Chiropractic
Dental
Medical
Nursing and Midwifery
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Senate Finance and Public Administration References Committee

14 April 2011

Submission

Contents

Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency

14 April 2011

Submission from the Agency Management Committee of the Australian Health Practitioner Regulation Agency

Executive Summary

Establishment of the National Registration and Accreditation Scheme (the National Scheme) is the most comprehensive and complex reform of health practitioner regulation ever undertaken in Australia, covering more than 528,000 health practitioners on the National Registers. It is one of the most ambitious regulatory reforms undertaken anywhere in the world, placing public and patient safety at the heart of health practitioner regulation.

There are significant advantages in national registration for the public and practitioners. For the first time, there are nationally-consistent standards that all practitioners must meet before they are registered to practise. The framework provided by the *Health Practitioner Regulation National Law Act* (the National Law) sets tougher standards designed for public protection. Registration and practice across geographic boundaries is no longer a barrier. Health practitioners can register once and practise Australia-wide. National registration means better and more consistent data across Australia for workforce planning. There is collaboration between the ten National Boards about matters of common interest and profession-specific focus on other issues.

Much credit must go to governments for envisioning and enabling a bold National Scheme that strikes a careful balance between public safety and supply of a flexible and qualified health workforce. The National Registration and Accreditation Scheme is not a Commonwealth scheme but has been established by states and territories through a national 'applied laws' model. The National Scheme is funded by registrant fees.

Implementing change of this ambition, scope and complexity, with significant transitional challenges, has led to some initial shortfalls in services to health practitioners. The Australian Health Practitioner Regulation Agency (AHPRA) has acknowledged these problems to the Australian Health Workforce Ministerial Council (the Ministerial Council) and in public communications with professional stakeholder groups.

The National Scheme began full operation from 1 July 2010, the day immediately following cessation of operation of over 80 state and territory boards. As such, there was no break between the start of the National Scheme and the end of previous state and territory-based regulation. This meant there was no opportunity to run or test new systems in parallel for any time. The staff members AHPRA needed to run the new National Scheme were focused until the last minute on winding up old boards. With more than 80% of staff from the previous boards joining AHPRA, the requirements of the implementation timetables and legislative uncertainty in some states up to the final moment of changeover, opportunities for staff training and preparation were very limited before 1 July 2010.

Despite the challenges of the transition from legacy arrangements to the new National Scheme, the fundamentals of the National Scheme are sound and AHPRA has established robust systems which are being strengthened progressively. AHPRA and the National Boards have had their work cut out to deliver nationally-consistent registration processes in the early phases of the National Scheme. The former boards' cultures and practices varied widely across the country, depending on profession and previous legislative arrangements.

AHPRA has invested heavily in developing and embedding uniform operating procedures and information technology to meet the new requirements of the National Law and establish national consistency. An extensive program of work is in train to address these start-up and transitional issues.

There are over 528,000 health practitioners on the National Registers across the 10 professions (as detailed in *Appendix 1*). More than one in 40 Australians is a registered health practitioner. The National Registers are publically accessible online. This allows the public, health practitioners and their employers to check a practitioner's registration status easily.

More than 370,000 health practitioners have renewed their registration since 1 July 2010. Almost 38,000 health practitioners have registered for the first time since 1 July 2010. There has been an overall increase in the size of the health workforce with a net growth of almost 13,000 registered health practitioners since 1 July 2010. There are around 75,000 students on the student register which commenced in March 2011. Data such as these clearly demonstrate the capacity of AHPRA, in partnership with the National Boards, to deliver the benefits that inspired the Council of Australian Governments (COAG) to commit to the reform and the benefits national registration creates for both registered practitioners and their patients. The professions are thanked for their engagement in working with AHPRA and the National Boards through the early implementation phase and their commitment to realising the lasting benefits of national registration[1].

[1] All data are as at 13 April 2011 unless otherwise indicated.

Introduction

1. The regulation of health practitioners in Australia has, since 1 July 2010, undergone reform on an unprecedented scale. The outcome of this process is a national system of health practitioner regulation in which uniform standards apply in each profession, increasing patient safety.

2. Historically, the regulation of health professionals was undertaken at the state and territory level, without a consistent approach across Australia. In July 2006, COAG agreed to implement a National Registration and Accreditation Scheme for health professionals, beginning with those professions required to be registered in all jurisdictions. In March 2008, COAG members signed the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* to implement the National Scheme by 1 July 2010.

3. The National Scheme involved the creation of a single national system for 10 health professions: medicine, nursing and midwifery, pharmacy, physiotherapy, psychology, osteopathy, chiropractic, optometry, dental and podiatry. The new arrangement aimed to provide stronger safeguards for the public, facilitate health practitioners moving around the country more easily, reduce red tape, provide stronger safeguards for the public and promote a more flexible, responsive, safe and sustainable health workforce.

4. The National Scheme is not a Commonwealth scheme, but has been established by states and territories through a national 'applied laws' model. The National Law has been enacted in each state and territory. It established a national system of regulation for health practitioners in the 10 health professions. Queensland enacted the National Law in terms agreed by the jurisdictions and other jurisdictions proceeded to adopt the National Law.[2] The Australian Health Practitioner Regulation Agency (AHPRA) is not a Commonwealth agency but a statutory body created by the National Law which operates in each state and territory.

5. Although the intention of the National Scheme was to implement uniform legislation, several jurisdictions have made amendments. New South Wales opted out of Part 8 of the National Law and retained its own complaints system, rather than using the national system for dealing with notifications about health practitioners.

6. The National Scheme, underpinned by the National Law, began on 1 July 2010 for states and territories other than Western Australia which joined the National Scheme on 18 October 2010. There was a target deadline of December 2009 for the passage of the National Law in each jurisdiction. However, only Queensland, Victoria and New South Wales had passed their respective legislation by the end of 2009.

7. The late timing of the passage of the legislation in some jurisdictions added significant uncertainty to planning for the transition to the National Scheme. Before 1 July 2010, there was limited access to the staff that would be implementing the new National Scheme, as most of them were still employed to administer the state and territory-based registration schemes and boards that needed to operate effectively until the National Scheme commenced.

8. The enacting legislation and date of passage in each jurisdiction is summarised in *Appendix 2.*

Objectives and guiding principles of the National Registration and Accreditation Scheme

9. The objectives of the National Scheme are stated in the National Law. In summary, they are:

   - protecting the public by ensuring that only suitably trained and qualified practitioners are registered
   - facilitating workforce mobility across Australia
   - facilitating the provision of high-quality education and training of health practitioners

[2] The exception is Western Australia which applied the National Law through corresponding or 'mirror' legislation.

- facilitating the rigorous and responsive assessment of overseas-trained health practitioners
- enabling 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.

10. The National Law also sets out three guiding principles for the National Scheme as follows:

- transparent, accountable, efficient, effective and fair operation of the National Scheme
- that the fees required to be paid under the National Scheme are to be reasonable having regard to the efficient and effective operation of the National Scheme, and
- that restrictions on the practice of a health profession are to be imposed only to the extent necessary to ensure health services are provided safely and are of an appropriate quality.

11. The National Law was shaped by the 65 Acts of Parliament it replaced. *Appendix 3* provides a complete list of the Acts. The National Law has set a new, nationally-consistent and, in many cases, higher benchmark for patient safety. In developing the National Law, where one jurisdiction had an arrangement which protected public safety more than arrangements in other jurisdictions, Ministers largely chose to incorporate that provision in the National Scheme. Significant features of the National Law are summarised in *Table One: Significant features of the National Law*.

12. In line with these features, the National Law requires National Boards to set five registration standards that every registered practitioner must meet, in relation to:

- English language skills
- professional indemnity insurance
- recency of practice
- continuing professional development, and
- criminal history.

These registration standards underwent extensive consultation, then consideration and approval by the Ministerial Council before they were implemented. An approved registration standard for a specific profession provides the benchmark against which every registration application from a health practitioner is assessed. The standards are guided by the principle of public safety.

Table One: Significant features of the National Law

Feature	Requirement under the National Law
Mandatory reporting for students and practitioners	Practitioners and employers must notify AHPRA of notifiable conduct by registered practitioners that would place the public at risk of harm, such as practising while intoxicated. Education providers must notify AHPRA if they reasonably believe that a registered student has an impairment that in the course of the student undertaking clinical training may place the public at substantial risk of harm.
Student registration	Students in approved programs of study must be registered from the point set by the relevant National Board (except psychology).
Criminal history checks	Applicants for initial registration must undergo a criminal history check. National Boards may also require criminal history checks at other times.
Continuing professional development	Practitioners must undertake the continuing professional development required by the relevant registration standard for their profession.
English language skills	Practitioners must meet the English language skills required by the approved registration standard for their profession to be eligible for registration.
Professional indemnity insurance (PII)	Registered practitioners must not practise their profession unless appropriate professional indemnity insurance arrangements are in place.
Recency of practice	Practitioners must meet the recency of practice requirements set in the approved registration standard for their profession.
Notifications	A nationally consistent process for managing notifications about registered health practitioners, and, in certain circumstances, registered students and for ensuring outcomes apply nationally.
Automatic expiry	If practitioners do not renew their registration by the end of the late period (one month after their registration expiry date), their registration will lapse and they will need to make a fresh application to become re-registered and be able to practise.
Identity checking	Applications for registration must be accompanied by proof of the applicant's identity.
Specialist registration	Separate registers of specialists are established under the National Law for the medical and dental professions.
Endorsements for extended practice	National Boards may grant endorsements for scheduled medicines, acupuncture and approved areas of practice in specified circumstances.
Standard registration categories	Before the National Scheme was introduced, registration categories varied between state and territory legislation and between professions. Under the National Law, there is a range of consistent and specific registration categories across professions against which transferring practitioners needed to be matched.

Entities responsible for the National Scheme

Entities are depicted in *Diagram One: Architecture of the National Scheme.*

Australian Health Workforce Ministerial Council (the Ministerial Council)

13. The Ministerial Council is made up of Health Ministers of each state and territory and the Commonwealth. The functions of the Ministerial Council are set out in the National Law. This sees a role for the Ministerial Council in some matters of policy; for example, the approval of registration standards recommended by the National Boards. However, the primary regulatory policy role lies with the National Boards.

14. The Ministerial Council can be advised by the Australian Health Workforce Advisory Council (AHWAC), an entity also established by the National Law.

National Boards

15. The National Law established a National Board for each of the regulated health professions. The functions of the Boards are set out in section 35 of the National Law and have a focus on protecting the public and guiding the professions. This includes responsibilities for registering health practitioners who meet the requirements of approved registration standards, investigating and managing concerns (known as notifications) about the performance, health or conduct of practitioners and developing standards, codes and guidelines. The National Boards set national fees which fund the services they provide to each profession, primarily through the work of AHPRA.

16. Section 37 confers a power of delegation on National Boards. National Boards have delegated many functions to AHPRA and Board committees (national or State and Territory or regionally-based) to support the efficient functioning of the National Scheme.

17. National Board members are appointed by the Ministerial Council. At least half, but not more than two thirds of National Board members must be practitioner members and the remaining members are appointed as community members. The membership of National Boards is set out in *Appendix 4*.

The Australian Health Practitioner Regulation Agency

18. AHPRA administers the National Scheme and provides operational and administrative support to the Boards in their core role of protecting the public. It performs the functions directly conferred on it by the National Law (section 25). AHPRA staff exercise functions delegated by each of the National Boards in relation to registration of health practitioners and investigation of notifications.

19. AHPRA is governed by the Agency Management Committee which has functions under the National Law including to ensure that AHPRA performs its functions in a proper, effective and efficient way. The membership of the Agency Management Committee is set out at *Appendix 5*.

20. In early 2011, the 10 National Boards and AHPRA developed a long-term strategy for the National Scheme, articulating a vision, mission, values and key strategic priorities for 2011 – 2014. The *National Registration and Accreditation Scheme Strategic Plan 2011-2014* is at *Appendix 6*.

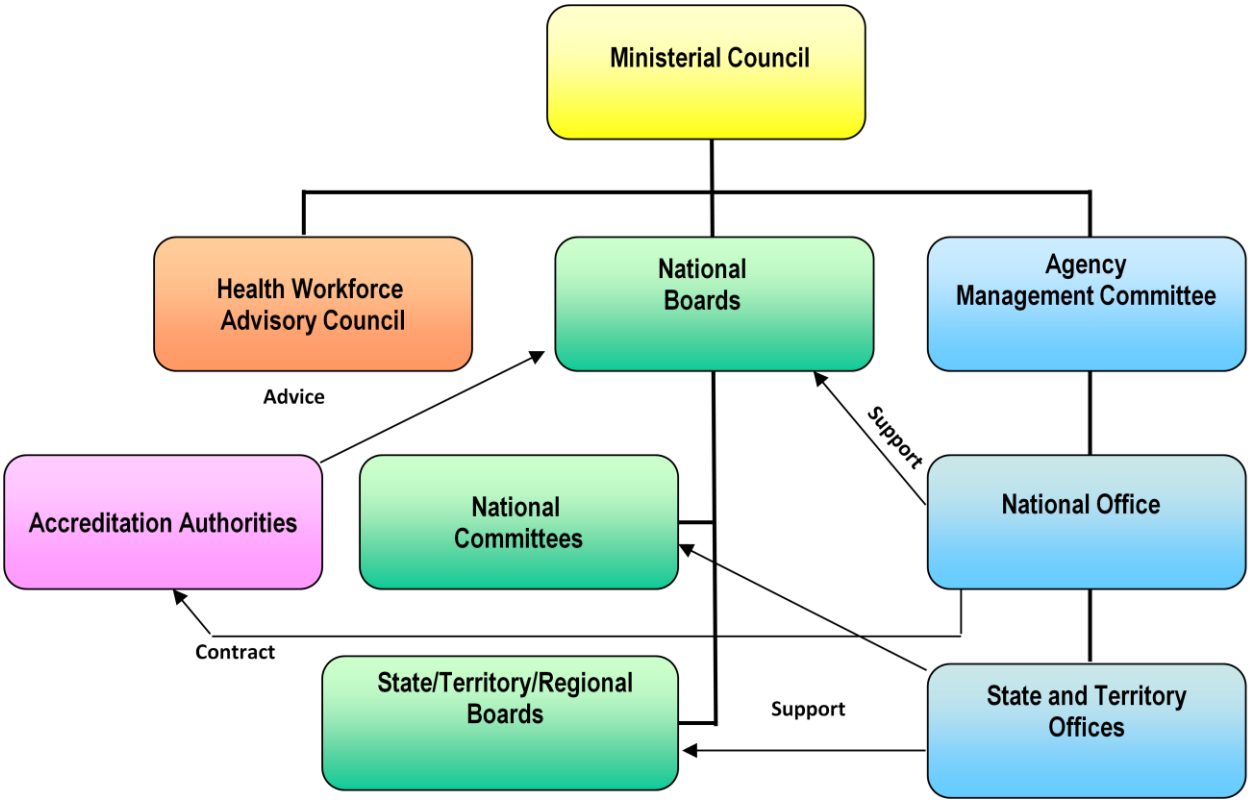


Diagram One: Architecture of the National Scheme

Information responding to the Terms of Reference

(a) Capacity and ability of AHPRA to implement and administer the national registration of health practitioners

21. AHPRA has the skills, capacity and ability to effectively implement and administer the national registration of health practitioners. The transition to the National Scheme has been a significant change management process with implications for every part of the health system. While there have been challenges in the initial implementation phase, AHPRA has progressively strengthened its capacity and ability to implement and administer the National Scheme.

22. AHPRA has an office in each state and territory and a small national office in Melbourne. *Appendix 7: AHPRA Organisational Structure* provides further details. AHPRA delivers the majority of services to health practitioners and the public through its network of state and territory offices. The organisational structure allows work to be allocated between offices at times of peak demand.

23. AHPRA has around 510 core full-time and part-time staff. With 80% of staff from previous state and territory registration boards opting to join AHPRA, staff brought substantial experience and expertise in professional regulation to the new organisation.

24. In addition, key individuals from previous boards have been recruited to senior management roles. For example, most of AHPRA's State and Territory Managers were recruited from previous chief executive officer roles in state and territory boards for medicine, pharmacy, nursing and allied health professions. Other managers have come from senior leadership positions in health-related areas.

25. In the start-up phase, the logistics of transferring staff to AHPRA from previous boards and establishing new offices and uniform procedures has been a major challenge. The personnel AHPRA needed to run the new National Scheme were very busy to the last minute working for and winding up old boards. The former boards' cultures and practices varied widely across the country, depending on profession and previous legislative arrangements. The requirements of the implementation timetables and uncertainty about some jurisdictions passing the necessary legislation to join the National Scheme meant that opportunities for staff training and preparation were very limited before 1 July 2010.

26. As a result, AHPRA and the National Boards have had their work cut out to ensure nationally-consistent registration processes in the first phase of the National Scheme. AHPRA is investing heavily in developing and embedding uniform operating procedures and information technology to meet the new requirements of the National Law and ensure national consistency. An extensive program of work is in train to address these start-up and transitional issues. Despite the challenges of the transition from legacy arrangements to the new National Scheme, the fundamentals of the National Scheme are sound and AHPRA has established robust systems which are being strengthened progressively.

27. AHPRA continues to develop the expertise of its workforce to build on the skills, experience and capacity to deliver the National Scheme effectively. As necessary, contractors with specific expertise have also been used in the transition and initial phases; for example, in information technology and communications, data management and project management.

28. A core strength in the National Scheme is the partnership between AHPRA and the National Boards. National Board members were appointed by the Ministerial Council, and the majority of members brought experience as a state or territory board member to their new national role. Partnership with the National Boards and the large numbers of experienced staff who joined the National Scheme has ensured that AHPRA's work is informed by an understanding of past approaches, international best practice and practical experience in health regulation.

29. AHPRA carries out the administration of all registration processes on behalf of the Boards within a set of arrangements formally agreed by each National Board. The National Scheme includes a mechanism for local decision-making within each jurisdiction. The National Law gives National Boards the option, where they consider it useful, to establish state, territory and regional Boards to deliver effective and timely local responses to health practitioner notifications and registrations.

(b) Performance of AHPRA in administering the registration of health practitioners

Registration of health practitioners

30. There are over 528,000 health practitioners on the National Registers across the 10 professions (see *Appendix 1*). Almost 38,000 health practitioners have registered for the first time since 1 July 2010. The National Registers are available online. This allows the public, health practitioners and employers to check a practitioner's registration status.

31. The National Law sets a maximum 90-day timeframe to assess an initial application for registration. Section 85 of the National Law provides that if a National Board does not decide an application for registration within 90 days of its receipt, or a longer period agreed between the Board and the applicant, the failure by the Board to make a decision is taken to be a decision to refuse to register the applicant. *Diagram Two: Flowchart of registration process* describes the steps in the registration process.

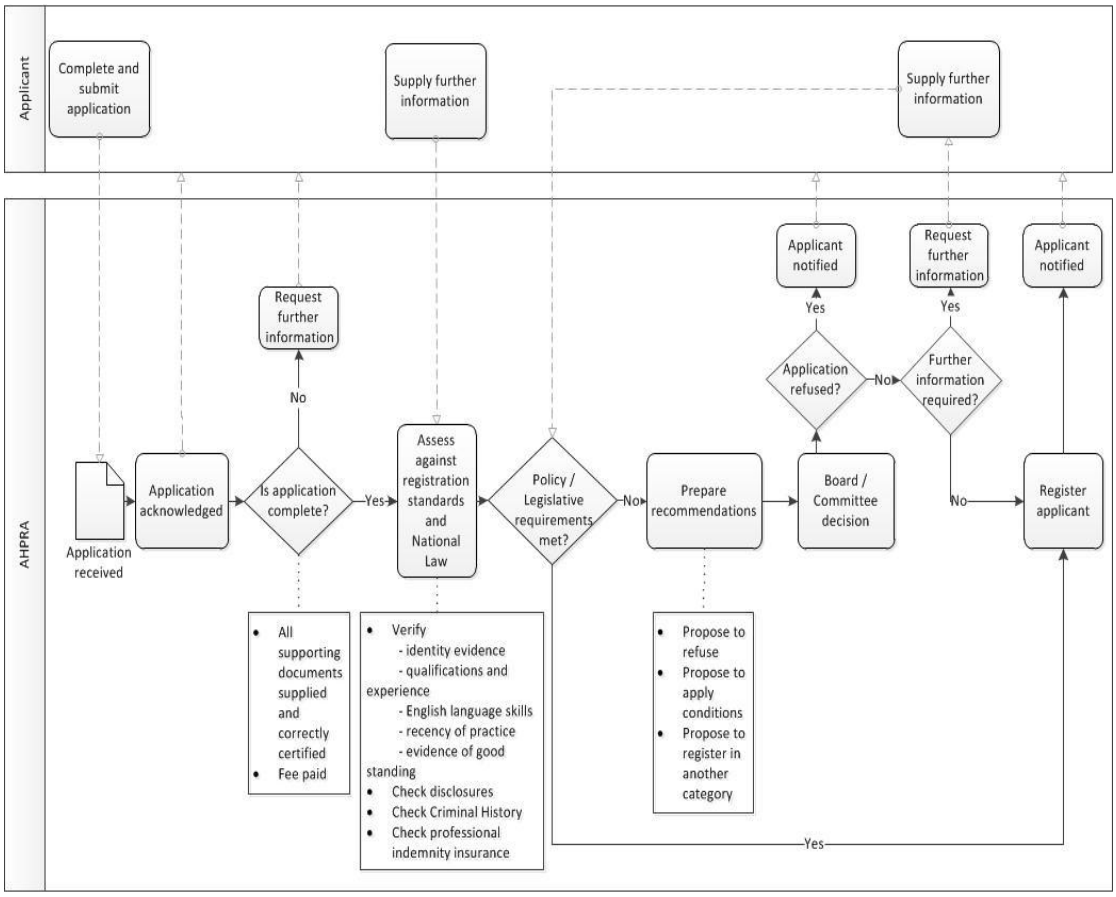


Diagram Two: Flowchart of registration process

32. The 90-day timeframe, and provision for agreement about a longer period, recognises that some applications for registration are inherently complex and require additional information to be provided by the applicant or other sources. For example, when an applicant declares an overseas criminal history, it may take some time to verify the necessary details.

33. A core challenge in health practitioner regulation is balancing the at times competing priorities of workforce supply and the safety and quality of health services delivered to the Australian public. Assessing and making determinations about eligibility for registration is not just an administrative process. To undertake its statutory role responsibly, AHPRA makes sure its operational processes support a thorough assessment of applications for registration. It also aims to do this in a timely way, noting that there are no externally agreed performance benchmarks for registration processes beyond the maximum period specified in the National Law.

34. The National Scheme has introduced a number of new requirements for health practitioners that stem from the core principle of public safety. In negotiating the National Law, Ministers sought to adopt the highest standards of public safety already in place within jurisdictions. *Table Two: Requirements to strengthen public protection* outlines how these new requirements have been implemented. These requirements undoubtedly provide a more robust regulatory system designed to better protect the public than the systems previously in place. They also ask more of practitioners and can add to the complexity and time involved in the registration process.

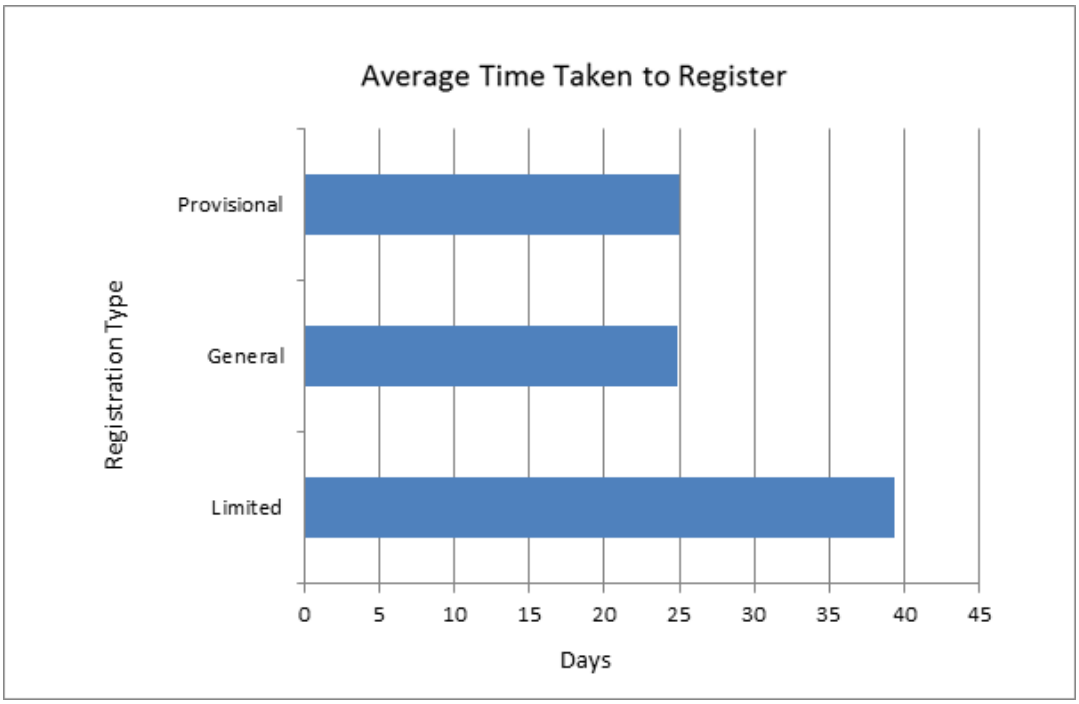
Table Two: Requirements to strengthen public protection

Requirement	Implementation	Practical effect
English language skills registration standard*	Practitioners who did not undertake their secondary and tertiary education in English in a specified country must demonstrate they meet the standard through completing an English language test.	Affected practitioners must sit an English language test specified in the registration standard and obtain the necessary test results to submit with their application. Tests are held at various times and locations in Australia through recognised external providers of testing services.
Criminal history registration standard	A criminal history check must be completed for each new application and National Boards may undertake ad hoc checks.	Criminal history reports are obtained from CrimTrac. Where an applicant has no criminal history, the report is usually obtained within 48 to 72 hours. However, if an applicant has a criminal history, the report may take a number of weeks to be returned, due to the need for checking by CrimTrac with each jurisdiction.
Recency of practice registration standard	The National Scheme introduced requirements for practitioners to meet the relevant Board's recency of practice requirements.	AHPRA must consider whether the applicant meets the relevant Board's recency of practice registration standard. This involves assessing the practitioner's practice history against the Board's requirements.
Continuing professional development registration standard	The National Scheme introduced requirements for all practitioners to undertake mandatory continuing professional development that meets the relevant Board's requirements.	New applicants must sign a declaration that they will meet the relevant requirements in their upcoming registration period. Applicants for renewal must sign a declaration that they have complied with the requirements.
Professional indemnity insurance registration standard**	The National Law provides that a practitioner must not practise unless appropriate professional indemnity insurance arrangements are in place.	Applicants self-declare their compliance and/or intention to comply with the Board's requirements.
Automatic expiry of registration	The National Law provides for automatic lapsing of registration at the end of the late period, one month after the registration expiry date. In some jurisdictions, before the enactment of the National Law, a practitioner was taken to continue to hold registration until such time as the regulatory authority decided. Therefore, in these jurisdictions, a failure to renew registration on time would not have resulted in the automatic lapsing of registration.	If a practitioner does not renew their registration before the end of the late period, AHPRA and the National Boards have no discretion under the National Law to extend registration and the practitioner must submit a new application for registration.
New common renewal dates	The National Scheme introduced new common renewal dates for each profession across Australia.	There is a transition period of transferring practitioners to the new renewal dates under the National Scheme. Practitioners have needed to adjust to changed renewal dates and transitional renewal periods.

**Further cross-Board work is underway on this registration standard. **Further work is underway on this registration standard by a number of Boards.*

35. The vast majority of applications have been dealt with within the 90-day timeframe. More straightforward applications for general registration can usually be decided in a shorter period. In line with AHPRA's commitment to improving customer service, AHPRA aims to

expedite the assessment and decision-making processes as far as possible without compromising rigour or public safety. *Diagram Three: Average time to assess and finalise applications for registration* sets out the average period in which applications are decided.



Note: The assessment of applications for limited registration is more complex as it generally relates to overseas qualified practitioners.

Diagram Three: Average time to assess and finalise applications for registration

36. In November 2010, AHPRA put in place a special graduate registration process for students graduating from programs of study approved under the National Law. This allows graduates to pre-apply for registration, before completing their program of study. Their application could then be pre-assessed, including proof of identity and criminal history checks, before their final academic results were provided by the education provider. When education providers advised AHPRA that graduates have completed the approved program of study, their registration application could be finalised.

37. In a deliberate strategy to smooth entry to the workforce, AHPRA prioritised applications from new graduates. To further enhance our services, AHPRA will be implementing an online graduate application process from July 2011 for graduates from approved programs of study.

38. AHPRA and the National Boards provide comprehensive information and resources about registration standards and requirements on their websites, accessible at www.ahpra.gov.au. Application forms can also be downloaded at this website.

Renewal of registration

39. Under the National Law, health practitioners must renew their registration on an annual basis. At the point of renewal, health practitioners are asked to make declarations in relation to meeting the standards of their National Board. Similar processes were in place under previous state and territory board arrangements. More than 370,000 health practitioners have renewed their registration since 1 July 2010 within the National Scheme.

40. The National Law does not set a time period for a decision on an application for renewal, as section 108 enables a practitioner to remain registered after he or she has made an application for renewal until the Board decides to renew or refuse to renew the registration. In most cases, where practitioners renew online and make no adverse declarations, their registration is updated within hours.

41. AHPRA has implemented a comprehensive system for sending renewal notices and reminders to health practitioners in the lead-up to their registration expiry and during the late period. This process is outlined in *Appendix 8*. In early renewal processes under the National Law, practitioners received one letter and one email/SMS reminder before the deadline for renewal (where AHPRA held data about email addresses and mobile phone numbers for health practitioners). A revised renewal process has now been implemented. Under this arrangement, practitioners receive one letter and four email/SMS reminders before the deadline for renewal as well as correspondence if they fail to renew by the deadline. AHPRA is currently implementing an intensive communications campaign to support the current registration renewal of more than 300,000 health practitioners nationally by 30 June 2011.

42. Practitioners are, in most instances, able to renew their registration online. To date, more than 70% of health practitioners who have renewed have done so online. AHPRA aims to increase the number of practitioners who use these online services, as this will be easier for health practitioners and is more efficient administratively.

Data Migration

43. In the transition period, issues with data AHPRA has received from some previous state and territory boards has affected the initial renewal process for some health practitioners. Until the National Scheme started on 1 July 2010, all data about health practitioners was held by state and territory registration boards, not by AHPRA. In the first months of operation, AHPRA has had to rely on these data, which were migrated to AHPRA, including the contact details of health practitioners.

44. As part of the transition to the National Scheme, an agreed data migration process was designed and implemented to ensure the data were as accurate as possible. This included AHPRA writing to more than 500,000 registrants before the start of the National Scheme, asking them to confirm the accuracy of the data held by their current registration board. Practitioners were asked to update their contact details with their current registration board before 30 June 2010, but AHPRA had no control over the extent to which this occurred.

45. More than one million names and addresses were consolidated to a single database from 42 databases located within state and territory registration boards throughout Australia. The source databases were built in a variety of different formats and technologies, including paper-based systems. The quality of the data varied widely between boards. More than 500,000 data records were cleansed, processed and migrated as active practitioner records into the AHPRA database.

46. Despite these efforts to establish accurate and complete records for each registered practitioner and each profession, there were a range of issues with the accuracy and completeness of the inherited data which became apparent as AHPRA renewed the registration of practitioners. AHPRA has undertaken significant work on data quality, including a data audit and continues to ask practitioners to update their information to ensure the integrity of the data AHPRA holds. There is also an obligation under the National Law for registered practitioners to notify changes to their principal place of practice, address or name. However, there is no obligation to provide email addresses, although the majority of health practitioners do provide this information.

47. Communicating these changes effectively has been an important requirement of early implementation. AHPRA has worked closely with National Boards and professional associations to ensure that its systems operate effectively, that information is clear and accessible and that work continues to help all health practitioners understand and meet their new responsibilities under the National Scheme. One example of this is the *AHPRA Report* which is a new monthly e-bulletin to interested stakeholders providing information on the implementation of the National Scheme.

48. One particular area in which employers and professional groups can assist is by helping applicants to provide complete documentation. AHPRA receives a significant number of applications that are incomplete, which extends processing times and delays decisions. A conservative estimate is that more than 60% of applications are incomplete. AHPRA is

working to increase the rate of complete applications by raising awareness and understanding of the new registration requirements among applicants, practitioners and employers and making information and forms AHPRA provides as accessible and clear as possible.

(c) Impact of AHPRA processes and administration on health practitioners, patients, hospitals and service providers

49. Registration and renewal processes affect a wide range of stakeholders, including patients, health practitioners, employers and service providers. AHPRA is committed to delivering high-quality health practitioner regulation through efficient and effective processes and administration.

50. While the primary responsibility for achieving and maintaining current registration resides with each health practitioner, AHPRA recognises that the design and implementation of its operational systems and processes play an important enabling role.

51. Implementing change of the ambition, scope and complexity of the National Scheme, with significant transitional challenges, has led to some initial shortfalls in services to health practitioners. AHPRA has acknowledged these problems to the Ministerial Council and in public communications with professional stakeholder groups.

AHPRA has established a substantial work program to improve its service delivery to health practitioners as summarised in *Table Three: Work program to improve service delivery*.

Table Three: Work program to improve service delivery

Issue	Current response	Outcome
Contacting AHPRA - when health practitioners have contacted AHPRA through its 1300 419 495 number to ask questions about the new National Scheme, or their application for registration, too many people have waited too long for the answers they need.	AHPRA has: • boosted resources for customer service teams in each AHPRA state and territory office • changed processes so that phone calls are now being managed directly by experienced staff in our state and territory offices wherever possible • established new back-up and peak demand capacity to better respond to variations in demand • established a login facility on the AHPRA website so practitioners can check their renewal application has been received – and confirm they may continue to practise while their application is being assessed and finalised • started work on an online facility to enable practitioners and employers to check the progress of registration applications, and • initiated website changes so that the information needed by practitioners is much easier to find.	90% of calls answered within four minutes. 70% of emails answered within two days, and one trial state answering 90% of emails within two days.

Issue	Current response	Outcome
Lapsing of registrants – a small number of practitioners did not renew their registration on time because of issues receiving or processing renewal documentation	AHPRA has: • established a fast-track application process for registrants who miss the renewal deadline, to streamline their re-registration, with no late or application fees in the first year • undertaken data audits and data improvement projects to improve the quality of contact data about health practitioners • enhanced renewal communication to give practitioners more notice of the renewal timeframes and more reminders if they do not renew (see Appendix 8) • recognised where data problems had arisen, and implemented an administrative procedure to address this with affected health practitioners, and • initiated a system that allows practitioners to indicate if they intend not to renew their registration.	As at 12 April 2011, 134 practitioners have applied for consideration under the special administrative procedure to achieve continuity of registration. New processes expected to significantly reduce lapsing registrants.
Lack of practitioner awareness of new registration and renewal requirements	AHPRA is working with professional associations, employers, education providers and students to improve awareness and understanding of new registration standards, requirements and processes.	More complete applications received.
Delays in obtaining registration certificates	AHPRA is: • establishing an online process to enable registrants to request a registration certificate • providing pop-out wallet sized registration cards with renewals, and • establishing a communications campaign to employers about the online National Registers.	Online availability of registration certificates.
Develop and embed standard operating processes	AHPRA has established more consistent and rigorous business processes and systems.	Streamlined business processes, greater consistency and service improvements.

Issue	Current response	Outcome
Employer services	Employer services enable employers to check the registration details of their employees online and amend employer contact details, including: • conversion of pre-AHPRA registration numbers - the employee registration number search capacity provides a quick way to obtain the new AHPRA-issued registration number of each employed health practitioner • multiple registration checks through an online subscription service where an employer can request the publicly-available registration details of multiple practitioners (up to 50,000 practitioners at a time) using their new AHPRA registration numbers; this is designed for use by large-scale employers and other eligible organisations, and • employer outreach to help employers better understand the requirements of the National Scheme and actively work with applicants to increase the number of complete applications received by AHPRA. The service will include workshops with those who help applicants to prepare / submit applications for registration to improve awareness of new requirements.	Employers understand the requirements of the National Scheme and have easy access to the data they require from the National Registers.
Improved online services	AHPRA is: • implementing an application tracking process to enable applicants and employers to check the progress of applications online; this will improve communication and the flow of information to applicants and employers, and also decrease the number of phone and email queries about application progress • expanding the range of online services for practitioners, including establishing graduate online applications, which will facilitate early applications, earlier registration and an increased practitioner population sooner, and • simplifying forms where possible and encouraging uptake of online renewal services.	Practitioners and employers have easy access to information and services online.
Data improvements	AHPRA is continuing to work on data cleansing and improvements, including ensuring that practitioners' preferred addresses provide a sound basis for key registration activities, such as mailings, renewals and other communications.	AHPRA has high-quality data and a program of continuous data review and improvement

(d) Implications of any maladministration of the registration process for Medicare benefits and private health insurance claims

52. Under the National Scheme, individual health practitioners hold primary responsibility for renewing their registration. AHPRA and the National Boards are responsible for communicating registration and renewal requirements clearly to practitioners. Practitioners

are responsible for their own registration status and renewal. The National Law also makes practitioners responsible for advising AHPRA about changes in principal place of practice, address or name.

53. This is no different from the responsibilities under many of the previous regulatory arrangements with state and territory boards before 1 July 2010. Despite this, each year some practitioners do not renew on time. Historically, between 5% and 10% of practitioners did not renew their registration on time. Some of these practitioners deliberately opt out of registration: to retire, or take parental leave or for other reasons. Others forget to renew on time.

54. The National Law provides for automatic expiry of registration at the end of the one-month late period after a practitioner's registration is due to expire. Section 112(6)(b) of the National Law provides that the registration 'expires at the end of the day that is 12 months after the day it starts.' However, section 108(2)(a) of the National Law provides that 'the registration... is taken to continue in force until... the end of the day that is one month after the day the period of registration would, ... have ended'.

55. If a practitioner does not apply to renew his or her registration before, or within one month of their registration expiry date, that registration must lapse and the practitioner is no longer registered as a health practitioner. If a practitioner wishes to practise, he or she must submit a new application for registration. Practitioners whose registration has lapsed must, under the National Law, apply for registration again and meet the requirements of registration if they wish to stay in practice. Under the National Law, they are not able to simply renew or restore registration once their registration has lapsed.

56. This is different to the arrangements in place in some jurisdictions before 1 July 2010. For example, previously there was some flexibility to manage the re-instatement of practitioners who did not renew on time in some jurisdictions or an extended 'grace' period (for example, three months in Victoria). Under the National Law, the Boards and AHPRA have no discretion and the registration of a practitioner who does not submit his or her renewal within the one-month late period following their registration expiry date must lapse.

57. Since 1 July 2010, AHPRA has finalised approximately 370,000 renewal applications, with 345,000 renewals due by 31 March 2011. In the period between the start of the National Scheme and 31 March 2011, the registration of approximately 24,894 practitioners lapsed. This represents 7.2% of all practitioners who were due to renew their registration in that period. While comparative performance information is patchy, AHPRA has found no evidence that there are more practitioners not renewing their registration than was the case in the past.

58. In this cohort, AHPRA was not able to distinguish between practitioners who deliberately opted out and those who inadvertently did not renew their registration. AHPRA has now developed a system to permit practitioners to advise AHPRA if they do not intend to renew their registration.

59. Of those practitioners who did not renew their registration, around 3,800 have re-applied for registration in the same profession and registration type/division. This represents 1.1% of all practitioners who were due to renew by 31 March 2011. This number suggests that, of the practitioners whose registration lapsed, the vast majority intentionally did not renew their registration.

60. AHPRA accepts that, in some cases, health practitioners have inadvertently let their registration lapse or were unaware of their obligation to renew their registration when it expired. The data in relation to these cases has been carefully analysed. *Table Four: Contributing factors to the lapsing of practitioners' registration* outlines the common contributing factors and the steps taken by AHPRA to address these issues.

Table Four: Contributing factors to the lapsing of practitioners' registration

Contributing factor	Solution
Confusion about the new requirements of the National Scheme, compounded by early difficulties in contacting AHPRA to get questions answered	Raise awareness of the new requirements of the National Scheme Ensure that practitioners can contact AHPRA to obtain information and answers to questions
In the past, greater leniency about reinstating practitioners on state and territory registers; neither AHPRA nor the National Boards have any powers of reinstatement under the National Law	Improve communication about renewal process and deadlines Provided fast-track application process and administrative procedure where practitioners inadvertently do not renew
Changes in renewal dates as a result of aligning all health practitioners to nationally-consistent renewal dates	Improve communication about renewal process and deadlines
Unfamiliar with registration correspondence coming from AHPRA, rather than previous Boards	Raise awareness about correspondence coming from AHPRA Improve communication about renewal process and deadlines
In a small number of cases, incomplete or inaccurate contact details	Improve data quality Administrative process put in place to correct any problems resulting

Fast-track procedure

61. AHPRA has worked with each of the National Boards to establish a fast-track application process for registrants whose registration has lapsed but who wish to remain in practice. This fast-track process is open for one month after the end of the late period. In the first year of the National Scheme, there are no additional registration fees for the fast-track registration process.

62. Because these practitioners have been registered until very recently, the fast-track process does not require proof of identity; does not require verification of qualifications (if this was recorded as part of previous registration); does not require verification of English language skills; and does not require registration history or work history. The process does require practitioners to make declarations about their continuing professional development and criminal history.

63. These applications are usually finalised within 48 to 72 hours of receipt of a complete application. However, if the practitioner has made an adverse criminal history declaration, AHPRA believes it is in the public interest to complete the criminal history review process, even when this may extend the processing time beyond 48 to 72 hours.

64. To apply using the fast-track process, practitioners can access the AHPRA website 'fast-track application'. This is only open for practitioners whose registration lapsed because they did not renew on time. To ensure public safety, it is not available to practitioners who have not been registered previously.

Administrative Procedure

65. In the initial renewal periods under the National Scheme, AHPRA has had to rely on practitioner address data received from previous state and territory boards. In a small number of cases, these data were not accurate or complete.

66. A special administrative procedure has been approved by the Agency Management Committee to address these one-off transition issues. The administrative procedure applies to the small numbers of practitioners who missed the renewal deadline and who state that they did not receive a renewal notice or whose application was not received by AHPRA and processed in a timely way.

67. AHPRA has recently sent a letter to practitioners who accessed the fast-track process as a result of their registration expiring in November and December 2010. This letter advises them of the administrative procedure and advises them to submit a statutory declaration if they faced administrative difficulties in renewing their registration. As of 12 April 2011, AHPRA has received 134 such statutory declarations out of 1935 letters sent.

68. Following receipt and consideration of this information, it may be possible to establish a continuity of registration status for these practitioners. In these cases, AHPRA will adjust the date of the practitioner's new registration so that it begins immediately after his or her previous registration lapsed.

69. Any adjustment to these registration dates may have implications for the practitioners and their patients related to payment of Medicare Benefits and other issues. AHPRA has worked with Medicare Australia to explain the administrative procedure so that Medicare Australia is able to respond to any Medicare-related queries from practitioners. It is a matter for Medicare Australia to deal with any practitioner issues in relation to Medicare entitlements.

(e) Legal liability and risk for health practitioners, hospitals and service providers resulting from any implications of the revised registration process

70. Under the National Law, as in previous state and territory registration schemes, individual practitioners are responsible for renewing their registration on time each year. In the past, between 5% and 10% of practitioners did not renew their registration.

71. One of the key changes to the registration of health practitioners under the National Law is the automatic expiry of registration. This occurs at the end of the one-month late renewal period, after registration expires. This was not the case in some jurisdictions before the National Scheme, when different arrangements were in place under previous legislation. For example, in some jurisdictions, a practitioner was taken to continue to hold registration until the regulatory authority decided that the practitioner was no longer registered. In others, the state or territory legislation allowed a three-month grace period and the restoration of registration, rather than requiring a new application. In these jurisdictions, a failure to renew registration on time would not have resulted in automatic lapsing of registration. AHPRA and the National Boards have no such discretion under the National Law.

72. The National Law creates an offence for a person who knowingly or recklessly holds themselves out as a registered health practitioner. Therefore, a practitioner who inadvertently fails to renew registration and continues to practise his or her profession is highly unlikely to be found by a court to be in contravention of the National Law.

73. Professional indemnity insurance policies held by some practitioners may limit the liability of the insurer, or exclude coverage entirely, in circumstances when the practitioner has engaged in unregistered practice. While AHPRA is not responsible for the coverage maintained by practitioners, AHPRA has sought to mitigate this risk by communicating with practitioners, professional associations and employers to remind practitioners of their responsibility to renew their registration. AHPRA has also used the administrative procedure outlined earlier in this submission to establish continuity of registration in appropriate circumstances.

74. The National Law introduced many changes that affect health practitioners. To help health practitioners adapt to the National Scheme, AHPRA has made significant efforts to make information about registration renewal and registration standards widely available. It has done this by providing information directly to practitioners when this is possible, as well as indirectly through professional associations, employers, industrial associations and the media. Some National Boards have published and distributed newsletters to registrants, including the Medical Board of Australia which mailed a hard-copy newsletter to every practitioner in September/October 2010, as well as publishing frequent updates on its website. AHPRA has implemented a 'fast-track' registration process to permit a practitioner to re-apply for registration if he or she did not renew on time and intends to continue to practise.

Relationship between AHPRA and Medicare Australia

75. AHPRA has no direct role in determining eligibility for Medical Benefits Scheme (MBS) payments or private health insurance claims, although eligibility is linked to registration as a health practitioner. Medicare determines eligibility for MBS payments under Medicare legislation. Eligibility for private health insurance claims is often linked to Medicare eligibility. AHPRA shares health practitioner data with Medicare Australia, as authorised by the National Law, as a public safeguard to ensure unregistered practitioners do not have access to Medicare entitlements.

76. AHPRA has worked closely with Medicare Australia in the implementation of the National Scheme. This work has included advice about the provision of data on registration status and issues related to how and when those data may best be used. At all times, AHPRA has operated in accordance with the National Law.

77. AHPRA does not consider that there has been maladministration of the registration process. It has continued to work with Medicare Australia to address renewal issues which may have implications for Medicare benefits.

(f) Liability for financial and economic loss incurred by health practitioners, patients and service providers resulting from any implications of the revised registration process

[Medicare issues are addressed in item (d) earlier in this submission]

78. AHPRA has worked with Medicare Australia to minimise disruption to patients and health practitioners that may arise from the changed requirements of the National Law, specifically the provisions related to lapsed practitioners. AHPRA provides Medicare with a list of practitioners whose registration has lapsed. Under procedures agreed between AHPRA and Medicare, Medicare contacts practitioners who are no longer registered and whose patients may no longer be entitled to a rebate. AHPRA also writes to these health practitioners. Practitioners can apply through the fast-track process if they wish to return to the National Register.

79. AHPRA has established a special administrative procedure to address any one-off transition issues in relation to practitioners who missed the renewal deadline and who state that they did not receive a renewal notice or whose application was not received by AHPRA and processed in a timely way. See paragraph 65.

(g) Response times to individual registration enquiries

80. When the National Scheme began, there was a new law, a new organisation, new staff, new processes and new requirements for over half a million health practitioners. AHPRA had anticipated a large number of queries, and had established a 1300 local call number,11 websites (for AHPRA and each of the National Boards) and an online enquiry form. However, the volume of phone and email questions in the initial phase of the National Scheme exceeded expected demand. AHPRA has acknowledged that, in the first few months, too

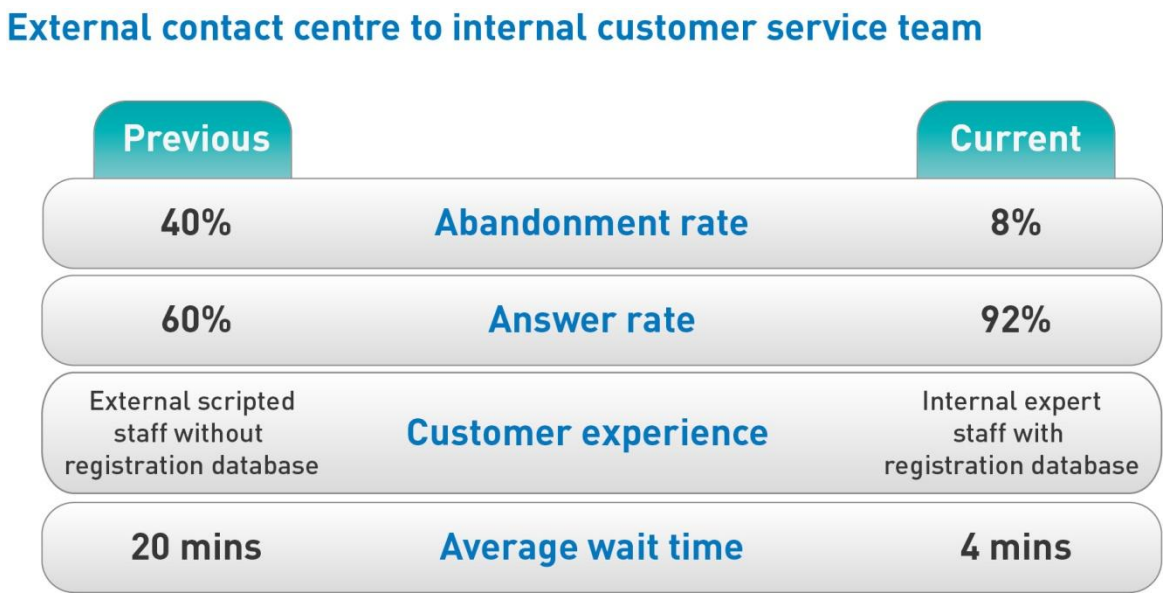
many people contacting AHPRA waited too long to speak with someone who could provide the answers they needed.

81. AHPRA has now established new systems and processes that are responding to this demand much more effectively. Because of the large volume of calls, initially telephone enquiries were handled by an external contact centre, which responded using standard scripts and without access to AHPRA's computerised registration system. This meant that they could deal effectively with basic queries, but any complex matters or advice about individual applications needed to be dealt with by the AHPRA state or territory office.

82. AHPRA has now brought its telephone handling function in-house, so that experienced staff members, within each of our state and territory offices with access to the computerised registration system, respond directly to calls. This means that the individual queries of health practitioners are able to be dealt with far more effectively and quickly. We have also increased the staffing of our customer service teams in each state and territory office to provide a capacity of managing up to 3000 phone calls per day.

83. The improvement in this service is illustrated by *Diagram Five: External contact centre to internal customer service team.* These data show sustained improvements in AHPRA's call handling, reduced termination of calls by callers and decreased wait times.

84. AHPRA has also done extensive modelling to better anticipate surges in demand, for example, around peak renewal periods. A risk mitigation plan is also being developed to provide back-up capacity on demand.



* Abandonment rate is the percentage of calls that are terminated after the threshold waiting time (for AHPRA 90 seconds) and before a customer service officer answers.

Diagram Four: External contact centre to internal customer service team performance

85. Responding to telephone enquiries is not always straightforward. AHPRA receives a huge range of queries, ranging from simple questions such as status of a registration application through to very complex questions about eligibility for registration which cannot be answered without research and consultation. All National Boards have extensive ongoing work plans to develop appropriate and consistent guidance for their profession. Improvements have also been made to the AHPRA website so that the information is easier to find.

(h) AHPRA's complaints handling processes

86. AHPRA has interpreted this reference as meaning how AHPRA deals with administrative complaints about the entities in the National Scheme rather than its responsibilities for dealing with notifications about health practitioners.

87. AHPRA and the National Boards are committed to transparency and accountability in all their functions, as well as delivering high standards of service. AHPRA, together with all National Boards, have adopted a *Complaint Handling Policy and Procedure*[3] (the Complaints Policy). This formalises a process through which dissatisfied applicants and practitioners can have their concerns about AHPRA or the National Boards fairly considered and addressed. The Complaints Policy was developed to provide this mechanism and has been in effect since 14 September 2010.

88. Under the Complaints Policy, any person who believes he or she has been subjected to conduct or behaviour which falls short of the standards expected of AHPRA or a National Board can make a complaint. AHPRA takes complaints seriously and recognises the benefit of investigating complaints in enabling problems to be identified and rectified so that service standards and delivery can be improved.

89. Complaints officers have been appointed in each AHPRA state and territory office and training has been provided so AHPRA is better equipped to investigate complaints and take appropriate action. Further, AHPRA is equipped to record and track complaints received so that it can identify common themes and address the underlying causes, which will be reported routinely to the Agency Management Committee and the National Boards.

90. AHPRA has analysed complaints to identify systemic issues. One issue which has been identified is the risk to practitioners who fail to submit an application before their registration expires. To mitigate these risks, AHPRA has developed a communication strategy, and developed the fast-track re-application process to permit practitioners to return to the register as soon as possible (as outlined at item (d) earlier in this submission).

The National Health Practitioners Ombudsman

91. The office of the National Health Practitioners Ombudsman is created by the National Law to undertake ombudsman functions under the *Ombudsman Act 1976* (Cth) (the Ombudsman Act), tailored for the National Scheme.

92. AHPRA works closely and collaboratively with the Health Practitioners Ombudsman. The primary role of the Health Practitioners Ombudsman is to receive complaints and help people who believe they may have been treated unfairly in administrative processes by the agencies within the National Scheme.

(i) budget and financial viability of AHPRA

93. AHPRA is funded solely by the registration and renewal fees paid by health practitioners. There is no ongoing government funding or subsidies, as existed in some jurisdictions before the commencement of the National Scheme.[4] AHPRA is keeping under close review whether it has all the resources it needs to effectively and efficiently manage the National Scheme. This is because the first year is a transitional year and there are a number of one-off costs associated with decommissioning of previous boards, transition and implementation.

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[3] The Complaint Handling Policy and Procedure is available at http://www.ahpra.gov.au/About-AHPRA/Complaints.aspx

[4] The only ongoing subsidy is for health practitioners in New South Wales where there is a subsidy in relation to the costs of the co-regulatory model with the Health Care Complaints Commission. In the first year of the National Scheme, this has meant that practitioners with a primary practice address in NSW have received a rebate on their national fee.

94. In some cases, transition and implementation costs have been higher than expected. There have been substantial costs involved in establishing AHPRA as a new national organisation responsible for implementing the National Scheme. There have also been substantial costs in decommissioning previous state and territory boards. However, AHPRA expects that it will be possible to realise efficiencies over time.

95. Participating jurisdictions and the Commonwealth funded a significant proportion of the costs associated with the implementation of the National Scheme. In addition, an agreed proportion of reserves held by the previous state and territory boards was used to support implementation. Certain funds from the early transfer of reserves held on behalf of National Boards were used to cover some of the implementation costs, particularly accommodation and fit out costs, as agreed with the Boards. Overall, reserves brought into the National Scheme from previous regulatory authorities have been less than expected.

96. In the first year, AHPRA has inherited registration renewal dates for health practitioners that have differed across states and territories, even within the same profession. Effectively, it will take up to 17 months before the new national fee can be applied uniformly to all registrants. For example, in Queensland the renewal cycle was July to June for most professions and practitioners registered in the previous scheme in June 2010 with the funds transferred to AHPRA as a pre-payment on 1 July 2010. However, these practitioners paid lower fees levied by boards before the National Scheme was introduced.

97. If the National Scheme requires more resources, additional revenue can only be raised by increasing the registration fees paid by health practitioners, in agreement with the National Boards. In most cases, it is not expected that fees should increase by more than the inflation rate on an annual basis. AHPRA and the National Boards have agreed to advise the Ministerial Council of any proposed fee increase above the inflation rate, on the basis of a business case.

98. Registration fees are set according to the principles established by the National Law and agreed with the Ministerial Council. One of the guiding principles of the National Scheme is that the 'fees required to be paid ... are to be reasonable having regard to the efficient and effective operation of the scheme'[5]. National fees must be set to ensure there is no cross-subsidisation between health professions.

99. AHPRA is also working with the National Boards to build reserves and provide adequate provisioning, for example, for the costs of legal proceedings in relation to individual practitioners. A key issue for the National Scheme is to carefully manage risk associated with notifications about the health, performance or conduct of health practitioners, including those most serious cases leading to Tribunal hearings. Under the previous system, in which there was some government assistance or funding for major legal cases involving health practitioners, no additional government funding is available to manage these cases under the National Law. The National Scheme also meets many of the costs of Tribunals in states and territories.

100. The National Law establishes a set of financial management responsibilities for AHPRA and National Boards. These include a requirement to submit audited financial statements to the Ministerial Council annually. The Victorian Auditor-General's Office has been appointed as AHPRA's auditor with the agreement of all jurisdictions. Further, the financial statements are included in AHPRA's annual report to the Ministerial Council, which is to be tabled in the Parliament of each participating jurisdiction and the Commonwealth.

Conclusion

101. Introducing the National Registration and Accreditation Scheme was visionary and ambitious. Despite the challenges of the early implementation phase, the benefits are now being realised. Australians can be assured that the National Scheme has patient and public safety at its heart. For the first time, there are nationally-consistent standards that all practitioners must meet before they are registered to practise. The framework provided by the National

[5] Schedule Part 1 Preliminary Section 3(3)(b) of the National Law

Law is robust and designed for public protection. Registration and practice across geographic borders in Australia is no longer an issue. Boards have consistent expectations of practitioners throughout the nation. There is collaboration between National Boards about matters of common interest and profession-specific focus on issues that require this.

102. Governments deserve credit for establishing and enabling a bold National Scheme that strikes the delicate balance between public safety and supply of a flexible and qualified health workforce. The professions deserve thanks for engaging with the new National Scheme, for working with AHPRA and the National Boards through the early implementation phase and for their commitment to realising the lasting benefits of national registration.

103. There are well-understood and distinct phases in the development and growth of all organisations, not least those with roles as complex as AHPRA. In organisational development terms, and as evidenced by the data in this submission, AHPRA and the National Scheme have now moved through the immediate start-up or implementation phase into a period of consolidation. There is no doubt that the benefits of national registration are being realised with the ongoing collaboration and support of the many stakeholders in the community and health sector whose needs the National Scheme ultimately serves.

Appendix 1

Number of practitioners by profession and by state and territory (nominated by the practitioner as their principal place of practice).

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Other*	Total
Chiropractor	57	1,460	21	682	347	42	1,149	460	108	**4,326**
Dental practitioner	330	5,584	119	3,528	1,571	319	4,136	2,069	499	**18,155**
Medical practitioner	1,715	27,798	936	16,971	6,922	2,033	21,353	8,241	2,015	**87,984**
Midwife	18	324	11	224	308	7	623	166	79	**1,760**
Nurse	4,379	79,004	2,867	54,415	26,987	7,497	76,598	28,240	8,874	**288,861**
Nurse and midwife	735	14,447	591	7,645	2,653	727	10,389	3,242	326	**40,755**
Optometrist	73	1,498	29	913	216	82	1,096	339	183	**4,429**
Osteopath	34	513	2	142	28	39	694	55	85	**1,592**
Pharmacist	405	8,104	177	4,992	1,834	606	6,308	2,826	586	**25,838**
Physiotherapist	425	6,536	138	4,105	1,827	382	5,482	2,649	642	**22,186**
Podiatrist	44	911	12	583	346	84	1,087	346	26	**3,439**
Psychologist	769	9,899	200	5,033	1,423	502	7,585	2,973	315	**28,699**
Total	**8,984**	**156,078**	**5,103**	**99,233**	**44,462**	**12,320**	**136,500**	**51,606**	**13,738**	**528,024**

* In some instances AHPRA does not have a record of a practitioner's principal place of practice. This may be because the practitioner maintains registration in Australia while working overseas.

Appendix 2

Summary of national legislation for the National Registration and Accreditation Scheme and introduction of the *Health Practitioner Regulation National Law Act* (the National Law) as in force in each state and territory

Jurisdiction	Legislation - national adoption and corresponding laws	Timing
Queensland	• *Health Practitioner Regulation National Law Act 2009* (Act B) gained Royal Assent on 3 November 2009; commenced 1 July 2010 • *Consequential Amendments – the Health Legislation (Health Practitioner Regulation National Law) Amendment Act 2010 – gained Royal Assent on 21 April 2010; commenced 1 July 2010*	Joined on 1 July 2010
New South Wales	• *Health Practitioner Regulation Act 2009 gained Royal Assent on 19 November 2009; commenced 1 July 2010* • *Health Practitioner Regulation Amendment Act 2010 (complaints handling and consequential amendments) was passed by both Legislative Assembly and Legislative Council on 8 June 2010, gained Royal Assent on 15 June 2010; commenced 1 July 2010*	Joined on 1 July 2010
Victoria	• *Health Practitioner Regulation National Law (Victoria) Act 2009* gained Royal Assent on 8 December 2009; commenced 1 July 2010 • *Consequential* amendments – the *Statute Law Amendment (National Health Practitioner Regulation) Act 2010* – gained Royal Assent on 30 March 2010; commenced 1 July 2010	Joined on 1 July 2010
Australian Capital Territory	• *Health Practitioner Regulation National Law (ACT) Act 2010* (adoption and consequentials) passed on 16 March 2010 and as such became a law of the ACT at that time (no Royal Assent required); commenced 1 July 2010	Joined on 1 July 2010
Northern Territory	• *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (adoption and consequentials) gained assent on 17 March 2010; commenced 1 July 2010 • *Consequential* amendments Bill – the *Health Practitioner (National Uniform Legislation) Implementation Act 2010* – gained assent on 20 May 2010; commenced 1 July 2010	Joined on 1 July 2010
Tasmania	• *Health Practitioner Regulation National Law (Tasmania) Act 2010* and *Health Practitioner Regulation National Law (Tasmania) (Consequential Amendments) Act 2010* passed on 17 June 2010, gained Royal Assent on 25 June 2010; commenced 1 July 2010	Joined on 1 July 2010
South Australia	• *Health Practitioner Regulation National Law (SA) Act 2010* (adoption & consequentials) passed on 29 June 2010, with Royal Assent and proclamation on 1 July 2010; commenced 1 July 2010	Joined on 1 July 2010
Western Australia	• *Health Practitioner Regulation National Law (WA) Act 2010* (corresponding law) passed on 19 August 2010, gained Royal Assent on 30 August 2010, to commence on proclamation • *proclaimed* on 18 October 2010	Joined on 18 October 2010
Commonwealth	• *Health Practitioner Regulation (Consequential Amendments) Act 2010* gained Royal Assent 31 May 2010, to commence on proclamation. • NB Commonwealth Bill makes consequential amendments to support implementation of the National Scheme; not required to have adoption law	Consequential amendments to take effect on proclamation.

Appendix 3

State and territory registration legislation and registration authorities for the 10 health professions in the National Scheme before commencement of the National Registration and Accreditation Scheme

Jurisdiction	Legislation (repealed unless otherwise indicated)	Registration Authority
Queensland	*Chiropractors Registration Act 2001* *Chiropractors Registration Regulation 2002*	Chiropractors Board of Queensland
	Dental Practitioners Registration Act 2001 *Dental Practitioners Registration Regulation 2002*	Dental Board of Queensland (including the regulation of dental auxiliaries)
	Dental Technicians and Dental Prosthetists Registration Act 2001 *Dental Technicians and Dental Prosthetists Registration Regulation 2002*	Dental Technicians & Dental Prosthetists Board of Queensland* *Note: Queensland's Dental Technicians Board continues to regulate dental technicians under the renamed *Dental Technicians Registration Act 2001* and *Dental Technicians Registration Regulation 2002*
	Medical Practitioners Registration Act 2001 *Medical Practitioners Registration Regulation 2002* *Medical Board (Administration) Act 2006*	Medical Board of Queensland Office of the Medical Board of Qld
	Nursing Act 1992 *Nursing Regulation 2005*	Queensland Nursing Council
	Optometrists Registration Act 2001 *Optometrists Registration Regulation 2001*	Optometrists Board of Queensland
	Osteopaths Registration Act 2001 *Osteopaths Registration Regulation 2002*	Osteopaths Board of Queensland
	*Pharmacists Registration Act 2001** *Pharmacists Registration Regulation 2001* *Note: Queensland continues to regulate pharmacy ownership via the renamed *Pharmacy Business Ownership Act 2001*	Pharmacists Board of Queensland
	Physiotherapists Registration Act 2001 *Physiotherapists Registration Regulation 2001*	Physiotherapists Board of Queensland

Jurisdiction	Legislation (repealed unless otherwise indicated)	Registration Authority
	Podiatrists Registration Act 2001 *Podiatrists Registration Regulation 2002*	Podiatrists Board of Queensland
	Psychologists Registration Act 2001 *Psychologists Registration Regulation 2002*	Psychologists Board of Queensland
New South Wales	*Chiropractors Act 2001* *Chiropractors Regulation 2007*	Chiropractors Registration Board
	Dental Practice Act 2001 *Dental Practice Regulation 2004*	Dental Board
	Dental Technicians Registration Act 1975 *Dental Technicians Registration Regulation 2008*	Dental Technicians Registration Board* Note: Board registered both dental technicians and dental prosthetists
	Medical Practice Act 1992 *Medical Practice Regulation 2008*	New South Wales Medical Board
	Nurses and Midwives Act 1991 *Nurses and Midwives Regulation 2008*	Nurses and Midwives Board
	*Optical Dispensers Act 1963** *Optical Dispensers Regulation 2007* * Note: NSW no longer regulates optical dispensers; this profession is not one regulated under the National Scheme	Optical Dispensers Licensing Board
	Optometrists Act 2002 *Optometrists Regulation 2004*	Optometrists Registration Board
	Osteopaths Act 2001 *Osteopaths Regulation 2007*	Osteopaths Registration Board
	Pharmacy Practice Act 2006 *Pharmacy Practice Regulation 2008*	Pharmacy Board of New South Wales
	Physiotherapists Act 2001 *Physiotherapists Regulation 2008*	Physiotherapists Registration Board
	Podiatrists Act 2003 *Podiatrists Regulation 2005*	Podiatrists Registration Board

Jurisdiction	Legislation (repealed unless otherwise indicated)	Registration Authority
	Psychologists Act 2001 *Psychologists Regulation 2008*	Psychologists Registration Board
Victoria	*Health Professions Registration Act 2005* *Health Professions Registration Regulations 2007*	Chiropractors Registration Board of Victoria
		Dental Board of Victoria * * Note: Victorian dental prosthetists were registered by the Dental Board
		Medical Practitioners Board of Victoria
		Nurses Board of Victoria
		Optometrists Registration Board of Victoria
		Osteopaths Registration Board of Victoria
		Pharmacy Board of Victoria
		Physiotherapists Registration Board of Victoria
		Podiatrists Registration Board of Victoria
		Psychologists Registration Board of Victoria
Australian Capital Territory	*Health Professionals Act 2004** *Health Professionals Regulation 2004** * Note: The *Health Professionals Act 2004* has not been repealed as it continues to apply to veterinary surgeons and medical radiation scientists in the ACT. Likewise, the *Health Professionals Regulation 2004* continues to apply to these residual professions. However, Schedules 2 to 11 and Schedules 13 and 14 of the Regulation (which relate to the professions transferred to the National Scheme) have been repealed.	ACT Chiropractors and Osteopaths Board
		ACT Dental Board
		ACT Dental Technicians and Prosthetists Board
		ACT Medical Board
		ACT Nursing and Midwifery Board
		ACT Optometrists Board
		ACT Pharmacy Board
		ACT Physiotherapists Board
		ACT Podiatrists Board
		ACT Psychologists Board
Northern Territory	*Health Practitioners Act 2004** *Note: As of 1 July 2010, the *NT Radiographers Act*	Chiropractors and Osteopaths Board of the Northern Territory
		Dental Board of the Northern Territory

Jurisdiction	Legislation (repealed unless otherwise indicated)	Registration Authority
Note: Podiatrists, and dental prosthetists were not registered in the NT before the National Scheme was introduced	was repealed. Radiographers are currently regulated in the NT under the *Health Practitioners Act 2004*, so it has not yet been repealed.	Medical Board of the Northern Territory
		Nursing Board of the Northern Territory
		Optometrists Board of the Northern Territory
		Pharmacy Board of the Northern Territory
		Physiotherapists Registration Board of the Northern Territory
		Psychology Registration Board of the Northern Territory
South Australia	*Dental Practice Act 2001* *Dental Practice (Election) Regulations 2007* *Dental Practice (General) Regulations 2007*	Dental Board of South Australia* *Note: SA dental prosthetists were registered by the Dental Board
	Chiropractic and Osteopathy Practice Act 2005 *Chiropractic and Osteopathy Practice (Election) Regulations 2006* *Chiropractic and Osteopathy Practice (General) Regulations 2006*	Chiropractic and Osteopathy Board of South Australia
	Medical Practice Act 2004 *Medical Practice (Elections) Regulations 2005* *Medical Practice (General) Regulations 2005*	Medical Board of South Australia
	Nursing and Midwifery Practice Act 2008 *Nursing and Midwifery Practice Regulations 2009*	Nurses Board of South Australia
	Optometry Practice Act 2007 *Optometry Practice (Elections) Regulations 2007* *Optometry Practice (General) Regulations 2007*	Optometrists Board of South Australia
	Pharmacy Practice Act 2007 *Pharmacy Practice Regulations 2007*	Pharmacy Board of South Australia

Jurisdiction	Legislation (repealed unless otherwise indicated)	Registration Authority
	Physiotherapy Practice Act 2005 *Physiotherapy Practice (Election) Regulations 2006* *Physiotherapy Practice (General) Regulations 2006*	Physiotherapists Board of South Australia
	Podiatry Practice Act 2005 *Podiatry Practice (Election) Regulations 2006* *Podiatry Practice (General) Regulations 2006*	Podiatry Board of South Australia
	Psychological Practices Act 1973 *Psychological Practices Regulations 1996*	South Australian Psychological Board
Tasmania	*Chiropractors and Osteopaths Registration Act 1997* *Chiropractors and Osteopaths Registration (Fees) Regulations 2006* *Chiropractors and Osteopaths Registration Regulations 2003*	Chiropractors and Osteopaths Registration Board
	Dental Prosthetists Registration Act 1996 *Dental Prosthetists Registration (Fees) Regulations 2000*	Dental Prosthetists Registration Board
	Dental Practitioners Registration Act 2001 *Dental Practitioners Registration (Fees) Regulations 2002* *Dental Practitioners Registration Regulations 2005*	Dental Board of Tasmania
	Medical Practitioners Registration Act 1996 *Medical Practitioners Registration (Fees) Regulations 2008*	Medical Council of Tasmania
	Nursing Act 1995 *Nursing (Fees) Regulations 2007* *Nursing Regulations 2005*	Nursing Board of Tasmania
	Optometrists Registration Act 1994 *Optometrists Registration (Fees) Regulations 2005*	Optometrists Registration Board

Jurisdiction	Legislation (repealed unless otherwise indicated)	Registration Authority
	Pharmacists Registration Act 2001 * *Pharmacists Registration (Fees) Regulations 2003* *Note: The Tasmanian Pharmacy Authority continues to regulate pharmacy ownership via the renamed *Pharmacy Control Act 2001*	Pharmacy Board of Tasmania
	Physiotherapists Registration Act 1999 *Physiotherapists Registration (Fees) Regulations 2000*	Physiotherapists Registration Board of Tasmania
	Podiatrists Registration Act 1995 *Podiatrists Registration (Fees) Regulations 2009*	Podiatrists Registration Board of Tasmania
	Psychologists Registration Act 2000 *Psychologists Registration (Fees) Regulations 2006*	Psychologists Registration Board of Tasmania
Western Australia NB. WA joined the National Scheme on 18 October 2010	*Chiropractors Act 2005* *Chiropractors Regulations 2007*	Chiropractors Registration Board of Western Australia
	Dental Act 1939 *Dental Board Rules 1973* *Dental Board Elections Regulations* *Dental Charges Committee Regulations 1973*	Dental Board of Western Australia
	Dental Prosthetists Act 1985 *Dental Prosthetists Regulations 1986*	Dental Prosthetists Advisory Committee, Western Australia
	Medical Practitioners Act 2008 *Medical Practitioners Regulations 2008*	Medical Board of Western Australia
	Nurses and Midwives Act 2006 *Nurses and Midwives Regulations 2007* *Nurse Practitioners Code of Practice 2004* *Nurses Code of Practice 2000*	Nurses and Midwives Board of Western Australia
	Optometrists Act 2005 *Optometrists Regulations 2006*	Optometrists Registration Board of Western Australia

Jurisdiction	Legislation (repealed unless otherwise indicated)	Registration Authority
	Osteopaths Act 2005 *Osteopaths Regulations 2006*	Osteopaths Registration Board of Western Australia
	Pharmacy Act 1964 *Pharmacy Act Regulations 1976*	Pharmaceutical Council of Western Australia
	Physiotherapists Act 2005 *Physiotherapists Regulations 2006*	Physiotherapists Registration Board of Western Australia
	Podiatrists Act 2005 *Podiatrists Regulations 2006*	Podiatrists Registration Board of Western Australia
	Psychologists Act 2005 *Psychologists Regulations 2007*	Psychologists Board of Western Australia

Appendix 4

Membership of National Boards

Chiropractic Board of Australia

Dr Phillip Donato, appointed as Chair and a practitioner member from South Australia

Mrs Esther Alter, appointed as a community member

Dr Stephen Crean, appointed as a practitioner member from Tasmania

Dr Graham (Bevan) Goodreid, appointed as a practitioner member from Western Australia

Mr Peter Groves, appointed as a community member

Dr Geoffrey Irvine, appointed as a practitioner member from New South Wales

Dr Amanda-Jane Kimpton, appointed as a practitioner member from Victoria

Dr Mark McEwan, appointed as a practitioner member from Queensland

Ms Margaret Wolf, appointed as a community member

Dental Board of Australia

Dr John Lockwood, appointed as Chair and a practitioner member (dentist) from New South Wales

Ms Susan Aldenhoven, appointed as a practitioner member (dental hygienist) from South Australia

Mrs Jennifer Bishop, appointed as a practitioner member (dental therapist) from Queensland

Dr Carmelo Bonnano, appointed as a practitioner member (dentist) from the ACT

Dr Gerard Condon, appointed as a practitioner member (dentist) from Victoria

Mr Stephen Herrick, appointed as a community member

Mr Paul House, appointed as a practitioner member (dental prosthetist) from Tasmania

Dr Mark Leedham, appointed as a practitioner member (dentist) from the Northern Territory

Mr Peter Martin, appointed as a community member

Mr Michael Miceli, appointed as a community member

Dr John Owen, appointed as a practitioner member (dentist) from Western Australia

Mrs Myra Pincott, appointed as a community member

Medical Board of Australia

Doctor Joanna Flynn, Chair and a practitioner member from Victoria

Professor Belinda Bennett, appointed as a community member

Doctor Stephen Bradshaw, appointed as a practitioner member from the ACT

Doctor Erica (Mary) Cohn, appointed as a practitioner member from Queensland

Ms Prudence Ford, appointed as a community member

Doctor Fiona Joske, appointed as a practitioner member from Tasmania

Doctor Charles Kilburn, appointed as a practitioner member from the Northern Territory

Mr Paul Laris, appointed as a community member

Professor Mark (Ken) McKenna, appointed as a practitioner member from Western Australia

Doctor Trevor Mudge, appointed as a practitioner member from South Australia

Ms Sophia Panagiotidis, appointed as a community member

Associate Professor Peter Procopis, appointed as a practitioner member from New South Wales

Nursing and Midwifery Board of Australia

Ms Anne Copeland, appointed as Chair and a practitioner member (registered nurse and midwife)

Ms Gillie Anderson, appointed as a community member

Ms Angela Brannelly, appointed as a practitioner member (registered nurse and midwife)

Professor Elizabeth (Mary) Chiarella, appointed as a practitioner member (registered nurse)

Dr Lynette Cusack, appointed as a practitioner member (registered nurse)

Professor Denise Fassett, appointed as a practitioner member (registered nurse)

Mrs Lynne Geri, appointed as a practitioner member (enrolled nurse)

Ms Louise Horgan, appointed as a practitioner member (registered nurse)

Ms Mary Kirk, appointed as a practitioner member (registered nurse and midwife)

Dr Christine Murphy, appointed as a community member

Ms Heather Sjoberg, appointed as a community member

Ms Margaret Winn, appointed as a community member

Optometry Board of Australia

Mr Colin Waldron, appointed as Chair and a practitioner member from Queensland

Mr Ian Bluntish, appointed as a practitioner member from South Australia

Mr John Davis, appointed as a practitioner member from New South Wales

Ms Judith Dikstein, appointed as a community member

Ms Jane Duffy, appointed as a practitioner member from Victoria

Mr Derek Fails, appointed as a practitioner member from Tasmania

Mr Garry Fitzpatrick, appointed as a practitioner member from Western Australia

Ms Peta Frampton, appointed as a community member

Mr Lawson Lobb, appointed as a community member

Osteopathy Board of Australia

Dr Robert Fendall (Osteopath), appointed as Chair and a practitioner member from New South Wales

Dr Melissa Coulter (Osteopath), appointed as a practitioner member from the ACT

Ms Helen Egan, appointed as a community member

Ms Amanda Heyes, appointed as a practitioner member from Western Australia

Dr Luke Rickards (Osteopath), appointed as a practitioner member from South Australia

Dr Natalie Rutsche (Osteopath), appointed as a practitioner member from Queensland

Ms Karen Stott, appointed as a community member

Adjunct Professor Philip Tehan, appointed as a practitioner member from Victoria

Ms Belinda Webster, appointed as a community member

Pharmacy Board of Australia

Mr Stephen Marty, appointed as Chair and a practitioner member from Victoria

Mrs Rachel Carr, appointed as a practitioner member from Western Australia

Mr Trevor Draysey, appointed as a practitioner member from South Australia

Mr John Finlay, appointed as a community member

Ms Laila Hakansson Ware, appointed as a community member

Mr Ian Huett, appointed as a practitioner member from Tasmania

Mr William Kelly, appointed as a practitioner member from the ACT

Mr Timothy Logan, appointed as a practitioner member from Queensland

Mr Gerard McInerney, appointed as a practitioner member from New South Wales

Ms Karen O'Keefe, appointed as a community member

Ms Bhavini Patel, appointed as a practitioner member from the Northern Territory

Dr Rod Wellard, appointed as a community member

Physiotherapy Board of Australia

Mr Glenn Ruscoe, appointed as Chair and practitioner member from Western Australia

Ms Alison Bell, appointed as a practitioner member from South Australia

Mr Tim Benson, appointed as a community member

Dr Susan Brady, appointed as a community member

Ms Anne Deans, appointed as a practitioner member from New South Wales

Dr Charles Flynn, appointed as a practitioner member from Victoria

Mrs Kathryn Grudzinskas, appointed as a practitioner member from Queensland

Mrs Elizabeth Kosmala, appointed as a community member

Ms Joanne Muller, appointed as a community member

Ms Karen Murphy, appointed as a practitioner member from the ACT

Mr Paul Shinkfield, appointed as a practitioner member from Tasmania

Ms Philippa Tessmann, appointed as a practitioner member from the Northern Territory

Podiatry Board of Australia

Mr Jason Warnock, appointed as Chair and a practitioner member from Queensland

Mr Ebenezer Banful, appointed as a community member

Associate Professor Laurie Foley, appointed as a practitioner member from Western Australia

Mr Mark Gilheany, appointed as a practitioner member from Victoria

Mrs Anne-Marie Hunter, appointed as a community member

Ms Catherine Loughry, appointed as a practitioner member from South Australia

Ms Helen Matthews, appointed as a practitioner member from the ACT

Ms Margaret (Joan) Russell, appointed as a community member

Dr Paul Tinley, appointed as a practitioner member from New South Wales

Psychology Board of Australia

Professor Brin Grenyer, appointed as Chair and a practitioner member from New South Wales

Professor Alfred Allan, appointed as a practitioner member from Western Australia

Ms Antonia Dunne, appointed as a community member

Ms Kaye Frankcom, appointed as a practitioner member from Victoria

Mr Geoff Gallas, appointed as a practitioner member from the ACT

Professor Gina Geffen, appointed as a practitioner member from Queensland

Dr Shirley Grace, appointed as a practitioner member from the Northern Territory

Mrs Irene Hancock, appointed as a community member

Ms Fiona McLeod, appointed as a community member

Mr Christopher O'Brien, appointed as a community member

Ms Ann Stark, appointed as a practitioner member from Tasmania

Mr Radovic (Radek) Stratil, appointed as a practitioner member from South Australia

Appendix 5

Membership of Agency Management

Peter Allen, Chairperson

Mr Allen is Chair of the Agency Management Committee, and has been since March 2009.

Mr Allen is Deputy Dean of the Australia and New Zealand School of Government (ANZSOG), and Victoria's Public Sector Standards Commissioner. He joined ANZSOG after more than 20 years in the Victorian Public Service (VPS) during which time he held several positions including Under Secretary in the Department of Human Services; Victoria's Chief Drug Strategy Officer; Secretary of the Department of Tourism, Sport and the Commonwealth Games; Secretary of the Department of Education; Director of Schools; and Deputy Secretary, Community Services.

Between 2001 and 2003, Mr Allen was a Vice-Chancellor's Fellow at the University of Melbourne, and prior to joining the public service, he was Director of Social Policy and Research at The Brotherhood of St Laurence.

Mr Allen's other roles include Director of the Victorian Institute of Forensic Medicine; National Vice President, and Victorian Vice-President of the Institute of Public Administration (Australia). He has previously been a member of the Councils of both the University of Melbourne and Deakin University.

Mr Allen holds a Bachelor of Arts and a Diploma in Journalism and was awarded a Centenary Medal in 2001.

Professor Constantine (Con) Michael AO

Professor Michael was appointed to the Agency Management Committee in March 2009 as a member with expertise in health, education and training.

Professor Michael is the Consultant Medical Advisor for St. John of God Health Care Inc. and Emeritus Professor of Obstetrics and Gynaecology at the University of Western Australia.

Professor Michael is the immediate past President of the Medical Board of Western Australia and the current Chair of the State Board (WA) of the Medical Board of Australia. Professor Michael is also a Director of the Australian Medical Council, a member of various State and National Medical Committees and Chair of the St John of God National Ethics Committee and Chair of the Reproductive Technology Council of Western Australia. He is a Director and Governor of the University of Notre Dame Australia and Chair of its Advisory Board of the School of Medicine Fremantle.

Professor Michael holds a Bachelor of Medicine and Bachelor of Surgery (UWA), Doctor of Medicine (UWA) and Diploma of Diagnostic Ultrasound. He is a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (a past President) and Fellow of the Royal College of Obstetricians and Gynaecologists, London (a previous Sims Black Professor).

Among his numerous awards, Professor Michael was named an Officer of the Order of Australia (AO) in 2001 for service to medicine, particularly in the field of obstetrics and gynaecology, as a contributor to the administration of the profession nationally and internationally and medical education.

Professor Genevieve Gray

Professor Gray was appointed to the Agency Management Committee in March 2009 as a member with expertise in health, or education and training.

Professor Gray is Professor of Nursing and Scholar in Residence at the Queensland University of Technology (QUT), Professor Emeritus University of Alberta and Adjunct Professor at James Cook University. In recent years she has been a Nurse Scholar for the World Health Organization, Geneva,

and worked in Canada as a Professor of Nursing, Dean & Director, WHO Collaborating Centre in Nursing & Mental Health for the University of Alberta and the World Health Organization. She is currently Director of QUT's Vietnam Nursing Capacity Building Program.

Professor Gray was previously Inaugural Chair of the International Academic Nursing Alliance, a member of the Multidisciplinary Board of the International Council of Women's Health Issues and member of the Deans Council, General Faculties Committee and Health Sciences Council of the University of Alberta.

Professor Gray has a General Nursing Certificate, Midwifery Certificate, diplomas in Nursing Education and Advanced Nursing Studies, a Master of Science (Nursing) and a Distinguished Life Fellowship from the Royal College of Nursing Australia.

Mr Michael Gorton AM

Michael Gorton was appointed to the Agency Management Committee in March 2009 as a member with business and administrative expertise.

Mr Gorton is a commercial lawyer with considerable experience providing legal advice on medical registration, training, education and administrative practice. As a principal of Russell Kennedy Solicitors, he has significant experience in business management and administration. He is a Board member of the Victorian Equal Opportunity & Human Rights Commission and a Chair of the Code of Conduct Committee of Medicines Australia.

Mr Gorton is a former Chair of the Infertility Treatment Authority, is a Board member of Melbourne Health, and has extensive experience in governance for a wide range of organisations including health and ethics committees.

Mr Gorton holds a Bachelor of Laws and Bachelor of Commerce.

In 2004, Mr Gorton received the Member of the Order of Australia (AM) for community service, particularly to the UN Association, Greening Australia, Aboriginal reconciliation and equal opportunity.

Professor Merrilyn Walton

Professor Walton was appointed to the Agency Management Committee in March 2009 as a member with business and administrative expertise.

Professor Walton is Professor of Medical Education (patient safety) in the School of Public Health Faculty of Medicine, at the University of Sydney and Visiting Professor and Affiliate of the Buehler Center on Aging, Health and Society, Chicago, USA. She is a member of the University of Sydney Academic Board, the NSW Institute for Medical Education and Training and is a member of the Australian Health Ethics Committee (National Health and Medical Research Council).

Previously, she was the Commissioner for the Health Care Complaints Commission NSW. (1993-2000).

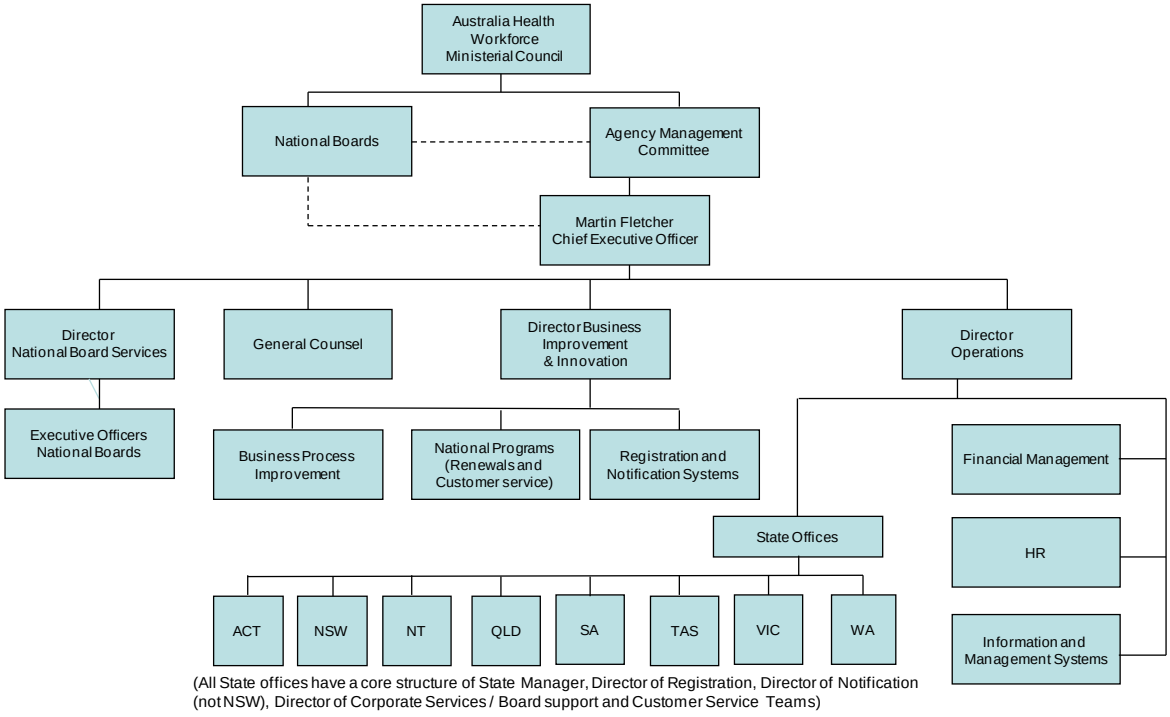
Professor Walton holds a Bachelor of Arts, Bachelor of Social Work, Masters of Social Work and Doctor of Philosophy.

Appendix 6


National Registration & Accreditation Scheme
Strategy 2011-2014
OUR VISION
A competent and flexible health workforce that meets the current and future needs of the Australian community
OUR MISSION
To regulate health practitioners in Australia in the public interest
OUR VALUES
In fulfilling our role:
• We act in the interest of public health and safety
• We work collaboratively to deliver high-quality health regulation
• We promote safety and quality in health practice
• Our decisions are fair and just
• We are accountable for our decisions and actions
• Our processes are transparent and consistent
KEY STRATEGIC PRIORITIES 2011-14
In accordance with the National Law and our values, we will:
1. Ensure the integrity of the National Registers
2. Drive national consistency of standards, processes and decision-making
3. Respond effectively to notifications about the health, performance and conduct of health practitioners
4. Adopt contemporary business and service delivery models
5. Engender the confidence and respect of health practitioners
6. Foster community and stakeholder awareness of and engagement with health practitioner regulation
7. Use data to monitor and improve policy advice and decision-making
8. Become a recognised leader in professional regulation
AHPRA
Australian Health Practitioner Regulation Agency

Appendix 7

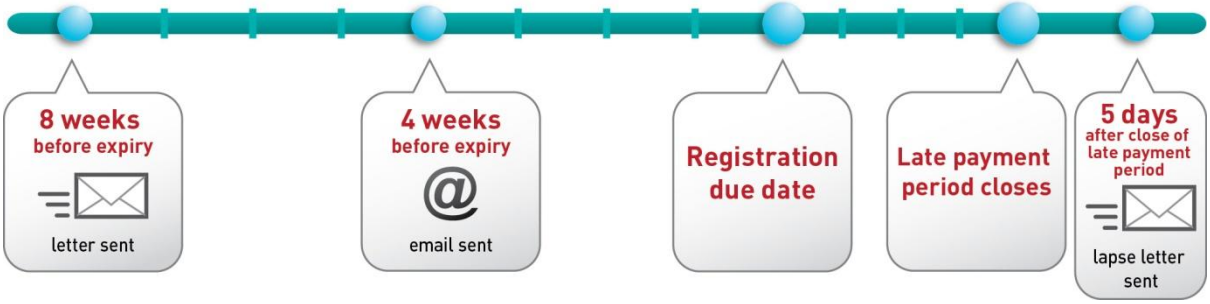
Australian Health Practitioner Regulation Agency
National Structure



(All State offices have a core structure of State Manager, Director of Registration, Director of Notification (not NSW), Director of Corporate Services / Board support and Customer Service Teams)

Appendix 8

Initial renewals notification under the National Law



Current renewals notification under the National Law