AHPRA submission to the Victorian Parliamentary Inquiry into the performance of the Australian Health Practitioner Regulation Agency

1 March 2013

Submission

Contents

Executive summary **2**

The National Registration and Accreditation Scheme at work **4**

AHPRA submission to the Victorian Parliamentary Inquiry **7**

Introduction 7

Background 8

Addressing the terms of reference 14

About the annual reports 14

Regulatory efficacy 16

Protection of the public 24

Cost effectiveness 38

Future directions 40

Conclusion 42

Appendix 1 Accreditation authorities and functions 43

Appendix 2 Transition timeline – journey to full implementation of the scheme 46

Appendix 3 Comparison between national and Victorian regulatory environments 47

Appendix 4 Registration processes 51

Appendix 5 Managing impaired health practitioners 52

AHPRA submission to the Victorian Parliamentary Inquiry

Executive summary

The National Registration and Accreditation Scheme (the National Scheme) has built on the strengths of the previous regulatory arrangements in Victoria to deliver strong and robust public protection. National regulation has raised the bar on public safety to a level higher than previously existed in any state or territory regulation scheme, including Victoria. There has been no weakening of standards.

The National Scheme is working effectively in Victoria with robust systems, effective processes and nationally consistent standards. This is made possible by strong working relationships between AHPRA, state boards and committees and with National Boards.

The design and structure of the National Scheme ensures ministerial oversight and accountability through the Australian Health Workforce Ministerial Council (Ministerial Council), and partnership between the National Boards and AHPRA to deliver the essential services of the National Scheme. Ministerial Council approves national standards which are consistent across professions wherever possible, and profession-specific when this is required. With funding provided by National Boards, accreditation authorities exercise their functions nationally.

Portability of registration has been an immediate benefit to practitioners. Since 2010, all health practitioners have been able to register once and renew annually. They can practise across Australia at any time, including in locum, emergency or disaster relief circumstances, within the scope of their registration. More than 22,000 Victorian health practitioners are estimated to have benefitted from these arrangements, because they no longer need to pay and register in multiple states and territories.

AHPRA maintains an online register that publishes up-to-date information about the current registration status of every registered health practitioner in Australia. Consumers have access to accurate, up-to-date information about the registration status of more than 580,000 health practitioners across 14 professions. More than 152,000 practitioners are based in Victoria. National registration means a practitioner can use a protected title that consumers recognise and understand. This assures the public that health services are being delivered by qualified practitioners who have met and maintain a national standard, regardless of where they provide care.

The scale and scope of the national register is unique internationally and is supported by an extended national register of students.

For the first time, as a result of the National Scheme, there are accurate, national data about health practitioners. These data are regularly published and are invaluable for governments and agencies undertaking health workforce planning, including in Victoria. Boards for the first time can use national data to inform the development of standards and policies that will keep the public safe.

One of the most important ways that the National Scheme protects the public is by dealing with practitioners who may be putting the public at risk as a result of their conduct, professional performance or health. Through an integrated information system, AHPRA can make sure concerns about individual practitioners do not ‘fall through the cracks’ if practitioners move interstate. Comprehensive data are reported in this submission and indicate that the number of notifications (complaints) about health practitioners is increasing. In 2012, for example,1,674 notifications were received in Victoria. Most were voluntary and around two thirds came from the community.

Strengthened mandatory reporting requirements in the National Scheme increase public safety across all regulated professions. In 2012, just under 10% of notifications were mandatory reports.

The National Scheme is self-funding through registration fees. There is no cross-subsidisation between the professions, so the full cost of regulation must be met by each participating profession, without government subsidy. The move to the National Scheme led to an initial increase in registration fees across all professions, in part to ensure that boards had reserves adequate to meet their legislative responsibilities under the National Scheme. However, National Boards have limited

increases to national Consumer Price Indexation (CPI) since 2010, except for nursing and midwifery in 2012. National Boards have committed to limiting fee increases to CPI if no unforeseen circumstances arise. AHPRA has implemented initiatives to improve cost effectiveness and take advantage of economies of scale.

Victoria has enjoyed unique benefits from the National Scheme, with the national AHPRA office in Victoria adding $30 million per annum to the Victorian economy.

While the National Scheme has been implemented successfully, there are areas for further improvement. The confidentiality provisions of the National Law are a barrier to providing information to notifiers compared to the previous Victorian legislation. More use of joint investigation processes with the Health Services Commissioner may better meet consumer needs for complaints resolution, while allowing boards to address issues of public safety. Protecting the public by effectively dealing with impaired practitioners who may pose a risk to patient safety is an ongoing focus for the National Boards and AHPRA.

The National Scheme is an internationally significant health reform, bringing together multiple jurisdictions and professions into a single regulatory framework. Through it, Victoria and Australia have a contemporary, high-quality regulatory system delivered by AHPRA in partnership with the National Boards, with the Ministerial Council providing high level oversight, and accreditation authorities exercising accreditation functions for the professions.

The National Registration and Accreditation Scheme at work

Sharing information to keep the public safe

The case studies below show the National Scheme at work. Both are actual incidents that have been de-identified and minor changes made to protect the privacy and confidentiality of practitioners involved.

Study 1: The suspended health practitioner who didn't 'slip through the cracks'

A Victorian employer made a mandatory notification about a health practitioner whose work had been deteriorating for several months.

Through the employer's performance management process, the health practitioner conceded she had a substance abuse issue and requested some time off work to enter an in-patient rehabilitation program.

The employer notified AHPRA. On receiving the notification, the Victorian Board of the National Board took immediate action and suspended her registration, pending an investigation.

All attempts by the Victorian Board through AHPRA to contact the health practitioner failed.

A short time later, the health practitioner successfully obtained an offer of employment in the Northern Territory (the NT) by producing a hard copy of the registration certificate she had been issued when she renewed her registration, before she was suspended.

Before allowing the health practitioner to start work, the NT employer routinely checked the national register and learned of the suspension. Despite the health practitioner's assurance there had been an administrative error, the employer contacted the AHPRA NT office, which immediately used the national health practitioner database to access the Victorian Board decision and confirm the suspension.

The health practitioner is now undergoing a health assessment, arranged through the NT office, and is not practising.

The public is safe and the health practitioner will be better placed to access rehabilitation.

Before the National Scheme, there was no national database accessible to regulators in different states and territories. Even with the mutual recognition legislation in place before 2010, the absence of an accurate and up-to-date online register, combined with local legal constraints, would have limited the information available to the employer and the regulator in the NT and ruled out such swift action to protect the public.

Study 2: Seamless and immediate management of a health practitioner with an impairment

AHPRA received a notification from a Victorian employer about a health practitioner who was working while affected by illicit drugs. The employer had been concerned about his performance and had been managing this, when the health practitioner acknowledged that he had been using illicit drugs.

On the same day as the notification from the employer was received, the National Board's Immediate Action Committee met, considered the notification, and took immediate action by proposing to suspend the health practitioner's registration. Consistent with the National Law, the practitioner was given 24 hours to make a submission to the Board about its proposal.

When contacted by AHPRA's Victorian team, the health practitioner immediately offered an undertaking to the National Board not to practise until after his formal submission had been considered. An undertaking is a binding legal agreement that is published on the register of practitioners. The health practitioner chose not to provide a submission, in response to the proposed action, and the Board's subsequent decision to suspend his registration took effect 24 hours later. The Board also required the health practitioner to have a health assessment.

AHPRA gave the health practitioner written notice of the suspension and the requirement for a health assessment, which was scheduled to take place three weeks later. The practitioner contacted AHPRA and explained that he intended to move interstate to Western Australia (WA) to help make a fresh start and support his recovery.

AHPRA's Victorian team immediately contacted their colleagues in WA, who arranged with the health practitioner for the health assessment to take place locally later that month. An integrated, national database and IT system supported the speedy and secure transfer of all relevant information electronically, so the regulatory processes could continue uninterrupted across borders.

Under the National Scheme, vital information was immediately accessible so the regulatory processes could continue smoothly, protecting the public while giving the practitioner the best chance of rehabilitation and a return to practice.

Victoria and the National Scheme in numbers

- 152,222 (or 26% of the national total of 583,000) registrants across all of the 14 health professions regulated under the National Scheme have a principal place of practice in Victoria.
- Of the 7,594 notifications received nationally, over 1,600 (21%) were received about Victorian health practitioners in 2012, including 500 matters referred through the Office of the Health Services Commissioner, Victoria.
- There were more than 110,000 students studying to be health practitioners in Australia as at December 2012, including over 28,000 (31%) in Victoria.
- A register of these currently enrolled students is maintained by AHPRA with information collected from 151 education providers nationally, 58 of which are Victorian
- Five National Boards (Medical, Nursing and Midwifery, Physiotherapy, Dental, and Psychology) have established either Victorian boards or committees or joint Victorian regional boards to manage (under delegation) the registration of health practitioners and notifications (complaints). The remaining nine National Boards have opted for a national committee model to perform these delegated functions. Support for all Victorian-based boards and committees and eight of the nine national committees is provided by the AHPRA office in Victoria.
- Of the 14 National Boards, six have a community member from Victoria.

- 14 practitioner members from Victoria are on the 14 National Boards, and three of these are appointed as Chairs of National Boards (for the Medical, Pharmacy, and Chinese Medicine Boards).
- The Chair of the Forum of National Board Chairs is from Victoria.
- The Chair of the AHPRA Agency Management Committee is from Victoria.
- AHPRA has a state office located in Melbourne, employing 20% of all AHPRA staff, making it the largest AHPRA office in Australia.
- In addition to the state office, the AHPRA national office is also located in Melbourne, employing an additional 18% of all AHPRA staff.
- The estimated benefit of the national office being located in Melbourne to the Victorian state economy is $30 million per annum.
- The secretariats for six of the 11 external accreditation councils and the three accreditation committees are based in Victoria.
- Victoria was the third state to enact legislation (on 8 December 2009) to enable the National Scheme to operate in Victoria from 1 July 2010.

The picture nationally in 2011/12

- On 30 June 2012, there were more than 548,500 health practitioners from 10 professions registered in the National Scheme, an increase of 3.47% on 30 June 2011.
- This had increased to nearly 583,000 by January 2013, including practitioners from the four new professions regulated under the National Scheme from July 2012 (Aboriginal and Torres Strait Islander health practice, Chinese medicine, occupational therapy, medical radiation practice).
- 775 of the 7,594 notifications that were received nationally were mandatory notifications.
- AHPRA renewed the registration of more than 557,000 health practitioners.
- AHPRA generated more than 1.5 million email registration renewal reminders.
- AHPRA responded to more than 517,000 phone calls to state and territory offices; more than 80% of which were answered within 90 seconds.
- AHPRA manages 15 websites, including one for each National Board, and these hosted almost eight million visits with more than 45 million page views.
- There were almost 39,000 enquiries at the state and territory office counters.
- AHPRA issued close to 550,000 certificates of registration to health practitioners across Australia.
- AHPRA and the National Boards issued nearly 100 media releases and responded to more than 1,300 media enquiries.
- AHPRA published six issues of *AHPRA Report*, a regular newsletter containing updates and news.
- The National Boards issued 20 newsletters and more than 100 communiqués in the same period.
- AHPRA requested more than 68,000 criminal history checks.
- AHPRA undertook the largest ever renewal in Australia when more than 333,000 nurses and midwives renewed their registration in May 2011. More than 92% renewed online, delivering cost savings in comparison to paper-based renewals.

AHPRA submission to the Victorian Parliamentary Inquiry

Introduction

1.1 The National Registration and Accreditation Scheme (the National Scheme) started on 1 July 2010. The National Scheme is one of the most ambitious reforms of health practitioner regulation undertaken anywhere in the world. Built on the strengths of previous regulatory arrangements, but with stronger public protections, it brought together 10 professions (now 14) into a single regulatory framework, supported by a nationally consistent law enacted by each state and territory parliament.

1.2 The National Scheme has been in place for nearly three years. Early transition challenges have been addressed and AHPRA systems and processes are working smoothly to support National Boards and enable them to meet their core regulatory responsibilities of protecting the public and facilitating access to health services.

1.3 AHPRA, in partnership with National Boards and their state boards and committees, administers the National Scheme in accordance with the National Law and any policy directions from the Australian Health Workforce Ministerial Council (Ministerial Council), to regulate more than 580,000 health practitioners from 14 health professions nationwide. The most important role of the National Boards is to protect the public and facilitate workforce mobility, accessibility and development.

1.4 The National Scheme's responsibilities include registering practitioners who are suitably trained and qualified to provide safe healthcare, investigating concerns about health practitioners (known as notifications) and managing the implications for registration of health practitioners, as necessary, as a result. The National Boards set the standards and policies that all registered health practitioners must meet. AHPRA maintains public registers of practitioners in each of these professions, and manages the initial registration of practitioners in each profession and their annual registration renewal. AHPRA supports the work of Boards in investigating and managing notifications. AHPRA also works with health practitioners, their employers and the public.

1.5 AHPRA supports National Boards in their work with independent accreditation councils and committees to approve standards to ensure graduating students are suitably qualified and skilled to apply to register as a health practitioner.

1.6 The National Scheme has delivered benefits both in terms of public protection and improvements for practitioners and their practice of the profession, including the following:

Improvements to public safety:

- national registers of health practitioners and specialists
- mandatory identity checking
- mandatory criminal history checking
- mandatory reporting of 'notifiable conduct' by health practitioners
- mandatory professional indemnity insurance arrangements
- student registration, and
- a national notifications (complaints) system for consumers.

Improvements for practitioners (for the public benefit):

- ability to register once (annually) and practise anywhere in Australia
- consistent national registration standards, codes and guidelines
- consistent national standards for continuing professional development
- greater collaboration and learning between professions that are part of a single national scheme, and
- more flexible options for dealing with notifications, particularly managing impairment.

Scope of submission

1.7 AHPRA appreciates the opportunity to contribute to the Victorian Parliamentary Inquiry and will participate in any way that assists the Legal and Social Issues Legislative Committee's understanding of how the National Scheme works in Victoria, including by appearing at any public hearings that the committee may hold.

1.8 The terms of reference for this inquiry require the Legal and Social Issues Legislation Committee to inquire into, consider, and report on the performance of AHPRA including the cost effectiveness, the regulatory efficacy of and the ability of the National Scheme to protect the Victorian public. In the context of a National Scheme operating across eight states and territories, it may prove challenging to separate and analyse the scheme's jurisdiction-specific components. Equally, given that AHPRA works in close partnership with the 14 National Boards to deliver the National Scheme in Victoria, distinguishing between the contributions of the Boards and AHPRA is not always simple.

Background

The origins of reform

2.1 In 2006, the Productivity Commission delivered a report after examining issues impacting on the health workforce and the challenges associated with the continued delivery of quality healthcare over the following 10 years in Australia. There had been significant but localised reforms to registration systems in states and territories from the mid-1990s.This reflected greater emphasis on community representation on, and input into, health practitioner registration boards, and a clearer focus that any mandatory registration requirements for health practitioners must have a clear justification in public protection. However, the Productivity Commission report presented a further and potentially seismic shift for health practitioner regulation in Australia by recommending a single national board for health professions be established, as well as a single national accreditation board for health professional education and training to deal with workforce shortages/pressures faced by the health workforce. These initiatives were proposed to increase these organisations' flexibility, responsiveness, sustainability, mobility and reduce red tape.

2.2 The 2006 Productivity Commission Report informed but did not constrain the 2008 decision of the Australian Government and the governments of each of the eight states and territories to establish a single, national registration and accreditation scheme for health practitioners.

2.3 The Council of Australian Governments' (COAG) Intergovernmental Agreement (the IGA) was signed on 26 March 2008. COAG agreed to establish a single, national scheme to commence on 1 July 2010, initially regulating 10 health professions and describing the process for Ministerial Council to later decide which additional health professions would be similarly regulated.

2.4 The IGA is accessible from AHPRA's website, www.ahpra.gov.au/Legislation-and-Publications/Ministerial-Directives-and-Communiques.aspx. It is important in describing the conceptual framework for a modern national regulatory scheme for the health workforce, as envisioned by COAG and implemented by Health Ministers.

2.5 The Health Practitioner Regulation National Law, as in force in each state and territory (the National Law), sets out the regulatory framework for the National Scheme. The National Law implements the commitment made by COAG through the IGA to establish the single National Scheme by 1 July 2010.

2.6 The current regulatory framework that AHPRA and the National Boards administer on a daily basis is based on the IGA and subsequent decisions about the design of the scheme made by Ministerial Council after extensive consultation on detailed policy papers provided from July 2008 to January 2009 and subject to an approved COAG regulatory impact assessment process.

2.7 There are important aspects of the implementation of the National Scheme that differ from the model described in the Productivity Commission report. The most obvious is that while there is a single registration and accreditation scheme that operates nationally, there are profession-specific national boards and accreditation authorities for each of the regulated professions. There is neither a single national board for all professions nor a single accreditation board for all health workforce education and training, including accreditation functions in relation to overseas trained health professionals as proposed by the Productivity Commission.

2.8 For accreditation arrangements, it is important to note that the Productivity Commission report acknowledged the challenges associated with its proposed reform being such a significant departure from the arrangements in place at the time. Appendix 1 provides more detail on accreditation arrangements in the National Scheme.

2.9 In terms of the registration function, in proposing consolidation into a single board, the Productivity Commission was seeking to facilitate a cross-profession approach to health workforce issues; to lock in national standards; to overcome the disadvantages associated with mutual recognition as it operated at that time; to deliver a consistent approach to such issues as protection of title and recognition of professions and specialties; and offer administrative and compliance cost savings.

2.10 These are the benefits that have been realised now through this national scheme operating under an applied national law in each Australian state and territory (as opposed to a mutual recognition or 'driver's license model') albeit with profession-specific national boards. The regulatory framework is substantially equivalent across Australia, and AHPRA has a continued focus on making improvements to ensure better operational consistency. The National Boards have (with the approval of the Ministerial Council) set national standards, with five domains for standards common across all of the professions. These are criminal history, professional indemnity insurance arrangements, English language skills, recency of practice and continuing professional development.

2.11 The National Boards and AHPRA are taking advantage of opportunities for collaboration and cross-profession approaches to regulation, and some of these initiatives are highlighted in the joint National Boards submission, as well as the Medical Board of Australia's response. As the scheme is maturing, AHPRA and the National Boards are working together to strengthen the delivery of these benefits, including administrative efficiencies over time.

2.12 Detailed information about the origins of the National Scheme, its structure, and the preliminary work undertaken in the 12 months before the scheme started on 1 July 2010, is provided in the National Scheme's inaugural annual report, the *AHPRA and National Boards annual report 2009/10*. All annual reports are published and are available from the annual reports section of AHPRA's website: www.ahpra.gov.au/Legislation-and-Publications/AHPRA-Publications.aspx.

2.13 The transition timeline from the signing of the IGA to the transition of the additional four health professions into the National Scheme on 1 July 2012 is at Appendix 2.

2.14 The committee's attention is also drawn to Dr Louise Morauta's account of the implementation of the National Scheme, including the challenges associated with reaching agreement on a national system, avoiding variations within a national system at local level and delays in legislation across multiple parliaments, and lessons for similar projects. This article, 'Implementing a COAG reform using the national law model: Australia's National Registration and Accreditation Scheme for health practitioners', is published in the *Australian Journal of Public Administration* (vol .70, 21 March 2011, pp. 75-83).

2.15 The committee may also be aware that, as required under Clause 14 of the IGA, an independent review of the National Scheme is to be initiated by Ministerial Council after three years of the scheme's operation across all participating states and territories. This national independent review can begin from 1 July 2013.

2.16 AHPRA understands that Ministerial Council has asked the Australian Health Ministers Advisory Council (AHMAC) to prepare terms of reference for the national review for

consideration by ministers. AHPRA and the National Boards look forward the opportunity to contribute to this independent national review at the appropriate time.

2.17 AHPRA understands that the Productivity Commission has expressed an interest in undertaking a follow-up inquiry into Australia's health workforce. The findings of this follow-up inquiry have the potential to provide significant insights into the benefits of a single national scheme and inform further reforms for consideration by governments.

2.18 The committee is likely to be aware that the Council of Australian Governments' (COAG) current reform agenda includes reforms aimed at boosting productivity, increasing workforce participation and mobility and improving the quality of public services. The Productivity Commission was asked to report every two to three years on the impacts and benefits of specified elements of the COAG reform agenda. For its first substantive report in this series, the Australian Government directed the commission to focus on regulatory reforms under the 'seamless national economy' stream, and on vocational education and training reforms and initiatives that support successful transitions from school.

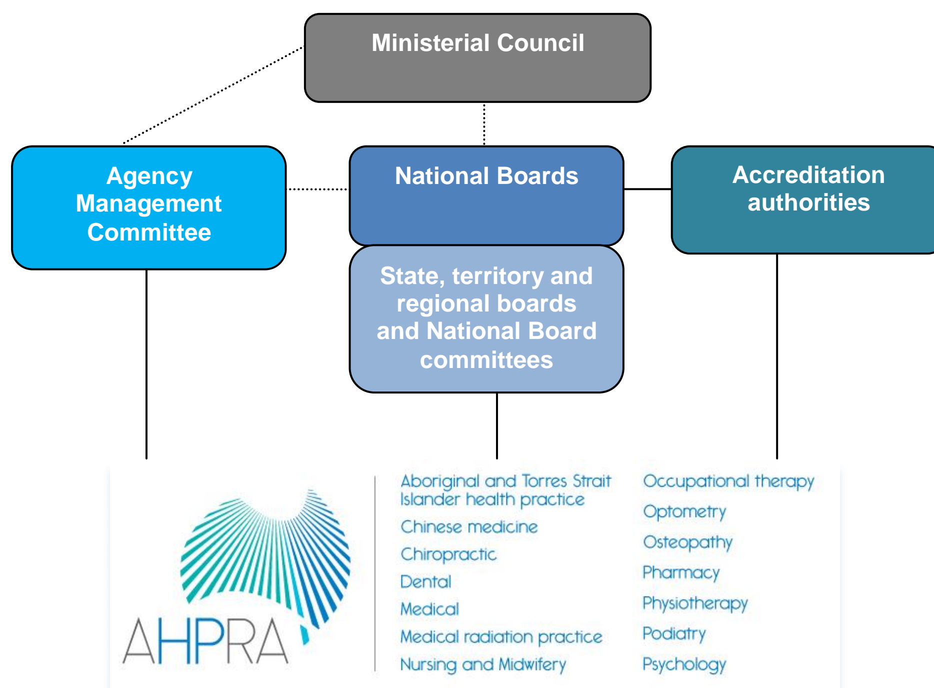
2.19 The resulting *Productivity Commission research report Vol 1, Impacts of COAG reforms: business regulation and vocational education and training (VET)* (April 2012) was released on 15 May 2012. The Productivity Commission observed that most of the COAG reforms had either just been implemented or remained to be implemented, and the impacts assessed and reported in the study were largely prospective, which impacted on their assessment approach. Chapter 10 focused on the health workforce, with the National Scheme being one of the initiatives that was implemented at the time of their review. The report concluded that while implementation was associated with significant, one-off costs, this reform should improve the productivity of the health sector over the long term.

This report may be of interest to the committee, and Chapter 10 is available online at: www.pc.gov.au/__data/assets/pdf_file/0019/116722/11-coag-reform-regulation-chapter10.pdf

Structure of the National Scheme and its interface with Victoria

2.20 While the structure of the National Scheme and reporting relationships between the key entities may appear complex on paper, on a daily basis the National Scheme is delivered by AHPRA in partnership with the National Boards, with the Ministerial Council providing high level oversight, and accreditation authorities exercising accreditation functions for the professions under the scheme (see figure below).

Figure 1: Structure of the National Scheme



2.21 The responsibilities of each entity are set out in the National Law, but are briefly as follows:

- The **Australian Health Workforce Ministerial Council** comprises the Health Ministers of each state and territory government and the Commonwealth Health Minister. Ministerial Council provides high level decision-making and ministerial oversight for the scheme. As a group, Ministerial Council makes a number of important decisions under the scheme by consensus, including approving registration standards and other proposals recommended by the National Boards, issuing policy directions as needed, and deciding if any other professions are to be regulated under the scheme.

  Since February 2011, at the request of ministers, AHPRA has provided regular updates on key operational activities and emerging issues to Ministerial Council at the Standing Council on Health meetings. This initiative has provided a welcome and timely opportunity for AHPRA and the National Boards to have direct, regular contact with all ministers and their advisors. We look forward to this opportunity continuing. This contact complements the bilateral discussions that AHPRA has, as needed, with individual Health Ministers on matters that are of particular interest to that state or territory. AHPRA and the National Boards are accountable to all nine Health Ministers.

  The consensus decision making of Ministerial Council is a critical component of the National Scheme. It provides each state and territory Health Minister and the Commonwealth Health Minister with the opportunity to debate and raise issues related to the National Scheme and make decisions at a national level that are informed by the administration of the health portfolio in their jurisdiction.

  There are also are some important decisions and interactions that individual Health Ministers can make independently of the consensus decisions made by Ministerial Council. For example, the Victorian Minister for Health:

  - decides and appoints the Chairs and practitioner and community members of the Victorian Board of the Medical Board of Australia, the Victorian Board of the Nursing and Midwifery Board of Australia, the Victorian Board of the Physiotherapy Board of Australia, and Victorian members on the ACT/Tasmania/Victoria Regional Board of the Psychology Board of Australia, and
  - may declare if there is an 'area of need' for health services if the minister considers there are insufficient health practitioners practising in Victoria (or a part thereof) to meet the needs of people living in Victoria. This enables a National Board to grant limited registration (area of need) to suitable practitioners to fill this need.

  In addition:

  - if an employer (eg a public health service) fails to notify AHPRA of a reasonable belief that a registered health practitioner has behaved in a way that constitutes notifiable conduct (the most serious of conduct or performance concerns), AHPRA must provide a report to the minister, who in turn, must report the employer's failure to a health complaints entity, the employer's licensing authority or other appropriate body in Victoria for action, and
  - after submission to the Ministerial Council, the Victorian Minister arranges tabling of the AHPRA and National Boards' annual report in the Victorian Parliament, with the other Health Ministers tabling in their respective Parliaments.

  As well as providing information and briefings to Ministerial Council to assist its consensus decision-making, AHPRA and National Board Chairs have bilateral discussions as needed or requested with individual Health Ministers, including the Victorian Health Minister. AHPRA state and territory offices are in regular contact with individual Health Ministers and their officials to bring local expertise to matters specific to a jurisdiction.

- The **14 National Boards'** primary responsibility is to develop national registration standards for their profession, develop and approve codes and guidelines, approve national accreditation standards developed by the accreditation authority for the profession, and to register suitably qualified and competent people and deal with

notifications about the health, conduct or performance of registrants (and in specific circumstances, registered students).

- AHPRA is governed by the **Agency Management Committee** which is responsible for overseeing AHPRA policy and ensuring AHPRA functions properly, effectively and efficiently in working with the National Boards. The membership of the committee is provided in detail on pages 12 to 14 of the *AHPRA and National Boards annual report 2011/12*. The Chair is Mr Peter Allen, from Victoria.
- **AHPRA** (with guidance from its Agency Management Committee) provides administrative and operational support to the National Boards, and works with the Boards to effectively and efficiently implement and administer the National Scheme in accordance with the National Law and any policy directions issued by Ministerial Council.
- Ministerial Council announced on 8 May 2009, that the accreditation function under the National Scheme would be independent of governments, but that Ministerial Council would have powers to act, for instance, where it believed that changes to an accreditation standard would have a significantly negative impact. This accreditation function is undertaken by the **accreditation authorities**.

  Each National Board is now required under the National Law to decide who will exercise the accreditation functions for the profession – either a single external accreditation body (such as a council) or a special committee established by the Board. If the accreditation authority is an external council, it works with the National Board to deliver assigned accreditation functions under a formal agreement with AHPRA on behalf of the Board. Accreditation functions also include assessments of overseas qualified practitioners, but as this is also a function of a National Board, in some cases National Boards are currently exercising this function. As a transitional arrangement for the start of the scheme, Ministerial Council appointed existing external accreditation bodies, such as the Australian Medical Council and the Australian Pharmacy Council, to exercise the accreditation functions for 3 years. More detailed information on the review of accreditation arrangements is provided at Appendix 1.

Key benefits for Victoria as a participating jurisdiction with the National Scheme

2.22 Victoria was the third state to enact state legislation (on 8 December 2009) following debate and passage unopposed by the Victorian Houses of Parliament to apply the National Law as a law of Victoria and enable the National Scheme to operate from 1 July 2010 in Victoria.

2.23 The **key benefits of the National Scheme** for health practitioners and health service users are as follows:

- **Mobility:** practitioners can practise anywhere in Australia within the scope of their current registration – state or territory barriers no longer exist.
- **Uniformity:** there are now consistent national standards in relation to registration and professional standards for each profession regardless of jurisdiction.
- **Efficiency:** over time, there is less red tape associated with registrations and notifications, processes are being streamlined and there are economies of scale (the IGA requires that the national scheme to be self-funding).
- **Collaboration:** there is sharing, learning and understanding of innovation and good regulatory practice between professions. Lessons learnt from the transition of the first 10 professions helped inform and support the successful transition for the next four professions from 1 July 2012.
- **Transparency:** there is a single, national online register displaying all registered health practitioners, including current conditions on practice (except health-related conditions), and a separate register of former practitioners whose registration has been cancelled since 1 July 2010 by a tribunal or a court.

2.24 The National Law for the scheme was shaped by the 65 Acts of Parliament it replaced and through the agreement of Ministerial Council. It took the best of previous state and territory based regulatory systems to create a single new nationally consistent law. While the National

Law set a new, nationally consistent and in many cases, higher benchmark for the regulation of health practitioners in the public interest, Victoria was very well positioned to help shape the national legislation and scheme having already enacted a single-state multi-profession regulatory framework.

2.25 The Victorian *Health Professions Registration Act 2005* (amended in 2007) provided for the registration of 12 health professions by 12 Victorian registration boards (which had previously been registered under separate Acts of Parliament). The Victorian Act also provided for accreditation arrangements, and the receipt, assessment and investigation of complaints about registered health practitioners. Victoria also had a well-established tribunal – the Victorian Civil and Administrative Tribunal (VCAT) – to hear the most serious matters about the performance and conduct of Victorian registrants. The Victorian legislation provided both a strong influence and a benchmark during the development of the National Law, consistent with what was agreed by COAG in the IGA.

2.26 The joint submission from the National Boards details their response to this inquiry. Importantly, many of the Boards from the smaller professions have noted the significant uplift in regulatory professionalism and efficiency made possible by the scale and capacity of the National Scheme. Strengthened policy development, systems and process rigour, access to professional advice and services as well as cross-profession collaboration are among the significant advances delivered to date.

2.27 Building on the original tables provided in the *Annual report 2011/12* (from page 10), the tables in Appendix 3 identify the key features, benefits and significant reform that accompanied the introduction of the National Law and commencement of the National Scheme, where possible, in comparison with the prior Victorian regulatory environment.

How the National Scheme works day to day in Victoria

2.28 While the National Scheme has a national focus, the vast majority of services to the Victorian community and practitioners are delivered through the Victorian AHPRA office. Led by State Manager Richard Mullaly, the office of 130 FTE staff ensures there is a local point of contact for the Victorian community, practitioners and stakeholders. The Victorian office has a set of delegated powers for its work with National Boards and their committees. It is also supported by an extensive range of national initiatives, systems and processes – many of which are delivered online.

2.29 Each National Board has adopted a decision-making structure best suited to the individual needs of its profession. More detail is provided in the joint National Boards' submission. The Victorian Boards of the Medical, Nursing and Midwifery, and Physiotherapy Boards meet regularly to make decisions about individual registration and notification matters involving Victorian practitioners, as delegated by National Boards. Decision-making about Victorian practitioners by other National Boards is supported by a range of national or regional boards and committees; all but one of which are supported by AHPRA's Victorian office.

2.30 There is a local registration team dealing with local registration matters for all National Boards. Notifications about Victorian practitioners are managed in Victoria with a team of assessment, investigation and compliance staff which supports the state boards and committees in their decision-making. A customer service team means that questions from the Victorian community and practitioners are answered locally.

2.31 There are strong and active links between across AHPRA state and territory offices, to support AHPRA's commitment to consistency, capability and service. Economies of scale enable all AHPRA's state and territory offices to coordinate their efforts, better manage workflow across offices and meet peak demands. AHPRA's *Business plan 2012/13* details a program of work aimed at realising the benefits and efficiencies of the National Scheme. The plan is accessible at: www.ahpra.gov.au/About-AHPRA.aspx

About the annual reports for the National Scheme

3.1 The terms of reference for the Victorian Parliamentary Inquiry require the committee to have regard to the three annual reports tabled in the Victorian Houses of Parliament by the Victorian Health Minister on 8 February 2011, 7 December 2011, and 13 November 2012 respectively. These annual reports for the National Scheme have been tabled in the parliaments of each state and territory and the Commonwealth.

Annual report 2009/10

3.2 The first annual report for the National Scheme published by AHPRA and the 10 National Boards and tabled in the parliaments of each state and territory and the Commonwealth, covers the period 2009-10 immediately before the scheme took effect in all states and territories (except Western Australia) from 1 July 2010[1].

3.3 The committee's attention is drawn to the *Annual report 2009/10*, which provides information and data about the establishment phase of the National Scheme (immediately before implementation on 1 July 2010). This report details the transition from state and territory registration schemes to the National Scheme (page 9), who administers the National Scheme (page 7), planning for the transition (pages 9-13) and the preliminary work undertaken by the 10 National Boards to develop national standards codes and guidelines and help prepare the professions for the transition (pages 15 to 38). The financial statements for a 16-month period to 30 June 2010 are published on pages 40 to 69.

Annual report 2010/11

3.4 The second annual report for the National Scheme describes the first year of operation, when AHPRA and 10 National Boards exercised their full statutory responsibilities from 1 July 2010. The report details how AHPRA strengthened systems to build a robust framework to support the national regulation of health practitioners.

3.5 AHPRA experienced some well-documented difficulties with transition and early implementation of the National Scheme. Equally well documented are the steps that AHPRA took to remedy these issues and confront the challenges of the transition from legacy arrangements to the new National Scheme. Despite these challenges, the fundamentals of the National Scheme were sound. AHPRA's major focus during this period was to get the basics right by progressively strengthening the systems and procedures required to effectively deliver the National Scheme in partnership with the National Boards, to ensure that services to the community and practitioners were more accessible and responsive.

3.6 Innovations and improvements in business processes and services to practitioners and the community are detailed in the report.

3.7 Complementing the 2010-11 financial statements for AHPRA, the annual report includes a financial overview of the National Scheme, outlining the costs of providing for the more robust and protective regulatory environment in place under the National Scheme.

3.8 The report describes AHPRA's commitment to building the strong partnerships that were critical in a complex environment in which most organisations were new or had new roles and responsibilities.

[1] *The National Scheme took effect in Western Australia on 18 October 2010 following passage of Western Australia's National Law.*

Annual report 2011/12

3.9 The third annual report for the National Scheme describes the second year of operation and AHPRA's commitment to service, consistency and capability in delivering the National Scheme. The report reveals the scope of the work of the National Scheme and the extent of its reach into the Australian community. At the end of June 2012, there were more than 548,000 registered health practitioners. This means that one in every 39 Australians is a registered health practitioner. The numbers in the annual report are large, indicating that the National Scheme is working at a scale never before undertaken in Australia in health practitioner regulation.

3.10 The data AHPRA collects are an invaluable resource. Consistent with the National Law, we publish and distribute data to help meet two of the core objectives of the National Scheme: protecting the public and facilitating the development of a flexible, responsive and sustainable workforce. National Boards use the data to shape policy development and inform standards of practice. Other organisations – including Health Workforce Australia, Medicare Australia, National E-Health Transition Authority (NEHTA) and major employers – use these data to inform workforce planning and prioritise patient safety.

3.11 AHPRA has signed a Memorandum of Understanding with the Australian Institute of Health and Welfare and Health Workforce Australia in relation to sharing information and exchanging data on Australian health practitioners – the MOU is available from: www.ahpra.gov.au/Legislation-and-Publications/Memoranda-of-Understanding.aspx.

3.12 The report also outlines the extensive work undertaken to successfully transition four new professions to regulation under the National Scheme from 1 July 2012. This included the two remaining Victorian-regulated professions of medical radiation practice (MRP) and Chinese medicine. While MRP was regulated in six of the eight jurisdictions, Victoria became the first and only jurisdiction in Australia to regulate the Chinese medicine profession in 2002 after a review which started in 1995. Accordingly, Victoria advocated for regulation of these two professions under the National Scheme and shared its considerable expertise to ensure the benefits of continued protection of the public in Victoria were extended to health service consumers in the other states and territories.

Term of reference: regulatory efficacy

Key messages

- The core roles of the National Scheme are protecting the public and facilitating workforce mobility, accessibility and development.
- Registration ensures that only those practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.
- To be registered, and maintain their registration, health practitioners must meet national registration standards set by their National Board which have raised the bar for public protection.
- An estimated 22,000 Victorian practitioners have directly benefitted from national registration as they no longer need to pay and register in multiple states and territories.
- An expanded student register is providing greater public protection.
- Audits are an important way to protect the public by regularly checking practitioner declarations about their compliance with registration standards.
- Community engagement in the National Scheme is being strengthened.

Registration

3.12 One of the main ways in which National Boards, supported by AHPRA, meet the objectives of the National Scheme is by making sure that only those practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. AHPRA works with each National Board to carefully consider every application for registration and assess it against the requirements for registration set in registration standards and the National Law.

Five common registration standards for all 14 health professions regulated under the scheme:

- *Continuing professional development registration standard*
- *Criminal history registration standard*
- *English language skills registration standard*
- *Professional indemnity insurance arrangements registration standard,* and
- *Recency of practice registration standard.*

These are available from each of the National Boards websites – in the *Registration standards* section. Go to www.ahpra.gov.au and follow the links.

3.13 Determining the outcome of applications for registration is not just an administrative process. Establishing and being satisfied about an applicant's fitness, suitability and qualification for registration is a cornerstone of good regulatory practice. Appendix 4 provides more detailed information on registration processes, as published in the *Annual report 2011/12.* A core challenge in health practitioner regulation is balancing the sometimes competing priorities of workforce supply and the safety and quality of health services delivered to the public.

3.14 In June 2011, there were just over 530,000 registered practitioners in Australia, with over 136,000 registered with their principal place of practice in Victoria. By the end of December 2012, with four new professions having joined the scheme, there were over 580,000 registered practitioners in Australia. The number of those registered in Victoria had grown to 152,222, an increase of 11.4% in the Victorian registered health workforce (see *Tables 1 and 2* below).

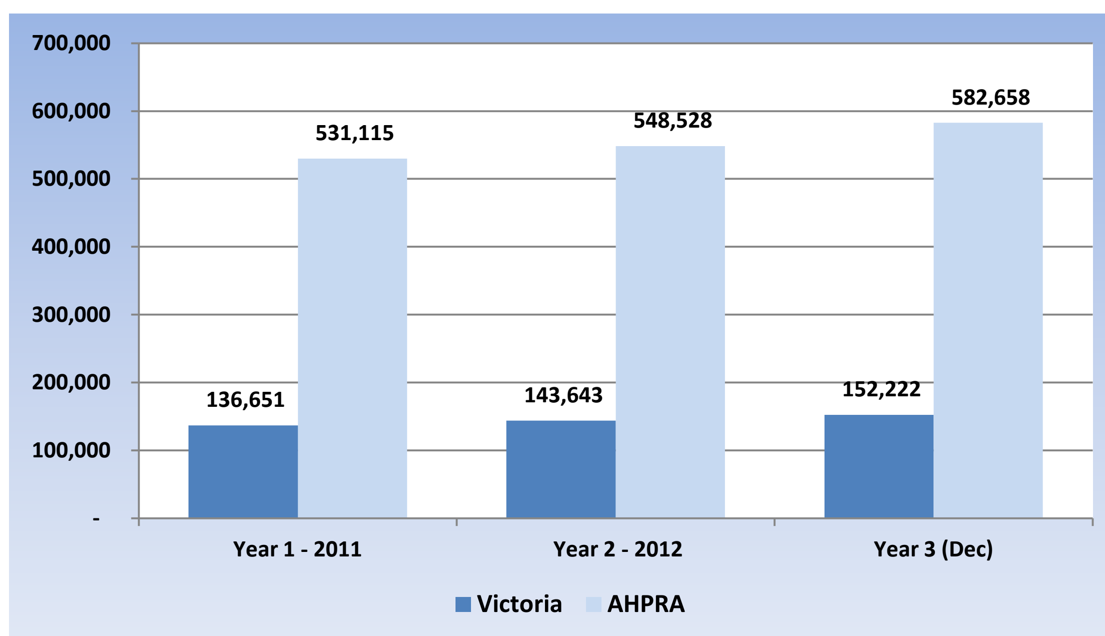
3.15 This sustained growth in the registered health workforce in Victoria indicates that the objectives of the National Scheme in enabling workforce development and access to services are being realised for the Victorian public.

Table 1: Practitioners registered under the national scheme by profession

	Jun-11		Jun-12		Dec-12 *	
Profession	**Victoria**	**National**	**Victoria**	**National**	**Victoria**	**National**
Aboriginal and Torres Strait Islander health practitioner					3	298
Chinese medicine practitioner					1,120	3,952
Chiropractor	1,138	4,350	1,202	4,462	1,260	4,610
Dental practitioner	4,092	19,319	4,358	19,087	4,564	19,759
Medical practitioner	21,238	88,293	22,365	91,648	22,391	91,749
Medical radiation practitioner					3,576	13,508
Midwife	625	1,789	747	2,187	789	2,426
Nurse	76,830	290,072	80,982	302,245	82,311	306,853
Nurse and midwife	10,375	40,324	10,297	39,271	8,521	33,363
Occupational therapist					3,406	14,255
Optometrist	1,094	4,442	1,163	4,568	1,166	4,586
Osteopath	715	1,595	843	1,676	899	1,761
Pharmacist	6,308	25,944	6,578	26,548	6,776	27,425
Physiotherapist	5,417	22,384	5,904	23,501	6,110	24,304
Podiatrist	1,084	3,461	1,195	3,690	1,239	3,825
Psychologist	7,735	29,142	8,009	29,645	8,091	29,984
Total	**136,651**	**531,115**	**143,643**	**548,528**	**152,222**	**582,658**

** Based on six months' data only*

Table 2: Registered practitioners in Victoria as proportion of national registered workforce



3.16 The Victorian office of AHPRA received and assessed more than 19,000 applications for registration in the 2012 calendar year, and together with the National Boards was able to finalise more than 16,400 of those applications (see *Table 3*). Finalising applications for registration, particularly from nursing and midwifery applicants, is affected by two major factors:

- Almost 2,500 applications are received from graduate nurses during the October – December period. These are finalised once course completion advice is received from the relevant tertiary institution, and this mostly occurs from December onwards.

- A number of applications from internationally qualified nurses and midwives (IQNMs) are finalised once a bridging course is completed. Applicants are given 12 months in which to complete the course.

3.17 During the course of 2012, the Victorian office of AHPRA completed a major project to reduce the timeframes for assessing applications from IQNMs. All applications are now assessed within 2-4 weeks of receipt and AHPRA communicates the outcome to applicants. In many cases, additional information is required.

Table 3: Applications received and finalised (January – December 2012)

	ATSI Health Practitioner	Chinese Medicine Practitioner	Chiropractor	Dental Practitioner	Medical Practitioner	Medical Radiation Practitioner	Midwife	Nurse	Occupational Therapist	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Total
Victoria																
Received	5	274	138	564	3,581	332	602	7,400	3,447	72	131	811	652	117	1,150	**19276**
Finalised	1	173	123	487	3,180	198	506	5,884	3,276	39	144	765	594	121	957	**16448**
AHPRA																
Received	78	5497	436	2115	14931	5735	2546	27003	8546	227	200	3601	2474	341	4306	**78036**
Finalised	28	4950	371	1939	13332	5136	2189	23878	7835	173	213	3434	2215	346	3902	**69941**

Workforce mobility and national registration

3.18 Facilitating national workforce mobility for health practitioners is an important objective of the National Scheme. Since 2010, health practitioners have been able to pay a single registration/renewal fee and practise anywhere in Australia within the scope of their registration. Under previous arrangements, separate fees and application processes would have applied in each jurisdiction and significantly affected the ease of mobility. Where practitioners were required to work in multiple interstate locations, particularly those located in border areas such as Albury-Wodonga, they faced additional financial and administrative burdens.

3.19 Before 2010, there were more than 637,000 active health profession registrations in Australia. With the inception of the National Scheme, this reduced to around 536,000 (see *Table 4).* This suggests that just under 15% of practitioners nationally had previously paid more than one registration fee. It is estimated that 22,000 Victorian practitioners have benefited and saved money through the payment of a single registration fee.

Table 4: Number of practitioners with multiple registrations before the National Scheme

Number of registrations held by individual practitioners before National Scheme	Number of registrations held by individual practitioners before National Scheme
457,163	1
135,282	2
17,190	3
15,604	4
11,159	5 -10
1,378	11 - 24
637,776	

Bringing the four new professions into the National Scheme

3.20 During 2011-12, AHPRA worked in partnership with the four new National Boards for the four professions (appointed by Ministerial Council in July 2011), as well as the existing 12 state and territory registration boards for these professions, to bring more than 29,000 health practitioners into the National Scheme for the first time. The four new professions were: Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupational therapy

3.21 Close to 7,500 of these practitioners were from Victoria – 4,824 Victorian-based registrants automatically transitioned to national registration and 2,582 new practitioners from Victoria were granted registration on 1 July 2012.

3.22 As at December 2012, a total of 8,105 practitioners from each of these professions have a principal place of practice in Victoria *(see Table 1).*

3.23 The *Annual report 2011/12* (pages 19-22) provides information on the work carried out by AHPRA and the four new National Boards to manage this transition and ready the professions for national regulation.

3.24 This transition was more complex than the first 10 professions because of the need to establish grandparenting provisions. While the number of practitioners to be regulated was smaller, their professions were only partially regulated (with practitioners being registered in one or more jurisdictions) across Australia. This resulted in a mix of already registered practitioners who automatically transitioned from their state or territory-based systems, alongside practitioners who needed to apply for registration for the first time. Many of these first-time national registrants had practised their profession for many years but had not been required to be registered to do so in their state or territory, and many were not aware that national registration would apply from 1 July 2012. A comprehensive communication strategy was implemented to ensure that these practitioners were aware of the national requirements and lodged their applications in time for national registration to be granted on 1 July, to minimise any risk of disruption to public health services, or to a practitioner's private sector practice.

Student registration

3.25 Although student registration was available under the previous Victorian legislation, the *Health Professions Registration Act 2005*, only medical students were registered before 2010. Victorian students in approved programs of study for the health professions now account for 25% of all registered students in Australia (see *Table 5*).

Table 5: Students registered by profession as at 10 December 2012

Profession	Approved Program of Study	Clinical Training Students	TOTAL Victoria	TOTAL National
Aboriginal and Torres Strait Islander health practitioner	-	-	-	23
Chinese medicine practitioner	366	-	366	863
Chiropractor	355	236	591	1,547
Dental practitioner	820	-	820	3,709
Medical practitioner	3,968	529	4,497	18,453
Medical radiation practitioner	373	-	373	1,780
Midwife	854	2	856	3,486
Nurse	15,545	195	15,740	64,247
Occupational therapist	355	85	440	1,627
Optometrist	186	75	261	917
Osteopath	466	1	467	528
Pharmacist	1,603	160	1,763	8,019
Physiotherapist	1,326	492	1,818	6,638
Podiatrist	483		483	1,642
TOTAL	**26,700**	**1,775**	**28,475**	**113,479**

3.26 Psychology students do not hold student registration under the National Law. The Psychology Board of Australia uses provisional registration for this purpose.

3.27 There are no fees for student registration, and AHPRA works directly with 58 education providers in Victoria to register all students who need to be registered.

3.28 As decided by Ministerial Council, the register of students is not publicly available.

3.29 The extension of the regulatory environment into the clinical training sphere further enhances the protection of the public. Notifications may be made about registered students, although the grounds are restricted to:

- being charged or found guilty of an offence that is punishable by 12 months' imprisonment
- having, or possibly having, an impairment, or
- contravening a condition on their registration or an undertaking given to a National Board.

Education providers must also notify AHPRA if they reasonably believe that a student has an impairment that may place the public at risk of harm in the course of any clinical training and/or placements. Six notifications were received from education providers in Victoria in 2012 (see *Table 8).*

Renewal of registration

3.30 Health practitioners in Australia must renew their registration annually. Each time they renew, they must make declarations to confirm that they meet the registration standards of their National Board. In 2012, AHPRA finalised more than 566,000 renewal applications nationally, including nearly 150,000 (or 26.5% of the total) in Victoria.

3.31 In the National Scheme, the annual registration renewal of the majority of practitioners is coordinated into three key dates:

- nursing and midwifery professions are due to renew by 31 May each year
- most of the medical profession is due to renew by 30 September each year, and
- all other professions, including the four new professions, are due to renew by 30 November each year.

3.32 All health practitioners, except those with limited or provisional registration for whom additional data are required, can renew their registration online. Online registration is a significant national capability now offered by AHPRA to all professions, irrespective of size, resulting in increased efficiencies and cost-effectiveness. In 2012, 87% of practitioners nationally and 85% in Victoria took up this option. Comparisons with previous years needed to be treated with caution as some practitioners renewed their registration more than once during 2010/11 in the process of aligning national renewal dates for each profession. It is worth noting that the *Annual report of the Nurses Registration Board of Victoria 2009/10* reports that 57% of Victorian nurses and midwives renewed online that year, and in 2008-09 the figure was 48%.

Audit

3.33 AHPRA is developing an auditing framework to assure compliance with mandatory registration standards through a practitioner audit project. Each time a practitioner applies to renew their registration they must make a declaration that they have met the registration standards for their profession. Practitioner audits are an important part of the way that National Boards and AHPRA can better protect the public by regularly checking these declarations by a random sample of practitioners. They help to make sure that practitioners are meeting the standards they are required to meet and provide important assurance to the community and the National Boards.

3.34 AHPRA has recently published a report on the first phase of the pilot audit, which was conducted with the pharmacy profession. This report is available online at: www.ahpra.gov.au/Registration/Audit.aspx.

3.35 The second phase of the audit pilot was run at registration renewal this year with the chiropractic, optometry, and pharmacy professions. Practitioners were randomly selected when they applied to renew their registration for the 2012-13 registration period. This applied to both paper and online renewal applications. AHPRA is now working through the audit process and information on the outcome of phase two of the pilot will be published in due course. An information pack was sent to practitioners selected for the audit, with additional information available on the AHPRA website at www.ahpra.gov.au under *Registration.*

Strong community involvement

3.36 Effective community membership of National Boards is a key element to protecting the public and a critical element of regulatory efficacy. AHPRA acknowledges the views expressed by the Victorian Health Minister, the Hon. David Davis, MP that there should be a focus on the role of consumers and their contributions to regulation under the National Scheme, and his questions about whether consumer views are represented adequately and strongly enough in the national registration arrangements.[2]

3.37 Under the (now repealed) Victorian *Health Practitioner Regulation Act 2005,* at least three community members and one lawyer member were required to be members of the 12 Victorian registration boards. The number of members appointed to those boards was no fewer than nine and no more than 12. There was scope for a community member to be appointed as Chair, but only in circumstances when the minister considered it necessary for the good operation of the board to recommend a member who was not a registered health practitioner.

3.38 The community membership on the National Boards is largely consistent with the arrangements in place in Victoria before the advent of the scheme. Importantly, community members on the National Boards have an active voice in the regulation of health professions and bring a range of perspectives to board discussions.

3.39 The National Law requires at least two members of the National Board to be community members and community membership must be no less than 1/3 of the total membership of the board. National Boards have either nine or 12 members (the size agreed by Ministerial Council). The Chair of a National Board must be a practitioner member. At least one member of a National Board must live in a regional or rural area.

3.40 When the statutory composition requirements are applied to each board, the following happens:

9- member boards	Aboriginal and Torres Strait Islander Health Practice; Chiropractic; Chinese Medicine; Optometry; Osteopathy; Podiatry; Occupational Therapy	• 6 practitioner members – each large state has a practitioner member, with the 6th member being from either NT or ACT or Tasmania. • 3 community members – for balance (and as appropriate) these members may come from the state/territories that do not have practitioner members.
12 -member boards	Dental; Medical; Nursing and Midwifery; Medical Radiation Practice; Pharmacy; Physiotherapy; Psychology	• 8 practitioner members – every state and territory has a practitioner member. • 4 community members – there will be some duplication of jurisdictions (e.g. there could be a practitioner member and a community member from the NT).

3.41 The National Law does not define what it means to bring a community or consumer perspective to the board, which supports diversity of views and backgrounds for community members. However, there is one important eligibility requirement to safeguard and support this diversity. To be eligible to be a community member on a National Board, a person must not now, or at any time have been, a registered health practitioner in the health profession for which the board is established. For example, a former registered nurse could not be appointed as a community member on the Nursing and Midwifery Board of Australia, even if that person was registered by a state board before 2010 or had not practised the profession of nursing for many years.

3.42 Public interest in being appointed to the National Boards as vacancies arise remains high. When Ministerial Council made appointments to 10 National Boards in July 2012, following the expiry of the inaugural terms of National Board members, 140 people expressed their interest for 33 vacancies. Ministers considered that this response reflected the considerable interest from the community in the work of the National Boards and the importance of the contributions that community members make to the Boards and the National Scheme.

[2] *Hansard. Legal and Social Issues Legislation Committee, Tuesday 23 October 2012, page 4688*

3.43 Victoria is well represented in membership on the 14 National Boards. As a large participating jurisdiction[3] it is a requirement of the National Law for there to be a practitioner member from Victoria on each National Board. A practitioner member is to be appointed by Ministerial Council as Chair of a National Board. The Chairs of the Chinese Medicine Board of Australia, Medical Board of Australia and Pharmacy Board of Australia are from Victoria. The Chair of the Pharmacy Board also currently chairs the Forum of National Board Chairs. In addition, there are community members from Victoria appointed by Ministerial Council on six National Boards: the Chinese Medicine Board of Australia, the Dental Board of Australia, the Nursing and Midwifery Board of Australia, the Osteopathy Board of Australia, the Pharmacy Board of Australia, and the Psychology Board of Australia.

3.44 AHPRA is also exploring other initiatives to strengthen community engagement and input into the National Scheme through the establishment of a national Community Reference Group. The Community Reference Group will be chaired by a community member appointed to one of the 14 National Boards.

3.45 The Community Reference Group will advise AHPRA and National Boards on ways in which community understanding and involvement in our work can be strengthened. This might include strategies for promoting greater community response to consultations, ways in which the national registers can be more accessible and better understood and strategies to build greater community understanding of how practitioner regulation works.

3.46 In late 2012, AHPRA entered into a partnership with the Consumer Health Forum of Australia (CHF) to engage with health consumers and the broader community across Australia. The partnership aims to:

- raise community awareness of health practitioner regulation
- increase community access to information about health practitioner regulation
- facilitate community input into the development of standards, codes of practice, guidelines and policies for health practitioners, and
- increase transparency, particularly in relation to the processes in place for managing notifications about registered health practitioners.

3.47 AHPRA also hosted community briefings in Adelaide, Sydney, Canberra, Melbourne, Perth, Darwin and Brisbane in the last half of 2012. The Melbourne forum was held on 19 November 2012.

[3] *A large participating jurisdiction is defined under the National Law to mean Victoria, Queensland, New South Wales, South Australia and Western Australia.*

Term of reference: protection of the public

Key messages

- The National Scheme aims to protect the public by dealing with practitioners who may be putting the public at risk as a result of their conduct, professional performance or health.
- The number of notifications about health practitioners is increasing.
- Strengthened mandatory reporting requirements provide greater public protection across all regulated professions.
- In 2012, the registration of 27 Victorian practitioners was suspended (22) or cancelled (5) through the National Scheme.
- Most practitioners take voluntary steps to address advertising breaches when they drawn to their attention, without Boards incurring additional costs associated with court action.
- The National Law requires that National Boards take only the action needed to protect the public.

Introduction

3.48 National Boards discharge their regulatory function to protect the community by investigating concerns raised about individual practitioners. When necessary, this can involve restricting the registration of practitioners who have been found to have engaged in unprofessional conduct or unsatisfactory professional performance; or managing practitioners whose health is impaired and may place the public at risk.

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

3.50 Notifications are dealt with by the National Boards through formal delegations to their committees, supported by AHPRA state and territory offices.

3.51 The National Boards, supported by AHPRA, treat all notifications seriously. Notifications are managed according to legal requirements, including confidentiality, privacy and natural justice principles.

3.52 Anyone can make a notification to AHPRA, which receives it on behalf of a National Board. There are two types of notifications: mandatory (under section 140 of the National Law) and voluntary (under sections 144 and 145 of the National Law).

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

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

3.55 During 2012, 1,674 notifications were received by the AHPRA Victorian office (see *Table 6*). This represents just over 1% of all registered Victorian health practitioners. Nationally, the number of notifications received represents 1.2% of the total number of registered practitioners.

3.56 In comparison, around 1,300 notifications were received by the 10 former Victorian registration boards during their final year of operation in 2009/10.

Table 6: Notifications received by type and profession – Victoria 2012

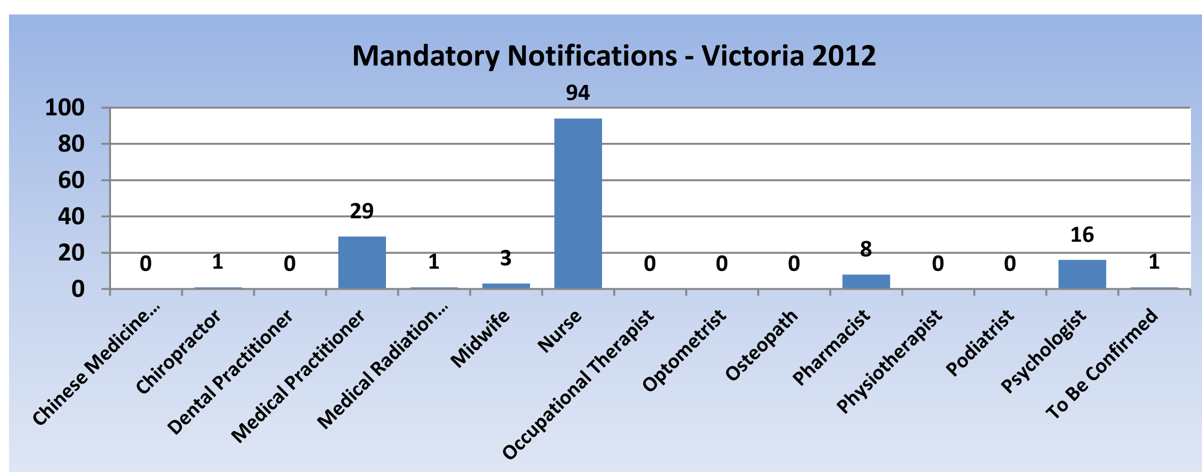
	Chinese Medicine Practitioner	Chiropractor	Dental Practitioner	Medical Practitioner	Medical Radiation Practitioner	Midwife	Nurse	Occupational Therapist	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	To Be Confirmed	Total	%
Mandatory	0	1	0	29	1	3	94	0	0	0	8	0	0	16	1	153	**9%**
Voluntary	8	15	208	800	4	3	198	3	19	2	85	17	9	86	64	**1521**	**91%**
Total	**8**	**16**	**208**	**829**	**5**	**6**	**292**	**3**	**19**	**2**	**93**	**17**	**9**	**102**	**65**	**1674**	**100%**

3.66 Of the 1,674 notifications received, almost 50% were about medical practitioners, 17% related to nurses and more than 12% to dental practitioners. This is broadly consistent with national patterns as reported in the *Annual report 2011/12*.

3.67 While more than 91% of notifications received in Victoria in 2012 were voluntary, registered health practitioners, employers and education providers have mandatory reporting obligations under the National Law. 9% of notifications received were identified as mandatory reports. The National Law provides protection from legal liability for people who make a notification in good faith. Under the previous Victorian legislation, only registered medical practitioners were required to notify the board if they formed the belief that another health practitioner or student was seriously impaired and might place the public at risk.

3.68 Of the mandatory notifications received in Victoria, more than 61% related to nurses and 19% to medical practitioners (see *Tables 6 and 7*). This is broadly in line with the national average figures of 54% for nursing, but below the national average figure of 28% for medical practitioners.

Table 7: Mandatory notifications by profession – Victoria 2012



3.69 In 2012, the largest number of notifications received by AHPRA Victoria (609 notifications or 36%) came directly from the community (patients, relatives or the public). A further 533 notifications (32%) were received on behalf of the community of Victoria through the Office of the Health Services Commissioner (HSC), reflecting the joint consideration of notifications between the National Boards and health complaints entities in the National Scheme *(*see *Table 8).* In effect, more than 66% were from the community either directly or through the HSC.

3.70 Nationally, 33% of notifications come directly from the community, with a further 27% from the health complaints entities in the respective jurisdictions. The relatively higher percentage of referrals received through the Office of the HSC may be attributable to the well-functioning relationship with the HSC in Victoria.

Table 8: Notifications received by source – Victoria 2012

Notification Source	Chinese Medicine Practitioner	Chiropractor	Dental Practitioner	Medical Practitioner	Medical Radiation Practitioner	Midwife	Nurse	Occupational Therapist	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not Stated	Total	%
Anonymous		1		14			8				5			3		**31**	**2%**
Drugs and Poisons				26							8					**34**	**2%**
Education Provider				2							1			3		**6**	**0%**
Employer			1	20		1	138				2	1		4		**167**	**10%**
Government Department			2	4			4					1		4		**15**	**1%**
HCE	1	1	123	301	2		15		12		4	4	5	5	60	**533**	**32%**
Health Advisory Service				5												**5**	**0%**
Hospital				2			5									**7**	**0%**
Insurance company				1						1		1				**3**	**0%**
Lawyer				8												**8**	**0%**
Member of Public	4	1	1	6			2				1			1		**16**	**1%**
Other Board			2	4		1	2				1	1	1	1		**13**	**1%**
Other Practitioner		2	3	49	2	4	51		2		17	3		23	1	**157**	**9%**
Patient	1	8	66	249	1		13	3	3		33	3	2	34	3	**419**	**25%**
Police				8			3				1	2				**14**	**1%**
Relative	2	1	4	108			27		1	1	13	1	1	18		**177**	**11%**
Self			1	3			9									**13**	**1%**
Unclassified		2	5	19			15		1		7			6	1	**56**	**3%**
Grand Total	**8**	**16**	**208**	**829**	**5**	**6**	**292**	**3**	**19**	**2**	**93**	**17**	**9**	**102**	**65**	**1674**	**100%**

Reasons for notifications

3.71 National Boards are responsible for overseeing investigations about the conduct, health and performance of registered health practitioners, except in NSW, which is a co-regulatory jurisdiction for managing notifications and complaints about national registrants based in that state. The principal grounds on which notifications may be made are:

- **health** (impairment) – the health practitioner has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect their practice of the profession (for practitioners) or their ability to undertake clinical training (students)

- **conduct** – the professional conduct of a registered health practitioner is of a lesser standard than might reasonably be expected by the public or professional peers, or

- **performance** - the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of their health profession is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience.

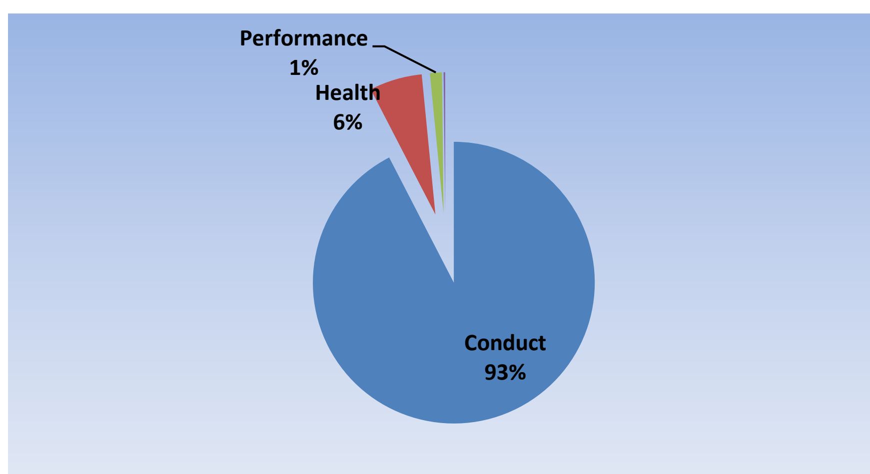
3.72 AHPRA categorises all notifications into one of these streams. In Victoria in 2012:

- 1548 notifications received related to the conduct of health practitioners (93%)
- 101 notifications received related to the health of health practitioners (6%), and
- 25 notifications related to the performance of health practitioners (1%) (see *Table 9 and Figure 2)*.

Table 9: Reasons for notifications – Victoria 2012

Notification Stream	Chinese Medicine Practitioner	Chiropractor	Dental Practitioner	Medical Practitioner	Medical Radiation Practitioner	Midwife	Nurse	Occupational Therapist	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not Stated	Total
Conduct	8	15	203	793	4	5	221	3	19	2	89	15	9	98	64	**1548**
Health		1	2	30	1	1	57				4	2		3		**101**
Performance			3	6			14							1	1	**25**
Grand Total	**8**	**16**	**208**	**829**	**5**	**6**	**292**	**3**	**19**	**2**	**93**	**17**	**9**	**102**	**65**	**1674**

Figure 2: Reasons for notifications by category – Victoria 2012



3.73 AHPRA and the National Boards have developed a classification system for notifications that reflects in greater detail the issues of concern about health practitioners that are notified to the boards.

3.74 The 1,674 notifications lodged in Victoria in 2012 span all issue categories (see *Table 10*).

Table 10: Notifications received by issue category – Victoria 2012

Notification Source	Chinese Medicine Practitioner	Chiropractor	Dental Practitioner	Medical Practitioner	Medical Radiation Practitioner	Midwife	Nurse	Occupational Therapist	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not Stated	Total	%
Anonymous		1		14			8				5			3		**31**	**1.9%**
Drugs and Poisons				26							8					**34**	**2.0%**
Education Provider				2							1			3		**6**	**0.4%**
Employer			1	20		1	138				2	1		4		**167**	**10.0%**
Government Department			2	4			4					1		4		**15**	**0.9%**
HCE	1	1	123	301	2		15		12		4	4	5	5	60	**533**	**31.8%**
Health Advisory Service				5												**5**	**0.3%**
Hospital				2			5									**7**	**0.4%**
Insurance Company				1						1		1				**3**	**0.2%**
Lawyer				8												**8**	**0.5%**
Member of the Public	4	1	1	6			2				1			1		**16**	**1.0%**
Other Board			2	4		1	2				1	1	1	1		**13**	**0.8%**
Other Practitioner		2	3	49	2	4	51		2		17	3		23	1	**157**	**9.4%**
Patient	1	8	66	249	1		13	3	3		33	3	2	34	3	**419**	**25.0%**
Police				8			3				1	2				**14**	**0.8%**
Relative	2	1	4	108			27		1	1	13	1	1	18		**177**	**10.6%**
Self			1	3			9									**13**	**0.8%**
Unclassified		2	5	19			15		1		7			6	1	**56**	**3.3%**
Grand Total	**8**	**16**	**208**	**829**	**5**	**6**	**292**	**3**	**19**	**2**	**93**	**17**	**9**	**102**	**65**	**1674**	**100%**

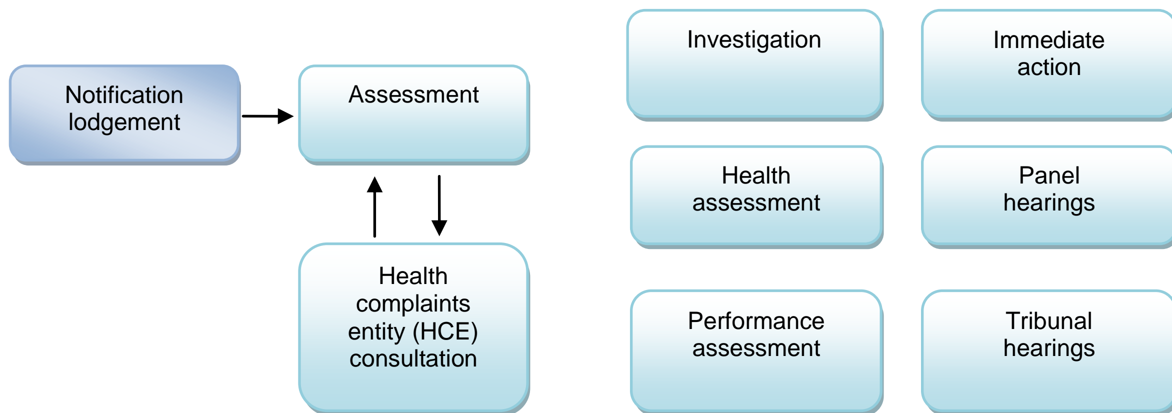
Stages in a notification

3.75 There is a nationally consistent process for managing notifications, which can include the following stages:

- lodgement
- assessment
- investigation
- health or performance assessment
- immediate action
- panel hearings, and
- tribunal hearings.

3.76 Notifications are not completed in a linear sequence. Importantly, not every notification goes through all the possible stages. For example, many notifications are closed after preliminary assessment. In complex cases, a notification can be involved in more than one stage at the same time and can take a number of possible pathways. One of the features of the National Law is its flexibility, so the notifications process can be tailored to the issues involved.

Figure 1: Notifications process



The stages in the notifications process do not necessarily apply to all notifications and are not completed in a linear sequence. In complex cases a notification can be involved in more than one stage at the same time.

Notification management

3.77 Under the National Law, a National Board has the power to decide no further action is required at any stage during the assessment or investigation of a notification. A matter can also be closed at any stage, and can be closed after a range of actions has been taken or sanctions applied.

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

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

- referring all or part of the notification to another body; this usually involves matters over which the Board does not have sole jurisdiction under the National Law
- no further action; a Board can decide to take no further action at any time during the assessment or investigation of a notification, but only after careful consideration of the issues raised
- accepting an undertaking, when a practitioner agrees to specific limitations or restrictions on practice; undertakings are recorded on the national register in accordance with the National Law and the practitioner is subject to monitoring to ensure compliance
- issuing a caution to the practitioner to practise in a particular way
- issuing a reprimand to the practitioner; a reprimand is a chastisement for conduct – a formal rebuke
- imposing conditions limiting the practice of the practitioner; the existence of conditions are recorded under the practitioner's name on the national register in accordance with the National Law and the practitioner is subject to monitoring to ensure compliance, or
- suspending registration though immediate action; a power which a Board may use at any time under the National Law if it has evidence there is a serious risk to the health and safety of the public. A Board's decision to take immediate action, to impose conditions or suspend a practitioner's registration is a serious interim action to protect the health or safety of the public. Only a tribunal has the power to apply a long-term suspension or cancel a practitioner's registration.

3.80 *Tables 11, 12, and 13* below provide details of the 1,479 notifications closed in Victoria in 2012. It is worth noting that a decreasing number of legacy (prior law) matters are still being managed through the notifications process. Prior law matters are those notifications which were open when the National Scheme started on 1 July 2010 and have been managed consistent with the Victorian law in place when the conduct occurred. These matters are recorded in the following tables as 'prior law matters', indicating that the outcomes available (and sometimes the processes involved) refer to the Victorian legislation in place at the time of the conduct, before the introduction of the National Law.

Table 11: Notifications closed in 2012 by source – Victoria 2012

Source	Chinese Medicine Practitioner	Chiropractor	Dental Practitioner	Medical Practitioner	Medical Radiation Practitioner	Midwife	Nurse	Occupational Therapist	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not Stated	Total	%
National Law Matters																	
Anonymous		1	3	14			9				3			4		**34**	**2.3%**
Drugs and Poisons				5							2					**7**	**0.5%**
Education Provider				2			1							2		**5**	**0.3%**
Employer				15			112				4	1		3		**135**	**9.1%**
Government Department			1	7			2				1	1		3		**15**	**1.0%**
HCE	1	2	101	250	1		10		8		1	4	2	7	45	**432**	**29.2%**
Health Advisory Service				3												**3**	**0.2%**
Hospital				2			2							1		**5**	**0.3%**
Insurance Company	1	1		1			1									**4**	**0.3%**
Lawyer				8			1				1			2		**12**	**0.8%**
Medicare				1												**1**	**0.1%**
Member of the Public		1	4	10			3				2			1		**21**	**1.4%**
Other Board		1		6		1	1				2			2		**13**	**0.9%**
Other Practitioner		8	2	48			42		3		7	3	2	14		**129**	**8.7%**
Patient		9	59	236		2	10	1	1	1	22	3	3	35	1	**383**	**25.9%**
Police				3												**3**	**0.2%**
Relative			7	81			14				18		1	21		**142**	**9.6%**
Self		1	1	3			6									**11**	**0.7%**
Unclassified		3	3	14			18				5		1	6		**50**	**3.4%**
(blank)			1	1			1			1	1			1		**6**	**0.4%**
Total National Law Matters	**2**	**27**	**182**	**710**	**1**	**3**	**233**	**1**	**12**	**2**	**69**	**12**	**9**	**102**	**46**	**1411**	**95.4%**
Prior Law Matters																	
Anonymous				1												1	**0.1%**
Drugs and Poisons				2												2	**0.1%**
Employer				1			7									8	**0.5%**
Government Department							1							2		3	**0.2%**

Source	Chinese Medicine Practitioner	Chiropractor	Dental Practitioner	Medical Practitioner	Medical Radiation Practitioner	Midwife	Nurse	Occupational Therapist	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not Stated	Total	%
HCE				2												2	**0.1%**
Hospital						1										1	**0.1%**
Insurance Company	1															1	**0.1%**
Other Practitioner	2			2		1	2									7	**0.5%**
Patient	1		3	15			1							3		23	**1.6%**
Police	1			1												2	**0.1%**
Relative				3										3		6	**0.4%**
Self							2									2	**0.1%**
Unclassified		1		7			1							1		10	**0.7%**
Total Prior Law Matters	**5**	**1**	**3**	**34**		**2**	**14**							**9**		**68**	**4.6%**
All matters	**7**	**28**	**185**	**744**	**1**	**5**	**247**	**1**	**12**	**2**	**69**	**12**	**9**	**111**	**46**	**1479**	**100%**

Table 12: Notifications closed by outcome at closure – Victoria 2012

Outcome at Closure	Chinese Medicine Practitioner	Chiropractor	Dental Practitioner	Medical Practitioner	Medical Radiation Practitioner	Midwife	Nurse	Occupational Therapist	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not Stated	Total	%
National Law Matters																	
Accept undertaking		4	16	11		1	37			2	1	1	1	5		**79**	**5.3%**
Caution or reprimand		6	14	33			21				25	1	1	6		**107**	**7.2%**
Impose conditions	1	2	13	27			44		1		2	1	1	10		**102**	**6.9%**
Suspend registration			1	1			4									**6**	**0.4%**
Not take immediate action				1			4									**5**	**0.3%**
No further action		14	69	441		2	117	1	6		40	8	6	79	2	**785**	**53.1%**
HCE to retain	1	1	68	187	1		6		5		1	1		2	44	**317**	**21.4%**
Refer all or part of the notification to another body			1	9												**10**	**0.7%**
Total National Law Matters	**2**	**27**	**182**	**710**	**1**	**3**	**233**	**1**	**12**	**2**	**69**	**12**	**9**	**102**	**46**	**1411**	**95.4%**
Prior Law Matters																	
Accept undertaking				2			2							1		5	**0.3%**
Caution or reprimand			1	4			3							1		9	**0.6%**

Outcome at Closure	Chinese Medicine Practitioner	Chiropractor	Dental Practitioner	Medical Practitioner	Medical Radiation Practitioner	Midwife	Nurse	Occupational Therapist	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not Stated	Total	%
Impose conditions	4		1	3		2	5							3		18	**1.2%**
Suspend registration				2												2	**0.1%**
Cancel registration				3			2									5	**0.3%**
No further action	1	1	1	19			2							4		28	**1.9%**
Not take immediate action				1												1	**0.1%**
Total Prior Law Matters	**5**	**1**	**3**	**34**	**0**	**2**	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**0**	**68**	**4.6%**
All Matters	**7**	**28**	**185**	**744**	**1**	**5**	**247**	**1**	**12**	**2**	**69**	**12**	**9**	**111**	**46**	**1479**	**100%**

Table 13: Notifications closed by stage at closure – Victoria 2012

Stage at Closure	Chinese Medicine Practitioner	Chiropractor	Dental Practitioner	Medical Practitioner	Medical Radiation Practitioner	Midwife	Nurse	Occupational Therapist	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not Stated	Total	%
National Law Matters																	
Preliminary assessment	1	11	115	494	1		100	1	11		26	5	4	59	46	874	**59.1%**
Health or performance assessment				23			50				2			5		80	**5.4%**
Immediate action				1												1	**0.1%**
Investigation		12	46	166		3	65			2	30	7	4	29		364	**24.6%**
Panel hearing		4	20	25			18		1		11		1	9		89	**6.0%**
Tribunal hearing	1		1	1												3	**0.2%**
Total National Law Matters	**2**	**27**	**182**	**710**	**1**	**3**	**233**	**1**	**12**	**2**	**69**	**12**	**9**	**102**	**46**	**1411**	**95.4%**
Prior Law Matters																	
Health or performance Assessment				2		1	1									4	**0.3%**
Investigation	1	1	1	10			2							4		19	**1.3%**
Panel hearing	1		2	7		1	4							4		19	**1.3%**
Tribunal hearing	3			15			7							1		26	**1.8%**
Total Prior Law Matters	**5**	**1**	**3**	**34**	**0**	**2**	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**0**	**68**	**4.6%**
All Matters	**7**	**28**	**185**	**744**	**1**	**5**	**247**	**1**	**12**	**2**	**69**	**12**	**9**	**111**	**46**	**1479**	**100%**

3.81 Of the 1,411 matters closed under the National Law during 2012, 317 were closed because they were retained and managed by the Health Services Commissioner. In 813 of the 1,162 (70%), matters retained and managed by AHPRA in Victoria, the National Board decided to take no further action. This compares to 80% nationally.

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

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

3.83 In 2012, the registration of 13 Victorian practitioners was suspended (8) or cancelled (5) as a result of action by a panel or tribunal, or as a result of a health assessment (see *Table 12*). Suspensions of the registration of a further 14 practitioners as a result of immediate action taken by a National Board are summarised in *Table 14*.

3.84 Details about most restrictions placed on a practitioner's registration, including suspensions, conditions, undertakings and reprimands, are published on the register of practitioners. The only restrictions not usually published relate to conditions on a practitioner's registration related to their health. This is consistent with the National Law, privacy law and health privacy principles.

Immediate action

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

- suspension or imposition of a condition on the registration of a practitioner or student, or
- accepting an undertaking from the practitioner or student, or
- accepting the surrender of the registration of the practitioner or student.

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

3.87 The National Boards initiated immediate action in 82 matters in Victoria during the year. In 67 (82%) of these cases, the practitioner's registration was restricted in some way as a result, usually pending the outcome of an investigation. The comparative national figure is 78%.

3.88 When restricting a practitioner's registration, the National Law requires the National Boards to have a proportionate response. The National Law requires that National Boards take only the action needed to protect the public.

Table 14: Immediate action outcomes – Victoria 2012

	Chiropractor	Dental Practitioner	Medical Practitioner	Nurse	Pharmacist	Physiotherapist	Psychologist	Unknown	Total
Outcomes at Closure									
Accept surrender of registration				1					1
Accept undertaking		3	1	10			1	1	16
Impose conditions		2	17	12	4		1		36
Refer for investigation or other action	1	1	5	4	1	3			15
Suspend registration		1	4	9					14
Total	1	7	27	36	5	3	2	1	82

Managing practitioners with impairment

3.89 One of the important functions of the National Boards is to manage practitioners whose impairment may pose a risk to the health and safety of the public. In Victoria in 2012, 101 notifications (or just under 6% of all notifications received) were about the health of registered practitioners.

3.90 Appendix 5 explains the core regulatory responsibilities of National Boards in the National Scheme in relation to managing impairment. These responsibilities under the National Law are distinct from the service to practitioners that may be provided by external health programs.

3.91 The National Boards and AHPRA recognise the special interest of the Victorian Minister for Health, the Hon. David Davis MP, in the Victorian Doctors' Health Program and the Victorian Nurses and Midwives Health Program. These were established by the former Victorian medical and nursing and midwifery registration boards in partnership with the Australian Medical Association (Victoria) and Australian Nursing Federation (Victorian Branch) respectively.

3.92 AHPRA is working with the National Boards to strengthen the consistency of processes and systems in place to manage and monitor practitioners with impairment. More detail is in the appendix and is also provided in the submission to the inquiry from the Medical Board of Australia. The joint work with AHPRA and National Boards would ensure that any external health program complemented the regulatory role of National Boards in relation to impairment, but did not compromise public safety.

Management of offences against the National Law

3.93 The National Law legislates for a number of offence provisions, including offences relating to advertising of regulated health services (section 133) and title protections (sections 113-119) including holding-out and practice protections for restricted dental acts, prescription optical appliances and spinal manipulation (sections 121-123) and, in South Australia, dispensing optical applicants (Part 5, *Health Practitioner Regulation National Law (South Australia) Act 2010*).

3.94 The National Boards have published advertising guidelines to help practitioners understand and meet the boards' expectations in this regard. These guidelines are common across National Boards and the first 10 National Boards in the National Scheme will shortly be consulting on proposed revisions to the guidelines.

3.95 AHPRA has established a Statutory Offences Unit to advise on potential breaches of the offence provisions of the National Law and to oversee the prosecution of all statutory offence matters, particularly those about advertising.

3.96 During the period January to November 2012, AHPRA in Victoria received 102 complaints/ notifications alleging breaches of the National Law. *Tables 15, 16, and 17* provide a breakdown by profession (where known or identified), source and issue. Nearly 80% of all alleged offences related to breaches of the advertising guidelines.

Table 15: National Law offences: allegations received by profession – Victoria 2012

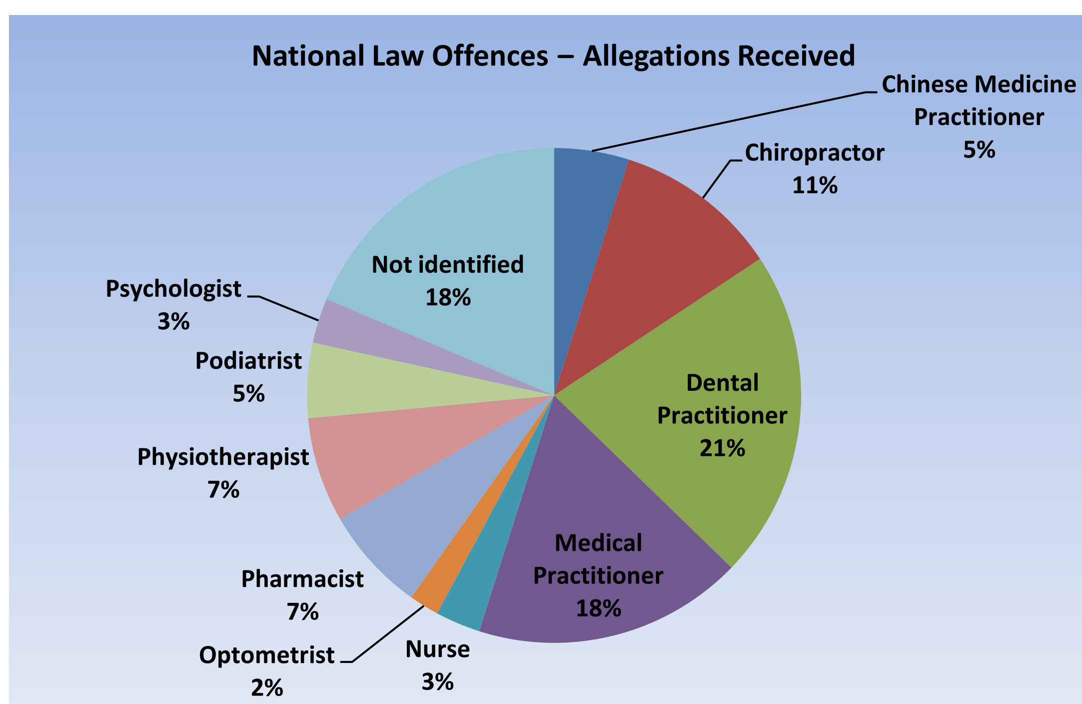


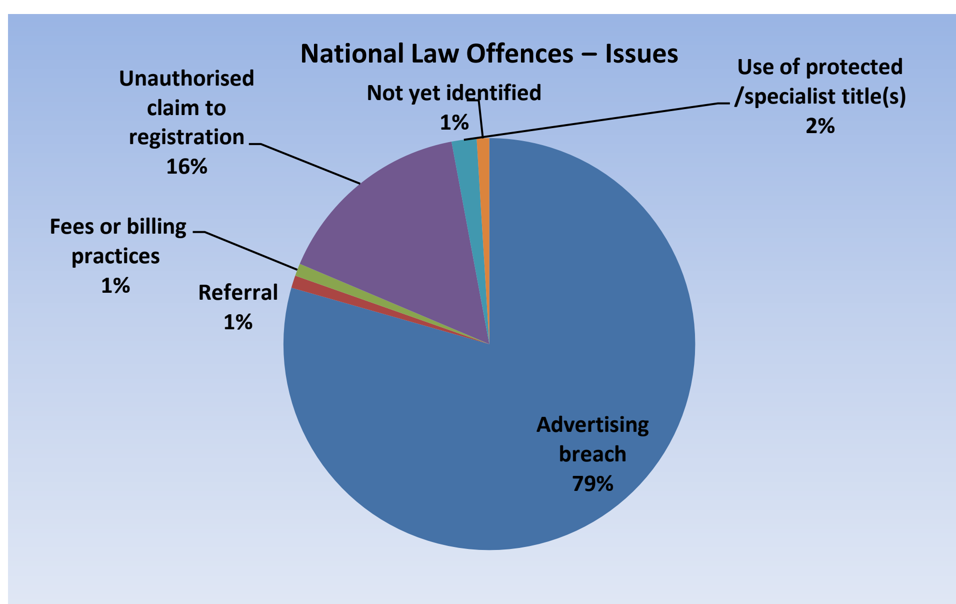
Table 16: National Law offences: allegations received by source – Victoria 2012

Source	Chinese Medicine	Chiropractor	Dental Practitioner	Medical Practitioner	Nurse	Optometrist	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not yet identified	Total	%
Anonymous	1	2	2	7	1				3		2	18	**17.6%**
Education Provider											1	1	**1.0%**
HCE											2	2	**2.0%**
Member of the Public	2		4		1			1			4	12	**11.8%**
Other Board		1	2									3	**2.9%**
Other Practitioner	1	7	5	7		2	7	1	1	1	6	38	**37.3%**
Patient			1									1	**1.0%**
Unclassified	1	1	7	3				5	1	1	2	21	**20.6%**
Not yet identified			1	1	1					1	2	6	**5.9%**
Total	**5**	**11**	**22**	**18**	**3**	**2**	**7**	**7**	**5**	**3**	**19**	**102**	**100%**
%	**4.9%**	**10.8%**	**21.6%**	**17.6%**	**2.9%**	**2.0%**	**6.9%**	**6.9%**	**4.9%**	**2.9%**	**18.6%**	**100%**	

Table 17: National Law offences: allegations received by issue (Victoria 2012)

Issue	Chinese Medicine	Chiropractor	Dental Practitioner	Medical Practitioner	Nurse	Optometrist	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not yet identified	Total	%
Advertising breach	3	10	21	16	1	2	7	7	5	1	8	81	**79.4%**
Delayed or inadequate or inappropriate referral	1											1	**1.0%**
Inappropriate fees or billing practices				1								1	**1.0%**
Unauthorised claim to registration/division/specialist registration/speciality – self or other	1		1	1	2					1	10	16	**15.7%**
Use of protected title(s) or specialist title(s)										1	1	2	**2.0%**
Not yet identified		1										1	**1.0%**
Grand Total	**5**	**11**	**22**	**18**	**3**	**2**	**7**	**7**	**5**	**3**	**19**	**102**	**100%**

Figure 3: National Law offences by issue (Victoria 2012)



3.97 The approach to managing complaints about advertising involves an escalating series of written warnings to practitioners, initially reminding them of their obligations in relation to advertising.

3.98 This approach has resulted in 93.8% of health practitioners taking appropriate action to address the advertising breach without recourse to further action by the relevant Board (see *Tables 18 and 19*). The approach is proportionate and mitigates risk to the public, without incurring the additional costs associated with court action. These costs would need to be borne by the National Scheme, and ultimately by registered practitioners.

3.99 The National Boards respond to complaints about advertising and have the power to initiate their own action or investigation without a complaint. If a practitioner fails to take corrective action, the National Board can consider taking legal action against them for noncompliance with the National Board's standards and guidelines.

Table 18: National Law offences: allegations closed by profession – Victoria 2012

National Law Offences - Closed	Chinese Medicine	Chiropractor	Dental Practitioner	Medical Practitioner	Nurse	Optometrist	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not identified	Total
Total	3	8	18	15	2	0	3	7	3	1	4	64

Table 19: National Law offences: outcomes at closure – Victoria 2012

National Law Offences - Outcomes at Closure	Chinese Medicine	Chiropractor	Dental Practitioner	Medical Practitioner	Nurse	Optometrist	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Not identified	Total	%
Breach remedied	2	8	18	14	1		3	7	3	1	3	60	**93.8%**
No further action	1				1						1	3	**4.7%**
Referred to PSR				1								1	**1.6%**
Total	**3**	**8**	**18**	**15**	**2**	**0**	**3**	**7**	**3**	**1**	**4**	**64**	**100%**

Term of reference: cost effectiveness

Key messages

- The National Scheme aims to protect the public by dealing with practitioners who may be putting the public at risk as a result of their conduct, professional performance or health.
- The National Scheme is self-funding through registration fees.
- There is no cross-subsidisation between the professions.
- The location of the AHPRA national office in Victoria adds $30 million per annum to the Victorian economy.
- AHPRA has implemented initiatives to improve cost effectiveness and deliver greater economies of scale.

Transition to a national self-funding scheme

3.100 Consistent with the IGA, the National Scheme is funded by practitioners' registration fees. There is no cross-subsidisation between professions.

3.101 The National Law requires that National Boards and AHPRA reach agreement on fees that are payable by health practitioners. These fees schedules form part of the published Health Profession Agreements. If a National Board and AHPRA are unable to reach agreement, the matter is referred to Ministerial Council for direction. Since the start of the scheme, there has been a standing agreement that, if a National Board and AHPRA propose to raise fees above the national consumer price index, a business case is brought to Ministerial Council so ministers can consider the case and provide advice.

3.102 The *Annual report 2011/12* (from page 107) includes more detailed reporting of National Board financial results (compared with the previous year's report) and a more detailed breakdown of each board's equity position since the start of the scheme. In the interests of transparency, National Boards have also published their Health Profession Agreements with AHPRA on their websites – accessible through www.ahpra.gov.au.

3.103 At the point of transition and during the first year of operation, there were concerns raised about the increase in registration fees under the National Scheme compared to previous state and territory-based registration fees. Importantly, the previous Victorian regulatory system was largely self-funding, unlike the systems of some of the other states and territories.

3.104 The main factors leading to increased fees in the National Scheme were advised to Ministerial Council at the time, and included the following:

- that the scheme needs to be self-funding, with each National Board assuming that there will be no additional government funding in the future
- there is no cross-subsidisation between professions – each profession needs to pay its own way
- fewer assets than expected were transferred to National Boards from existing state and territory boards
- the cost of implementation, including investment in new IT systems and customer service infrastructure and processes, was greater than anticipated and more than the funding allocated by governments, and
- National Boards need to fund important new services as part of the National Scheme (including the new national complaints model to operate across all jurisdictions and the co-regulatory arrangements in NSW, student registration which is at no cost to the student, and costs associated with mandatory identity and criminal history checks and mandatory reporting).

3.105 Since the start of the scheme, National Boards have applied only CPI fee increases to the national fees, except for nursing and midwifery, which applied an above-CPI fee increase in 2012. National Boards have maintained their commitment to limiting fee increases to CPI if no unforeseen circumstances arise.

Recent initiatives to help improve cost effectiveness and deliver greater economies of scale

3.106 AHPRA placed a major emphasis in 2011/12 on implementing initiatives which supported nationally consistent work processes that benefit the public and health practitioners and helped make the administration of the scheme more cost-effective.

Major initiatives
• Increasing the uptake of online registration renewals to consistently above 90%, making it easier for practitioners to renew. • Rolling out new national processes for managing notifications through each state and territory office. • Increasing consistency and reducing unnecessary variation in administering the National Scheme, through standardised processes. • Supporting all meetings with electronic paperwork, leading to savings and improved document security. • Reducing both high mail/print costs and our environmental footprint through email renewal campaigns. • Rationalising printing of registration certificates to reduce costs and improve sustainability. • Facilitating multi-profession policy development. • Establishing multiple data-exchange partnerships, for example with Health Workforce Australia and the Australian Institute of Health and Welfare, and Medicare Australia and NEHTA.

Economic benefits particular to Victoria from the national AHPRA office

3.107 On 8 May 2009, the Ministerial Council announced its decision that the national office of AHPRA would be located in Melbourne, Victoria. Victoria therefore has both the national office and the Victorian office. These two offices are located on Levels 7 and 8 of 111 Bourke Street, Melbourne.

3.108 An analysis of the economic benefits for Victoria from having the national office located in Melbourne indicates that the additional economic benefit is $30 million per annum to the Victorian economy. Victoria has also received the economic benefit of the implementation of the National Scheme since 2009, as the national implementation effort was based in Victoria.

3.109 The National Boards mainly meet in Victoria. In 2013, the National Boards plan to have 149 of their 168 meetings in Melbourne.

Future directions

Key messages

- While the National Scheme has been implemented successfully, there are areas for further improvement.
- The confidentiality provisions of the National Law are a greater barrier to providing information to notifiers than existed under previous Victorian legislation.
- Greater use of joint investigation processes with the Health Services Commissioner may better meet consumer needs for complaints resolution, while allowing National Boards to address any wider issues of public safety.
- Protecting the public through effectively dealing with impaired practitioners who may pose a risk to patient safety is an ongoing focus for National Boards and AHPRA.
- There may be opportunities to explore these issues during the three-year independent review of the operation of the National Scheme that is expected to begin later in 2013.

4.1 Much has been achieved to implement the National Scheme in a short time to benefit the public and practitioners of Victoria and all other Australian states and territories. In this section we identify a number of areas that could improve the way the National Scheme works in Victoria.

4.2 Through the AHPRA *Business plan 2012/13*, we have clearly articulated areas of focus and further innovation. The business plan makes three overarching commitments: to service, consistency and capability. AHPRA also published a service charter in 2012, detailing the standards of service the community and practitioners can expect from us, and the steps that can be taken if these standards are not met. The business plan and service charter are accessible from AHPRA's website: www.ahpra.gov.au/About-AHPRA.aspx.

Providing information to notifiers: clearer and more transparent

4.3 When the National Scheme began, a new national system of managing notifications about the health, conduct or performance of registered health practitioners was introduced.

4.4 The confidentiality provisions of the National Law restrict the information that can be disclosed to notifiers (section 192(4) refers). In effect, this means AHPRA can provide no information to notifiers explaining a decision by a National Board to take no further action about a concern they have raised.

4.5 AHPRA is working with National Boards to improve communication with notifiers within the requirements of the National Law, using plain English, and in a timely way. AHPRA also publishes information about the notifications process on our website so it is readily accessible: www.ahpra.gov.au/Notifications-and-Outcomes/Notification-Process.aspx.

4.6 AHPRA's annual reports provide statistical information on the outcome of notifications made under the National Law. AHPRA and the National Boards would also like to be able to provide more information about National Board decisions to individual notifiers, to help them understand and in many cases accept the outcome of their notification. Under previous legislation, the former boards were able to give notifiers from Victoria more information about the status, progress, and outcome of their notification than the National Law currently permits.

4.7 There may be opportunities to explore this issue during the three-year independent review of the operation of the National Scheme that is expected to begin later in 2013.

Working with the Victorian Health Services Commissioner

4.8 A key feature of the scheme's national system of notifications is the interface with each state and territory health complaints entity (HCE). The National Law requires the Boards and the HCEs to share complaints and notifications and to agree on how to deal with each complaint or notification. If the HCE and board cannot agree, the most serious action proposed must be taken. A Memorandum of Understanding (MoU) between AHPRA and health complaints entities has been developed and is published at www.ahpra.gov.au/Legislation-and-Publications/Memoranda-of-Understanding.aspx.

4.9 In Victoria, this interface is managed between AHPRA's Victorian Office (under delegation from the National Boards) and the Victorian Health Services Commissioner (HSC) and that office. A strong, cooperative working relationship has been developed between the organisations. There is a high level of accord when it comes to deciding which body should deal with notifications/ complaints and where needed, debate on matters where opinion may differ. Joint consideration contributes to a robust, quality decision-making process which helps ensure the most appropriate action is taken, and that the public interest is a central tenet of the decision-making.

4.10 As reported in the *Annual report 2011/12,* 60% of notifications in 2011/12 came from the public. Of these, 1,525 or 33% came directly from the community (patients, self-reports, relatives or the public) and 1,250 (27%) across all professions were received from HCEs in each state or territory. This reflects the importance of the joint consideration of notifications between the National Boards and HCEs under the National Scheme. The comparative Victorian figures of 38% and 32% respectively have been referenced earlier in this submission (see *Table 10* on page 28).

4.11 A strength of the current processes is that the HCEs can focus on an individual's complaint and seek resolution. By contrast, as regulators, the National Boards must focus on action that might be needed to address the health, conduct or performance of individual practitioners to protect the public.

4.12 This difference in focus is not always readily understood by consumers, and can lead to a gap between what the person making a complaint is seeking, and what the National Scheme can deliver.

4.13 With the Health Services Commissioner, AHPRA is exploring whether there are opportunities to better use existing powers in the National Law to run parallel processes. This would allow, in appropriate cases, the HSC to review systems issues or progress towards conciliation, while AHPRA and the National Boards concurrently pursue appropriate regulatory action. This parallel investigative approach requires careful thought to prevent duplication of effort or unwise use of resources.

4.14 There may also be additional action recommended as a result of the legislative review of the Victorian *Health Services (Conciliation and Review) Act*.

4.15 Another area of focus is the timeliness of advice from AHPRA, and its impact upon the ability of the HSC to achieve its statutory timeframes, particularly in relation to matters received by both the HSC and AHPRA. Delays are now infrequent, but AHPRA and the HSC continue to work collaboratively in seeking a solution to this issue, which affects a small number of notifiers.

External health programs

4.16 The role of National Boards and AHPRA under the National Law in managing practitioners with impairment is outlined in Appendix 5. There is a separate but complementary service that can be provided by external programs that help promote and maintain practitioners' health. The submission from the Medical Board of Australia provides additional relevant information about that Board's approach.

4.17 The National Boards and AHPRA recognise the special interest of the Victorian Minister for Health, The Hon. David Davis MP, in the Victorian Doctors' Health Program and the Victorian Nurses and Midwives Health Program.

4.18 AHPRA is working with National Boards on the scope and consistency of processes and systems in place to manage and monitor practitioners with impairment, within the National Scheme. We are also considering the implications for external programs focused more widely on practitioner health. AHPRA and the National Boards will continue to work with relevant stakeholders and keep governments informed of developments.

Conclusion

The data in this submission demonstrate that National Registration and Accreditation Scheme is working effectively in Victoria to protect the public, facilitate access to health services and support the development of a flexible, responsive and sustainable health workforce.

The vast majority of registered health practitioners only interact with AHPRA when they are first registered and when they renew their registration each year. Particularly in the first year of operation, there were concerns voiced about the increase in registration fees in the National Scheme, and a view that individual practitioners were not getting value for their registration dollar.

The introduction of the National Scheme came at a cost to health practitioners: an unavoidable consequence of a self-funding scheme. All registration systems place a burden – in cost and compliance – on practitioners, to keep the public safe. That is why the cost of effective regulation must be balanced by the benefits to the public. Unlike professional associations and unions, whose clear and valued role is to represent the interests of their members, the National Law requires both AHPRA and National Boards to place the public interest first, by ensuring that only suitably qualified and competent practitioners are granted and retain their registration.

Victoria was in a comparably strong position before entering the National Scheme, having already established a single piece of legislation to regulate 12 health professions, operated a largely self-funding scheme, and led the way on initiatives such as non-medical prescribing, regulation of Chinese medicine practitioners and promoting strong consumer representation on registration boards. It is therefore understandable that the Victorian Health Minister has a particular interest in the regulatory efficacy, cost effectiveness and ability of AHPRA, the National Boards and the National Scheme itself to protect the Victorian public.

This submission details the implementation of the National Scheme in Victoria. Operational data focus on the activity of the Victorian office during the 2012 calendar year. AHPRA will continue to partner with the National Boards and other agencies to implement continuous improvements to strengthen nationally consistent operations, without losing the valued local expertise, knowledge, and input of the Victorian Health Minister, government officials and other statutory bodies to ensure that Victoria (and other states and territories) have a local voice in this national scheme.

AHPRA is available to answer any supplementary questions from the Legal and Social Issues Legislation Committee or to brief the committee directly about the value of national regulation for Australia's registered health practitioners.

Appendix 1

Accreditation authorities and functions

Accreditation functions

The National Law establishes a new statutory framework for accreditation functions. The National Law defines the accreditation function as:

(a) developing accreditation standards for approval by a National Board; or
(b) assessing programs of study, and the education providers that provide the programs of study, to determine whether the programs meet approved accreditation standards; or
(c) assessing authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study relevant to registration in a health profession, to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by the authorities have the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia; or
(d) overseeing the assessment of the knowledge, clinical skills and professional attributes of overseas qualified health practitioners who are seeking registration in a health profession under this Law and whose qualifications are not approved qualifications for the health profession; or
(e) making recommendations and giving advice to a National Board about a matter referred to in paragraph (a), (b), (c) or (d).

Each National Board is required under the National Law to decide who will exercise the accreditation functions for the profession – either a single external accreditation body (e.g. a council) or a special committee established by the Board. If the accreditation authority is an external council, it works with the National Board to deliver assigned accreditation functions under a formal agreement with AHPRA on behalf of the Board. Accreditation functions also include assessments of overseas qualified practitioners. As this is also a function of a National Board, in some cases National Boards are currently exercising this function.

While there are some differences of process, all accreditation arrangements involve accrediting education providers and programs of study for each profession to make sure that students and graduates are provided with the knowledge, skills and professionalism to practise in the profession in Australia. Depending on the profession, the range of accredited courses includes undergraduate and graduate courses leading to registration; post-registration courses such as specialist training programs; bridging courses for overseas trained practitioners; and re-entry to practice programs. Accreditation authorities may also assess overseas authorities in order to decide whether people who complete the exam or program of study conducted or accredited by the authority are suitably qualified to practise in Australia.

The accreditation authorities that exercise accreditation functions for the National Scheme and work with the National Boards are:

National Board	Accreditation authority
Aboriginal and Torres Strait Islander Health Practice Board of Australia	*Committee of the Board*
Chinese Medicine Board of Australia	*Committee of the Board*
Chiropractic Board of Australia	Council on Chiropractic Education Australasia
Dental Board of Australia	Australian Dental Council
Medical Board of Australia	Australian Medical Council
Medical Radiation Practice Board of Australia	*Committee of the Board*
Nursing and Midwifery Board of Australia	Australian Nursing and Midwifery Accreditation Council
Occupational Therapy Board of Australia	Occupational Therapy Council (Aust & NZ) Inc
Optometry Board of Australia	Optometry Council of Australia and New Zealand
Osteopathy Board of Australia	Australian and New Zealand Osteopathic Council
Pharmacy Board of Australia	Australian Pharmacy Council
Physiotherapy Board of Australia	Australian Physiotherapy Council
Podiatry Board of Australia	Australian and New Zealand Podiatry Accreditation Council
Psychology Board of Australia	Australian Psychology Accreditation Council

These accreditation authorities vary significantly and range from:

- very small organisations supported by a part-time secretariat provided by a professional services firm to large organisations which have their own dedicated staffing and physical infrastructure
- organisations that accredit fewer than ten programs of study to organisations that accredit hundreds of programs of study, and
- organisations that have been operating since the mid-1980s to organisations established in the last 12 months.

The secretariats for six of the 11 external accreditation entities and the three accreditation committees are based in Victoria.

Accreditation as a statutory function

Bringing accreditation into a legislative framework has meant significant change for those accreditation authorities that existed before the National Scheme began and for new authorities formed to exercise functions under the National Law. Recognising the scope of that change, there has been a focus on clarifying the new requirements under the National Law and to progressively document and develop approaches that better/more completely address the objectives and guiding principles of the National Law. This move to a statutory framework for accreditation has often meant changes to the constitution or governing documentation of the accreditation authority.

One mechanism to support this has been the establishment of a joint working group, the Accreditation Liaison Group, to progress issues that affect multiple accreditation authorities and/or Boards. The Accreditation Liaison Group includes representatives of external accreditation entities, National Board Chairs and AHPRA.

Quality Framework for the Accreditation Function

The accreditation authorities, National Boards and AHPRA have agreed to a Quality Framework for the Accreditation Function, to support quality assurance and continuous quality improvement of accreditation under the National Law. The Quality Framework is the principal reference document for National Boards and AHPRA to assess the work of accreditation authorities and was used in the recent review of accreditation arrangements for the first 10 professions to be regulated under the National Law.

The Quality Framework is broad. It is based on both international and national best practice frameworks for accreditation, in particular the work of Professions Australia (2008) and the European Consortium for Accreditation (2004). As noted by Professions Australia, the aim of the accreditation process is not just quality assurance but also to support continuous quality improvement of professional education and training to respond to evolving community need and professional practice. It is important that the Quality Framework supports this approach and in addition, that it supports the development of good practice in implementing accreditation functions and allows diversity among accreditation authorities and the assessment of those accreditation authorities.

The principles underpinning the Quality Framework are:

- the COAG principles for best practice regulation
- the objectives and guiding principles of the scheme in the legislation (see below), and
- the independence of accreditation decision-making within the parameters established by the National Law.

The Quality Framework is designed to delineate broad domains and then more specific attributes under those domains. The Quality Framework is not a checklist, and can be interpreted flexibly and adapted as necessary to suit different contexts. It will be reviewed at least every three years.

Reviews of accreditation arrangements

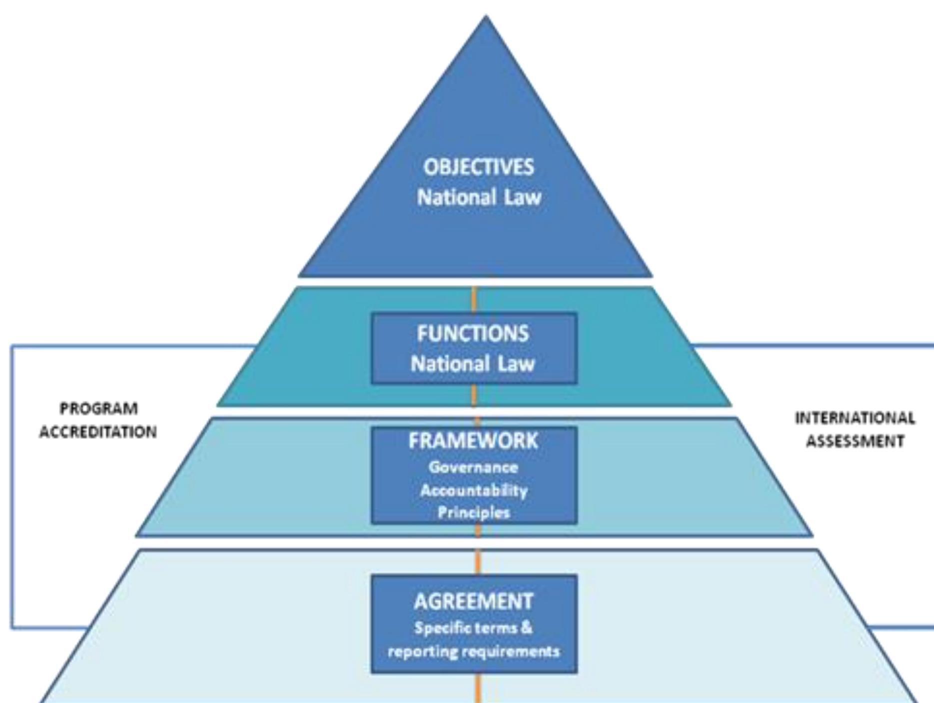
Section 253 of the National Law requires the National Boards for the first 10 professions to be regulated under the National Scheme to review their arrangements for the exercise of accreditation functions for the relevant profession by 30 June 2013. The National Boards began their reviews in mid- 2012, recognising that the reviews needed to be completed in time to allow a reasonable lead-time for any changes to the current arrangements.

The review process was founded on principles agreed by the National Boards, the accreditation authorities (through the Australian Health Professions Councils' Forum) and AHPRA. The review included wide-ranging consultation as required by the National Law.

Seven of the National Boards finalised their review by January 2013, with two Boards expected to finalise the reviews early in 2013 and one Board continuing to negotiate with its council to address issues raised in the review. The first seven Boards have carefully considered feedback received during the review process. In each case, the National Board has decided that accreditation functions for the profession will continue to be exercised by the relevant council for a further period. The National Boards' decisions are subject to a program of work, including work on key issues identified by each Board to be addressed during that period.

In deciding that the accreditation function should continue to be exercised by the Health Professions Councils, the National Boards were conscious of the need to balance the requirement for flexibility and responsiveness to developments such as the review of the National Registration and Accreditation Scheme, with the need for certainty and continuity for education providers and to enable effective planning and efficient management by the councils. Accordingly, the Boards will build appropriate flexibility into their future arrangements with the councils. The quality assurance and continual improvement principles reflected in the Quality Framework and the work referred to above will also be an aspect of the future arrangements.

The four professions who entered the National Scheme on 1 July 2012 are expected to review their accreditation arrangements by 1 July 2015.



Appendix 2

Transition timeline – journey to full implementation of the National Scheme

Date	Event
Jul 2006	COAG agrees to establish a single national registration scheme for health professionals and single accreditation scheme for health education and training
Mar 2008	COAG members sign Intergovernmental Agreement to establish National Scheme by 1 July 2010
Nov 2008	Queensland's *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (Act A) establishes the Ministerial Council, the National Boards and AHPRA
Nov 2008 – Apr 2009	Consultation on the National Scheme with stakeholders through National Registration and Accreditation Implementation Project (NRAIP), led by Dr Louise Morauta
Dec 2008	Ministerial Council assigns accreditation functions to external accreditation councils for 10 professions (nursing and midwifery appointed April 2010)
Mar - Sept 2009	Agency Management Committee members and National Boards for 10 professions appointed by Ministerial Council
Nov 2009 – Aug 2010	All states and territories enact the National Law
Mar 2010	Ministerial Council approves registration standards developed by National Boards following widespread consultation
Apr – Jun 2010	National Boards and AHPRA advise registrants on transition arrangements to National Scheme
1 Jul 2010	500,000 health practitioners transfer to national registers, the National Law and National Scheme begin, National Boards start regulating 10 professions, AHPRA begins operations, more than 400 staff transfer
July – Aug 2010	More than 2,400 new applications for registration finalised, AHPRA resolves 70% of more than 50,000 telephone calls, answers more than 14,000 emails and web queries

Date	Event
Sept 2010	More than 27,000 practitioners renew registration successfully, employer can bulk check employee registration details on national registers
Oct 2010	WA joins the National Scheme, National Scheme achieves 100 days of operation (8.10.2010), first mass medical renewal of registration for 40,000 medical practitioners – fewer than 2% do not renew on time
Nov 2010	Early application service introduced for up to 30,000 graduates, first AHPRA annual report published
Jan 2011	Online service to check receipt of registration renewal introduced
Feb 2011	Customer service teams start in each AHPRA state and territory office
Mar 2011	AHPRA and National Boards release National Registration and Accreditation Scheme strategy
Apr 2011	Australia's first national student register registering almost 100,000 students, first national snapshot of registered health practitioners
May – Jun 2011	Online registration introduced for graduating students, around 98% of 320,000 practitioners due to renew registration on time
Jul 2011	Ministerial Council appoints members of four new National Boards: Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice, occupational therapy
Dec 2011	Ministerial Council approves registration standards developed by four new National Boards following widespread consultation
Feb – Jun 2011	Early applications received from practitioners (4 more professions); comprehensive communication strategy implemented to advise practitioners of transition and registration arrangements; AHPRA partners with state, territory boards to assist plans for wind-up of functions
1 Jul 2012	More than 29,000 practitioners from the 4 professions regulated under National Scheme for first time 14 National Boards exercising full functions under National Scheme COAG agreement fully implemented

Appendix 3

Comparison between national and Victorian regulatory environments

The table below identifies **key features and significant reforms** that accompanied the introduction of the National Law and the beginning of the National Scheme, and where possible a comparison with the former Victorian regulatory environment:

Key feature	New national requirement under National Law	Equivalent in Victorian Law
Getting registered		
Student registration	Students in approved programs of study must be registered from the point set by the relevant National Board (except for psychology) – no registration fee, not on public register	Under the *Health Professions Registration Act 2005* (HPRA), only medical students were registered in Victoria
Criminal record (mandatory)	Applicants for initial registration must undergo a criminal history check; National Boards may require check at any time; registrants must declare change at annual renewal	Not previously required, nor were responses systematically managed
English language skills	Applicants must meet the English language skills required by the approved registration standard for the profession to be eligible for registration	Differing requirements in order to qualify for an exemption
Identity checking (mandatory)	Applications for registration must be accompanied by proof of the applicant's identity	Processes in place, but less rigorous than those which now apply
Specialist registration	Separate registers of specialists established for medical specialists, podiatric surgeons and dental specialists (Ministerial Council approves specialist registration standards, list of specialties and specialist protected titles)	Specialist medical registration and specialist 'endorsement' for dentists; no separate specialist register
Endorsements on registration (for extended practice)	National Boards may grant endorsements for scheduled medicines, acupuncture, and approved areas of practice in specified circumstances	Equivalent endorsements on registration. Victorian model provided the basis for national model
Standard registration types	Before the National Scheme was introduced registration types varied between state and territory legislation and between professions. Under the National Law there are a range of consistent and specific registration types across professions, across Australia	Victorian-specific and largely equivalent (but not exactly the same as other states and territories). Practitioners registered in Victoria before the start of national regulation for the profession automatically transitioned to an equivalent national registration type
Staying registered		
Continuing professional development (CPD)	Practitioners must undertake CPD required by the approved registration standard for the profession	Suggested but not required by boards No direct link to registration
Professional indemnity insurance (PII) arrangements	Practitioners must not practice the profession unless PII arrangements are in place which meet the approved registration standard for the profession	Varying requirements across professions

Key feature	New national requirement under National Law	Equivalent in Victorian Law
Recency of practice	Practitioners must meet the recency of practice requirements set in the approved registration standard for the profession	No standard requirement
Registration expiry	If practitioners do not renew their registration by the due date (or at the end of the late period one month after their registration expiry date) their registration will lapse. They will need to make a new application to become re-registered and able to practise	Annual renewal of registration Restoration of registration if lapsed
Managing notifications (complaints)		
Notifications	Nationally consistent process for managing notifications (complaints) about registered health practitioners and, in certain circumstances, registered students Nationally consistent decisions by boards and findings by responsible tribunals to ensure outcomes apply nationally (in Victoria, as decided by the then Health Minister, VCAT is the responsible tribunal) If a practitioner's registration is suspended or cancelled this applies nationally – no 'border hopping'	Largely reflects what was in place in Victoria for managing complaints about practitioners with relevant board and VCAT Victorian system helped inform the National Scheme approach
Strengthening and clarifying of the roles between National Boards and health complaints entities	Requires National Boards and the health complaints entity to share notifications and complaints about registered health practitioners and agree at preliminary assessment the most serious course of action – gives the Victorian Health Services Commission (and the other state/territory equivalents) a key role in the preliminary stage of the process	Largely reflects what was in place in Victoria and the established relationship between Victorian registration boards and the Victorian Health Services Commissioner; however, relationship not previously formalised in the manner specified in the National Law
Mandatory reporting – registered students and practitioners	Practitioners and employers must notify AHPRA of notifiable conduct by registrants that would place the public at risk of harm, such as practising while under influence of drugs or alcohol. Education providers must notify AHPRA if they reasonably believe that a registered student has an impairment	Registered medical practitioners required to notify the Board if they formed the belief that another health practitioner or student was seriously impaired and may place the public at risk
National advertising restrictions	Restricts a person from advertising a regulated health service in a false or misleading way or offering inducements or using testimonials	Yes – similar provision in Victorian HPRA 2005 provided model for national restriction

The table below identifies the **changes and reforms** introduced by **the National Scheme** as but also in comparison with Victoria:

Key benefit in National Scheme	Pre-National Scheme	In Victoria pre-scheme
One national scheme ❖	Eight separate regulatory systems	State-based regulatory regime
One nationally consistent law	65 different pieces of regulatory legislation *(more than 70 after the 2012 transition of four professions)*	One state law – HPRA – covering the regulation of twelve health professions as well as the operation of pharmacies, pharmacy businesses, pharmacy departments and pharmacy depots
One National Board per profession, supported by committees at national, state and territory level (now 14 nationally regulated professions)	85 health practitioner registration boards *(97 after the 2012 transition of four professions)*	One state board per profession (12 professions regulated)
One national agency (AHPRA) – with an office in each state and territory	38 regulatory organisations, with differing administrative support arrangements *(50 after the 2012 transition of four professions)*	Each of the 12 boards employed staff, or contracted a separate corporate entity, for the purposes of maintaining the registers and administering the requirements of the Act
Australia-wide registration for all practitioners regulated under the National Scheme	Registration required in multiple jurisdictions to practice in more than one state or territory	Victorian practitioners would need to seek registration under 'mutual recognition' arrangements to practise in another state or territory
One fee schedule per profession, with no cross-subsidisation between professions	Fee differences across states and territories	Fees set out in the Victorian regulations per profession (a self funding scheme); but separate fees would need to be paid if registered in other states or territories
One set of national registers of practitioners per profession, available online at www.ahpra.gov.au Practitioners have online access to their registration details Employers and consumers can check practitioner registration status online	1.2 million data items held by 85 boards Not all registers electronically accessible or publishing the same information about current registration status	A separate register for each profession; not all accessible online
National consistency as registration conditions and types are standardised within and across professions	Differences in conditions and types of registration within and across professions	Differences in conditions and types of registration across professions
Uniform registration standards within professions and broad consistency among professions	Differences in requirements to be eligible for registration in each state and territory	State-specific requirements for each profession, with no automatic interstate portability of registration
Able to capitalise on the digital age and expand online services for practitioners and the	Largely paper-based systems	Online renewal available for some professions; uptake not as high as now being experienced

Key benefit in National Scheme	Pre-National Scheme	In Victoria pre-scheme
community and to improve accessibility for employers		(e.g. in 2009-10, the online renewals figure for the Medical Practitioners Board of Victoria was 65%, and for the Nurses Registration Board of Victoria, 57%)
Nationally consistent data on the regulated professions *Example: quarterly registration data is now published for each of the 14 professions (September 2012 now available)*	Limited national data on practitioners, and no single verifiable source of national registration data	Victorian data included in published annual reports; manual comparison of data kept by other state and territory regulatory agencies to form national picture

❖ *NSW operates a co-regulatory model where notifications about registrants are managed through the NSW Health Care Complaints Commission and the Health Professional Councils*

Appendix 4

Registration processes

The *Annual report 2011/12* (from page 70) provides detailed information on registration types available under the National Law, and processes for managing registrations and renewals.

The extract below focuses on the **registration process**, for the information of the committee.

The time it takes to process applications for registration varies according to the type of registration requested and the particular requirements of the application.

Routine applications for renewal of registration take less time to manage and assess than more complex registration applications.

The registration process

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

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

Stage 2: Assessment – the supplied information is assessed against registration standards.

Stage 3: Recommendation – a recommendation may be to register, register with conditions, or refuse. If the application is straightforward and the recommendation is to register, a delegate of the National Board may register the applicant without referring to the relevant National Board. Complicated cases will be referred to the National Board or its committee for resolution. The Board or its delegate may accept the recommendation or take some other action such as requiring the applicant to undergo, for example, an examination or health assessment. When all information is available, the Board's decision will be to register, register with conditions, or refuse the application.

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

Stage 5: Submission – if a National Board proposes to register with conditions or refuses the application, the applicant will be informed at this stage. The applicant may then elect to make a submission to the Board.

Stage 6: Submission assessment – the response from the applicant is considered and a final decision is made.

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

Stage 8: Withdrawn/incomplete – if a required response from the applicant is not received within a reasonable period, the application is closed as withdrawn and incomplete. In this situation, applicants are not able to take their case to a tribunal for review.

Appendix 5

Managing impaired health practitioners

The AHPRA *Business plan 2012/13* details a commitment to strengthening the consistency of processes and systems in place to manage and monitor practitioners with impairment across AHPRA. In partnership with National Boards, AHPRA is exploring best practice and setting a course for ongoing improvement.

In this context, we are defining:

- the nature, extent and limits of the role of the National Boards and AHPRA in relation to impaired practitioners based on the provisions of the Health Practitioner Regulation National Law (the National Law) under which we operate
- the role of treating practitioners in the National Boards' regulatory management of impaired practitioners
- the potential role of external programs, and
- the underlying philosophy, values and principles of how we assess and manage impaired practitioners.

The context in which we operate

The National Boards (the Boards) with the Australian Health Practitioner Regulation Agency (AHPRA) operate under the National Law which has as one of its primary objectives '…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'.[4]

One of the ways in which Boards and AHPRA protect the public is through the regulatory management of practitioners who are or may be impaired.

The National Law defines impairment as a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practise the profession.

The National Law gives the Boards a range of powers in relation to the assessment and management of impaired practitioners. These powers are intended to be protective and not punitive. Boards can:

- ask practitioners to undergo a health assessments to determine whether they are impaired
- take immediate action if they believe that because of a practitioner's health, they pose a serious risk to people and it is necessary to take immediate action to protect public health or safety
- impose conditions
- accept undertakings
- caution a practitioner
- refer a practitioner to a health panel, or
- refer a practitioner to a tribunal.

Underlying philosophy, values and principles of the assessment and management of impaired practitioners

Noting the context in which we operate:

- The **role** of the Boards and AHPRA is to regulate impaired practitioners in the interests of public health and safety by assessing and managing the risks of their practice.

[4] Section 3.2 (a)

- The **approach** of the Boards and AHPRA is to work with impaired practitioners in ways that are respectful and non-punitive, aiming to enable practitioners to remain working provided they can do so safely.
- The **values** of the Boards and AHPRA are transparency, accountability, fairness, consistency.
- The **processes and decision making** of the Board and AHPRA are rigorous and based on the best available evidence.
- The Boards and AHPRA communicate clearly and respectfully.

Nature, extent and limits of the role of Boards and AHPRA in relation to impaired practitioners

When Boards are assessing and managing impaired practitioners, they are undertaking a **risk assessment** and ongoing risk management

Boards assess the risk to the public when they assess notifications about practitioners who may be impaired and Boards reassess at regular intervals the risk to the public posed by a practitioner who is impaired. This is the purpose of monitoring a practitioner.

A risk assessment informs the subsequent regulatory management of the impaired practitioner. It requires expert judgment and is a structured approach, assisted by the use of risk assessment tools

Boards take the necessary regulatory action to manage the risks posed by a practitioner's impairment, while complying with the **guiding principle** of the National Law that 'Boards should only impose restrictions on the practice of a health profession if it is necessary to ensure health services are provided safely and are of an appropriate quality'. Therefore, Boards aim to keep practitioners in practice, with appropriate safeguards in place (such as conditions), if it is safe to do so

The assessment of the risk of a practitioner's impairment takes into consideration the specific **context** and **scope** of their practice. That means that practitioners with similar levels of impairment but registered to practise in different professions (and even within the same profession but in different divisions, specialties etc.) may be treated differently by Boards. The regulatory management is based on the risk that is posed by the practice of the individual practitioner and is not formulaic.

Boards seek to carry out their regulatory role in ways that are **respectful** and **supportive** of practitioners. Their role is not to provide therapy, treatment or pastoral care.

Boards have an interest in ensuring that practitioners are accessing appropriate health care as part of the ongoing risk mitigation. In effect, they rely on treating practitioners for this.

Boards have a low threshold for deciding to ask a practitioner to have an independent health assessment, as this ensures the Board makes an informed decision about the extent of the risk to the public and informs the Board's risk assessment. **Not all practitioners who are assessed need to be monitored**. The decision to monitor is an active decision of a Board and the practitioner will only be monitored if it is necessary to manage a risk posed by an impairment.

If a Board believes that a practitioner should be monitored because their impairment poses a risk to the public, that **monitoring** should be undertaken by AHPRA and the Board. While some technical elements of monitoring may be delegated (for example specialist drug screening), responsibility for ordering, managing and overseeing the monitoring remains the responsibility of AHPRA and the Board.

Boards only have a role in the management of practitioners with an illness **if** that illness results in impairment as defined in the National Law.

Consistent with the provisions of the National Law, the Board's approach is **protective**. It is not intended to be punitive.

The role of treating practitioners

The **role** of treating practitioners is to treat their (practitioner) patient.

Boards should **not** be approving treating practitioners. The choice of treating practitioner is made by the impaired practitioner

There may be occasions when Boards may have **concerns** about a treating practitioner (due to conduct, health or performance issues). It is not the Board's role to interfere with the therapeutic relationship between the impaired practitioner and treating practitioner. However, it may be appropriate for the Board to seek more frequent independent assessments in these circumstances A registrant's treating practitioner must never also be the Board-appointed independent assessor. There is a **fundamental conflict** between the two roles.

Treating practitioners can provide useful information to Boards about a practitioner's fitness to practise. **Treating practitioner reports** should not contain details about confidential aspects of the impaired practitioner's history or therapy.

Information in reports from treating practitioners should be limited to:

- confirming whether or not an impaired practitioner is attending the treating practitioner and is complying with recommended treatment and
- confirming whether, in the treating practitioner's opinion, the impaired practitioner's impairment is/is not likely to affect their ability to practise their profession safely.

The potential role of external health programs

The National Law defines **health program** as a program providing education, prevention, early intervention, treatment or rehabilitation services relating to physical or mental impairments, disabilities, conditions or disorders, including substance abuse or dependence. The term 'health program' refers to external health programs.

The assessment and monitoring of impaired practitioners by the Boards and AHPRA should not be confused with health programs and should be called something other than 'health programs'. As AHPRA and National Boards are assessing and monitoring impairment, they could be called 'impairment programs'. This will avoid any confusion with external health programs.

Some Boards may decide to fund external health programs. If they do so, it is important to be clear about the respective roles of the Boards and AHPRA, and the external health program. In particular, it is arguably inappropriate for external health programs to be delegated the responsibility to oversee the monitoring of practitioners whose impairment may pose a risk to the public.

Potential roles of external health programs could include:

- providing telephone advice
- maintaining resources, such as a website and lists of providers who are willing to treat health practitioners
- providing education – for example for education providers, providers of health care, etc.
- training practitioners in how to manage patients who are health practitioners, and
- providing assistance with returning to work – help to source appropriate positions/supervision/mentoring, etc.

Conclusion

The philosophy, values and principles for the assessment and management of impaired practitioners are based on the provisions of the National Law. This makes their application equally relevant across all the National Boards, regardless of the profession that each Board regulates.

Different professions have varying levels of risk associated with their practice. Therefore, while the philosophy, values and principles may be the same, practitioners are likely to have different outcomes when they present with a similar levels of impairment because of the different risks posed by their practice.

A risk-based approach which is non-punitive, and which aims to keep practitioners at work if it is safe to do so, is consistent with the provisions in the National Law and is defensible to the public and to the professions.