 specified structural 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 and at least three members of the Scheme Delivery and Development Leadership Group.

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 an implementation plan to be communicated to Health Ministers within 12 months.

3.3.1 The Capability Review should focus on:

a. **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.

b. **Leadership structures and culture:** Structure 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.

c. **Collaboration and engagement:** Assessing connections internally and externally, including with Ministers and jurisdictions, Ahpra Board and National Boards, other regulators, community, professions and academia.

d. **Delivery:** Testing for: 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.

e. **Workforce:** Examining 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.

f. **Enabling functions:** Resource allocation matched to strategy and priorities; IT system implementation and change management (including AI-enabled regulation); strengthening data analytics; corporate operations.

3.3.2 The Independent Capability Review should ensure specific consideration of:

a. Strengthening regulatory intelligence.

b. Investigations structures and skills.

c. Clinical advice models.

ACTION 3.4

Ahpra Board to pursue immediate strategic priorities identified in this Review through its current cycle of review of the *National Scheme Strategy (2025-30)* and present the revised Strategy to HWT and Ministers within 6 months, with a report to Ministers on implementation of the Scheme Strategy in each future Quarterly Performance Report.

3.4.1 This Scheme Strategy and the associated development process should include:

a. Identifying actions already taken to implement HMM directions and agreed recommendations relating to the National Scheme and any actions yet to be taken (including timeframes for those).

b. Establishing major projects to deliver the following:

i. 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.

ii. Review of the annual budget and regulatory fee setting processes within the Scheme, with a view to proposing principles for use of registrant fees, 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.

iii. Review the National Board appointment selection criteria and process, with the following objectives:

- Retaining Ministerial approval of Board Chair and Deputy Chair appointments.
- Streamlining selection processes for other Board positions, including delegation to National Scheme Board.
- Including explicit requirements for board members to adopt a Scheme-wide approach to performing regulatory functions.
- Formalising representation of the Community Advisory Council on Board selection panels.

iv. Strengthen 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.

v. Establish and oversee a more structured and transparent processes for review and revisions to accreditation and registration standards and Codes of Conduct. There should be 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.

vi. Producing a Regulatory Intelligence Report at regular intervals, identifying emerging risks to public health and safety and the regulatory strategy for these risks (including the specific role of the National Scheme and the nature of collaboration with other health regulators).

c. Outlining Scheme development/ improvement opportunities that are in the broader public interest.

d. Identifying and advising Ministers of any proposed projects or reforms that are not considered to be consistent with registrant funding principles and which may warrant consideration of government funding

e. Considering relevant National Health Practitioner Ombudsman oversight data, evidence, and recommendations on issues and opportunities to improve the Scheme.

f. Considering possible legislative reforms to improve the effectiveness of health practitioner regulation, for consideration of the Policy and Legislation Committee of HWT.

ACTION 3.5

Health Ministers to issue a Policy Direction pursuant section 11 of the National Law, requiring the Ahpra Board to strengthen focus and accountability for accreditation functions with specified actions to achieve this over a 2-year period.

3.5.1 Ahpra Board to re-mandate and potentially reconstitute the Independent Accreditation Committee (IAC) as the entity to oversee and guide delivery of accreditation reforms within the Scheme.

3.5.2 Ahpra Board to set immediate priorities and timeframes for the IAC work program, which should include:

a. Prioritising development and implementation of workforce impact analysis requirements within accreditation standard setting and approval processes, to support effective operation of the current section 11(4) Ministerial Power of Direction on accreditation functions.

b. Reviewing and strengthening the Quality Framework for Accreditation to inform future Accreditation Agreements.

c. Reducing duplication between the accreditation bodies in the Scheme- including opportunities for merging accreditation entities if this would be equally effective but more efficient.

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.

3.5.3 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, and fostering collaborative solutions.

3.5.4 Require the Independent Accreditation Committee to present a report within 18 months for the purposes of advice to HWT on:

a. Progress of actions to achieve accreditation reform and accountability.

b. The nature and potential benefits of further policy or legislative amendments– including the option of a further Ministerial Power of Direction.

ACTION 3.6

HWT Policy and Legislation Committee to consider and advise on any further administrative, policy or legislative actions required to strengthen accreditation functions, within 24 months.

3.6.1 Monitor and report on implementation of recommendations from the 2023 National Health Practitioner Ombudsman inquiry into accreditation (including actions relating to specialist medical training sites) and actions taken by Ahpra based on this Review.

3.6.2 Consider advice from the Ahpra Board and the Independent Accreditation Committee on possible further actions.

ACTION 3.7

Health Ministers agree to maintain the current voluntary approach to amalgamation of existing National Boards. This must be 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 specified 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 show cause as to why they could not 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.

Benefits

Strategy and context

Priorities and directions for health professions regulation are formal and clear.

Alignment of public safety and workforce objectives.

Single line of health regulation and workforce policy advice to Ministers.

Inclusive strategy setting – defined structures and opportunities for stakeholder input.

All health regulators working together.

Integration of health, ageing and disability professions regulation.

Workforce data and regulatory intelligence inform policy decision making.

Expanding the Scheme via integrated regulation

Risk-based regulation across all health professions.

Immediate action to address emerging health risks within existing board structures.

Co-design process to develop new lighter touch, cost effective registration model.

Complete nationwide implementation of Code of Conduct for non-registered practitioners – including National Register of Prohibition Orders.

New regulatory tools to avoid harm from exploitative business models.

Simpler, smarter regulation

Resetting Ahpra functions and structures

One entity accountable for performance and development – National Scheme Board.

Leadership structures ensure all National Boards work to clear Scheme-wide priorities and on cross-profession solutions.

Profession and consumer voices embedded at strategy and operational levels.

Financial sustainability and transparent fee setting prioritised.

Culture and capability lift to deliver more proactive, effective and compassionate regulation.

Unified national complaints handling

Consumers can make a complaint about any health practitioner or organisation in one place.

Complaints navigator service for consumers now and single front door over time.

Ahpra and state and territory complaints bodies are working together – not in isolation.

Early resolution is taken whenever possible.

Ahpra investigation and disciplinary role reserved for more serious alleged breaches of standards.

Investigation is more timely and procedurally fair.

THEME 4:

Delivering best practice health complaints handling nationally

The problem defined

The Review has recorded the deep frustration and confusion of consumers, practitioners and health service providers about the processes for managing complaints.

The problems present most starkly in the delays and lack of customer centrism in Ahpra processes, which have significant impacts on both health consumers and practitioners. They also extend to the broader problem of the absence of structures and processes for Ahpra to link with the State and Territory Health Complaints Entities (HCEs). This means that there is disjointed regulation, not just for registered practitioners but also in the related endeavours of managing complaints about non-registered practitioners and health organisations.

There is a universal stakeholder view that complex and dysfunctional complaints handling arrangements are a significant element of eroded public confidence in the integrity of health practitioner regulation.

ELEMENTS OF THE PROBLEM

LOW CONFIDENCE AND HIGH FRUSTRATION WITH COMPLAINTS HANDLING

For consumers there is an overwhelming choice of where to take a complaint, and insufficient assistance to find the right avenue to do so. They find themselves having to navigate between Ahpra, the health service providers, and/or the HCE in each state and territory jurisdiction to have their issues heard.

Consumers want a single point of entry to make a complaint. They want, but do not currently have, access to the full range of solutions from the outset – including outcomes such as facilitated resolution, an apology, explanation and/or refund.

Consumers do not want to make a notification to Ahpra only to have it retuned with a determination of no further action, as currently occurs for over 85% of notifications. In some cases this is with the suggestion that they should take the matter elsewhere.

Equally, practitioners should not have a complaint sitting within the Ahpra notifications process if there is no prospect of it warranting disciplinary action and when there are better, faster and more proportionate ways of managing the issues raised.

The overwhelming emphasis when a notification is made to Ahpra is on consideration of disciplinary action. This is at the expense of initial consideration of potentially more appropriate and less intrusive and punitive solutions, in cases where the concerns are understandable but do not justify disciplinary solutions.

Practitioners and the professions are increasingly dissatisfied that there are not sufficiently clear and well developed processes for filtering out vexations or frivolous notifications.

Practitioners understandably object to the frequency with which notifications are made and subject to lengthy consideration even when in 85% of case there is no further action required.

While the guiding principles of the legislation require that the National Scheme operates in a transparent, accountable, efficient effective and fair way, the typical experience is otherwise. For consumers and practitioners alike Ahpra processes lack timeliness, transparency and natural justice. They experience Ahpra communication as unhelpful and bureaucratic.

While many of the challenges of navigating and understanding the complaints handling system could be mitigated by seamless integration of Ahpra and HCE processes, these entities do not work together in a well-structured and collaborative way. This is a significant contributor to the unabating frustration and fractured confidence in the management of health care complaints and notifications.

FRAGMENTED RESPONSES TO SERIOUS REGULATORY EVENTS

When a significant regulatory event occurs, it is fair to say that there is difficulty for the public in understanding the roles and responsibilities of the different regulators, and who will be taking what action and within what timeframes.

There is also no assurance that the factors causing a particular regulatory issue or event will trigger a review of whether other similar situations have arisen and/or whether there are systemic issues that can be addressed to avoid a recurrence. This is concerning in the context of the significant proportion of people for whom the primary motivation for making a complaint is to ensure that others do not have the same experience, and also in the context of the imperative for a learning approach to regulation.

SERIOUS INVESTIGATIONS NOT WELL HANDLED

While robust investigation of serious matters is at the core of effective health practitioner regulation, there are signs that there is not the necessary investigation capacity and capability within Ahpra and deteriorating timeliness is a reflection of this.

The evidence available to the review was that 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.[20] There was also evidence of cases that had been in the process for more than three years, but not yet brought before a tribunal.[21]

Poor timeliness is always an issue in regulation. This is of even more significant concern when a practitioner is subject to immediate action. In these cases they are either prevented from practising or subject to significant limitations on practising. The reasons for prolonged investigation timeframes are not apparent or not convincing. Procedural fairness and humanity is at the heart of this matter, in the context of the significant personal and economic impact on practitioners.

BOARD ROLE AND CLINICAL INPUT IN REGULATION DECISIONS

Generally, there is not sufficient level of national board confidence in Ahpra investigative and regulatory capability and there are not sufficient systems and processes in place for effective oversight of the performance of these functions. This has been a significant roadblock to increased delegation of decision-making, which is otherwise necessary for improving efficiency.

Clinical advice is recognised as being central to effective regulatory decision-making. Notwithstanding this the current clinical advice model within the National Scheme appears underdeveloped, which is a further impediment to increased delegation of decision making by Boards.

Boards express tentative recognition of the potential for increased cross-profession decision making in cases where there are issues that are ‘profession-blind’ such as sexual misconduct and cultural safety. However, there is not yet sufficient momentum to achieve this.

TRIBUNAL PROCESSES AND DECISIONS

Recent years have seen a very significant decline in the use of more informal Panel processes for disciplinary decision making. This gives rise to a question as to whether there is overreliance on Tribunals and inadequate consideration to options that could potentially be more cost effective and timely.

There is understandable concern about potential inconsistency in tribunal processes and decisions, including in sensitive matters such as sexual misconduct, boundary violation and family and domestic violence cases.

Analysis of issues and opportunities

COMPLAINTS MANAGEMENT REFORM A MUST

It is impossible to ignore the chorus of voices urging significant improvement in the processes and structures for managing complaints about health practitioners.

It is far more difficult to identify a simple and fast solution. Significant structural reform is arguably beyond reach.

Nevertheless, the imperative to fix health complaints handling 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, which they report as their dominant experience.

Reduction in administrative delays and humanisation of the processes are the overriding objectives, with a significant proxy for success being effective alternative ways of managing the 85-90% of notifications that currently go to Ahpra but are finalised with "No Further Action". The earlier identification and management of vexatious complaints is also a key professional bodies and medical colleges, recognising that the impact of these notifications cannot be underestimated.[22]

A UNIFIED NATIONAL COMPLAINT HANDLING SYSTEM

Ahpra and the six HCEs within the National Scheme operate in relative isolation from one another and sometimes to differing ends, across the full spectrum of policy, business process, systems development, communication, and data analysis functions. The poor experiences of health consumers and the regulated health sector reflect this.

The Review gave close consideration of the option of a seismic shift in the architecture of health complaints handling in Australia, in the form of replacing State and Territory Health Complaints Entities and Ahpra notifications function with a national complaint handling body. The issues and implications of this approach were canvassed in detail in Consultation Paper 2.

The Review noted that this option strains against the Review Terms of Reference (which exclude NSW and QLD from Terms of Reference 1, 2 and 3).[23] More fundamentally the consultation drove the conclusion that there would be significant, and most likely insurmountable, obstacles to achieving the outcome. It also noted that if this were to be pursued, new complexities would it inevitably replace the old.

To pursue a national complaints handling body would require an unavoidably lengthy, elaborate and costly process, including a series of policy, legislative and administrative changes within and across all jurisdictions. Such an endeavour would be hampered by uncertain outcome and inevitably there would be little or no focus on substantive improvements in the interim. The most likely outcome would be one set of complexities being replaced with new complexities.

The option of a national complaints handling body aside, there must be 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.

> There is an opportunity to overhaul the current complaints process and promote greater consistency and transparency in complaints management. The RACGP is generally supportive of measures to simplify and streamline complaints handling by harmonising processes across jurisdictions.
>
> RACGP

The Review has concluded that the outcomes sought by stakeholders could occur if complaints are first considered by the HCEs. They have wider and different powers than Ahpra and the ability to channel complaints quickly into resolution pathways, if appropriate. This would minimise trauma to the practitioner and optimise potential for resolution.

Only those matters meeting the threshold for consideration of a breach of professional standards would then progress to Ahpra.

The Review is therefore proposing the establishment of a National Health Complaints System Implementation Group (the 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 important that this be a national initiative. It recognised that NSW and Queensland regulatory arrangements are out of scope for this Review and that this proposed action could be seen as inconsistent with this. However, the Review also notes the requirement (under Term of Reference 4)[24] 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 way 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 the proposal would therefore 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.

In short, involvement of NSW and Queensland in this Project would accelerate progress towards bringing to life a nationally unified complaints system, with significant public benefits.

THE ATTRIBUTES OF A UNIFIED HEALTH COMPLAINTS HANDLING SYSTEM

Design of a unified system requires careful consideration and collaboration. Stakeholder support for increased responsibility for complaints triaging for HCEs and a reset partnership between them and Ahpra is appropriately conditional upon the need for a very high level of confidence about the prospect of improved timeliness, transparency and appropriate natural justice in any new arrangements.

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 should be able to be made as a complaint to the HCE in the jurisdiction where the service occurred. This should be irrespective of whether the complaint relates to a registered practitioner, a non-registered practitioner, a health organisation or a mix of these. The consumer should not be expected to differentiate, this is the job of the regulator.

It is expected that the complaint would 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, if used judiciously and as an aid to and not a replacement for human decision making.

> The single front door procedure proposed by this review is supported as it places the responsibility for choosing the right organisation to manage a complaint firmly with the complaints organisation rather than with the consumer. As part of this single front door process, we also support the idea of a single complaint form that can be used across all jurisdictions, which would mean that a consumer and their advocate only have to write their complaint once, regardless of which organisation ends up managing it.
>
> Health Consumers' Council WA

> While the use of AI in streamlining complaints handling may offer benefits, we emphasise that robust safeguards, transparency and clinical oversight are essential …AI should support- not replace- professional judgement.
>
> AMA

A resolution pathway should be available for any complaint that is more suited to this approach.

- The method and process for triaging and referring a complaint should be consistent, irrespective of the jurisdiction.
- 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.
- 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.

This is the essence of the single front door approach.

With these design attributes in mind, the Terms of Reference for the Implementation Group will also need to be unambiguous about the factors and issues to be considered in the design process, including:

- 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 and consistent mobilisation of AI features.
- Maintaining and continuing to strengthen cultural safety across all complaints and notification functions.
- Ensuring access to clinical advice for HCEs.
- 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.
- Developing agreed communication protocols and products relating to all possible outcomes of a complaint – co-designed with health consumer peak bodies.
- 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.

FIGURE 5: UNIFIED NATIONAL HEALTH COMPLAINTS SYSTEM

A FLEXIBLE AND STAGED IMPLEMENTATION APPROACH

While there is broad appeal and support for this 'single front door model' and a high degree of confidence across Health Complaints Entities that it is both possible and worthwhile, it comes with the need to undertake further work to bring it to fruition.

> HaDSCO supports the reform option for a unified national approach for a health complaints system with the concept of a 'single front door' for complaints and notifications and for this to be the Health Complaints Entities (HCEs) in each State and Territory, e.g., HaDSCO in Western Australia. However, the reform options will need to factor in the need for a 'fit for purpose' approach in recognition that each State and Territory operates under different legislation and the jurisdiction of the HCEs varies across Australia.
>
> The work has already been done via the Statutory Review of the HaDSC Act to recommend these changes and consideration given to how these would be implemented. They are considered achievable within the 3-year implementation timeframe with appropriate support to approve and legislate the changes.
>
> The Health and Disability Services Complaints Office (HaDSCO)

> A federated single front door, appropriately standardised for consistency across the country (taking into account jurisdictional particularities) is a sensible solution to ongoing confusion by the public and professions.
>
> Consistent and clear triaging and referral processes implemented across the jurisdictions would mitigate against a lack of timeliness about which AHPRA is concerned.
>
> The federated single front door will have funding implications for the HCEs.
>
> SA Health and Community Services Complaints Commissioner

> Our experience in Qld is that the single front door offers significant benefits for people making complaints and notifications, and the triaging and joint consideration processes with Ahpra provides timely and effective decision-making processes through sharing risk regulatory frameworks and collaborative working relationships.
>
> OHO Queensland

The Review proposes an Opt-In approach to implementation of the 'single front door' model over a 3-year implementation timeframe. This recognises the need for jurisdictional flexibility to consider and address any required adaptations to their current complaints handling processes, systems, legislation or resourcing. There are a number of considerations informing this approach.

- 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 any requirement for legislative change.
- In the majority of cases the additional volume of matters for the HCE to triage would be relatively low and more than manageable. The data indicates small and manageable number of notification that would be diverted annually to HCEs in ACT (285), NT (182), Tasmania (389) and South Australia (1,293). Its application in these jurisdictions may be achieved with relatively straightforward process or systems adjustment, under existing legislation and organisational arrangements.

- In other jurisdictions though, the volume of notifications transferred would be higher and administrative and legislative change would likely be required. This is most likely for WA (1,717 transfers) and Victoria (4,509 transfers). The process and legislation change could be modelled on the best of the arrangements already in place and would deliver significant benefits, but will take more time.
- Financial aspects will require early consideration and resolution. The Health Complaints Entities draw attention to the need for a funding model and associated funding agreements, to enable HCEs to provide the triaging of complaints based on an objective activity-based funding model.
- Ahpra seeks to ensure that any arrangements for the transfer of this triaging function do not result in cost shifting or any diminution in its ability to deliver its core statutory functions.
- At the operational level, a concerted program of complaints systems and process integration will be required, assisted by the selective and sensitive deployment of AI-enabled triaging and risk assessment tools.

It is acknowledged clarity around these assurance matters and associated implementation steps is an important first step and needs to occur through a mix of multilateral and bilateral deliberations.

To achieve this, the recommendations propose that the Implementation Group commence by developing a new MOU between Ahpra and the HCEs, which will serve the purpose of setting out early agreement on the parameters and priorities for the design of the unified approach and a collective program of work to connect processes and systems. This will provide a basis for subsequent bilateral discussions as jurisdictions progress towards opting-in, when and as jurisdiction arrangements allow.

AN EARLY FOCUS ON CUSTOMER FACING IMPROVEMENTS AND COMMUNICATION

Recognising that the proposed unification Project will take time under this staged implementation approach, the Review has identified several immediate measures that should be taken to address specific pressure points in complaints handling and build confidence in it through tangible improvements.

An early action for the proposed 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.

There are opportunities to build on actions that Ahpra has advised it is already considering or progressing, to address issues and suggestions raised by consumers, practitioners and policy makers.

- Establishing a Complaints Navigator Service to assist consumers to:
  - Understand the process of making a complaint and the timeframes.
  - Know possible outcomes from the complaint.
  - Address any concerns they may have about the outcome of the complaint.

  The Review has noted that this is an initiative already commenced by Ahpra and the primary observation is that co-designing the service with Health Complaints Entities and the Community Advisory Council of Ahpra will be critical to success.
- Ensuring implementation of National Health Practitioner Ombudsman recommendations for improving management of vexatious complaints.

> Where is their evidence in their vexations screening tool? …Its not used properly or appropriately.
>
> Practitioner submission

- Instituting a formal national communications protocol with HCEs to ensure cross jurisdictional liaison on new serious and sensitive regulatory events, and to set out more clearly roles and responsibilities and the intention of timely action, with agreed public communication messages.

Introducing a statutory right of review for notifiers is also necessary and should be progressed as a matter of priority by the Policy and Legislation Committee of HWT. This is in line with contemporary complaints handling principles and would enable a person who does not believe that their matter has been given adequate consideration to ask Ahpra within a specified time to review the matter.

SYSTEMIC ISSUES ARISING FROM COMPLAINTS AND RISKS

A contemporary regulatory posture also requires a more proactive and systemic approach to practitioner regulation. The National Scheme must rise above reacting to individual notifications, seizing opportunities to prevent notifications and to highlight possible system improvements arising from individual matters.

The Review has concluded there is scope to elevate this aspect of the National Scheme.

Stakeholders questioned whether there is a sufficiently structured case review process or mindset where high risk or high sensitivity matters arise. They were seeking increased confidence that, in addition to undertaking the routine operational decisions on the individual triggering case, there would be targeted identification and assessment of similar or related open or closed matters. This is important to considering the effectiveness and consistency of the regulatory response across cases and also the need for any systemic response – such as changes to a code or standards to signal clear conduct expectations going forward.

In instances where there is significant sensitivity or risk and a pressing need to ensure confidence in a comprehensive regulatory response, this Review is proposing a protocol or practice of joint communication between national and state regulators. It is envisaged that this communication protocol goes beyond the individual case, addressing systemic issues and the relative roles and responsibilities of each entity.

A stronger appreciation of the regulatory significance and impact of the standard setting and education roles of the National Scheme is advocated. Regulatory incidents offer potential for insight into weaknesses in professional standards. Responses may include setting or resetting benchmarks for performance and behaviour to which all practitioners will be held, aligning these with contemporary public expectations and risks.

> A regulatory system that prioritises resolution and learning, rather than protracted punitive processes, will be more effective and more just and lead to better outcomes for the Australian health system.
>
> Royal Australian and New Zealand College of Radiologists

Action 3.4.1 (for Ahpra to deliver a Regulatory Intelligence Report at regular intervals, identifying emerging risks to public health and safety and outlining the regulatory strategy for these risks), speaks to this need.

A more structured program for linking regulatory intelligence to review of Codes of Conduct and practitioner guidance (also proposed above in Action 3.4) would also provide an improved opportunity for conduct and performance expectations to keep step with common and emerging issues across professions. The intended result is to ensure that Conduct issues relevant to all professions (such as sexual boundary violation, domestic violence, criminal matters, discrimination and bullying) are the subject of consistent standards across professions.

The Review also observes that additional focus on higher practitioner awareness of their obligations is important. As standards and codes are set and reset, practitioners should be educated and regularly updated on their obligations. This should not be a passive exercise relying only on the practitioner. The Review observes the requirement for a more concerted and ongoing program of training and education of practitioners conducted in collaboration with profession bodies.

In essence, reflective regulation, coupled with measures to ensure that obligations are well understood by all practitioners as they evolve, must become a feature of the National Scheme.

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 particularly if consideration is to be given to increased delegation of notification decision making from the National Boards to Ahpra.

> RACMA supports national consistency in complaints processes that are …informed by clinical insight. Late-career doctors, scope of practice expansion and team-based care quire nuanced complaints-handling mechanisms.
>
> RACMA

To achieve the required nuance and expertise driven decision making that is sought, requires deeper consideration of current capability and governance of clinical input across professions and function, with systematic consideration of options for further strengthening.

This is reflected in recommended action 3.3.2 for the clinical input capability and models to be a specific focus for the proposed Independent Capability Review of Ahpra.

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. It is difficult to overstate the strength of the imperative for improvement in this domain of the National Scheme, particularly where immediate action has been taken pending completion of an investigation.

> 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

> 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 innocence is yet to be determined.
>
> Submission 68 – Not for Publication

Delay has a serious human impact and the importance of the work that Ahpra has commenced on alleviating practitioner distress cannot be underestimated.[25] There is wide support for progressing this work, to ensure that practical arrangements for supporting practitioners are in place.

Ultimately, the greatest alleviation to the distress experienced by practitioners will occur from reducing investigation timeframes to the fullest extent possible. 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.

There remains a need for a defined and milestone driven program of business improvement. Investigation progress and performance must be assured and visible to the parties, to the Ahpra Board, National Boards and stakeholders more broadly.

More effective case management of the highest risk and highly sensitive investigations is an immediate imperative. This should include explicit timeframes and investigative protocols for at least those investigations 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 important that practices associated with placing investigations 'on hold' are reviewed and adjusted. This is readily apparent from the thought provoking of the Victoria Supreme Court in *Wilks v Psychology Board of Australia*.[26] 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. 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.

The Review has identified specific actions that must be progressed without delay and in parallel to uplift investigations performance. This should occur irrespective of the current National Health Practitioner Ombudsman inquiry into delays in investigating "immediate action" cases, which may suggest additional actions.

- 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.
- 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.

- 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 that would result in extending the period that an investigation is open beyond 12 months be decisions of the Board, not regulatory officers.
  - An obligation on regulatory officers and the Boards to consider the personal and financial impacts on a practitioner in any decision to place and investigation 'on hold'.
- 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 actions to foster establishment of MOUs with each jurisdictional police force to facilitate the reliable exchange of information where misconduct is also of a potentially criminal nature.

> The AMA supports the recommended actions, including a comprehensive audit of all outstanding cases over 12 months. A balanced approach that considers the functional reputation al and mental health risks practitioners face is welcomed.
>
> AMA

PROSECUTION DECISION MAKING AND MANAGEMENT

There is an undeniable 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.

The Review was particularly struck by the strength of judicial commentary on this specific issue in *Peers v Medical Board of Australia*.[27]

> ***PEERS V MEDICAL BOARD OF AUSTRALIA* – 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.

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.

The first question that arises from *Peers v Medical Board of Australia* is how the outcomes of specific tribunal cases inform regulatory policy and legislative reform.

Ahpra has 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 be 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 was not the subject of advice in the Litigation Report that is produced for the Regulatory Performance Committee of the Board. The litigation team considered that legislative reform was not required. However, this is a decision over which the Ahpra Board should have a clearer line of sight. Even if the ultimate position is that policy and process adjustments are sufficient to address the concerns raised, there should also be clarity around the nature of the changes required, the responsibility for driving those changes, timeframes for delivering the change and an assessment of their effectiveness once in place.

What seems to be missing is a sufficiently honed process for assessing the significance of criticism of Ahpra policy or process arising from significant tribunal cases, determining what ought to be done to respond, and follow through on the actions required. It would be expected that there would be Board visibility and involvement in this.

On the specific legal issue raised in *Peers v Medical Board*, it appears that the Ahpra position is 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).

While the Ahpra position is noted, a judicial review will focus only on the legality of the decision and not the merits of it. This is likely to place more burden on the practitioner. Given that the policy objective is to recognise and alleviate undue practitioner distress, the implications of not pursuing legislative change must be the subject of a clear policy determination.

The Review observes that it may assist to be unambiguous in section 199 of the National Law (which identifies the decisions made within the National Scheme that are appellable) that a merit appeal against a Board's decision not to revoke an earlier imposed suspension (in response to a request from a practitioner) is allowed.[28]

The quest of stakeholders for reduced timeframes and conscious minimisation of practitioner impacts also shone a light on current practices and arrangements in relation to the exercise of the discretion to determine the forum in which to progress disciplinary action.

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 reduced distress to the practitioner and relevant witnesses. However, the Review has found that use of this avenue for progressing disciplinary matters is now all but inactive.

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.[29]

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 National Board forms the view that there is no public interest in pursuing the matter.

   This is considered to be a very narrow exception to the requirement in section 193 and offers very limited discretion. Ahpra advises that this is 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 whether on balance a decision is in the public interest. Here, there must simply be no public interest in referring the matter.

   Ahpra also notes that Section 193A(3) requires information about each instance of reliance upon section 193A to be published in the annual report. On this basis Ahpra concludes that the intention was section 193A will be sparingly used.

   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).

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.

The Review has 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. This could work alongside greater board discretion to refer a matter for disciplinary action via a panel rather than through a tribunal. The discretion may include consideration of factors such as whether there is a reasonable belief that cancellation, disqualification and/or prohibition is likely or appropriate.

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 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 consistent and robust decision making.

The Review also sees potential to strengthen analysis of tribunal and Court decisions and comments 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.

Recommended directions and actions

DIRECTION 04

Progress implementation of a unified national approach to health complaints and require immediate focus on improved management of high-risk matters within 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. This would include finalising implementation of the National Code of Conduct for Non-registered Practitioners (in accordance with Action 2.5 under Direction 02).

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. Maintaining and continuing to strengthen cultural safety across all complaints and notification functions.

f. Ensuring access to clinical advice for HCEs.

g. Prioritising establishment and maintenance of processes for timely referral to Ahpra of complaints about registered practitioners and which involve significant breaches of professional standards.

h. Review communication templates for consumers and providers through co-design processes, to promote improved customer centrism and consistent style and content.

i. Reporting against specified Performance Indicators.

j. Identifying any current barriers to information sharing and refreshing information sharing protocols and ensuring IT systems integration to achieve secure transfer of information

k. 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.

l. 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 national complaint handling explanatory information as an immediate priority, to communicate the Integrated Health Professions Regulation Framework (links to action 2.1) and present a joint message on proposed reforms to complaints handling, 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 and to take a more systemic approach to regulation by:

- Establishing a Complaints Navigator Service through a codesign approach with Health Complaints Entities and the Community Advisory Council of Ahpra.
- 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.
- Considering the need for additional 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 specified 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 Independent Capability Review. This links to 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 action 3.4.1(b).

b. An audit of all Ahpra investigations that have been open for more than 12 months to be completed within 3 months, with active consideration of actions that would ensure timely completion of those matters and of measures that can be taken to minimise the number and proportion of investigations that take more than 12 months.

c. Review and revise the policy and procedure for placing investigations 'on-hold' and managing those investigations. These policy adjustments should include:

i. Tighter limitations on the circumstances where placing an investigation on-hold can be considered.

ii. A requirement that all proposed actions under the 'on-hold policy' that would have the effect of extending the period of an investigation beyond 12 months (from the point of a determination that investigation is required) be submitted to the Board for determination.

iii. An obligation on Ahpra officer and the Board to consider the personal and financial impacts on a practitioner in any decision to place an investigation on hold.

d. Identifying categories of notifications that pose a higher risk or are of higher sensitivity (including those where the practitioner has already been suspended or constrained from practising). For these, 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. This links to action 3.7.1.

4.3.3 Work with jurisdictions to foster formal MOU arrangements with police where these do not currently exist, to ensure timely information exchange where registered health practitioners are also the subject of police investigation or criminal prosecution.

ACTION 4.4

Ahpra Board to request the Regulatory Performance Committee to identify tribunal cases presenting significant commentary on the adequacy of Ahpra practices and processes, and advise on potential policy or legislative change.

ACTION 4.5

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 4.6

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

ACTION 4.7

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.

Benefits

Strategy and context

Priorities and directions for health professions regulation are formal and clear.

Alignment of public safety and workforce objectives.

Single line of health regulation and workforce policy advice to Ministers.

Inclusive strategy setting – defined structures and opportunities for stakeholder input.

All health regulators working together.

Integration of health, ageing and disability professions regulation.

Workforce data and regulatory intelligence inform policy decision making.

Expanding the Scheme via integrated regulation

Risk-based regulation across all health professions.

Immediate action to address emerging health risks within existing board structures.

Co-design process to develop new lighter touch, cost effective registration model.

Complete nationwide implementation of Code of Conduct for non-registered practitioners – including National Register of Prohibition Orders.

New regulatory tools to avoid harm from exploitative business models.

Simpler, smarter regulation

Resetting Ahpra functions and structures

One entity accountable for performance and development – National Scheme Board.

Leadership structures ensure all National Boards work to clear Scheme-wide priorities and on cross-profession solutions.

Profession and consumer voices embedded at strategy and operational levels.

Financial sustainability and transparent fee setting prioritised.

Culture and capability lift to deliver more proactive, effective and compassionate regulation.

Unified national complaints handling

Consumers can make a complaint about any health practitioner or organisation in one place.

Complaints navigator service for consumers now and single front door over time.

Ahpra and state and territory complaints bodies are working together – not in isolation.

Early resolution is taken whenever possible.

Ahpra investigation and disciplinary role reserved for more serious alleged breaches of standards.

Investigation is more timely and procedurally fair.

Endnotes

1 *Health Practitioner Regulation National Law* 2009, Section 3 (2) sets out the objectives of the National Scheme:

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

(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

(c) to facilitate the provision of high quality education and training of health practitioners; and

(c) to build the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples; and

(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and

(e) to facilitate access to services provided by health practitioners in accordance with the public interest; and

(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

2 *Health Practitioner Regulation National Law* 2009, Section 3A.

3 Terms of Reference for the Review available at: https://www.health.gov.au/sites/default/files/2024-06/independent-review-of-complexity-in-the-national-registration-and-accreditation-scheme-terms-of-reference.docx

4 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.

5 S Dawson (2025). *Consultation Paper 2: Consultation Outcomes and Reform Directions*. Available at: https://www.health.gov.au/resources/publications/consultation-paper-2-consultation-outcomes-and-reform-directions?language=en.

6 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&chksum=NwgooGtzxb6JjNBIEP9Lhg==.

7 Commonwealth Guidance on Ministerial Statements of Expectations is in Commonwealth Department of Finance (2023) Regulator Performance (RMG 128). Available at: https://www.finance.gov.au/government/managing-commonwealth-resources/regulator-performance-rmg-128.

8 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.

9 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. p129 suggested seven indicative priority self-regulated professions -dieticians, Sonographers, Audiologists, Exercise physiologists, Speech pathologists, Social workers and Counsellors.

10 *Australian Health Ministers Advisory Council (AHMAC) Information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions* (2018). Available at: https://www.ahpra.gov.au/Search.aspx?q=AHMAC%20criteria%201995.

11 Whole of Government Impact Analysis 2023 – 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).

12 *Australian Health Ministers Advisory Council (AHMAC) Information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions* (2018), p15. Available at: https://www.ahpra.gov.au/Search.aspx?q=AHMAC%20criteria%201995.

13 *Health Care Complaints Act 1983* (NSW), Division 7A.

14 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.

15 See for instance Submission 17 – Australasian College of Dermatologists.

16 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.

17 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.

18 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&chksum=70Su42ntfnsZN%2bFOeEWKQg%3d%3d.

19 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=YE1XW9tLtpZFD7LUE0lGGg%3d%3d.

20 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.

21 *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.

22 Submission 53 – Royal Australian College of General Practitioners.

23 Terms of Reference available at: https://www.health.gov.au/sites/default/files/2024-06/independent-review-of-complexity-in-the-national-registration-and-accreditation-scheme-terms-of-reference.docx.

24 Ibid. Term of Reference 4 requires: "Review current regulatory principles for the National Scheme ….and make recommendations on improvements to increase effectiveness and efficiency and promote a stewardship approach, without adding unnecessary complexity…"

25 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.

26 *Wilks v Psychology Board of Australia (2024)*. VSC 2, 12 January 2024. Available at: https://aucc.sirsidynix.net.au/Judgments/VSC/2024/T0002.pdf.

27 *Peers v Medical Board of Australia* [2024] VSC 630 (15 October 2024) Available at: https://aucc.sirsidynix.net.au/Judgments/VSC/2024/T0630.pdf.

28 Noting the judicial uncertainty on this point in *Peers v Medical Board of Australia (2024)*. VSC 630 15 October 2024. Available at: https://aucc.sirsidynix.net.au/Judgments/VSC/2024/T0630.pdf.

29 Correspondence from J. Orchard, General Counsel, Ahpra, 1 August 2024.

This is a deep and wide transformation program that will require sustained effort over three to five years.

Success will depend not just on the strength of the strategic directions, but on the discipline with which they are delivered. Careful sequencing and clear priorities will be essential to ensure the work is achievable and that there is early improvement while systemic change is planned and delivered.

Priority actions should build on reform work that is already underway and add momentum and structure to that work. This recognises the initial governance and practice changes that Ahpra has commenced in anticipation of the review findings. It also recognises the evolving status of health workforce planning and strategy through collaboration between HWT and the professions.

There should also be immediate action to address the most acute pressures on the health practitioner regulation – with a focus on rebuilding confidence in complaints handling and investigation timeliness and responsiveness as well as taking measured steps toward expansion of regulation under the Scheme.

These priority actions are necessary to provide a solid foundation and strong leadership for the broader suite of changes proposed by the Review.