Multiprofessional Regulation in Australia
7.14 POPULATION DENSITY—June 2010

People per sq km
- 100.0 or more
- 10.0 to 100.0
- 1.0 to 10.0
- 0.1 to 1.0
- Less than 0.1

Source: Regional Population Growth, Australia (3218.0).
• Federal system of government
• Joint government funders
• 9.3% of GDP on health
• 70% public / 30% private mix
• Good health status overall
• Health priorities
• Population priorities
Health Practitioner Regulation

- 1837 – regulation of medical practitioners in Van Diemen’s Land (Tasmania)
- Predates UK by 21 years
- States have power to register/ regulate - not Commonwealth
- History of piecemeal changes
- Major transformation in past 5 years
NRAS - Origins

- Jan 2006 - Productivity Commission report
- March 2008 - COAG decision to establish a national scheme
- 1 July 2010 - National Registration and Accreditation Scheme starts (WA – 18 Oct 2010)
Major transformation since 2010

Eight State and Territory based arrangements ➡ One national scheme

>95 health profession boards ➡ 14 health profession boards

75 Acts of Parliament ➡ Nationally consistent legislation (largely)

38 regulatory organisations ➡ One national organisation (AHPRA)

1.5 million data items from 94 sources ➡ National online registers
What’s different?

National Law

- Enacted in all States/Territories
  - Objectives
    - Protection of the public
    - Workforce mobility within Australia
    - High quality education and training
    - Rigorous and responsive assessment of overseas trained practitioners
    - Facilitate access to services in accordance with the public interest
    - Enable a flexible, responsive and sustainable health workforce and enable innovation

- Title protection rather than scope of practice
AHPRA/Board partnership

AHPRA works with 14 National Health Practitioner Boards to:

- **Set professional standards** - entry into the profession
- **Register practitioners** - compliance with standards (annual renewal)
- **Maintain national registers**
- **Manage notifications** - address concerns about ‘fitness to practice’
- **Accreditation** - set standards for educational pathways to registration
Over 600,000 Practitioners
<table>
<thead>
<tr>
<th>Profession</th>
<th>Risk Profile [Deloitte analysis 2013]</th>
<th>Registrants 2013-14</th>
<th>Proportion of total Registrants</th>
<th>Notifications 2013-14</th>
<th>Proportion of total notifications</th>
<th>Notifications per 1,000 practitioners 2013-14</th>
<th>Monitored Registrants&lt;sup&gt;15, 16&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>5</td>
<td>99,379</td>
<td>16.0%</td>
<td>5,585</td>
<td>55.6%</td>
<td>56.2</td>
<td>1,654</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>4</td>
<td>362,450</td>
<td>58.5%</td>
<td>2,010</td>
<td>20.0%</td>
<td>5.5</td>
<td>1,228</td>
</tr>
<tr>
<td>Psychology</td>
<td>3.5</td>
<td>31,717</td>
<td>5.1%</td>
<td>487</td>
<td>4.8%</td>
<td>15.4</td>
<td>187</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>3.5</td>
<td>28,282</td>
<td>4.6%</td>
<td>514</td>
<td>5.1%</td>
<td>18.2</td>
<td>234</td>
</tr>
<tr>
<td>Dentistry</td>
<td>3.5</td>
<td>20,707</td>
<td>3.3%</td>
<td>951</td>
<td>9.5%</td>
<td>45.9</td>
<td>190</td>
</tr>
<tr>
<td>Podiatry</td>
<td>3</td>
<td>4,129</td>
<td>0.7%</td>
<td>54</td>
<td>0.5%</td>
<td>13.1</td>
<td>22</td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
<td><strong>2.5</strong></td>
<td><strong>26,123</strong></td>
<td><strong>4.2%</strong></td>
<td><strong>134</strong></td>
<td><strong>1.3%</strong></td>
<td><strong>5.1</strong></td>
<td><strong>93</strong></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>2.5</td>
<td>16,223</td>
<td>2.6%</td>
<td>43</td>
<td>0.4%</td>
<td>2.7</td>
<td>101</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>2.5</td>
<td>4,845</td>
<td>0.8%</td>
<td>111</td>
<td>1.1%</td>
<td>22.9</td>
<td>49</td>
</tr>
<tr>
<td>Chinese Medicine</td>
<td>2.5</td>
<td>4,271</td>
<td>0.7%</td>
<td>26</td>
<td>0.3%</td>
<td>6.1</td>
<td>870&lt;sup&gt;17&lt;/sup&gt;</td>
</tr>
<tr>
<td>Osteopathy</td>
<td>2.5</td>
<td>1,865</td>
<td>0.3%</td>
<td>11</td>
<td>0.1%</td>
<td>5.9</td>
<td>9</td>
</tr>
<tr>
<td>Medical Radiation Practice</td>
<td>2</td>
<td>14,387</td>
<td>2.3%</td>
<td>28</td>
<td>0.3%</td>
<td>1.9</td>
<td>135</td>
</tr>
<tr>
<td>Optometry</td>
<td>2</td>
<td>4,788</td>
<td>0.8%</td>
<td>66</td>
<td>0.7%</td>
<td>13.8</td>
<td>12</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Health Practice Board of Australia</td>
<td>1</td>
<td>343</td>
<td>&lt;0.1%</td>
<td>6</td>
<td>&lt;0.1%</td>
<td>17.5</td>
<td>9</td>
</tr>
<tr>
<td><strong>Totals (five higher volume and risk professions)</strong></td>
<td>n/a</td>
<td>542,535</td>
<td>87.6%</td>
<td>9,547</td>
<td>95.0%</td>
<td>n/a</td>
<td>3,493</td>
</tr>
<tr>
<td><strong>Totals (nine lower volume and risk professions)</strong></td>
<td>n/a</td>
<td>76,974</td>
<td>12.4%</td>
<td>479</td>
<td>4.8%</td>
<td>n/a</td>
<td>534</td>
</tr>
<tr>
<td><strong>Total (all professions)</strong></td>
<td>n/a</td>
<td>619,509</td>
<td>100%</td>
<td>10,047&lt;sup&gt;18&lt;/sup&gt;</td>
<td>100%</td>
<td>n/a</td>
<td>4,027</td>
</tr>
</tbody>
</table>
Forum of National Board Chairs

• All National Board Chairs plus AHPRA Executive and Chair
• Critical role in cross-professional approaches to common regulatory issues
• Collaboration and consultation
• Not a decision-making body
Harmonising Registration Standards

1. Criminal history
2. English language requirements
3. Professional Indemnity Insurance arrangements
4. Continuing Professional Development
5. Recency of Practice

Codes and Guidelines
- Advertising
- Mandatory reporting
- Conduct
Regulatory principles describe our approach to regulating health practitioners

Regulatory principles for the National Scheme

These principles are designed to shape thinking about regulatory decision-making in the National Scheme. They are endorsed by all the National Boards and the Agency Management Committee.

The principles will apply to different function areas in different ways. Collaborating with your colleagues, and discussing the differences with them, will add depth to your understanding of them.

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, and
   - 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 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.
Power to take Immediate Action (s. 156)

• Reasonable belief:
  • Because of a practitioner’s conduct, performance or health, the practitioner poses a serious risk to persons; or
  • Necessary to protect public health or safety.

• 474 matters (2013-14)
  • Lower regulatory load professions: 18 (14 resulted in sanction)

• Improve efficiency/effectiveness of decisions
  • Shared committee
Challenges

• Perceived loss of identity/role/voice
• “Bespoke” activities
• Leadership/governance
NRAS Evolution

2010
AHPRA Launched

2010-13
Establishment

Rapid establishment

Senate Inquiry

Focus on overcoming establishment challenges and operationalising the National Scheme

2014
Review & Restructure

Four new professions join National Scheme

Organisational change: clarify organisational roles and purpose

Queensland Forrester Report

Victorian Parliamentary Inquiry Report

3 Year National Scheme review

2015 → Performing

Improving regulatory performance and stakeholder engagement

2015 → Performing

Organisational change: clarify organisational roles and purpose

Four new professions join National Scheme

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Conclusion

- NRAS working well – needs more time to mature
- Independent Review may be determinative
- No going back