

A unique and substantial achievement:

Ten years of national health practitioner
regulation in Australia

10



**Ahpra
& National
Boards**

Key dates in the National Registration and Accreditation Scheme

- June 2004** The Council of Australian Governments (COAG) agrees to commission a paper on health workforce issues.
- March 2005** The Australian Government asks the Productivity Commission to examine the health workforce.
- January 2006** The Productivity Commission delivers its report: [Australia's health workforce: Productivity Commission research report, 22 December 2005.](#)
- July 2006** COAG agrees to establish a single national registration scheme for health professionals.
- March 2008** An intergovernmental agreement to establish a national scheme by 1 July 2010 is signed by the Prime Minister and all premiers and chief ministers.
- December 2008** Accreditation functions are assigned to external accreditation councils (excluding nursing and midwifery and podiatry).
- March 2009** Ahpra's Agency Management Committee members are appointed.
- August 2009** National Board members are appointed by the Ministerial Council.
- 1 July 2010** The National Scheme starts in all states and territories except Western Australia.
Ten professions are regulated: chiropractic, dental, medical, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology.
- October 2010** The National Scheme starts in Western Australia.
- 1 July 2012** Four more professions – Aboriginal and Torres Strait Islander Health Practice, Chinese medicine, medical radiation practice and occupational therapy – join the National Scheme.
- 1 July 2014** Queensland becomes a co-regulatory jurisdiction with the Office of the Health Ombudsman (OHO) established.
- December 2018** Paramedicine joins the National Scheme as a newly regulated profession.
- 1 July 2020** Ten years since the National Scheme started.

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A proud achievement

Ten years on from establishing national health practitioner regulation in Australia, it is worth reflecting on the significance of this historic achievement.

Since its start in 2010, the National Registration and Accreditation Scheme has been a very important national regulatory reform of great ambition.

It benefits everyone accessing healthcare anywhere in Australia. It has established national registration standards for the professions that underpin national mobility of registered health practitioners. It has continued to develop national accreditation standards for education providers with a strong focus on the quality of our future health professionals to promote a more flexible, responsive and sustainable health workforce. And it has a central focus on patient safety.

It has published a national online register so that anyone can look up the registration details of a practitioner. This is a very critical resource for the community and health services.

The impetus for the scheme arose from the 2005 Productivity Commission review of the health workforce. In 2006 the Council of Australian Governments (COAG) determined to establish a single national registration scheme for health professionals, a key recommendation of the review.

From the different legislative routes available to achieve this once-in-a-lifetime reform, the national law model was adopted.

The *Health Practitioner Regulation National Law Act* had to pass through state and territory parliaments, and Western Australia had to pass corresponding legislation to produce the national result we now see.

Achieving policy agreement across every state and territory and with the Commonwealth was a big task, which saw strong ministerial leadership. The National Law replaced more than 65 different pieces of legislation and established National Boards for each regulated profession and a new organisation, Ahpra, which replaced 85 separate regulatory boards.

This was achieved through leadership, cooperation and collaboration across jurisdictional borders.

The registered health workforce has grown and evolved considerably in 10 years, and the scheme has continued to mature over this time. There are now 16 regulated professions with over 750,000 registered health practitioners. As the focus turns to the next phase of the scheme, I want to recognise the significance of what has been achieved, as well as the challenges that will undoubtedly lie ahead, as regulation responds to our ever-changing healthcare environment.

To everyone who contributed to this and who keeps the scheme working and evolving, on behalf of the COAG Health Council, thank you.



The Honourable Natasha Fyles, MLA

Chair, COAG Health Council

Looking back, looking forward

From my vantage point as a relative newcomer as the Chair of the Agency Management Committee since July 2019, I acknowledge both the enormous work already done and the challenges and opportunities ahead.

A 10-year anniversary offers the opportunity to take stock and reflect.

In the past, regulators were set apart, working behind the scenes, not speaking out publicly. Increasingly they – and we – are coming into public view. Our work is part of the wider health system. It is by working in partnership that we can make the biggest difference.

Australians want a high-quality health system that is safe, accessible and accountable. The community expects a high standard from the health practitioners we go to for treatment and care. This expectation applies across all professions.

Responding to these expectations and managing a large volume of work in a timely and responsive way is a significant undertaking.

In essence, it is about protecting the public interest and public safety. Ten years in, we are becoming much better at quantifying and analysing risk and ensuring the right regulatory response.

Most health practitioners want to offer the best care for their patients and work hard to do that, sometimes in difficult situations. A small number fail to meet the standards set for them. A very small number are criminal. We need to acknowledge the good of the majority, while restricting the harmful.

The issues we face as regulators are not unique to either health or Australia. We want our banks to be ethical as well as profitable, our electricians to do no harm, and traffic infringement penalties to be commensurate with the offence. As practitioners and patients have become more mobile, regulators are on the move too. Internationally we are learning from each other and identifying best practice.

The next 10 years will see digital advances and technological change in our sphere. Disruption brings both new opportunities and challenges.

Let's celebrate our achievements, which start with the considerable accomplishment of creating and establishing the National Scheme in the first place. I look forward to working together to accomplish more, as we strive to be a leading risk-based regulator enabling a competent and flexible health workforce to meet the current and future needs of the Australian community.

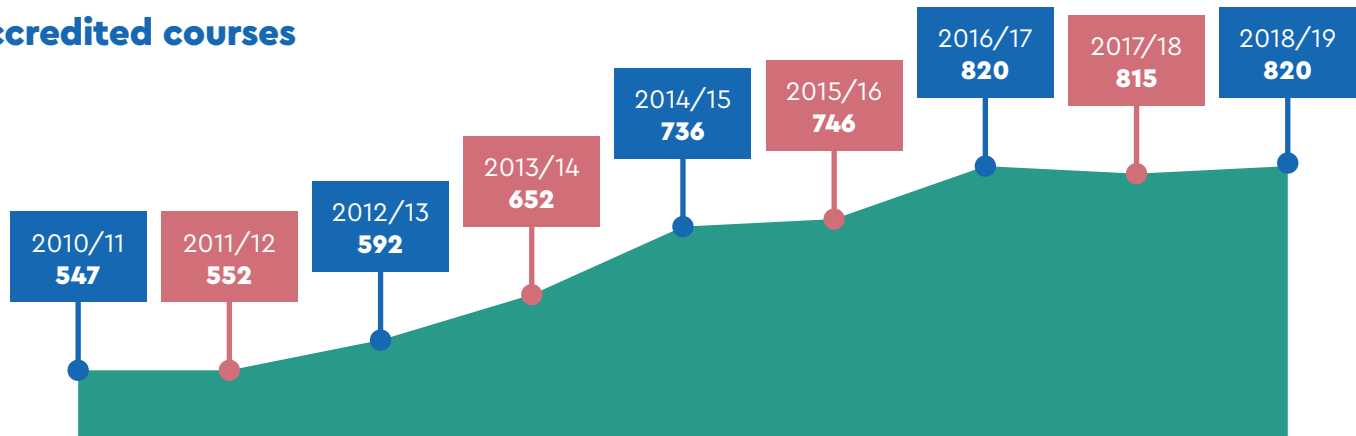


Ms Gill Callister PSM

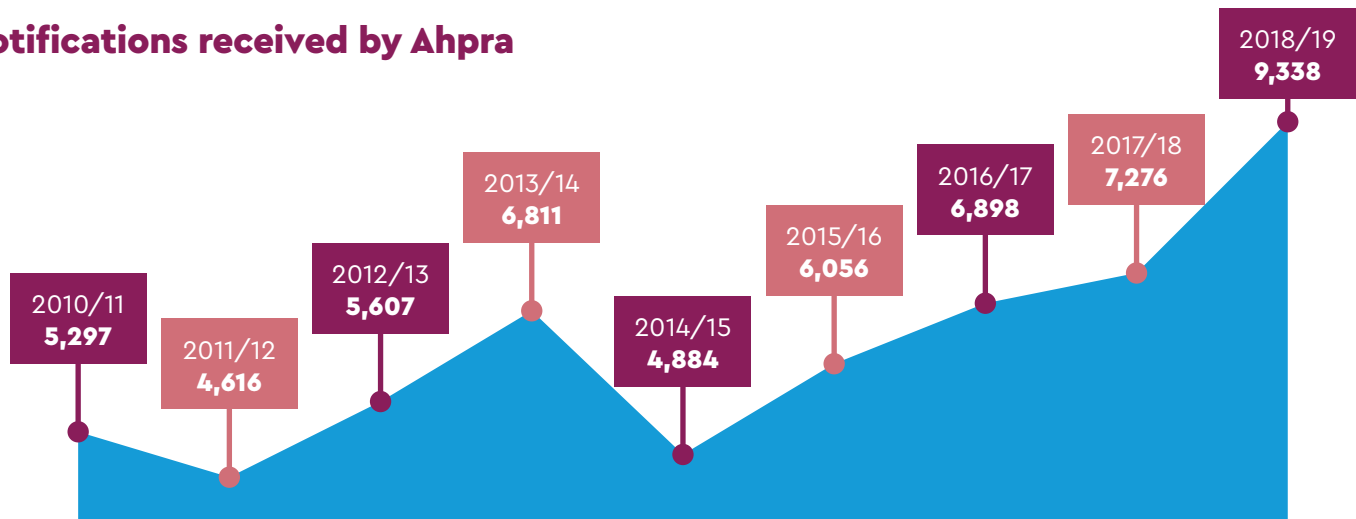
Chair, Agency Management Committee, 2019–

Growth of the National Scheme

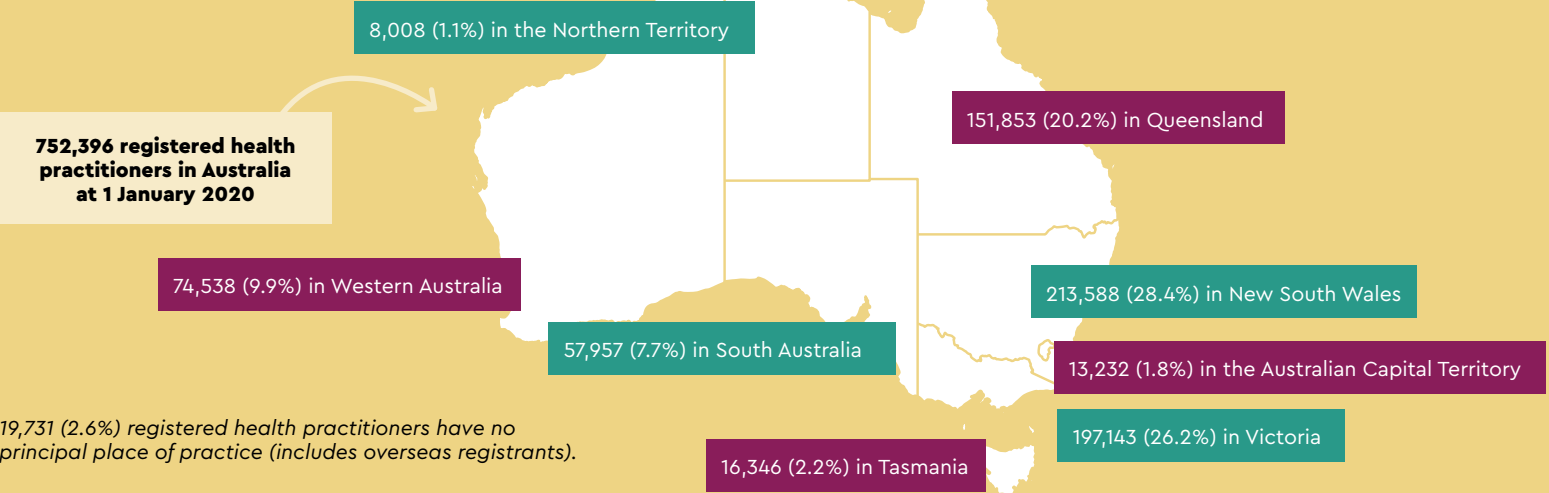
Number of accredited courses



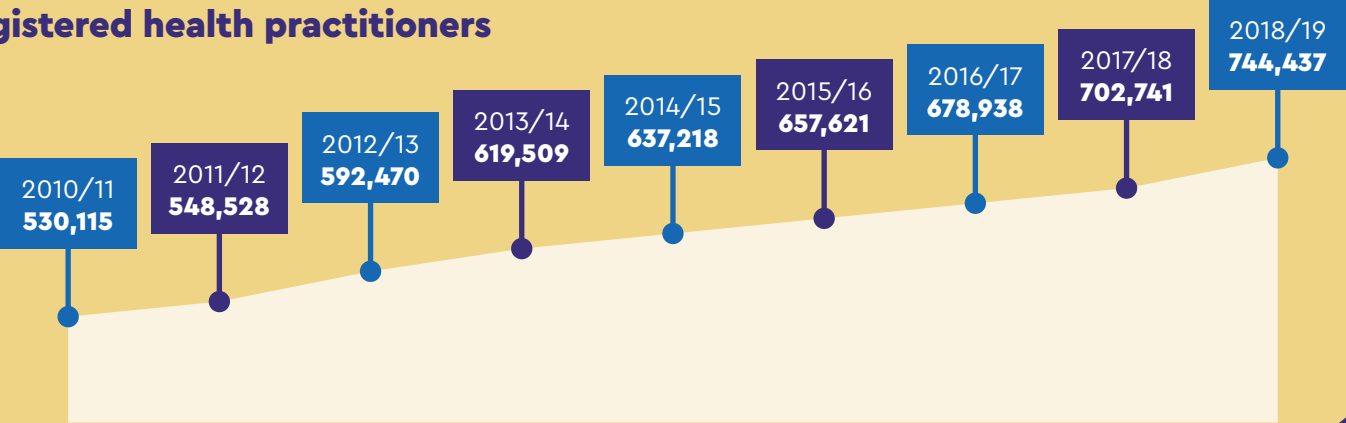
Number of notifications received by Ahpra



Registered health practitioners at 1 January 2020



Number of registered health practitioners



How and why national registration came about

Workforce needs

In March 2005 the Australian Government asked the Productivity Commission to examine workforce pressures facing the health system and to propose solutions to ensure the continued delivery of quality healthcare over the next 10 years.

Part of the brief was to consider regulatory factors affecting the supply and distribution of the health workforce in Australia. At that time, registration of health practitioners in Australia involved eight separate state and territory regulatory systems with differing legislation, requirements and scope of professions covered. There were 85 separate health practitioner boards and more than 65 different pieces of legislation.

The Productivity Commission's report, *Australia's health workforce*, was released in January 2006. Not surprisingly, it highlighted significant barriers to workforce mobility, supply, efficiency and safety caused by the fragmented regulatory arrangements across Australia and across professions.

Put simply, a doctor in Victoria couldn't assist in an emergency response to floods in Queensland without first becoming registered in Queensland; a nurse trained in New South Wales needed to seek re-registration on moving to Western Australia; and a practitioner barred in South Australia could still register and practise in Tasmania.

To deal with workforce shortages and pressures faced by the Australian health workforce, to increase its flexibility, responsiveness, sustainability and mobility, and to reduce red tape, the report recommended that there be a single national registration scheme for health professionals, as well as a single national accreditation system for education and training.

Greater focus on safety

Another driver for reform was to better address identified failures in professional practice. Failures – instances of practitioner neglect, repeated misconduct or negligence – and the subsequent media attention

that these issues gained contributed to changing community expectations.

It was intended that national registration would better protect the Australian community by raising the bar and reducing the risk that practitioners could avoid sanction by moving around Australia.

Agreement to reform

In July 2006, COAG agreed in principle to establish a single national registration scheme for health professionals. They further agreed to establish a single national accreditation scheme for health education and training to simplify and improve the consistency of current arrangements.

On 26 March 2008, the 'Intergovernmental agreement for a National Registration and Accreditation Scheme for the health professions' was signed by the Prime Minister, the premiers of all states and the chief ministers of the territories. It set out the framework under which the National Scheme would operate. It mandated 'a Ministerial Council,

an independent Australian Health Workforce Advisory Council, a national agency with an agency management committee, national profession-specific boards, committees of the boards, a national office to support the operation of the scheme, and at least one local presence in each state and territory' (*Intergovernmental agreement for a National Registration and Accreditation Scheme for the health professions*, p. 11).

The scheme would ensure that 'all regulated health professionals are registered against consistent, high-quality national professional standards and can practise across state and territory borders without having to re-register in each jurisdiction' (www.coaghealthcouncil.gov.au/NRAS). This would also help to protect the public.

The National Registration and Accreditation Scheme started on 1 July 2010 across Australia, and in Western Australia on 18 October 2010.

From the 2005 Productivity Commission report

Deficiencies in present arrangements

Many participants considered that the current registration arrangements have considerable deficiencies. In particular, many contended that the current fragmented and uncoordinated multiplicity of registration boards with their variable standards inhibits workforce efficiency and effectiveness, hinders workforce innovation and flexibility across jurisdictional borders, and increases administrative and compliance costs.

The benefits would be considerable

The Commission expects that its package of proposals would considerably enhance the efficiency and effectiveness of health workforce arrangements in Australia and facilitate adjustment to the significant demand and supply pressures that will emerge in the years ahead. In particular, the Commission sees its package as:

- driving reform to scopes of practice, and job design more broadly, while maintaining safety and quality;
- delivering a more coordinated and responsive education and training regime for health workers;
- underpinning the accreditation of health workforce courses and providers and the registration of health professionals with nationally consolidated and coherent frameworks; and
- providing the financial incentives to support access to safe and high-quality care in a manner that promotes, rather than hinders, innovation in health workplaces.

[Australian Government Productivity Commission, *Australia's health workforce: Productivity Commission research report, 22 December 2005*, pp. 135–6 and p. 303](#)

First steps towards a National Scheme

Following the COAG decision to create a National Scheme, extensive consultation took place to determine its shape and to set it up. There was a huge number of stakeholders to involve, considering that there were multiple registration bodies and 10 different professions commenting on the proposed scheme.

A small team was established to do the immense volume of preliminary work required for the official start of the scheme. Reporting to the heads of all Australian health departments, from May 2008 to December 2009 Dr Louise Morauta PSM PhD headed up this implementation team for the new scheme, working within a very tight timeframe.

From the different legislative routes available to achieve health practitioner reform, the national law model was adopted. Under this model, legislation is enacted in one jurisdiction and applied by other participating jurisdictions as a law, except for Western Australia, which passes corresponding legislation. Its advantages include that it creates a

national system and greater national consistency while maintaining the major role of each of the states and territories in the regulation of their health workforce.

The *Health Practitioner Regulation National Law Act 2009* (the National Law) was complex legislation. Queensland was identified as the host jurisdiction for the legislation. And the legislation then needed to pass through all state and territory parliaments to produce a national result.

Achieving policy agreement was a big task. National consensus was built with strong ministerial leadership and engagement supported by extensive and iterative consultation. Over 1,000 people attended forums around the country and more than 650 written submissions were received in response to the consultation papers issued in 2008 and 2009.

Ministers agreed that New South Wales (NSW) could continue with its existing and separate arrangement for complaints. The National Law provided for co-regulatory jurisdictions.

Unique features

The design and scope of the multiprofessional and national focus of the National Scheme is unique internationally. Three major features stand out.

First, the National Law includes both public safety and workforce objectives. This in part reflects the provenance of the National Scheme following the Productivity Commission report on the health workforce. It also reflects that regulation occurs within a health workforce context.

Second, the National Law regulates title rather than scope of practice. While health practitioners are expected to practise within the limits of their competency, training and expertise, it means that regulation is not an unnecessary barrier to workforce reform because the National Law does not prescribe the scope of what a registered health practitioner can do. The National Law only specifically restricts some dental acts, the prescription of optical appliances and spinal manipulation.

Third, the governance of the National Scheme sees a finely balanced model of regulation, with distinct governance roles in regulatory policy, standards and decision-making, with input from the professions through the work of National Boards but involving important roles for the community, Australian Health Practitioner Regulation Agency (Ahpra) and governments.

The magnitude of the task was recognised. The Chairs of the 10 National Boards called the reform 'extraordinary in its vision and scale' and the Royal Australian College of Physicians said that it was 'a massive undertaking'. The reform was 'the most comprehensive and complex reform of health practitioner regulation ever undertaken in Australia' with implications for every part of the health system.

Senate Finance and Public Administration References Committee, The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA), June 2011

Extract from the National Law

- (2) The objectives of the national registration and accreditation scheme are—
- (a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
 - (b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
 - (c) to facilitate the provision of high quality education and training of health practitioners; and
 - (d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
 - (e) to facilitate access to services provided by health practitioners in accordance with the public interest; and
 - (f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.
- (3) The guiding principles of the national registration and accreditation scheme are as follows—
- (a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;
 - (b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;
 - (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

Regulatory landscape before and after the National Scheme

		State/territory boards before the National Scheme								Since the National Scheme								
		NSW	Qld	Vic	Tas	ACT	WA	SA	NT	NSW	Qld	Vic	Tas	ACT	WA	SA	NT	
Joined in 2010	Nurses and midwives	●	●	●	●	●	●	●	●	→	Nursing and Midwifery Board of Australia							
	Medical practitioners	●	●	●	●	●	●	●	●	→	Medical Board of Australia							
	Psychologists	●	●	●	●	●	●	●	●	→	Psychology Board of Australia							
	Physiotherapists	●	●	●	●	●	●	●	●	→	Physiotherapy Board of Australia							
	Pharmacists	●	●	●	●	●	●	●	●	→	Pharmacy Board of Australia							
	Dental practitioners	●●	●●	●	●●	●●	●●	●	●	→	Dental Board of Australia							
	Optometrists	●●	●●	●	●●	●●	●●	●	●	→	Optometry Board of Australia							
	Chiropractors	●	●	●	●	●	●	●	●	→	Chiropractic Board of Australia							
	Osteopaths	●	●	●	●	●	●	●	●	→	Osteopathy Board of Australia							
	Podiatrists	●	●	●	●	●	●	●	○	→	Podiatry Board of Australia							
Joined in 2012	Aboriginal and Torres Strait Islander Health Practitioners	○	○	○	○	○	○	○	●	→	Aboriginal and Torres Strait Islander Health Practice Board of Australia							
	Chinese medicine practitioners	○	○	●	○	○	○	○	○	→	Chinese Medicine Board of Australia							
	Medical radiation practitioners	○	●	●	●	●	●	○	●	→	Medical Radiation Practice Board of Australia							
	Occupational therapists	○	●	○	○	○	●	●	●	→	Occupational Therapy Board of Australia							
2018	Paramedics	○	○	○	○	○	○	○	○	→	Paramedicine Board of Australia							

- Regulatory board ○ Profession did not have a designated registration/licensing body ● State/territory board — Regional board
- Had separate dental technician and dental prosthetist boards and/or committees as well as dental boards
- Had optical dispensing boards and/or committees as well as optometry boards — Had combined osteopathy and chiropractic boards

Before and after – the changed face of health practitioner regulation in Australia

Eight separate regulatory systems	→	One National Scheme (with NSW and later Queensland as co-regulators)
65 different pieces of legislation	→	One nationally consistent law
85 health practitioner registration boards	→	One National Board for each profession, supported by committees
38 regulatory organisations	→	One national agency
Separate registration required to practise in different states or territories	→	Australia-wide registration, for all practitioners covered by the scheme
Fee difference across states and territories	→	One fee schedule for each profession, with no cross-subsidisation
1.2 million data items held by 85 boards	→	One national online register of practitioners
Different dates to renew registration across jurisdictions	→	One annual renewal date for each profession from 2012
Differences in conditions and types of registrations within and across professions	→	National consistency as registration conditions and types are standardised within and across professions
Differences in requirements to be eligible for registration	→	Uniform registration standards within professions and broad consistency across professions
Largely paper-based systems	→	Ability to expand online services for practitioners and the community to improve accessibility
Limited national data on practitioners	→	Nationally consistent data on the regulated professions

The transition

The National Law is designed to support a system that is transparent, accountable, efficient, effective and fair. These principles are written into the legislation that governs the National Scheme.

The Agency Management Committee, the governing board of Ahpra, was appointed by the Australian Health Workforce Ministerial Council in March 2009. The intergovernmental agreement specified that its membership was to comprise one independent chair, who was to be an eminent person not currently or recently practising in a health profession; at least two people with relevant health and/or education and training expertise; and at least two people who were not current or former practising health professionals and who had business or administrative expertise.

The inaugural members were Mr Peter Allen (Chair), Mr Michael Gorton AM, Professor Genevieve Gray, Professor Constantine (Con) Michael AO and Professor Marilyn Walton AM. The Agency Management Committee

played a crucial role in overseeing the establishment of Ahpra and, more broadly, the National Scheme.

In August 2009, the Australian Health Workforce Ministerial Council announced the membership of the 10 new National Boards. These boards, which comprise both practitioner and community members, invested considerable time and wisdom in developing the registration standards that, from 1 July 2010, underpinned the regulation of 10 professions across Australia.

Ahpra's inaugural Chief Executive Officer (CEO), Mr Martin Fletcher, began work in December 2009.

The scheme begins

In 2010, within two years of COAG deciding to establish the National Scheme, the pieces were in place to implement this once-in-a-lifetime reform of regulation in Australia – introducing a whole new approach. National Boards were ready to start their regulatory role. The Ahpra leadership team was in place around the country, the new legislation was passed, new structures had been

established to support the operation of the National Scheme, all state and territory Ahpra offices had been leased and a national IT system was established to replace the diverse technologies and systems.

More than one million names and addresses from 42 state and territory databases were migrated into Pivotal, a new data management software program.

With the cooperation of the regulatory entities in place before the National Scheme, the support and effort of the jurisdictions, the hard work of the implementation team, and the preparatory work of National Boards, the National Scheme was created.

The initial implementation proved very challenging. Early problems included:

- significant difficulties in responding to a huge volume of queries from practitioners who were uncertain about the implications of the scheme
- having to initiate registration and renewal processes while dealing with the inconsistent and uneven quality of some of the data

- practitioner distress when lapsed registration under the National Law required them to re-apply rather than simply quickly renew (as had been the case in some jurisdictions previously)
- the need to equip staff with new knowledge and skills to deal with a new law, new standards, new systems and new requirements.

A Senate Finance and Public Administration References Committee inquiry in 2011 scrutinised the early implementation of the scheme. Implementation issues were identified including insufficient resourcing, the tight timeframe, data quality, callers' difficulty in getting accurate and timely responses, and a lack of staff training. Many of the issues identified were ones we had started to address. The concerns raised were valid but most submissions from organisations confirmed support for the scheme.

Getting the National Scheme into operation was a complex and concentrated effort by many people, and a herculean task. Transformational change of this magnitude to a regulatory system was without precedent both within Australia and internationally.

The advent of enabling legislation for a National Registration and Accreditation Scheme, while novel, was received with various levels of enthusiasm across jurisdictions. But it was more exciting to think that regulation was to be done by business plan, nationally. A pathologic fervour for some.

The early meetings to interview executives were punctuated with getting-to-know-you introductions and followed on completion by DIY wine tastings across capital cities. The real inductions came with the initial meetings of Board Chairs and airport lounge networks.

All to facilitate a magnanimous crowd of devoted regulators willing the scheme onwards. 'You're smart, just get it done'. And find the way we did. We all seemed to want the shiny new red car to fly.

**Dr John Lockwood AM (dentist),
Inaugural Chair, Dental Board of
Australia, 2009–18**

When the clock ticked over at midnight on 1 July 2010, we were as ready as we could be. We held a meeting at five o'clock every night to update each other on progress and issues (such as floods in Brisbane isolating the office there!).

Our IT person was beginning to look quite unkempt because of so many hours at work. One evening he was looking all neat and tidy with a new haircut and Martin asked him, 'When did you have time for a haircut?' His honest answer was, 'During the fire evacuation drill'. That's how hard everyone worked to pull it all together. There was lots of camaraderie and a lot of coffee.

**Ms Jill Humphreys, Executive
Officer, Aboriginal and Torres Strait
Islander Health Practice, Ahpra**

With the introduction of the National Scheme:

- practitioners needed to meet national standards in core domains; national standards underpin national mobility of registered health practitioners
- regardless of where a practitioner was based in Australia, they could register once, renew yearly and practise anywhere within the scope of their registration as long as they continued to meet the standards
- courses of study needed to meet national standards to be Board-approved
- all students enrolled in an approved program of study were to be registered for the first time¹
- all registered health practitioners and the particulars of their registrations were published on a public, online register
- anyone could raise a concern about the health, conduct or performance of a registered health practitioner anywhere in Australia.

¹ Education providers are responsible for registering their students with Ahpra. The student register is private and no fees are payable.

On the first day, we had nice offices, all new furniture and new office equipment and computers. However, it took a few days before computers and phones started working.

All functions were state-based when we started. Gradually that has changed and all functions have or are going to be based along national lines.

In the early days, everything was paper driven. It has been great to see how we have evolved over the 10 years, made great progress in the electronic space and obtained systems that can talk to each other. We can still make more progress.

**Mr Graham Wood,
Senior Finance Business Partner, Ahpra**

In the early days it was policy and forms development on the run at times ... issues and categories we hadn't even considered OR had time to develop before 1 July suddenly became urgent.

From March 2010, there was a small National Office team based at 120 Spencer Street, Melbourne, which was an older style office building. Then on 1 July we turned up to our brand new national office at 111 Bourke Street to start work along with all the other Melbourne-based people who had previously been based in the offices of the different regulators. A lot of people didn't even know each other, and many were taking on new roles. It was a strange and exciting time. It was the day we had been working so hard to get to.

**Ms Tanya Vogt, Executive Officer,
Nursing and Midwifery, Ahpra**

Transition timeline

- March 2008** COAG intergovernmental agreement signed to implement a National Registration and Accreditation Scheme by 1 July 2010
- May 2008** National project team established, led by Dr Louise Morauta PhD PSM
- November 2008** *Health Practitioner Regulation (Administrative Arrangements) National Law Bill 2008 (Act A)* passed and in force in Queensland
- December 2008** Health ministers assign accreditation functions to external accreditation councils (excluding nursing and midwifery and podiatry) for the first three years
- March 2009** Agency Management Committee members appointed
- Ministers assign accreditation functions for podiatry to external accreditation council
- August 2009** National Board members appointed by Ministerial Council
- September 2009** First meetings of National Boards
- November 2009** *Health Practitioner Regulation National Law Act 2009 (Act B)* gains Royal Assent to start 1 July 2010 in Queensland
- December 2009–
January 2010** Ahpra CEO and national management team in place and receive handover from project team
- February 2010** Ahpra state and territory managers appointed and recruiting senior staff
- March 2010** Most eligible staff from state and territory regulators accept offer to transfer to Ahpra
- Ministerial Council approves mandatory registration standards for National Boards
- April 2010** Ministers assign accreditation authority for nursing and midwifery
- April–June 2010** National Boards advise registrants on transition arrangements
- June 2010** Final preparation for transfer of data from current boards to Ahpra
- Health Profession Agreements finalised
- Most state and territory board members indicate their desire to transfer to the new National Scheme
- July 2010** National registration and accreditation begins in all jurisdictions (other than in Western Australia, which joined in October 2010)
- 500,000 registrants transfer to national registers
- Over 400 staff nationally transfer to Ahpra
- Ahpra offices open in every capital city
- [Australian Health Practitioner Regulation Agency annual report 2009/10](#)

National Boards, accreditation authorities and Ahpra

National Boards

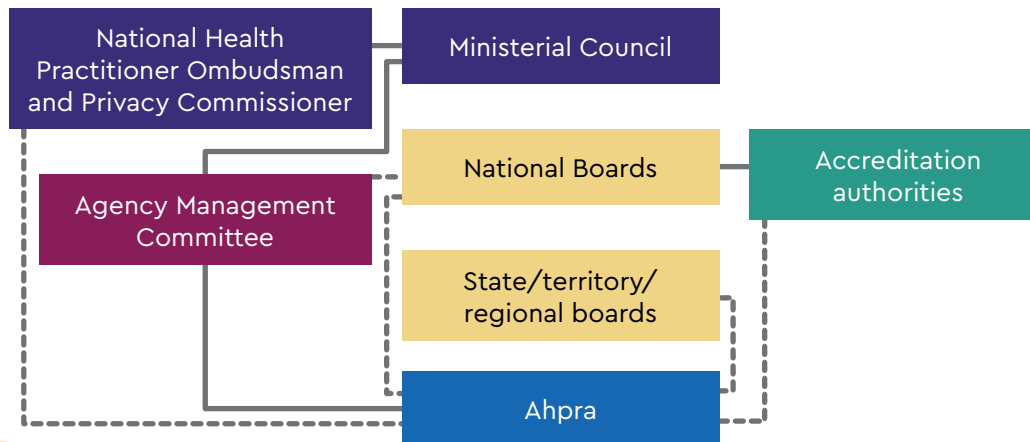
- Primary role is regulatory decision-making in the public interest
- Set national registration requirements and standards
- Oversee various regulatory processes including registration, and the receipt, assessment and investigation of notifications (complaints)
- Approve accreditation standards for the professions
- Approve qualifications for entry into the professions

Accreditation authorities

- Assigned accreditation functions by the National Board
- Develop accreditation standards for Board approval
- Accredit programs of study
- Submit accredited programs of study to National Boards for approval
- Monitor approved programs of study
- Assess overseas-trained practitioners applying for registration in Australia for some professions

Ahpra

- Administers the scheme
- Supports National Board decision-making
- Establishes and administers procedures for managing registration, compliance and (except in NSW and Queensland) notification matters
- Manages and prosecutes offence complaints
- Provides legal interpretation
- Makes recommendations to the Boards and committees
- Is the first contact point for all enquiries about registration, notifications, and from employers, governments and stakeholders



NSW has a co-regulatory arrangement for managing notifications. In Queensland, Ahpra manages matters referred by the Office of the Health Ombudsman.

As we negotiated the first few years of the new National Scheme, one of the biggest challenges for National Boards and jurisdictional boards and committees, the Agency Management Committee, and Ahpra staff was the development and implementation of a regulation system on a national scale.

This required all of us to agree to a consistent regulatory approach both strategically and operationally. Not as individual Boards siloed within the scheme doing what we have always done, but as an interactive part of the whole.

This required a significant shift in Boards' and committees' thinking to operate for the benefit of the scheme and not only in the interests of our own profession.

**Associate Professor Lynette Cusack,
Chair, Nursing and Midwifery Board
of Australia, 2014–**

Most health practitioners practise safely and well. In 2018/19, 1.7 per cent of all registered health practitioners had a notification made about them. National Boards and Ahpra responded to over 9,300 notifications.

Managing notifications

The regulation of health practitioners aims to serve the public interest by ensuring that only those who are fit to practise safely are registered. One way we seek to achieve this is by responding to concerns (referred to as notifications) about individual practitioners that may raise questions about adherence to professional standards and public and patient safety.

Ahpra works in partnership with National Boards to manage notifications about practitioners' performance, health or conduct that may place the public at risk of harm.

Every notification we receive is assessed for potential risk to the public. When our assessment determines that we need more information we investigate further. When we identify that a practitioner poses a serious risk we can take immediate action to limit a practitioner's registration while that investigation takes place.

The number of notifications increases each year. Common issues include clinical care, medication issues, practitioner behaviour and communication.

The medical profession receives the highest number of notifications. The majority of notifications, around 70 per cent, close with no further action taken beyond the assessment or investigation.

National Boards can refer serious allegations to an independent tribunal. Tribunal decisions can be appealed but most appeals are not upheld. Boards can also establish panels.

All health practitioners, their employers and education providers have mandatory reporting responsibilities if they believe certain standards have been breached.

NSW and Queensland are co-regulatory jurisdictions. The process for handling notifications in these states is different. However, the outcomes of notifications dealt with through these co-regulatory arrangements apply nationally and are recorded on the national register.

National Boards and Ahpra work closely with health complaints entities (HCEs) in each state and territory to decide which organisation should take responsibility for, and manage, a complaint or concern.

National Boards and committees

Many people have contributed to the ongoing success of the National Scheme. The members of National Boards, state, territory and regional boards, committees, panels and working, reference and advisory groups make an enormous and valued contribution. We thank them all and acknowledge here the Chairs of National Boards and the Agency Management Committee.

Agency Management Committee

Mr Peter Allen, Inaugural Chair,
5 March 2009 to 28 April 2014

Mr Michael Gorton AM, Chair,
28 April 2014 to 4 July 2019

Ms Gill Callister PSM, Chair,
4 July 2019, ongoing

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Mr Peter Pangquee, Inaugural Chair,
1 July 2011 to 30 June 2014

Presiding Members: **Mr Bruce Davis**,
26 November 2014 to 30 June 2016 and
1 March to 31 August 2017; **Mrs Lisa Penrith**,
1 February to 1 August 2016; and
Ms Renee Owen, 1 August 2016 to 1 March
2017 and 1 September to 15 December
2017

Ms Renee Owen, Chair,
15 December 2017, ongoing

Chinese Medicine Board of Australia

Distinguished Professor Charlie C. Xue,
Inaugural Chair,
1 July 2011, ongoing

Chiropractic Board of Australia

Dr Phillip Donato OAM (chiropractor),
Inaugural Chair,
10 August 2009 to 30 August 2014

Dr Wayne Minter AM (chiropractor),
Chair, 31 August 2014, ongoing

Dental Board of Australia

Dr John Lockwood AM (dentist),
Inaugural Chair,
10 August 2009 to 2 October 2018

Dr Murray Thomas (dentist), Chair,
2 October 2018, ongoing

Medical Board of Australia

Dr Joanna Flynn AM, Inaugural Chair,
10 August 2009 to 31 August 2018

Dr Anne Tonkin, Chair,
2 October 2018, ongoing

Medical Radiation Practice Board of Australia

Mr Neil Hicks, Inaugural Chair,
1 July 2011 to 1 July 2016

Mr Mark Marcenko, Chair,
21 November 2016, ongoing

Nursing and Midwifery Board of Australia

Ms Anne Copeland, Inaugural Chair,
10 August 2009 to 30 August 2013

Associate Professor Lynette Cusack,
Presiding Member, 31 August 2013 to
5 May 2014; Chair, 6 May 2014, ongoing

Occupational Therapy Board of Australia

Dr Mary Russell PhD, Inaugural Chair,
1 July 2011 to 27 February 2015

Ms Julie Brayshaw, Presiding Member, 24
February 2015 to 28 February 2016; Chair,
29 February 2016, ongoing

Optometry Board of Australia

Mr Colin Waldron, Inaugural Chair,
10 August 2009 to 30 August 2015

Mr Ian Bluntish, Chair, 31 August 2015,
ongoing

Osteopathy Board of Australia

Dr Robert Fendall (osteopath),
Inaugural Chair,
10 August 2009 to 30 August 2014
Dr Nikole Grbin (osteopath), Chair,
31 August 2014, ongoing

Paramedicine Board of Australia

Associate Professor Stephen Gough
ASM, Inaugural Chair,
19 October 2017, ongoing

Pharmacy Board of Australia

Mr Stephen Marty, Inaugural Chair,
10 August 2009 to 30 August 2015
Mr William Kelly, Chair,
31 August 2015 to 2 October 2018
Mr Brett Simmonds, Chair,
2 October 2018, ongoing



*The late Steve Marty, Inaugural Chair
of the Pharmacy Board, a tireless
contributor, 27 March 1948–4 March 2019*

Physiotherapy Board of Australia

Mr Glenn Ruscoe, Inaugural Chair,
10 August 2009 to 30 August 2012
Mr Paul Shinkfield, Chair,
30 August 2012 to 22 January 2016
Dr Charles Flynn PhD, Presiding Member,
22 January to 22 November 2016; Chair,
23 November 2016 to 2 October 2018
Ms Kim Gibson, Chair,
2 October 2018, ongoing

Podiatry Board of Australia

Mr Jason Warnock, Inaugural Chair,
10 August 2009 to 30 August 2012
Ms Catherine Loughry, Chair,
30 August 2012 to 2 October 2018
Dr Cylie Williams PhD, Chair,
2 October 2018, ongoing

Psychology Board of Australia

Professor Brin Grenyer, Inaugural Chair,
10 August 2009 to 31 August 2018
Ms Rachel Phillips, Chair,
2 October 2018, ongoing

National Board members are appointed by the Ministerial Council and state, territory and regional board members by the relevant Minister for Health. The work of the National Scheme is not possible without the right people serving on boards and committees. At least a third of all National Board, state, territory and regional board positions are filled by community members.

Each year Ahpra provides administrative support to fill hundreds of statutory vacancies, including: National Boards; National Board committees and panels (including advisory assessor panels and lists of approved persons for panels); and state, territory and regional boards and committees.

Since the start of the National Scheme, 575 appointments have been made to National Boards. This includes new appointments and reappointments. In all, 14 people have served on the Agency Management Committee.

Information about practitioners

One of the most important tasks of a regulator is to provide an accurate, complete and accessible list of those practitioners who are registered.

Previously, there were some state-based registers for some professions but nothing that provided a national picture. With the National Scheme, for the first time we had a register accessible to the public and employers across all professions and all states and territories.

Since 2010, Ahpra has published a publicly accessible online register of practitioners, providing information about the registration of any health practitioner. In 2019 our register had over 14 million pageviews and 3.5 million unique pageviews from users external to Ahpra. Of those external users, 35 per cent visited once but the rest (65 per cent) revisited multiple times.

As decisions are made about a practitioner's registration, renewal or disciplinary proceedings, the register is updated to inform the public and

employers of the current status of individual practitioners and any public restrictions placed on their registration.

A separate register lists individuals whose registration has been cancelled by a tribunal or court on the grounds of impairment, performance or conduct.

We have more to do to build community and employer awareness of the register and to make it easier to use. In 2016 we implemented the 'Be safe in the knowledge ... you're seeing a registered health practitioner' campaign to raise public awareness of the national register. The campaign was primarily delivered through social media channels and local newspapers.



While it is now online, in many ways the register is largely unchanged since the inception of regulation in Australia in the nineteenth century. Meanwhile, health practice and patient care – and patient expectations of that care – have changed significantly. In 2019, for example, we decided to improve transparency for the public by providing easier access to already-public disciplinary decisions by courts and tribunals when there was an adverse finding about a registered health practitioner.

In all our work, including what we publish on the register of practitioners, we need to balance the community's right to know with fairness to practitioners. We are also sensitive to privacy concerns. There is an important and ongoing debate about privacy versus transparency and where the public interest lies.

The continued development of the register to meet these changing needs will be a major focus over the next decade of the National Scheme.

Employer portal

We established the Practitioner Information Exchange (PIE) Service in 2014 in response to a need to efficiently and securely transfer practitioner data in bulk to health entities, government departments and co-regulators. It was originally designed to meet Ahpra's regulatory obligations and provide a mechanism for health employers to ensure their employees are registered.

As the Australian Government has embarked on a digital transformation, we have seen a significant increase in government agencies accessing PIE services. These range from large-scale customisations of PIE to support initiatives such as SafeScript and National Real Time Prescription Monitoring, to smaller projects supporting the validation of health practitioner credentials and personal information. Other subscribers include public and private hospitals, healthcare businesses, pharmaceutical companies, medical insurers, and nursing and aged care agencies. PIE has approximately 100 subscribers and our web-based Multiple Registration Check service has about 1,200.

Over the years we've been able to see how demand for practitioner information has evolved, and how subscriber expectations about technology and access to the information have changed. We can now further explore two-way information exchanges and improve our current technology, ensuring we remain a modern regulator and support employers to manage human resources, and clinical and risk management from one data source.

An international workforce

Australia continues to welcome a large number of health professionals who are trained in other countries.

Around 20 per cent of Australia's 400,000-plus nurses and midwives gained their initial qualification overseas. The Nursing and Midwifery Board of Australia (NMBA) and Ahpra have done considerable work to establish a consistent, evidence-based assessment process for internationally qualified nurses and midwives (IQNMs) who apply for registration in Australia. This is to ensure that all nurses and midwives meet the same standards of competency, no matter where they gained their qualifications.

The NMBA will transition to a new evidence-based model of assessment for IQNMs in 2020. All IQNMs will participate in a two-part orientation program to support their transition to our healthcare context. IQNMs who hold relevant, but not substantially equivalent, qualifications (and who meet the mandatory registration standards) will be assessed according to an outcomes-based model, replacing the current need for bridging programs.

In their report [Lost in the labyrinth: report on the inquiry into registration processes and support for overseas trained doctors](#) released in 2012, the House of Representatives Standing Committee on Health and Ageing made recommendations about reducing red tape, duplication and administrative hurdles faced by international medical graduates (IMGs). The Medical Board of Australia has worked with the Australian Medical Council, specialist colleges, stakeholders and government to review assessment pathways, refine the processes for assessment, establish and review [Good practice guidelines for the specialist international medical graduate assessment process](#); streamlining and improving experiences for IMGs seeking registration.

Building a common regulatory framework

By 2013, National Boards and Ahpra had been working with the National Law for three years. We had developed common processes for our regulatory work but, despite being a single scheme, our stakeholders were reporting that we were sometimes making different decisions from jurisdiction to jurisdiction and from Board to Board.

With a shared commitment to fairness, transparency and consistency, we needed a way to ensure we captured that commitment. The answer lay in part with the regulatory principles.

The principles are simple. They capture in a few sentences the essence of our decision-making. They are based on the National Law and prioritise public protection. They introduce the concept of risk-based regulation into our everyday language and they are clear that we are here to protect and not to punish. They also acknowledge the importance of community confidence and working with the professions to achieve good outcomes.

The principles recognise that regulatory decision-making is complex and contextual, requiring judgement, experience and common sense. It requires decision-makers to consider the facts of each case and to use the principles to guide their decisions.

The principles are an important tool to help us to communicate our decision-making. Introducing risk as a concept means that we can explain when it is necessary to take regulatory action – and when it is not necessary. Basing our decisions on risk also allows us to be more rational in our allocation of resources.

All the Boards and Ahpra signed up to the principles. After an initial 12-month pilot, they were formally adopted and are now a routine part of our work. They are referred to in reasons for decisions, and in communicating with practitioners and notifiers. As decision-makers have become accustomed to using them, they have become a part of our everyday language.

They are particularly helpful to support decision-making when it has been difficult to reach a consensus view about a decision.

The principles support decision-making that is consistent and balanced. The principles are published online, so it is clear what people can expect from us and how we will manage the work that comes before us.

We are integrating the consistent assessment of risk throughout our work as our systems and processes become streamlined and nationally consistent. This is helping us to focus our regulatory efforts where they are needed most.



Regulatory principles

1 The Boards and Ahpra **administer and comply with the *Health Practitioner Regulation National Law***, as in force in each state and territory. The scope of our work is defined by the National Law.

2 We protect the **health and safety 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.

3 While we balance all the objectives of the National Registration and Accreditation Scheme, **our primary consideration is to protect the public.**

4 When we are considering an application for registration, or when we become aware of concerns about a health practitioner, **we protect the public by taking timely and necessary action under the National Law.**

5 In all areas of our work we:

- **identify the risks** that we are obliged to respond to
- **assess the likelihood and possible consequences** of the risks
- **respond in ways that are proportionate and manage risks** so we can adequately protect the public.

This does not only apply to the way in which we manage individual practitioners but in all of our regulatory decision-making, including in the development of standards, policies, codes and guidelines.

6 When we take action about practitioners, **we use the minimum regulatory force appropriate to manage the risk** posed by their practice, to protect the public. **Our actions are designed to protect the public and not to punish practitioners.**

While our actions are not intended to punish, we acknowledge that practitioners will sometimes feel that our actions are punitive.

7 Community confidence in health practitioner regulation is important. Our response to risk considers **the need to uphold professional standards and maintain public confidence in the regulated health professions.**

8 **We work with our stakeholders**, including the public and professional associations, to achieve good and protective outcomes. **We do not represent the health professions or health practitioners.** However, we will work with practitioners and their representatives to achieve outcomes that protect the public.

Intelligent regulation must eliminate the really poor performers without distorting the activities of the majority of performers.

**Baroness Onora O'Neill CBE,
A question of trust, The Reith
Lectures, BBC Radio 4, 2002**

Protected titles under the National Law

Only registered health practitioners who are suitably trained and qualified are able to use protected titles.

Profession	Protected titles	Profession	Protected titles	Profession	Protected titles
<i>Aboriginal and Torres Strait Islander Health Practice</i>	<ul style="list-style-type: none"> Aboriginal and Torres Strait Islander Health Practitioner Aboriginal Health Practitioner Torres Strait Islander Health Practitioner <p><i>For this profession health practitioner is capitalised in its protected titles to distinguish them from descriptions such as health workers.</i></p>	<i>Dental</i>	<ul style="list-style-type: none"> Dentist Dental therapist Dental hygienist Dental prosthetist Oral health therapist 	<i>Nursing and Midwifery</i>	<ul style="list-style-type: none"> Nurse Registered nurse Nurse practitioner Enrolled nurse Midwife Midwife practitioner
<i>Chinese medicine</i>	<ul style="list-style-type: none"> Chinese medicine practitioner Chinese herbal dispenser Chinese herbal medicine practitioner Oriental medicine practitioner Acupuncturist 	<i>Medical</i>	<ul style="list-style-type: none"> Medical practitioner <p><i>There are also 86 specialist medical titles associated with specialties approved by the Ministerial Council.</i></p>	<i>Occupational therapy</i>	<ul style="list-style-type: none"> Occupational therapist
<i>Chiropractic</i>	<ul style="list-style-type: none"> Chiropractor 	<i>Medical radiation practice</i>	<ul style="list-style-type: none"> Medical radiation practitioner Diagnostic radiographer Medical imaging technologist Radiographer Nuclear medicine scientist Nuclear medicine technologist Radiation therapist 	<i>Optometry</i>	<ul style="list-style-type: none"> Optometrist Optician
				<i>Osteopathy</i>	<ul style="list-style-type: none"> Osteopath
				<i>Paramedicine</i>	<ul style="list-style-type: none"> Paramedic
				<i>Pharmacy</i>	<ul style="list-style-type: none"> Pharmacist Pharmaceutical chemist
				<i>Physiotherapy</i>	<ul style="list-style-type: none"> Physiotherapist Physical therapist
				<i>Podiatry</i>	<ul style="list-style-type: none"> Podiatrist Chiropodist
				<i>Psychology</i>	<ul style="list-style-type: none"> Psychologist

Developing regulatory practices

The creation of the National Scheme brought together many deep-rooted traditions and practices from dozens of regulators into a single, Australia-wide system. We had to find common ground to help us define what drives us and how we work under the National Law and decide what kind of regulator we needed and wanted to be.

The work of academic and author Professor Malcolm Sparrow and other international regulatory partners influenced how we matured and how we will continue to evolve. We strive to be risk-based, outcome-focused and people-centred. Our focus is on building trust and confidence

Building on Malcolm Sparrow's theoretical contribution, Dr Anna van der Gaag CBE, former Chair of the Health and Care Professions Council in the UK, helped us shape what it meant to be a leading risk-based regulator in Australia in action.

Mr Harry Cayton CBE, former Chief Executive of the Professional Standards Authority in the UK, explored with us what this meant from a systems perspective and lessons to be learned from UK and international experience.

Right-touch regulation

- be clear about the problem
- quantify the risk
- pay attention to unintended consequences
- keep it simple.

Mr Harry Cayton CBE



Professional standards

The start of the National Law not only enabled consistent standards for a single profession across all states, it also made several professional standards mandatory. This included recency of practice, continuing professional development, English language skills, criminal history and professional indemnity insurance arrangements. Before the National Scheme there were different approaches across the country and across professions, and in some states and territories and professions regulation did not address them at all.

To facilitate the inaugural 10 professions' transition into the National Scheme, the initial approach was to work towards national consistency for each profession. This was achieved in a very tight timeframe, with Boards developing and providing the relevant mandatory professional standards for approval by Ministers. This was successful in establishing national consistency for each profession, and the minimum infrastructure required to start national regulation of the first tranche of health professions to enter the scheme. A similar approach was also taken in establishing the other ethical and professional standards for each profession.

It wasn't long after national registration started that the next phase of work began, with National Boards and Ahpra working together to develop more consistency between professions and to have the standards informed by contemporary research. For instance, the continuing professional development standard was informed by how people learn best. The professional standards have been further enhanced in subsequent reviews. Most of the current standards reflect this ongoing evolution and improvement

and they provided a stable base to support the introduction of the newest profession into the scheme (paramedicine).

Over 10 years, National Boards have developed at least 184 registration standards, 38 codes and 157 guidelines, and conducted more than 72 consultations. Consultations often covered multiple registration standards.

The regulatory craft

Regulators, under unprecedented pressure, face a range of demands, often contradictory in nature:

- be less intrusive – but be more effective
- be kinder and gentler – but don't let the b*st*rds get away with anything
- focus your efforts – but be consistent
- process things quicker – and be more careful next time
- deal with the important issues – but do not stray outside your statutory authority
- be more responsive to the regulated community – but do not get captured by the industry.

Professor Malcolm Sparrow

Sparrow, M (2000) [The regulatory craft: controlling risks, solving problems, and managing compliance](#). Washington: Brookings Institution Press, p. 17, cited in Organisation for Economic Cooperation and Development (2014) [The governance of regulators](#), OECD best practice principles for regulatory policy. Paris: OECD Publishing.

Cross-profession collaboration

Cross-profession collaboration, a unique feature of the National Scheme, has progressively strengthened over the past 10 years. Having a single regulation system across multiple professions allows greater opportunities to collaborate to develop standards and approaches that are harmonised and provide greater protection of the public. Healthcare is increasingly multidisciplinary and team-based.

Multiprofession health practitioner regulators exist in other countries, but the National Scheme is the only one regulating such a broad spectrum of professions. While our National Law requires National Boards to consult each other, cross-profession collaboration is much more significant than that. National Boards and Ahpra actively explore opportunities to work together and to develop consistent regulatory approaches across areas that involve similar issues, such as advertising guidance and codes of conduct, through to professional indemnity insurance requirements.

This has important benefits for practitioner regulation and ultimately for the safety and quality of healthcare. It enriches our work by drawing on the depth and breadth of knowledge and experience across National Boards.

Cross-profession collaboration enables the most efficient and effective use of research and other resources. Each profession is necessarily unique and makes a distinct contribution. However, consistent approaches can facilitate shared understanding, interprofessional practice and team-based care, all of which benefit the practitioners and the public. Consistency also makes it easier for the public to understand what to expect from registered health practitioners.

Scheme Chairs confer

National Board Chairs meet quarterly as the Forum of (National Registration and Accreditation Scheme) NRAS Chairs, along with the Agency Management Committee Chair and senior Ahpra staff. The forum is convened by the Agency Management Committee Chair and a Board Chair who is appointed for a 12-month term.

The role of the forum is to help the profession-specific Boards to work individually but together under the National Scheme. This is crucial as we've grown from the initial 10 National Boards of 2010 to 15 Boards representing 16 professions in 2019 (the Nursing and Midwifery Board of Australia regulates two professions – nursing and midwifery).

We have three main objectives: to focus on the wellbeing of the National Scheme; to ensure coordinated strategy and national responses on public policy issues; and to facilitate cross-professional interaction and scheme consistency and efficiency.

It's vital that we each understand the other professions and the particular issues at play for them. For consistent contemporary health regulation, we all need to arrive at a common concept and way of applying it.

Mr Ian Bluntish
Chair, Optometry Board of Australia, 2015–
Co-Convenor, Forum of NRAS Chairs, 2018–19

Stakeholder engagement

Professional regulation has many stakeholders – no part of the community or health system is untouched by our work.

National Boards and Ahpra consult with advisory groups to gather feedback, information and advice on a wide range of issues. This is both profession-specific and multiprofession in focus.

We also establish reference and working groups on specific issues and at certain times. Examples include the Aboriginal and Torres Strait Islander Health Strategy Group, the Expert Panel on Drug and Alcohol Screening, the Prescribing Working Group and the Scheduled Medicines Expert Committee.

We regularly consult with two ongoing advisory groups – the Community Reference Group and the Professions Reference Group.

Professions Reference Group

A forerunner of the Professions Reference Group (PRG) met as early as 2008 as part of implementing the National Scheme. Following the 2011 Senate inquiry, and arising out of a recommendation of that inquiry, its role was formalised.

It provides a forum for Ahpra to engage constructively on National Scheme and cross-profession issues with associations representing the regulated professions. The PRG consists of one representative for each of the regulated health professions and one for the Health Professions Accreditation Collaborative Forum. It is chaired by a member of the group.

PRG membership includes:

- Australian Chiropractors Association
- Australian Dental Association
- Australian Medical Association
- Australian & New Zealand College of Paramedicine
- Australian Nursing and Midwifery Federation

- Australian Physiotherapy Association
- Australian Podiatry Association
- Australian Psychological Society
- Australian Society of Medical Imaging and Radiation Therapy
- Council of Presidents of Medical Colleges
- Federation of Chinese Medicine, Acupuncture Societies of Australia, Australian Acupuncture and Chinese Medicine Association¹
- Health Professions Accreditation Collaborative Forum
- National Aboriginal and Torres Strait Islander Health Worker Association
- Occupational Therapy Australia
- Optometry Australia
- Osteopathy Australia
- Pharmacy Guild of Australia.

¹ The Chinese medicine representative is selected from one of these bodies.

Community Reference Group

Ahpra established its Community Reference Group (CRG) in 2013. This was the first time a national group, with a focus on health practitioner regulation, had been established.

A community voice is central to how we do our work. It ensures that as a scheme we understand the priorities and expectations of the people we are here to serve. Our CRG provides feedback and advice on how to better understand and, most importantly, meet community needs.

The CRG is a well-informed expert advisory group and members have a thorough understanding of the scheme, the law and operational considerations. Members provide a consumer perspective and bring their knowledge and experience representing community priorities and concerns. For example, we seek their advice on: draft Board policies; how we can improve the way we engage and consult with the community; how we may better safeguard the confidentiality and safety of notifiers; and their thoughts on how to help patients and consumers navigate the complaints system.



The first Community Reference Group confronted the challenges at the intersection between the habits of regulation and the dynamic day-to-day needs and rights of healthcare consumers and the community. The challenge before us was to promote a more human approach, and a greater understanding that the scheme not only protects the public but serves them, and relies on their goodwill, participation and support to succeed.

It took courage and genuine commitment to give us the resources, respect, line of sight and cultural environment to act as a trusted critical friend. Our frank and fearless advice promoted formative soul-searching for the scheme that perhaps wasn't always easy. Happily, the result is a National Scheme that is increasingly measuring its success against community standards for transparency, accountability, collaboration, responsiveness and compassion.

Ms Jen Morris, CRG member, 2013-18

Working with jurisdictions

Collaboration and engagement with state, territory and Commonwealth government health officials in providing advice to Health Ministers has been critical to both the establishment and the continued success of the National Scheme. This started well before its official beginning in 2010. Governments have a key role to play in the stewardship of the National Scheme.

Before National Boards or Ahpra were established, governments worked with an Australian Health Ministers' Advisory Council (AHMAC) National Registration and Accreditation Implementation project team to implement the COAG agreement to establish a scheme. This included carrying out the design decisions of the then Australian Health Workforce Ministerial Council, which were enshrined in the first National Law.

Until late 2017, we engaged with health department officials through AHMAC's Health Workforce Principal Committee (HWPC). The HWPC provided advice to AHMAC which in turn made recommendations to the Ministerial Council on a range of matters arising.

Ahpra established a Jurisdictional Advisory Committee (JAC) in July 2017. The JAC first met in November 2017 and was supported by a new officer-level forum, the Jurisdictional Officers Forum (JOF), which provides informed and expert advice to the JAC.

Together, the JAC and JOF are an important forum for AHMAC member delegates to consider, advise and achieve consensus on matters that are central to the scheme, including:

- priorities set by AHMAC/Ministers relevant to the National Scheme
- proposals that require approval of, or a decision by, Health Ministers under the National Law
- significant policy and regulatory issues relevant to the operation of the National Scheme (including those raised by National Boards, Ahpra and jurisdictions)
- advice considered by Health Ministers (such as business cases under the agreed fee-setting policy)
- issues that have a real or potential impact on the National Scheme.

The JAC has met 10 times since 2017. The flowchart opposite shows how Ahpra works effectively with jurisdictions to progress the work of the National Scheme within the flow of major government mechanisms.



National Board/Ahpra draft proposals

Key proposals include new or revised registration standards, codes and guidelines and applicants for appointment and reappointment to National Boards.

Preliminary/Public consultation process

Draft proposals are released for consultation and managed by National Boards and Ahpra and jurisdictional input is sought.

Jurisdictional Officers Forum

The JOF comprises health officials from every state and territory and Commonwealth health department. It meets at least six times a year to consider National Scheme matters and provide informed and expert advice to the JAC.

Jurisdictional Advisory Committee

The JAC comprises senior health officials from every state and territory and Commonwealth health department and is chaired by the CEO of Ahpra. Proposals that need to be approved or matters that require a decision by AHMAC and the Ministerial Council are progressed through the JAC four times a year.

Australian Health Ministers' Advisory Council

AHMAC is the advisory and support body to the Ministerial Council. Its members are the heads of each state and territory health department. Should a National Scheme proposal require Ministerial approval, it is first considered by AHMAC, which meets three to four times a year.

Ministerial Council

The Ministerial Council oversees the work of the National Scheme under the National Law. Its members are Health Ministers from each state and territory and the Commonwealth. The Ministerial Council meets three times a year to approve proposals and make decisions about National Scheme matters.

Queensland becomes a co-regulatory jurisdiction

In 2013 the then Queensland Minister for Health introduced legislation to establish the Office of the Health Ombudsman (OHO) and make Queensland a co-regulatory jurisdiction in the National Scheme.

These arrangements were introduced by the Minister following reviews of medical regulation in Queensland that were highly critical of delays and regulatory decision-making.

In Queensland, OHO receives all health service complaints and decides which complaints about the health, conduct or performance of registered health practitioners should be referred to National Boards and Ahpra to manage.

Since the OHO was established, we have worked collaboratively in the best interests of the Queensland community. OHO data is increasingly being incorporated into Ahpra's publicly available data as we seek to provide complete national data on complaints about registered health practitioners.

Welcoming new professions

Four new professions in 2012

From the start it was agreed by Health Ministers that a further four professions – Aboriginal and Torres Strait Islander Health Practice, Chinese medicine, medical radiation practice and occupational therapy – would join the scheme from 1 July 2012. We had two years to get ready!

A new challenge was incorporating professions that had not previously been regulated in some states and territories under an existing scheme.

Aboriginal and Torres Strait Islander Health Practitioners had only been required to be registered in the Northern Territory – and as Aboriginal Health Workers. So, there was substantial work with the governments of other states and territories to identify the cohort of practitioners who required registration.

Chinese medicine practitioners had only been required to be registered in Victoria, so similar issues were involved. In Chinese medicine there were special challenges inherent in the extreme diversity of qualifications from all over the world and the process of verifying these.

Occupational therapists had been registered in four of eight jurisdictions and medical radiation practitioners in six of eight jurisdictions (but with different divisions – for example, nuclear medicine technicians, radiation therapists and diagnostic radiographers) so there were slightly different issues. Some practitioners could automatically transition into the National Scheme based on holding state or territory registration (as their counterparts did two years earlier), while

others needed to apply for registration and demonstrate their eligibility and suitability.

For the first time National Boards needed to have a grandparenting registration standard. This standard set out how practitioners who could not automatically transition into the National Scheme as they did not have an approved current qualification, but who had been legitimately practising for many years, could demonstrate their eligibility for registration. This required careful crafting of the standard and rigorous scrutiny of evidence to support registration applications. The requirement for all National Boards to develop an English language registration standard was carefully considered, especially by the Chinese Medicine Board of Australia whose registrants include a significant cohort of practitioners of Chinese background, many of whom trained in China.

These four new professions coming into the scheme in 2012 benefited from the experience of the first 10 professions.

Ahpra used to feel like a start-up. Every time something strange happened – inevitable in the early days – everybody jumped to it. I learned so much, simply because I was around the day that we sent out the wrong email and someone needed to fix it. That way of working is reactive and sometimes stressful, but it helps you to understand the organisation more deeply and make connections. This means you do your job better too.

Ms Tash Miles, Strategic Communications Designer, Ahpra

What is great about the scheme is also the biggest challenge, its size. This creates so many opportunities to streamline processes and share lessons.

**Dr Cylie Williams PhD,
Chair, Podiatry Board of Australia, 2018–**

There was much to be learnt, for example, about:

- communication with previously unregistered health practitioners
- close partnering between Ahpra and newly established National Boards under a new, unfamiliar and still evolving regulatory model
- constructive relationships with professional associations, governments, employers and universities, which also needed to prepare for changes to policies and processes
- implementing the transitional provisions in the National Law to support a smooth transition
- the pressure to develop and consult on the required registration standards in time for them to be approved by Ministers and communicated to practitioners – especially to those who needed to lodge an application.

Establishing four new ground-breaking National Boards to ready these professions for registration and regulation took considerable effort and stamina by those involved. On 1 July 2012, 29,382 practitioners from these four professions became regulated under the National Scheme, increasing the registered health practitioner workforce by 5.3 per cent.

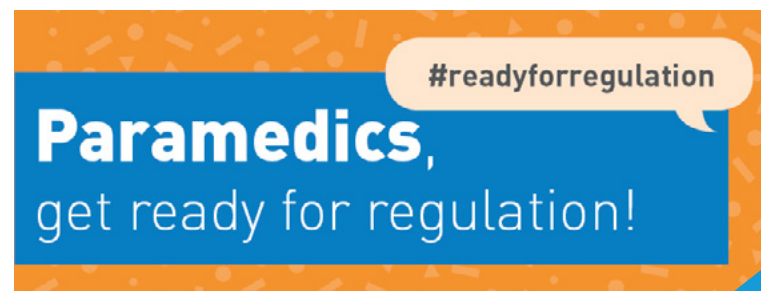
Paramedics in 2018

The most recent profession to join the National Scheme was paramedicine, which became a regulated profession on 1 December 2018. Paramedicine is the first profession to enter the scheme that was not already regulated in at least one state or territory.

The Ministerial Council decided on 6 November 2015 to establish the Paramedicine Board of Australia and tasked the Board and Ahpra with readying the profession for regulation. The Board was appointed in early October 2017 and met later that same month. By 30 June 2019 over 17,000 paramedics had become registered in the National Scheme.

The Paramedicine Board benefited greatly from the foundation laid by the experience and previous work of other National Boards and Ahpra. This helped the Board develop professional standards, policies and processes, which enabled a smooth transition into the National Scheme within a short period.

The support and commitment of the paramedicine profession, its major employers and professional bodies played a critical role in informing paramedics of the forthcoming change and supported the successful transition into the National Scheme.



Accreditation

The accreditation system provides assurance to the community that people seeking registration are suitably trained, qualified and competent to practise as health practitioners in Australia.

Accreditation authorities develop, review and submit accreditation standards to National Boards for approval. They also assess and accredit education providers and programs of study against those approved standards, and they are often responsible for assessing overseas-trained practitioners.

Accreditation authorities may be external entities, or they may be committees established by the Board. They are an important part of the scheme and work closely with each other, Boards and Ahpra.

The assignments to accreditation authorities have been reviewed twice since 2010. Currently, accreditation functions are assigned to 10 accreditation councils and five committees.

An accreditation perspective

The education and assessment of students and new entrants into health professions is a vital part of any effective regulatory scheme. In 2010, accreditation had a strong foundation, with the majority of professions entering the National Scheme having national accreditation bodies, many with several decades of experience.

Through the then-named Health Professions Accreditation Councils Forum, established in 2007, the collective expertise of these authorities was an excellent way to collaborate and support younger accreditation authorities to evolve and ensure best-practice standards and processes.

An early focus was to develop the Quality Framework as a basis for effective and transparent reporting.

Recent challenges include responding to government reviews, working with changes to the education sector and consumer expectations, outlining the value we create in the scheme and achieving ongoing assignments from our respective National Boards.

Our successes come from working collaboratively to improve the quality, efficiency and effectiveness

of accreditation and assessment functions. We have collectively implemented projects on interprofessional education, safe use of medicines, and education for cultural safety. We have strengthened our relationships with our partners in higher education and government and are now trusted partners of our National Boards.

We are excited about the prospects for our continuing role. Our strategy outlines how we will improve health outcomes through leadership, innovation, stakeholder responsiveness, and effectiveness and efficiency. By embracing new technologies and teaching methods and systems, the future is bright and full of opportunities for us to have a positive influence on the health of all Australians.



Ms Bronwyn Clark

*CEO Australian Pharmacy Council;
Chair, Health Professions Accreditation
Collaborative Forum*

Independent oversight – the Ombudsman

Trust in the decision-making processes of regulators is essential. The establishment of the office of the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC) demonstrates that the National Scheme values fairness and accountability.

I was appointed Ombudsman and Commissioner in 2018 and it is a privilege to build on the work of my predecessors.

In Swedish, Ombudsman generally translates to mean a representative or protector of citizens. My office sees every complaint as an opportunity not only to resolve someone's concerns, but also to identify systemic issues that may be affecting others.

As awareness of the NHPOPC has grown and the work of the Boards and Ahpra has developed, the number of people sharing their concerns has increased. In the past five years, there has been a five-fold increase in approaches, from 173 in 2014/15 to 1,035 in 2018/19. Currently, the majority of concerns are about the notifications process.

The way my office manages complaints has also changed over time. We formalised our investigation model in 2016 and in 2018 introduced a new complaint transfer process to achieve quick and effective complaint resolutions with Ahpra.

In 2019 my role expanded to include reviewing decisions about requests for access to documents under Freedom of Information legislation.

Most importantly, my office has continued to provide meaningful outcomes to individual complainants, while working with Ahpra and National Boards to bring about valuable improvements in process and policy. These include:

- the creation or review of multiple policies and procedures in notifications and registration processes
- enhanced communication with notifiers and practitioners, including providing more detailed and informative reasons for decisions
- improvements in record-keeping and information management.

I also conducted the office's first own motion investigation during 2019 into confidentiality safeguards for people who make notifications about registered health practitioners. The recommendations from this review will influence improvements in how Ahpra and National Boards manage the privacy of notifiers during the notifications process.

It is an honour to serve as the Ombudsman and Commissioner on the 10-year anniversary of the National Scheme. I look forward to ongoing success as my office works closely with Ahpra and National Boards to strive for the best in regulation.



Ms Richelle McCausland

National Health Practitioner
Ombudsman and Privacy Commissioner

A creative community with a cause

I first visited Ahpra in January 2012. At that time, there were 10 National Boards, 530,000 names on the register, 17,000 grandparenting applications and around 600 staff supporting the work.

At the time of my most recent visit in 2018, there were 15 Boards, over 700,000 on the register and over 900 Ahpra staff. Any comparison with a health professional regulator anywhere else in the world will demonstrate just what an achievement this has been.

The National Scheme replaced a state-based system of professional regulation, each with different legislation, standards and processes for each professional group. But to set up a national scheme, across Australia's states and territories, across the initial 10 diverse professions, using innovative technology, was not just a legislative and operational mountain. It was also about winning hearts and minds.

This was a transformational change to health professional regulation, reinforcing two important changes in the evolving nature of health and care. First, the increasingly multidisciplinary

nature of healthcare itself, and second, placing the patient at the centre and offering the community shared decision-making at a personal and policy level.

Over the years, the scheme has also become a world leader in its approach to using data to refine its work, understanding and using risk-based approaches, and sharing learning with the wider regulatory community.

No transformational change happens without stumbling, taking wrong turns, and finding the way again. It cannot happen through good legislation and processes alone. It needs strong, listening leaders.

Social innovator Charlie Leadbetter once observed that successful organisations, wherever they exist in the world, are 'creative communities with a cause'. They tend to share several key attributes – creative leaders, and people in pursuit of a transformational goal.

The National Scheme is a testament to both, and I have no doubt that the next 10 years will see it going from strength

to strength, bringing benefits to healthcare in Australia as well as to the regulatory community worldwide.

Dr Anna van der Gaag CBE

Former Chair of the Health and Care Professions Council, UK; Visiting Professor, Ethics and Regulation, University of Surrey, UK



Reviews and inquiries – a well-scrutinised scheme

In our first 10 years our performance and aspects of our work have been reviewed by independent and external parties.

- June 2011** The Senate Finance and Public Administration References Committee publishes its report: The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA).
- February 2014** KPMG provides its Australian Health Practitioner Regulation Agency organisational review final report.
- March 2014** The Victorian Government's Legislative Council Legal and Social Issues Legislation Committee releases its report: Inquiry into the performance of the Australian Health Practitioner Regulation Agency.
- June 2014** Health Issues Centre provides its report: Setting things right: improving the consumer experience of AHPRA including the joint notification process between AHPRA and OHSC (Office of the Health Services Commissioner).
- December 2014** Mr Kim Snowball submits his Independent review of the National Registration and Accreditation Scheme for health professions, final report December 2014. Commissioned by the Australian Health Ministers' Advisory Council. Released August 2015.
- December 2015** KPMG provides its report: Australian Health Practitioner Regulation Agency: review of notifications systems and processes. Commissioned by Ahpra October 2015.
- November 2016** The Senate Community Affairs References Committee inquiry tables its report: Medical complaints process in Australia.
- February 2017** Professor Ron Paterson submits his Independent review of the use of chaperones to protect patients in Australia. Commissioned by the Medical Board of Australia and Ahpra August 2016. Released April 2017.
- May 2017** The Senate Community Affairs References Committee inquiry releases its report: Complaints mechanism administered under the Health Practitioner Regulation National Law.
- November 2017** Professor Michael Woods submits his Australia's health workforce: strengthening the education foundation, independent review of accreditation systems within the National Registration and Accreditation Scheme for health professions, final report November 2017. Commissioned by the Australian Health Ministers' Advisory Council. Released October 2018.

A scheduled review

In forming the National Scheme, the intergovernmental agreement set out that a review of the scheme after three years of operation would help to assess the extent to which it had met its objectives. In April 2014, Ministers appointed Mr Kim Snowball, a former Director-General of Health in Western Australia, to carry out this review, which included extensive consultations across the health sector.

Informed by public forums in each state and territory, and more than 230 written submissions to a public consultation discussion paper, the reviewer noted the considerable achievements of the National Scheme, starting with the consolidation of the many previous regulatory systems across Australia into one. This was in many ways a unique achievement, particularly in a country with a federated system of government such as Australia.

Mr Snowball recognised the 'unique and substantial achievement' of the scheme and found 'overwhelming support' for the National Scheme as

a positive step forward for regulation of Australia's health professionals. He also noted that many of the initial administrative and operational issues had been resolved, and the challenge ahead was to build on the foundations that had been well established in the scheme's first years.

The review also identified a number of gaps in the accountability arrangements for the scheme; opportunities to improve regulatory effectiveness and efficiency through the potential consolidation of lower volume boards; and the need for significant improvements to gain public and practitioner confidence.



[Australian Health Ministers' Advisory Council, Independent review of the National Registration and Accreditation Scheme for health professions, final report December 2014](#)

Recommendations

Mr Snowball proposed 33 recommendations to Health Ministers, which covered:

- mechanisms to ensure the National Scheme remained accountable and transparent about its performance
- strategies to improve the efficiency and effectiveness of regulatory decision-making, including the potential to consolidate nine of the 14 National Boards
- a set of actions to improve the experience of practitioners and notifiers
- work to improve the accreditation functions of the National Scheme
- improvements in the engagement of Aboriginal and Torres Strait Islander people with the National Scheme.

Commitment to improve

Having received the report of the independent reviewer, Health Ministers carefully considered his recommendations. Critically, Ministers decided not to consolidate the existing National Boards, instead relying on other mechanisms to improve the effectiveness of the National Scheme. They also agreed to changes to the National Law to enable Ministers to consolidate or disband National Boards in the future by regulation following consultation, rather than by legislative change, should this be needed.

Ministers agreed to implement a work program responding to the recommendations that would:

- improve consumer responsiveness and the notifications process, including to amend the National Law to enable National Boards to provide notifiers with reasons for decisions about notifications
- amend the National Law to boost public protection mechanisms
- work to improve the engagement of Aboriginal and Torres Strait Islander people with the National Scheme
- work to improve both the governance of the National Scheme and the accreditation function within the scheme.

During this period, National Boards and Ahpra, who had heard the feedback from stakeholders during the review, began a program of work to improve the notifications process.

Our legislative framework

Legislation was passed by every state and territory parliament to enable the National Scheme to begin:

- **Queensland:** *Health Practitioner Regulation National Law (Queensland) Act 2009*
- **New South Wales:** *Health Practitioner Regulation (Adoption of National Law) (NSW) 2009*
- **Victoria:** *Health Practitioner Regulation National Law (Victoria) Act 2009*
- **Australian Capital Territory:** *Health Practitioner Regulation National Law (ACT) 2010*
- **Northern Territory:** *Health Practitioner Regulation (National Uniform Legislation) (NT) Act 2010*
- **Tasmania:** *Health Practitioner Regulation National Law (Tasmania) Act 2010*
- **South Australia:** *Health Practitioner Regulation National Law (South Australia) Act 2010*
- **Western Australia:** *Health Practitioner Regulation National Law (WA) Act 2010*

In a dynamic and ever-changing environment, it is important to ensure the National Law remains contemporary. There have been two significant revisions:

- Following the decisions of Ministers in 2015 on the Snowball review, the *Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017* was passed in the Queensland Parliament, paving the way for national regulation of paramedics, and for notifiers to be better informed.
- In February 2019, the *Health Practitioner Regulation National Law and Other Legislation Amendment Act 2018* was passed by the Queensland Parliament. Amendments were made about the mandatory notifications framework, and offence provisions changed from being summary offences to indictable offences with increased penalties.

In late 2019 the COAG Health Council decided on two policy directions to National Boards and Ahpra, using their powers under the National Law. These policy directions make clear that public protection should be paramount in the administration of the scheme.

Independent review of chaperoning

In August 2016, the Medical Board of Australia and Ahpra commissioned an independent review of the use of chaperones to protect patients in Australia. This action was taken in the wake of media reports that a neurologist, who was facing criminal charges following allegations of indecent assault on a patient, was permitted to practise subject to the condition that an approved chaperone be present. It was alleged that the doctor had indecently assaulted a patient while a chaperone was present.

The review was carried out by Professor Ron Paterson, a senior professor of law, and completed in February 2017.

Professor Paterson considered whether, and in what circumstances, it was appropriate to impose a chaperone condition on the registration of a health practitioner as an interim measure to protect patients while allegations of sexual misconduct were investigated. He was also asked to recommend whether other changes were needed to better protect patients and the public.

The report found that chaperones were of limited effectiveness in protecting patients and there were better ways to protect and inform patients when allegations of sexual misconduct were made against a health practitioner. Professor Paterson recommended that the use of chaperones while an investigation was underway should be replaced by gender-based prohibitions and suspensions.

The review identified areas for improvement in the handling of sexual misconduct cases by the Medical Board and Ahpra to ensure that notifiers (especially victims) are treated with

empathy and sensitivity; that immediate action and speedy investigation take place where warranted to protect the public; that regulatory decisions are taken on a consistent basis, in accordance with the National Law and policy guidance; and that practitioners are treated fairly. All recommendations were accepted by both the Medical Board and Ahpra, and implemented.

The Medical Board established a specialised Sexual Boundaries Notifications Committee and Ahpra introduced specialised training for its investigators to improve our responses to sexual boundary allegations.

A critical challenge for any health regulator faced with allegations of sexual misconduct by a health practitioner is deciding what, if any, immediate action should be taken to protect patients and the public pending an investigation.

Professor Ron Paterson in his foreword, Independent review of the use of chaperones to protect patients in Australia, February 2017



The Sexual Boundaries Notifications Committee first met in July 2017. It is a dedicated team of specialist trained members comprising practitioner and community representatives from state and territory boards. A major strength is the partnership that has been developed between the committee and the Ahpra investigators and support staff.

We are committed to timely, thorough, fair and consistent action on notifications when there is an allegation of boundary violation

and/or sexual misconduct by a medical practitioner. The work of the committee is both confronting and rewarding.

We recognise that the paramount responsibility of the Board is public protection and the prevention of harm. We certainly accept and respect the trust the public and the profession place in us.

**Ms Christine Gee,
Chair, Sexual Boundaries
Notifications Committee,
Medical Board of Australia**

Reshaping our approach

The evolving expectations of the public and practitioners, and the outcomes from key inquiries, including royal commissions, are changing how we do things. One example is how we investigate sexual boundary complaints.

In the same year as the chaperone review, the Royal Commission into Institutional Responses to Child Sexual Abuse published its findings and recommendations.

Both reports had a profound impact on our approaches to managing and making decisions about allegations of sexual boundary violations by medical practitioners in Australia.

The implementation of recommendations and application of lessons from these reports has had a significant impact on the way we approach the investigation of these allegations.

Ms Gail Furness SC, counsel assisting the Child Sexual Abuse Royal Commission, has spoken at National Board functions.



Lessons from system failures

Avoidable patient death is a tragedy that affects individuals, families and entire communities. Nothing underlines the importance of effective regulation more than seeing how seriously things can go wrong when systems fail, with far-reaching and sad consequences.

In 2015 the Department of Health and Human Services in Victoria was alerted to a cluster of potentially avoidable newborn and stillborn deaths at Bacchus Marsh Hospital (Djerriwarrh Health Services). This led to several system reviews and an overhaul of how health authorities, including Ahpra, work together and share information. The Victorian Government established Safer Care Victoria to improve quality and safety across Victoria's public healthcare system.

Although the focus of the reviews was on issues related mainly to governance within the health system, we wanted to identify lessons for us. As well as the investigations we conducted into individual health practitioners, we also worked to improve how we assess and manage notifications and how we can contribute to system-wide improvements.

We asked KPMG to review our work to see what lessons we could learn. The review was designed to examine the effectiveness of changes introduced since 2012 and consider further options for improvement.

The report² recommends actions in five main areas:

- better risk assessment
- management of high-risk matters
- greater transparency
- culture (address perceptions of being pro-practitioner and shift this perception)
- performance.

Ahpra accepted all the recommendations of the report and developed, implemented and reported on an action plan. Although the review only looked at our Victorian operations, many of the solutions were applied nationally.

Actions we took included working with Victorian health services to increase awareness of mandatory reporting requirements and working with Safer Care Victoria to help detect and respond to concerns about standards and safety. We established a regulatory compact with the Department of Health and Human Services that sets out the ways we will share and manage information in the public interest and within the National Law to improve patient safety.

² KPMG, [Australian Health Practitioner Regulation Agency: review of notifications systems and processes, final report December 2015.](#)

Working to improve our regulatory performance

Our performance matters: it directly influences the trust and confidence that others have in us.

Ahpra staff and Board and committee members are crucial to our performance. The partnership between National Boards, their committees and Ahpra is the foundation for the quality of our work.

Monitoring our performance allows us to track the timeliness and quality of our work, identify where we need to be focusing our regulatory efforts, see how consistent we are in our processes, experience and decisions, and identify areas for improvement. It is also an important part of our accountability to the community.

Ahpra reports on its performance regularly, including publishing quarterly performance reports. The Agency Management Committee's Regulatory Performance Committee provides oversight and provides regular reports to National Boards.

As the registered health workforce and the number of notifications we receive continues to grow each year, it is clear that we need to act in ways that allow us to respond to changing needs and help us do our work better.

Over recent years we have moved our regulatory operations teams to a national structure, working from each of our capital city offices. We have introduced new decision-making models working closely with Boards and committees.

Arranging our teams to work nationally by regulatory function, not by location, has given us clearer national

visibility of our work. This has helped us make the most of our people's skills and expertise across our national workforce, Boards and committees.

As part of this, we also developed new tools to assess risk that allow us to identify matters early that will likely need regulatory action. It also means identifying matters that can be dealt with more quickly – when registering applicants who are qualified and eligible, as well as the more timely closure of notifications.

We are embedding access to clinical input across all our regulatory processes, particularly relevant for notifications as the majority of the concerns raised are about clinical care. Expert clinical advisers are appointed to consult on specific clinical issues. This helps us to understand the implications of the information we receive, in the context of the profession and the practice setting.

The work to establish the scheme is done and we are now facing new challenges. We are focused on engaging more strongly with the profession and the community, getting clearer about how we assess risk, improving the experience of notifiers and practitioners involved in notifications, and evaluating our effectiveness in protecting patients. The scheme has the right basic architecture and the right strategy, and its greatest strength is the people who serve on boards and committees and who work for Ahpra.

**Dr Joanna Flynn AM, Inaugural Chair,
Medical Board of Australia, 2009–18**

Accreditation systems review

Following the Snowball review, Health Ministers commissioned a major independent review of accreditation in the National Scheme.³

In October 2016, health economist Professor Michael Woods was appointed to conduct the review. Consultations were held in 2017 and Professor Woods submitted the final report to Ministers in late 2017. Ministers released the final report in October 2018 and consulted on the recommendations in early 2019.

The review helped accelerate our maturing approaches to accreditation governance, cost analysis and reporting, while continuing our focus on achieving the potential of accreditation. Governments recognised that the National Scheme has made demonstrable progress on accreditation issues since the review started.

The review identified a range of issues such as the need for strengthened

governance, greater transparency and accountability, enhanced consistency and reduced duplication. While many of these issues were already known, the review gave them additional focus and priority. It was also an important opportunity for us to understand a range of perspectives on the scheme's work in accreditation and to test our strategic direction and approaches.

In early 2018, the Agency Management Committee also established an Accreditation Advisory Committee

to lead and oversee accreditation governance, accountability and transparency. Subsequently, new contemporary accreditation agreements and terms of reference, key performance indicators (KPIs) to measure progress on high-priority accreditation issues, and initial principles for accreditation funding and fee setting were developed as a basis for further reform.

Ahpra has worked with National Boards, and with input from



³ Australian Health Ministers' Advisory Council, [Australia's health workforce: strengthening the education foundation, independent review of accreditation systems within the National Registration and Accreditation Scheme for health professions, final report November 2017](#)

accreditation authorities, to develop new KPIs for accreditation, reflecting most of the themes in the review.

In June 2019, Ahpra signed new five-year accreditation agreements with the 10 external accreditation councils.

In July 2019, National Boards approved new terms of reference for accreditation committees that mirror the main aspects of the agreements.

These new agreements and terms of reference started in July 2019 and include new KPIs that reflect agreed priorities such as addressing cultural safety, reducing regulatory burden and duplication, and responding to health and workforce priorities.

In February 2020, Ministers agreed (in-full, in-part or in-principle) to many of the recommendations and also agreed that Ahpra should establish an independent accreditation committee with broad stakeholder membership to provide advice on relevant accreditation reforms. We look forward to working collaboratively with stakeholders.

Our work to achieve the potential of accreditation in public protection, educational innovation and workforce sustainability continues.

I believe strongly in the need to support the vast majority of practitioners who practise safely and ethically, while dealing swiftly and effectively with those few who fall short and represent a threat to the safety of the community.

**Dr Anne Tonkin,
Chair, Medical Board
of Australia, 2018-**



A robust, effective regulator

Following our early years, surviving was an achievement! But I am most proud of what we have become – a robust, effective regulator, regarded internationally as a model for others.

We are much better at explaining what we do to health professionals, government, the community and the media. We are a complex scheme – often a mystery to outsiders. So, we need to be better at helping others navigate our processes. Part of that work has been explaining what we cannot and do not do.

We are not a punitive scheme. We work within our limits. Legislative reform is not easy or rapid.

The reality is that we are 'only as good as our last mistake'. Regulation is never perfect, but others can be unforgiving when we are not as fast, effective or user-friendly as expected.

**Mr Michael Gorton AM, Chair, Agency
Management Committee, 2014-19**

Several things stand out

Aboriginal and Torres Strait Islander health strategy:

Aboriginal and Torres Strait Islander people, through the representative agencies involved, have defined cultural safety for the National Scheme. The strategy group is the decision-maker, not the Agency Management Committee. This is a fundamental commitment.

Digitisation: We should be proud of what we have achieved in the digital area so early in the organisation's life. The very high percentage of online renewals – 99.2 per cent – is testament to this.

Transparency: We have made progress in moving away from a black-letter law approach towards greater transparency. This is particularly so in our communications with notifiers. It has also been aided by our work with the Ombudsman.

Cyber safety: Our cyber safety/privacy breaches record is outstanding – we haven't had any. So many other bodies, including banks and government entities, have had very serious breaches of significant amounts of confidential and protected data. We have achieved cyber safety with a modest budget.

Forum of Scheme Chairs: We have demonstrated the success of this collaborative forum in the National Scheme legal structure. We shouldn't underestimate this initiative. It has been fundamental to building goodwill and trust to enable us to achieve internal reforms in what is otherwise a very complex legal framework.

Research strategy: This strategy is still in its infancy, but it has great potential to inform our regulatory decision-making.

Financial arrangements: Our new equity model will enable us to manage the aggregated balance sheets of National Boards more efficiently. Combined with the activity-based costing work underway, if we do it well, it will bring benefits to registrants and give the scheme the resources to be more agile, adaptive and transparent.

Leading WHO collaboration with Southeast Asia and the Western Pacific: This is a long-term, worthwhile investment, a compliment to a 'young' Ahpra. We have much to share with our neighbours, and much we can learn from them.



Ms Barbara Yeoh AM

Agency Management Committee member 2014–



I remember flying to Melbourne in 2010 to become the 'Pivotal super user' for the Canberra office and seeing Pivotal for the first time in detail. After that we had the big training manual to teach everyone else in the office how to use it. I remember thinking how sophisticated the system was and how much potential it had – it was an impressive upgrade from our previous system. Now, 10 years on, we have outgrown it and we're looking for something sophisticated enough to meet our ever-growing list of needs for the next 10.

Mr Adam Young, National Manager, Registration, Ahpra

A key decision a regulator makes is whether to be 'statute-driven' or 'mission-led'. The former has a strict focus on the legislation, the administration of it and compliance, accompanied by a narrow and careful interpretation of the law. To be mission-led, however, is to focus on the long-term aim, the hoped-for outcome (such as public safety and reducing patient harm). While the legislation is the guide, it is not the daily playbook.

What kind of a regulator do we choose to be? Our legislation allows for a measure of choice. What does effective regulation look like in our context? Recognising that there is a choice to be made and reflecting that decision in the way we regulate is integral to our future.

Professor Kieran Walshe, Professor of Health Policy and Management, University of Manchester, UK, presentation at the Medical Board of Australia conference in Melbourne, May 2018



Research and working with partners

One of the advantages of the National Scheme is that, for the first time in Australia, it provides much more complete data and information about Australia's registered health workforce. From the very beginning, we have invested in research and evaluation.

Our research work has matured from an early commissioning approach in 2010 to establishing a dedicated in-house expert research team doing original research in 2014. Since then, we have partnered with leading academic researchers. In 2011, we collaborated with the University of Sydney under an Australian Research Council linkage grant on the project 'National registration of health practitioners: a comparative study of the complaints and notification system under the national system and in NSW'. In 2014, we entered into a three-year National Health and Medical Research Council-sponsored partnership with the University of Melbourne on the 'Notifications to the Australian Health Practitioner Regulation Agency: Identifying "hot spots" of risk to help improve the quality and safety of healthcare' project.

We have hosted several research summits where we showcased the work of other regulatory researchers as well as our own original research.

We have progressively developed a more strategic approach to our research work, building frameworks for research governance and data access and increasingly integrating research and evaluation as fundamental to all our work. As a risk-based regulator, research is now deeply embedded in our strategy and reflected in our strategic objectives to ensure we focus our resources on high priority areas that help us keep the public safe. In 2017, we published the first research framework to explain our research priorities and principles and get the best value from our investment in research. In early 2019, we established an advisory group of prominent international regulatory experts to inform our research work.

As our research journey continues, we are now starting to explore the transformative potential of data analytics and machine learning to enhance our regulatory effectiveness.

A sample of publications

- Carney, T, Beaupert, F, Chiarella, M, and others (2016) Health complaints and regulatory reform: implications for vulnerable populations?, *Journal of Law and Medicine* 23(3), 650–61.
- Satchell, CS, Walton, M, Kelly, PJ, and others (2016) Approaches to management of complaints and notifications about health practitioners in Australia, *Australian Health Review* 40(3), 311–18.
- Spittal, MJ, Bismark, MM, and Studdert, DM (2019) Identification of practitioners at high risk of complaints to health profession regulators, *BMC Health Services Research* 19, 380.
- Thomas, LA, Milligan, E, Tibble HM, and others (2018) Health, performance and conduct concerns among older doctors: A retrospective cohort study of notifications received by medical regulators in Australia, *Journal of Patient Safety and Risk Management* 23(2), 54–62.
- Tibble, HM, Broughton, NS, Studdert, DM, and others (2017) Why do surgeons receive more complaints than their physician peers?, *ANZ Journal of Surgery* 88(4), 269–73.

The value of research

Australia probably has the best health practitioner regulatory data in the world. We have data on more than 750,000 health practitioners from 16 health professions. My research team at the university works with large datasets of complaints about health practitioners and lawyers. We analyse the data to identify hot spots of risk to help make patients safer and to support practitioners in providing good care.

We do a lot of myth busting. A current myth is that doctors can't seek help for their own mental health conditions because of a fear of mandatory reporting. Our research shows mandatory reports about doctors by their treating practitioner are very rare. They usually only happen when a doctor lacks insight – perhaps they have a dementia or psychosis and don't understand the risks they pose to patient safety.

But the average doctor with depression or anxiety should know that they can see their GP, and receive confidential treatment, without any need to worry about a mandatory

report to the Medical Board as long as they're taking sensible steps to keep their patients safe.

Less than 5 per cent of doctors account for about 50 per cent of patient complaints. We've done some research that showed by the time a doctor has had three complaints made to the Medical Board, they're highly likely to have more complaints made against them unless something is done. Knowing that helps regulators focus their resources and intervene with that 5 per cent group of doctors.

Sometimes there are small pieces of a puzzle that make up a bigger picture. My research team would like to do more data linkage studies. The inquiry into the deaths of babies at Djerriwarrh Health Services' Bacchus Marsh Hospital highlighted that when a health service is in trouble many agencies can see a different small piece of the puzzle.

The hospital knew about some concerns, the Medical Board knew about some concerns and the Department of Health knew about some concerns.

But nobody could see the full picture, which contributed to the preventable deaths of babies. We need to get better at data linkage to put those pieces of the puzzle together.

Associate Professor Marie Bismark

Dame Kate Campbell Fellow, Public Health Law, Melbourne School of Population and Global Health, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne



Enabling informed choices

Advertising can be a useful way to communicate the services health practitioners offer to the public so that consumers can make informed choices. The National Scheme introduced national rules about how regulated health services can be advertised, and anyone advertising such a service needs to meet those obligations. After 10 years, it is clear that most registered health practitioners and other advertisers want to comply with the National Law requirements. We aim to make compliance as easy as possible and our approach to this goal has significantly evolved since the National Scheme started.

From the outset, National Boards published joint Guidelines for advertising regulated health services to explain advertisers' obligations under the National Law. At that stage, the only consequence available for ongoing non-compliance was prosecution.

The guidelines were revised and released in 2014 with additional information to clarify the obligations. The approach to compliance

was largely unchanged and we kept receiving complaints about practitioners who did not understand their obligations.

In 2017, after reviewing our experience, we launched the Advertising compliance and enforcement strategy to support improved compliance. This strategy, which remains in place today, introduced a risk-based enforcement and educative approach. It moved complaints about lower-risk advertising breaches to a dedicated Advertising Compliance team. For advertising complaints involving registered health practitioners, disciplinary processes provided a lever for compliance. Under the strategy, only the more serious cases and those that don't involve registered health practitioners are considered for prosecution. To support this approach, we developed a suite of resources and tools to help practitioners and other advertisers better understand their obligations.

Under this strategy, nearly 50 per cent of registered health practitioners become compliant in response to an initial contact from us about a

breach. The remainder become compliant when we propose to impose conditions on their registration that restrict how they can advertise.

We are now evaluating the strategy and exploring additional ways to improve compliance. Audit processes will move us from a complaint-driven, reactive model of compliance to one that is proactive and addresses compliance of all members of a profession, not just those practitioners who have a complaint lodged about their advertising.

Responsible
advertising in
healthcare:
**Keeping
people
safe**

Offences and prosecutions

It is a gross violation of the trust of the community for a person to falsely claim to be a registered health practitioner when they are not. The National Law includes important provisions making it an offence for people not registered as a health practitioner to use protected titles (like nurse or dentist), to hold themselves out as being registered, to perform certain restricted acts (like spinal manipulation or some dental acts) or to advertise inappropriately. These are known as offences.

The prohibitions are crucial to ensure that the community can be confident that those from whom they seek health services are appropriately qualified and registered.

It became evident during the first few years of the scheme that Ahpra needed a specialist internal unit to consider the complaints being received and to properly investigate and prosecute the most serious breaches (which was done in a magistrates' or local court).

The seriousness of the conduct was soon recognised and in 2019 the National Law was amended to convert most of the offences into indictable offences (capable of being prosecuted before juries) with increased penalties including higher maximum fines and up to three years' imprisonment.

Today our Criminal Offences Unit is made up of inspectors (former detectives) and lawyers (including former prosecutors) who work closely together to investigate and prosecute offenders. It is active in prosecuting matters in various courts across the country, with an ever-increasing list of successful prosecutions behind it. We have initiated 80 prosecutions in 10 years. Of the 64 completed prosecutions, guilty findings were made in all cases.

**Successful prosecution of fake doctor
a serious signal to others**

**Counsellor convicted of claiming to
be a psychologist and providing false
information**

**Former pharmacist who practised when
suspended has been fined**

**Landmark decision sees a suspended
physiotherapist convicted and
receiving largest fine ever**

**Chiropractor convicted and fined for
using testimonials in his advertising**

**A student has pleaded guilty to
claiming to be a registered nurse**

**Regulator lays charges on misleading
print advertising**

**Repeat offender fined for holding himself
out as a registered optometrist and
unlawfully prescribing optical appliances**

Monitoring practitioners with restrictions

Restrictions (conditions or undertakings) can be placed on a practitioner's registration to safeguard public and patient safety. This can occur as an outcome of a notification, or when a practitioner applies for registration or renewal of registration.

Monitoring and compliance describes the process of gathering information that helps National Boards to assess practitioners' compliance with any restrictions on their registration, or to confirm they have ceased practising when their registration is suspended or cancelled. By identifying any non-compliance and acting swiftly and appropriately, Ahpra supports Boards to manage any risk to public safety.

Ahpra has recognised that compliance is an ongoing priority. In 2014 we established a single point of accountability. Since then we have:

- established a comprehensive resource framework incorporating the policies, procedures and guidelines that staff must use to monitor compliance
- developed and set up an internal, online National Restrictions Library

of common restrictions used across the regulatory functions of National Boards. This ensures a best-practice approach to monitoring and managing risk, consistency between jurisdictions and professions in imposing restrictions, and consistency in the restrictions appearing on the national register

- strengthened our monitoring of practitioners who misuse substances (drugs or alcohol) through the introduction of hair testing, implementing a national standard for screening, engaging a national collection and pathology service and establishing an expert panel to oversee this work
- implemented an agreement with the Department of Human Services for receiving Medicare data to ensure timely completion of investigations and effective monitoring of compliance
- introduced risk-based reporting to Boards, which enables them to oversee Ahpra's monitoring of practitioners and to quickly respond to non-compliance.

This year the Aboriginal and Torres Strait Islander Health Strategy Group has instigated and progressed significant reform to help achieve equity in health outcomes and embed cultural safety; we are really proud of our achievements.

**Professor Gregory Phillips,
Co-Chair, Aboriginal and
Torres Strait Islander Health
Strategy Group, 2016–20**



Aboriginal and Torres Strait Islander health strategy

At our combined meeting of National Boards and Ahpra in 2016, Professor Gregory Phillips challenged us on what we would do to address the differences in health outcomes between Aboriginal and Torres Strait Islander people and other Australians. This was a pivotal moment that marked the beginning of an ambitious and important initiative.

Self-determination is an important part of this work. Only Aboriginal and Torres Strait Islander people can define cultural safety, assess whether something is culturally safe or decide the priorities in this area.

The National Scheme's Aboriginal and Torres Strait Islander Health Strategy Group met for the first time in February 2017 to lead this work, and a caucus of Aboriginal and Torres Strait Islander members was soon established. The group is leading and steering our work on how the National Scheme can embed cultural safety in the way regulation works.

By July 2018, 37 entities, including National Boards, Ahpra, accreditation authorities and Aboriginal and Torres Strait Islander health experts, committed to doing their part to

help to eradicate racism from the health system. The [National Scheme Aboriginal and Torres Strait Islander health strategy statement of intent](#) aims for health equity by 2031 and was developed in close partnership with many Aboriginal and Torres Strait Islander organisations and experts.

In 2018, Ahpra's first *Reconciliation action plan* (RAP) was endorsed by Reconciliation Australia. RAP working groups, set up in all our offices, lead local engagement with staff and Aboriginal and Torres Strait Islander communities, organisations and businesses.

In 2019, Ahpra recruited two Aboriginal and Torres Strait Islander staff members to set up the Aboriginal and Torres Strait Islander health strategy program team. That same year, led by the Aboriginal and Torres Strait Islander Health Strategy Group, the program implemented the first phase of the group's planned five-year strategy, including:

- partnering with the National Health Leadership Forum to develop, consult and finalise a baseline definition of cultural safety for the National Scheme
- commissioning high-quality cultural safety training for all staff, Board and committee members
- recommending and advocating for changes to the National Law to ensure consistency in cultural safety for Aboriginal and Torres Strait Islander people
- providing ongoing support to increase participation by Aboriginal and Torres Strait Islander people on Boards, committees and accreditation authorities, and attracting and retaining Aboriginal and Torres Strait Islander staff members.



Collaboration with the World Health Organization

During the life of the National Scheme, National Boards and Ahpra have engaged with the World Health Organization (WHO) on health workforce regulation in the Pacific Region. By 2016, the idea of the National Scheme developing a formal collaboration with WHO was gathering momentum. At the same time, we were regularly attracting international interest, having been highlighted in an Organisation for Economic Cooperation and Development (OECD) publication⁴ as an international leader in the regulation of health professionals. International peers were also asking National Boards and Ahpra for advice on health practitioner regulation.

By establishing a regional network of health workforce regulators and providing regulatory and technical expertise, the National Scheme could help contribute to the regulatory standards and practices. This is important because of the increased movement of both practitioners and patients within the region. After extensive engagement with WHO's Western Pacific Regional Office, we received our formal designation as a collaborating centre in early 2018. Work began on the jointly agreed work plan that outlined expected activities for our collaborating centre from 2018 to 2021. In April 2019, Ahpra officially launched the WHO Collaborating Centre for Health Workforce Regulation.

Establishing the Western Pacific Regional Network of Health Workforce Regulators was a major objective. Currently, our network has members from over 20 countries in the region,

⁴ OECD (2015) *OECD reviews of health care quality: Australia 2015: raising standards*, OECD reviews of health care quality. Paris, OECD Publishing.

seeking to share knowledge about regulation and working together to improve standards. We held four regional network webinars in 2019, on a range of health workforce regulation topics, and we will continue the series in 2020.



Since our designation, we have welcomed bilateral engagement opportunities from several nations in the region (Laos, Malaysia, Vietnam, Brunei, Fiji and Hong Kong) and for the purpose of information sharing and technical advice.

In September 2019 the Chinese Medicine Board of Australia, RMIT University and our collaborating centre co-hosted a meeting on strengthening regulatory systems for traditional and complementary medicine practitioners in the Western Pacific Region.

In the next two years we will consolidate and progress the relationships and networks that have been established and continue our commitment to strengthening health workforce regulation in the Western Pacific Region.

Contributing on the international stage

Aside from our work with WHO, National Boards and Ahpra have established strong relationships with regulators from around the world. These relationships help us to learn from the experiences of others and allow us to work together to lift the regulation standards for the health workforce globally.

A good example has been our involvement with the international organisation the Council for Licensure, Enforcement and Regulation (CLEAR), which started in 2013. CLEAR promotes regulatory excellence through networking, conferencing and learning programs. One of the many benefits has been the rollout of a nationally based training program for all Ahpra investigators, which has led to greater consistency and quality in their work. This work was done in partnership with CLEAR and is based on a certified investigator training program. An indicator of this close involvement is that in 2019 Ms Kym Ayscough, Ahpra's Executive Director for Regulatory Operations, was appointed as President of CLEAR, the first president drawn from the Southern Hemisphere.

In 2018, CLEAR recognised the outstanding contribution that Dr Joanna Flynn AM, retiring Chair of the Medical Board of Australia, had made to professional regulation and honoured her career of service with the presentation of the 2018 Regulatory Excellence Individual Award. In 2019, CLEAR presented the 2019 Regulatory Excellence Group Award to three staff – Mr Matthew Hardy, National Director, Notifications; Ms Susan Biggar, National Engagement Adviser; and Ms Monica Lambley, Program Manager – for their work to improve the notifier and practitioner experience.

Some notable examples of international engagement include:

- the Nursing and Midwifery Board of Australia's membership and work with the International Nurse Regulator Collaborative, a collaboration dedicated to promoting excellence in regulation and sharing of regulatory intelligence between nursing regulators
- the Medical Board of Australia and Ahpra's contribution to the International Association of Medical Regulatory Authorities (IAMRA); this includes our hosting, in partnership with IAMRA, of the 12th International Conference of Medical Regulation in Melbourne in 2016
- the Physiotherapy Board of Australia working with the International Network of Physiotherapy Regulatory Authorities
- the Psychology Board of Australia's integral role in the International Declaration on Core Competencies in Psychology, and significant input into the development of the international core competencies for the profession
- the work and structure of Ahpra's Community Reference Group being adopted by other regulators internationally.

The National Scheme enjoys a close relationship with health workforce regulators in Canada, the UK and the USA.



Harnessing digital opportunities

Managing digital innovation is a challenge for any organisation. We are updating our technology so we have solid foundations and are better able to respond to changing community and stakeholder expectations, the way health practitioners practise, and our internal work environment.

Expectations are being shaped by the technology offered in commercial settings – think banking apps, mobile phones and parcel delivery tracking. Increasingly these technical advances are being seen and expected in health and regulatory settings. For health practitioners, workplaces and work methods will undergo massive changes.

For many practitioners the only time they engage with us is once a year, to renew their registration. We are working to make this a more seamless process through better online services, while still retaining appropriate levels of rigour. Before the National Scheme, it was the norm for practitioners to fill in printed forms and post or deliver them by hand. Now, over 99 per cent of practitioners renew online.

Electronic document verification can check that the details provided by applicants for registration match the records of the issuing government authority. Last year criminal history checks for over half of all applications were also streamlined through more efficient online processes.

While software can provide data and insights, we also have the opportunity to be risk-informed and can potentially prevent harm before it happens. Artificial intelligence can identify patterns and make suggestions – for applicants for registration, investigators and notifiers. Predictive analysis can look at proactive possibilities, not just reactive or responsive processes. This is something we are just starting to explore.

In 2014, we launched our first social media presence on both Twitter and Facebook, at the height of debate about the social media guidelines that practitioners must meet. This was the first way for us to actively engage with practitioners en masse and with other stakeholders more broadly. From a halting start, we soon became more active and more effective in how

and when we engaged. Social media allowed us to become part of existing communities and provide a new way for people to contact us directly.

Technological advances are helpful, but as a regulator we are sensitive to privacy concerns. We only want to know the information we need to know and only want to collect what we actually need. We must have appropriate levels of transparency in place.

In the future, automation will continue to streamline important but administrative tasks and allow us to focus our people on activities like reasoning, problem solving and critical analysis. Time-saving processes are valued, but many services and activities require and benefit from real people and personal attention.

Ahpra's role is to be a fast follower or an early adopter. We are not ourselves a digital disruptor or a technology developer, rather a regulator who is affected by, and responsive to, digital disruption. We must be mobile-ready and able to allow people the flexibility to engage with us how they want.



Building trust and confidence

Trust is fundamental to our work as a regulator. We rely on members of the public and health practitioners to engage with us as we regulate more than 750,000 health practitioners across Australia.

The public must trust that we will ensure that only safe, ethical and competent health practitioners are registered to practise. They must also be confident that when they raise concerns about the health, performance or conduct of a health practitioner with us, we will be fair, unbiased and humane in how we manage those concerns.

Practitioner trust and confidence is also critical for effective regulation. As the 'regulated party' in a risk-based regulation system, there are several valuable roles that practitioners play in keeping the public safe. Most importantly, practitioners need to meet professional standards, as set by the Boards. Belief that these standards are appropriate and reasonable is clearly linked to a commitment to fulfil them.

Evidence gathered over several years has given us insight into how we are viewed by some of our most important stakeholder groups. We also rely on hundreds of other stakeholders to collaborate with us to keep the public safe and these partnerships must be based on trust.

Social research

We need to hear from our stakeholders to be able to do the best job we can as regulators, particularly as one in 17 people working in Australia is a registered health practitioner.

In 2018 we surveyed health practitioners and members of the community for the first time about their awareness and understanding of our work, and their levels of trust and confidence.

Our aim was to better understand what the broader community, regulated health professions and our other stakeholders think and feel about us, particularly in areas of understanding, confidence and trust. The project included a short anonymous survey to random samples of practitioners and the community.

Just over half of practitioners expressed confidence in Ahpra (51 per cent) and National Boards (56 per cent) and their purpose to keep the public safe.

Of the members of the community who were aware of Ahpra and the National Boards, 71 per cent expressed trust in Ahpra and 72 per cent were confident Ahpra is doing everything it can to keep the public safe. A total of 63 per cent said they trusted a National Board and 58 per cent were confident the Board is doing everything it can to keep the public safe.

Our core role is to protect the public. We published the results and now have a baseline against which to monitor changes over time.

Practitioner and notifier experience

Regulators worldwide have increasingly focused on the experience of complainants and practitioners throughout the notification process. This is, at least in part, a response to high levels of dissatisfaction with the complaints process generally and a growing recognition of the unintended harm that the experience can cause to both groups. Without trust and confidence in regulation, and if concerns stop being raised with regulators, systems will fail.

We began to focus on improving the experience in 2017 by asking for input from those who had recently been through a notification. We have now received over 6,000 responses to our surveys (60 per cent from practitioners) and conducted 84 interviews. The data reveal a surprising symmetry of views between the two groups, with the highest levels of dissatisfaction centred on questions of fairness, communication (often, specifically, transparency), timeliness, stress and outcomes.

Notifiers often feel everything is weighted against them in favour of practitioners; disappointment with the outcome is high with over 70 per cent of matters resulting in no further action.

Daunting. It was just me making a complaint as a sole individual going up against someone who seems like they have all these titles and qualifications. I felt like I was out of my depth (notifier).

At the same time, practitioners often felt the process was biased against them, that they were treated like a criminal, and felt *guilty until proven innocent* (practitioner).



In response to the feedback, we have changed the way we communicate, trained staff differently, focused on greater transparency, attempted to address myths and misconceptions through accessible resources (for example, concise 'process postcards', videos and podcasts), and collaborated to help the public get to the 'best place' for their concern.



Our ongoing commitment to public safety

There are drawbacks to trawling back through a decade of anything.

We run the risk of glossing over the tough times or overlooking the smaller day-to-day achievements and, instead, focusing on the big-ticket milestones.

In this publication, we have drawn on a snapshot of memories and achievements, both challenging and celebratory, to paint a picture of the first 10 years of the National Registration and Accreditation Scheme.

On 1 July 2010, the historic day Australia got its national regulatory system, 'challenging' was certainly one of the words on our minds as we felt the weight of our responsibilities.

Australia, in a spirit of federated cooperation, was implementing a state- and territory-based national scheme regulating a specific group of professions.

A strong memory I have of this time is my admiration for our people and partners, and the steadfast dedication and passion – sometimes loud and at the forefront, other times a background murmur – carrying our work forward.

National Boards and Ahpra staff were implementing what some had dismissed as an impossible task, and they did so successfully. That pragmatic determination that was so apparent in our people in 2010 is still there today.

Ahpra people – and the Boards and committees with whom we work in such close partnership – are problem-solvers, considered thinkers and overwhelmingly passionate about the work of regulation. These people have been a huge part of all that has been achieved over the past 10 years.

I am enormously proud of all that has been achieved by Ahpra, Boards and accreditation authorities. My huge thanks to everyone who has played a part in establishing and building the regulatory system we have today.

Good regulation requires strong partnerships, constant vigilance and a commitment to continually improve. Looking ahead, I believe our focus must be on how we ensure practitioner regulation is effective, accountable and humane.

We will continue to adapt and evolve in a rapidly changing healthcare environment. And, most importantly, we must maintain our core focus on public and patient safety.



Mr Martin Fletcher

Chief Executive Officer, Ahpra

Published

Australian Health Practitioner Regulation Agency

**A unique and substantial achievement:
Ten years of national health practitioner regulation in Australia**

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Acknowledgements

Ahpra acknowledges the Traditional Owners of Country throughout Australia and the continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures and Elders past, present and emerging.

Our thanks and appreciation to everyone who has been part of making and sustaining the National Registration and Accreditation Scheme.

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