Australian Health Workforce Ministerial Council

(AHWMC)

Submission

Senate Finance and Public Administration References Committee

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

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Standards of safety and quality in the Australian health system

1. Australia's health system is recognised internationally for its high standards of quality and safety. Its processes and systems for ensuring that people providing health services are suitably qualified are comprehensive and robust, and focussed on protecting the safety and well-being of the Australian community.
2. Health practitioners in regulated professions must meet certain requirements before they are permitted to provide services in Australia. These requirements are designed to ensure high standards of quality and safety, and in some cases, will result in practitioners operating under a range of conditions, including under supervision and restrictions on area and/or scope of practice.

National Registration and Accreditation Scheme (NRAS) - Overview

3. The Australian Constitution provides that the power to regulate health professions resides with the states and territories not the Commonwealth.
4. The NRAS is a national scheme which has now been legislated in all states and territories. It commenced on 1 July 2010 in all jurisdictions except Western Australia, and on 18 October 2010 in Western Australia. NSW joined on a co-regulatory basis whereby complaints and performance issues continue to be dealt with on a state level.
5. NRAS is a single national registration and accreditation system for 10 health professions, namely medicine, nursing and midwifery, pharmacy, physiotherapy, psychology, osteopathy, chiropractic, optometry, dental and podiatry. Four further 'partially regulated' professions are due to join NRAS on 1 July 2012, namely Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupational therapy.
6. The objectives of the NRAS are to:
    - provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
    - facilitate workforce mobility across Australia;
    - facilitate the provision of high quality education and training of health practitioners;
    - facilitate the rigorous and responsive assessment of overseas trained health practitioners;
    - facilitate access to services provided by health practitioners in accordance with the public interest; and
    - enable the continuous development of a flexible, responsive and sustainable health workforce and enable innovation in the education of, and service delivery by, health practitioners.
7. NRAS is a profession-led scheme, which consists of a National Board for each of 10 regulated professions, supported administratively by the Australian Health Practitioner Regulation Agency (AHPRA) and overseen by the Australian Health Workforce Ministerial Council (AHWMC) in accordance with the *Health Practitioner Regulation National Law Act 2009.* The AHWMC is comprised of Health Ministers from all states and territories and the Commonwealth.
8. The greater consistency in registration and accreditation across states and territories under NRAS provides assurance to members of the public that all health practitioners are subject to the same high quality professional standards regardless of where the health service is accessed. If a health practitioner is deregistered or has conditions placed on the registration, this now automatically applies across all states and territories, as a result of the new national scheme.

9. The *Health Practitioner Regulation National Law Act 2009*, known as the National Law, provides for the full operation of NRAS. The legislative framework for NRAS is an "applied laws" model, meaning that one jurisdiction passes the law through its Parliament and other states and territories amend or introduce legislation to apply the law in their respective jurisdictions.

10. On 3 November 2009, Queensland, as the lead state, introduced the Health Practitioner Regulation National Law Act 2009 (Qld) which established new National Boards and detailed the substantive provisions for registration and accreditation. All states and territories, except Western Australia, introduced their legislation to apply the law in their jurisdictions. Western Australia enacted a corresponding law.

11. Under NRAS, there is a single National Board for each profession. The National Boards are independent of governments and are responsible for all matters relating to the registration of practitioners and for setting the standards for the profession. Boards are appointed by Ministers and are comprised of practitioner and consumer members. Some professions (dental, psychology, physiotherapy, medical and nursing and midwifery) have chosen to establish state, territory or regional offices of the National Board.

12. The National Boards are supported in their operations by AHPRA. AHPRA's operations are governed by the National Law and overseen by an Agency Management Committee. AHPRA is responsible for providing administrative support to the 10 national health practitioner boards, including managing the registration processes for health practitioners and students around Australia and publishing national registers of practitioners.

Role of Ministerial Council

13. While NRAS is led by the professions, and the National Boards are independent of governments, governments agreed to the importance of having a national scheme for quality of health workforce and therefore decided to oversee and invest in the establishment of a national scheme. NRAS however is run by the professions with an administrative agency and a management oversight committee appointed by the Australian Health Workforce Ministerial Council (AHWMC).

14. The AHWMC has an ongoing and defined role but had not intended or expected continued administrative involvement except at the 'lightest touch' level. Under the National Law, Ministers are responsible for approving registration and accreditation standards put forward by the National Boards, approval of specialist registration and approval of areas of practice for the purposes of endorsement. Ministers can only give directions to National Boards or the national agency under limited circumstances specified in the legislation.

History of NRAS

15. Prior to the introduction of NRAS, there were 85 separate health practitioner boards across the states and territories for the 10 professions that are currently covered by the national scheme, more than 65 different pieces of legislation and eight separate state and territory regulatory systems. This meant that there was limited consistency in the registration of health practitioners across the states and territories and there were incidences of health practitioners moving from one state to another to avoid scrutiny, potentially putting patients at risk. While there were some mutual recognition provisions in place for most professions, practitioners working across borders were still required to be registered and pay fees in all jurisdictions where they practised.

16. In December 2005, the Productivity Commission delivered a report on issues impacting on the health workforce including the supply of, and demand for, health workforce professionals. This report included proposed solutions to ensure the continued delivery of quality healthcare over the following 10 years. The report recommended that there should be a single national registration board for health professionals, as well as a single national accreditation board for health professional education and training.

17. On 14 July 2006, the Council of Australian Governments (COAG) agreed to establish a national registration scheme for health professionals and a national accreditation scheme for health education and training. As major decisions on some aspects of the scheme were still unclear as late as January 2008, and as a result of stakeholder feedback, final agreement by COAG on the structure of the scheme was not reached till March 2008 and the original implementation date of July 2008 was considered to be unachievable.

18. At the Australian Health Ministers' Conference (AHMC) in July 2007, it was agreed to establish a single national scheme, with a single national agency encompassing both the registration and accreditation functions.

19. Ongoing negotiations across jurisdictions and between the jurisdictions and the 10 health professions continued throughout 2007, with agreement being reached in a number of key areas. At the same time, an Intergovernmental Agreement (IGA) between the states and territories and the Commonwealth was developed and negotiated and agreed. On 26 March 2008, the COAG signed the Intergovernmental Agreement (IGA) to implement the NRAS by 1 July 2010. COAG allocated $19.8 million over 4 years for the implementation of NRAS.

20. On signing of the IGA, responsibility for implementation was passed to Health Ministers. A National Registration and Accreditation Implementation Project (NRAIP) team was established in May 2008, headed by Dr Louise Morauta, to work with all governments to develop and implement the NRAS. The NRAIP team led the development of legislation, engagement with stakeholders, and work to establish the national agency.

21. Under the applied laws model used for the implementation of NRAS, the Queensland Government was given responsibility for passing the legislation underpinning the NRAS. To implement the new scheme, legislation was introduced in the Queensland Parliament in two stages.

22. The first piece of legislation was introduced in the Queensland Parliament on 29 October 2008 (Bill A) and received Royal Assent on 25 November 2008. The *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (Act A) established the structure of the NRAS, including the new national agency, the Australian Health Practitioner Regulation Agency (AHPRA), the Australian Health Workforce Ministerial Council (AHWMC) and the National Boards.

23. The appointments of external accreditation authorities to exercise accreditation functions for the first 10 health professions were also made by AHWMC under Act A. The accreditation functions for the majority of professions were assigned before the 10 National Boards were appointed in September 2009, and all were in place before 1 July 2010. For the first 10 health professions, assignment of accreditation functions in most cases resulted in a continuation of arrangements that existed prior to the start of NRAS.

24. In September 2008, Health Ministers announced arrangements for a formal consultation process on the policy parameters. This consultation process was led by the NRAIP team in conjunction with the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee, a cross-jurisdictional committee of AHMAC. Following a meeting in May 2009, AHWMC acknowledged and welcomed the very high level of participation by consumers, practitioners and regulatory bodies in the consultation process noting that over 1,000 people attended forums around the country and over 650 written submissions were received in response to consultation papers issues in 2008 and 2009.

25. As a result of this consultation process and the feedback received, AHWMC agreed that a number of changes should be made, particularly in the areas of accreditation, the role of state bodies and complaints handling.

26. In March 2009, the Senate Community Affairs Legislation Committee undertook an initial inquiry into NRAS. It noted that changes to the original proposal had occurred as a result of the work undertaken by NRAIP. These changes were seen to respond to the concerns raised by the professions. Recommendations from this inquiry are at

Attachment B.

27. An Agency Management Committee was appointed by AHWMC in March 2009 to establish AHPRA.

28. In June 2009, prior to parliamentary consideration of the second piece of legislation, Bill B, AHWMC authorised the release of an exposure draft. During the consultation period, consultation forums were held in all jurisdictions as well as a national forum in Canberra to present and discuss the draft Bill. There were around 957 attendees at these forums and 568 submissions were received. In response to the consultations, Ministers agreed to consider making some changes to the scheme, particularly in relation to accreditation functions, arrangements for smaller jurisdictions, the protection of public interest, the inclusion of partially regulated professions, transition for practitioners in occasional practice and criminal history checks.

29. Bill B was introduced in the Queensland Parliament in August 2009 and received Royal Assent on 3 November 2009. This Bill repealed and replaced Act A.

30. On 31 August 2009, AHWMC appointed 108 inaugural members of the 10 National Boards. The appointments were made at this stage to enable the National Boards to begin preparatory work for the commencement of the new national scheme on 1 July 2010. These appointments followed a public consultation process on the size and composition of the boards.

31. The membership of the new boards drew heavily from the existing state and territory boards and among the 72 practitioner members appointed 66 were serving on state and territory registration boards, with 39 of these being the chair of those boards. Among the 36 community members, 34 were currently on state and territory registration boards. These appointments ensured the transition of necessary expertise to the new arrangements.

32. In December 2009, the newly appointed Chief Executive Officer of AHPRA, Mr Martin Fletcher, commenced work. Between January 2010 and February 2010, a senior management team was appointed to AHPRA and, upon passage of state and territory legislation, existing staff from state and territory boards transferred to the new agency.

33. Upon passage of the legislation, Bill B became the *Health Practitioner Regulation National Law Act 2009 (Qld)*, known as the National Law. The National Law details the substantive provisions for registration and accreditation and repealed and replaced the first tranche of legislation. Some of the matters covered by this legislation include:

    - registration arrangements;
    - complaints, conduct, health and performance arrangements;
    - accreditation arrangements;
    - privacy and information sharing arrangements.

34. The remaining states and territories (with the exception of Western Australia) then passed legislation applying the National Law as a law of their own jurisdiction commencing on 1 July 2010. NSW joined the Scheme on a co-regulatory basis. This means that while NSW adopted the National Law in relation to registration and accreditation functions, it has retained state-based procedures (through state professional councils and the independent Health Care Complaints Commission) for conduct, performance and health issues.

35. The Western Australian Parliament's scrutiny of the Health Practitioner Regulation National Law (WA) Bill 2010 (National Law) resulted in WA's later entry into NRAS (October 2010) and several amendments were made to the National Law during the Parliamentary debates. The amendments applicable to WA included, but were not limited to:

    - Mandatory reporting exemption for the treating practitioner;

- Inclusion of physician as a protected title;
- Amendment to the guiding principles to delete "and are of an appropriate quality" and replace with "consistent with best practice principles"; and
- The disallowance provisions of the National Law do not apply to WA.

36. Dates of passage of the legislation through the various Parliaments are shown in Table 1. Key steps in the development and implementation of NRAS is at Attachment A.

37. The Commonwealth is not required to apply the National Law because under the Constitution the regulation of health practitioners is the responsibility of states and territories. However, the Commonwealth introduced a Bill on 24 February 2010 (Bill C) to make consequential and transitional amendments to the *Health Insurance Act 1973* to streamline Medicare processes and align the Commonwealth legislation with the National Law.

38. On 25 February 2010, Bill C was referred to the Senate Community Affairs Legislation Committee for inquiry. This inquiry recommended that AHPRA clarify definitions on its website, and that the Bill be passed. Recommendations from this Committee inquiry are at Attachment C.

Table 1: Legislation passed in the States and Territories

Queensland	Health Practitioner Regulation National Law Act 2009 - gained Royal Assent on 21 April 2010 (joined NRAS 1 July 2010)
New South Wales	Health Practitioner Regulation Act 2009 - gained Royal Assent on 15 June 2010 (joined NRAS 1 July 2010)
Victoria	Health Practitioner Regulation National Law (Victoria) Act 2009 - gained Royal Assent on 30 March 2010 (joined NRAS 1 July 2010)
Australian Capital Territory	Health Practitioner Regulation National Law (ACT) Act 2010 - passed on 16 March 2010 (no Royal Assent required) (joined NRAS 1 July 2010)
Northern Territory	Health Practitioner Regulation (National Uniform Legislation) Act 2010 - gained assent on 17 March 2010 (joined NRAS 1 July 2010)
Tasmania	Health Practitioner Regulation National Law (Tasmania) Act 2010 - gained Royal Assent on 25 June 2010 (joined NRAS 1 July 2010)
South Australia	Health Practitioner Regulation National Law (South Australia) Act 2010 - gained Royal Assent 1 July 2010 (joined NRAS 1 July 2010)
Western Australia	Health Practitioner Regulation National Law (WA) Act 2010 - gained Royal Assent 30 August 2010 (joined NRAS 18 October 2010)

39. The Commonwealth's *Health Practitioner Regulation (Consequential Amendments) Act 2010* received Royal assent on 30 March 2010.

40. The amendments to the Commonwealth legislation (and associated regulations) will

commence on a date to be proclaimed, once data processes and systems used by both AHPRA and Medicare Australia are fully aligned. Until that time, existing arrangements will continue to apply.

41. The NRAS, including the full functions of AHPRA, commenced on 1 July 2010 in all states and territories except Western Australia, where the full operation of the scheme commenced on 18 October 2010.

NRAS since 1 July 2010

42. On 1 July 2010, NRAS commenced operations with 10 fully functioning National Boards, a national agency (AHPRA) based in Melbourne with offices in every state and territory and live websites for AHPRA and the National Boards. On 5 July 2010, online national registers for each profession also went live.

43. Approved registration and accreditation standards are in place for all 10 professions. There are mandatory registration standards in the areas of criminal history checking, English language standards, professional indemnity insurance, continuing professional development, and recency of practice. These standards were put forward to the AHWMC for approval by the National Boards following extensive consultation with the professions.

44. Since 1 July 2010, the National Boards have met regularly, generally on a monthly basis, to consider a wide range of issues including individual registration applications, professional standards and practitioner concerns. Board decisions are being published in monthly communiqués which are posted on the AHPRA website.

45. AHPRA advises that it has also assisted the various boards to conduct public consultations in relation to developing or amending standards, codes and guidelines and that its legal team has provided advice to the National Boards to clarify their standards where necessary. In addition, AHPRA advises that state and territory branches of the National Boards, where established, have performed a number of key tasks, particularly in relation to applications for registration.

46. Since it commenced, AHPRA has assisted with the registration of more than 525,000 health practitioners, consisting of more than 344,000 renewals and more than 31,500 first time registrations across all 10 health professions. By March 2011, 100,000 students had also been registered across nine of the 10 registered professions.

Ongoing role of the Australian Health Workforce Ministerial Council (AHWMC)

47. Health Ministers from all jurisdictions have led the development and establishment of the NRAS. The Council of Australian Governments (COAG) developed the IGA which established the basis for NRAS and appointed the NRAIP team. Health Ministers, through the Australian Health Ministers' Conference (AHMC) appointed the boards and the Agency Management Committee. The AHWMC was established under the NRAS legislation and, in June 2010, established Australian Health Workforce Advisory Council (AHWAC) to provide independent advice to Ministers as required. In the concentrated months of work leading up to implementation, AHWMC considered and approved national standards for each profession, worked with the accreditation agencies, undertook national consultation on the structure of NRAS and associated legislation.

48. In developing the National Law, AHWMC responded to stakeholders' concerns and developed a national scheme which would be the first nationally consistent regulatory legislation developed in agreement between states, territories and the Commonwealth as equal participants.

49. AHWMC will continue to play an important role in the national scheme through the performance of its statutory functions under the National Law. AHWMC has ongoing responsibility for approving national registration standards, appointing members of the National Boards, the Agency Management Committee and AHWAC.

50. In addition, significant decisions will need to be made by AHWMC in the coming months, notably in relation to the inclusion of the four partially regulated professions into NRAS by 1 July 2012. Other issues which will require the consideration of AHWMC include: options for the regulation of unregistered health practitioners; development of criteria for assessing the recognition of new specialties; and consideration of the inclusion in NRAS of further health professions, such as paramedics.

Comments against the Terms of Reference

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

51. It is acknowledged that the establishment of the National Scheme was a significant undertaking involving a transition from 85 state based organisations administering registration schemes to the establishment of the 10 National Boards and AHPRA as a single national cross profession administration. In the 10 months since its establishment, AHPRA has experienced some initial capacity and operational issues.

52. However since its formal establishment on 1 July 2010, AHPRA has reviewed and improved its capacity and ability to undertake its key functions. An example of this is the recent appointment of a Director of Business Improvement and Innovation in acknowledgement of the need for AHPRA to build its capacity in business improvements.

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

53. In the initial establishment phase states and territories have, to varying degrees, identified concerns in the following areas:

    (a) difficulty in contacting AHPRA, particularly through national call centre arrangements;

    (b) responsiveness to queries and complaints;

    (c) delays in the processing of registrations, re registrations and changes to registrations;

    (d) differences in the application of policies, standards and administrative procedures between the states and territories;

    (e) lack of access to information regarding status and progress of registration applications for both registrants and employers;

    (f) additional administrative requirements on employers and education providers;

    (g) inaccurate information on the registers and the website;

    (h) delays or lack of timeliness, in providing information and advice both through the website and by post.

54. The transition to the new arrangements has affected jurisdictions differently, with some States reporting few problems with the establishment of NRAS.

55. For example, WA and SA have not experienced any major issues regarding the processing of registration renewals. In WA, there have been reports of isolated administrative issues affecting individual or specific groups of health practitioners, but these are not considered to be of major concern and rather are a reflection of the significant change arising from the introduction of the NRAS.

56. AHPRA's WA State Office has performed satisfactorily. This can be attributed to several factors.
    - WA's later entry into NRAS resulted in additional time for training of staff.

- Later entry also meant that some of AHPRA's systemic problems were already addressed.
- Transition of nearly 100 per cent of the previous state board staff ensured a skilled and experienced workforce and vital maintenance of corporate knowledge.

57. In SA, there were reports of lack of timeliness in communications and difficulties contacting AHPRA through the national call centre. However, there was a marked improvement in response times when calls were diverted to AHPRA's SA office.

58. Victoria, as a jurisdiction with a large health workforce, was significantly impacted by the introduction of the National Scheme. Confusion was experienced in Victoria when eight of the ten professions, including 85,000 Victorian registered nurses and midwives, faced their first re-registration under the National Scheme at the end of December 2010 and a number of practitioners failed to successfully renew their registration within the grace period provided under the National Scheme. Many of these issues were eventually resolved however considerable effort will be required to ensure that this confusion does not repeat in May 2011 when these nurses will, after a short registration period, be required to again renew their registration. The registration of overseas qualified practitioners also remains an issue in Victoria with a backlog of applications understood to be awaiting processing.

59. AHPRA has acknowledged the initial operational difficulties experienced in some jurisdictions. The most productive approach to resolving identified issues has been for direct communication between the relevant AHPRA State Office and the respective state/territory health department. Regular bilateral meetings have been implemented in most jurisdictions and AHPRA has been responsive and willing to examine options to address identified issues. The National Registration and Accreditation Scheme Sub Committee of Australian Health Ministers Advisory Council (AHMAC) has also taken a role in providing collective government feedback to AHPRA.

60. At its meeting of 17 February 2011, the AHWMC agreed that action needed to be taken to address the concerns being raised about registration processes during the transition to the new Scheme. It was agreed to provide additional support and expertise to assist AHPRA in managing the registration function. Additional monitoring of AHPRA has been introduced and AHPRA will be required to report to future meetings of Health Ministers.

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

61. Some delays in registration have had an impact upon practitioners and heath services. In some instances the time taken to process registration applications, particularly for overseas applicants, has resulted in delays in the commencement of employment for and for others has delayed the establishment of private practice. Some patients have also had appointments cancelled or rescheduled.

62. Under AHPRA's data release protocols with states and territories, which were endorsed by AHMAC, each jurisdiction is to receive annual unit record de-identified data for each of the registered professions. This data is very important in allowing jurisdictions to conduct forward projections and to respond to queries as simple as the number of doctors currently working in individual jurisdictions. This data is not yet available to states and territories, affecting their ability to accurately plan for future workforce needs.

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

63. Under the National Law, individual health practitioners have primary responsibility for

renewal of their registration. If a registration is not renewed by the due date, there is a 30 day 'grace' period before registration lapses and the practitioner's name is removed from the national register.

64. Patients who are treated by an unregistered health practitioner (including practitioners whose names have been removed from the register because of lapsed registration) are not eligible for Medicare benefits under the *Health Insurance Act 1973*.

65. The Commonwealth became aware of a small number of practitioners claiming that their registrations had lapsed because of issues such as not receiving renewal notices from AHPRA. In some cases, these practitioners continued to provide services, unaware that their registrations had lapsed and that their patients could not receive Medicare rebates for the services provided.

66. Because claims for benefits through the Department of Veterans Affairs (DVA) and private health insurers rely on data from Medicare Australia, there was potential for DVA and private health insurance (PHI) claims to also be affected.

67. The Department of Health and Ageing worked closely with professional groups, Medicare Australia and AHPRA to resolve this issue. AHPRA established a fast-track process to assist practitioners to return to the register as quickly as possible. In addition, a procedure was established to address registration issues for practitioners whose registration was affected by transitional issues (such as incorrect address details held on the AHPRA database). AHPRA has written to practitioners who fast tracked their registration because they had missed their renewal deadline in November and December 2010 due to the new arrangements. These practitioners are now able to complete a statutory declaration up until Monday 2 May 2011, if they believe that their registration has been incorrectly dealt with.

68. AHPRA will advise Medicare Australia directly that the provider is registered and Medicare Australia will then seek to process the practitioner's record within two days of receipt of this updated information, allowing patients to resubmit outstanding or rejected bulk bill claims. This procedure has ensured continuous registration and the payment of Medicare and DVA benefits to affected practitioners and their patients.

69. PHI rebates are not payable for out of hospital services where a Medicare rebate is payable. Data from Medicare Australia shows that, since the commencement of NRAS, some 97% of claims rejected by Medicare for provider-related reasons (including, but not limited to, the practitioner not being registered) were for out of hospital services. This means that these claims would not have been covered by PHI and therefore no PHI claims would have been rejected for these services.

70. For in hospital services with a Medicare component, a claim is processed through Medicare Australia before being submitted to the insurer. Where the AHPRA procedure addresses registration issues for a practitioner for the purposes of Medicare, it also addresses registration issues for associated PHI claims.

71. There are some services provided out of hospital that are not covered by Medicare but are covered by ancillary insurance tables (eg. orthodontic care). As these services are not covered by Medicare, and many of the practitioners providing these services are not registered with Medicare, insurers cannot rely on the Medicare system for information about registration status. Insurers have their own arrangements for verifying the registration status of these health practitioners. Jurisdictions are unable to provide information about these arrangements.

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

72. Jurisdictions are not able to comment on legal liability and risk for practitioners or their employers resulting from the implications of NRAS. Any implications would depend on the specific circumstances of the practitioner and employer.

73. In more general terms, NRAS's benefits of increased mobility for health practitioners working across state boundaries, consistent national registration and professional standards, improved collaboration between National Boards and improved transparency for the public are expected to reduce the risk of regulatory failure.

74. Similar to the requirements of previous State Registration Boards, registrants are required to act in accordance with their accountabilities outlined in the National Law. For some health practitioners these accountabilities and legal liabilities have changed with the introduction of NRAS and in some jurisdictions, practitioners now need to meet standards that are higher than in the past.

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

75. Jurisdictions do not have the detailed information available to allow for comment on the financial losses, if any, incurred by practitioners, patients or service providers as a result of the revised registration process itself or by any problems with that process.

76. It should be noted, however, that many practitioners who would previously have been required to register in multiple jurisdictions are now financially better off as they are only required to register once and pay one registration fee.

(g) response times to individual registration inquiries

77. Initially, AHPRA had a single call centre located within its Melbourne offices which handled all registrants' enquiries from both the web and via telephone. Due to the high volume of calls, the pathway through which calls were managed, and the diverse nature of the callers' enquiries there were issues with the timeliness and accuracy of responses.

78. AHPRA acknowledged these issues, and has undertaken work to remedy the situation including decentralisation of the call centre function, creating notification teams at each site, increasing the number of AHPRA staff responding to enquiries, and intensifying staff training. This strategy appears to have had a positive effect with the level of complaint to state/territory health departments noticeably decreased.

(h) AHPRA's complaints handling processes

Complaints about AHPRA Operations

79. The same communications issues identified with AHPRA operations have been a source of concern in AHPRA's handling of complaints about its operations. The scale of the issue was evident from the number of contacts made with the National Health Practitioner Ombudsman Privacy Commissioner (NHPOPC). Many of the issues raised would, under normal circumstances, have been expected to have been resolved by AHPRA in the first instance. However as result of frustration on the part of registrants and employers unable to make contact or get satisfactory responses from AHPRA callers resorted to making contact with the NHPOPC. An indication of the improvement in AHPRA operating in this area is the significant decrease in calls to the NHPOPC in recent months about not being able to contact AHPRA easily.

Notifications

80. A significant role for AHPRA is the management of notifications to Boards regarding registrant health, conduct or performance. AHPRA inherited all open notifications and disciplinary matters from state and territory Boards (other than NSW) at 1 July 2010. AHPRA is currently managing approximately 3000 notifications, including those received since 1 July 2010.

81. As NRAS has only been established for 10 months it is difficult to provide comment on AHPRA's handling of these matters.

(i) budget and financial viability of AHPRA

82. It is noted that financial obligations for AHPRA and the administration of NRAS are set out by, or are influenced by, a number of mechanisms including the Intergovernmental Agreement (IGA) provisions, the National Law and the financial principles for the transfer of liabilities from the state and territory boards agreed by the AHWMC.

83. It is recognised that the Scheme has been established to be self-funded from registrations with the initial set up including contributions of assets from existing state boards. It should be noted that some of the existing state and territory boards did not have a sufficient asset base to cover the full cost of their liabilities, resulting in a lower funding contribution to some of the National Boards than was expected. Given that it was agreed that there would be no cross subsidisation between professions, this resulted in some National Boards being in a more robust financial position at their inception than others.

84. While governments support NRAS and some have provided additional financial support to AHPRA in the establishment phase NRAS should become self sufficient and there should not be an ongoing reliance on Commonwealth, state and territory government funding. This means that the financial obligations of AHPRA and the National Boards need to be fully considered when setting registrant fees.

85. As has been noted above, AHPRA and the National Boards are reliant on registrant fees for funding, and at the present level AHPRA has resource constraints which limit capacity and performance. It is important that financial sustainability is an element in all decisions about the structure and scope of NRAS.

(j) any other related matters

86. It should be acknowledged that NRAS is the first national scheme of its type to operate in Australia, and that it has only been operational for 10 months.

87. It is important to note that the responsibility for NRAS is shared amongst a number of entities, the National Boards and the Boards' committees, the AHWMC, and AHPRA. AHPRA's role is to provide support to the National Boards to enable those boards to carry out their statutory functions.

88. AHPRA functions within an overall assessment model. This includes professional standards set by each of the 10 National Boards in association with the relevant Accreditation Authority. There is some indication that there is, at times, confusion in the different roles played by AHPRA, the National Boards and local boards and that this confusion may lead to issues that arise from decisions of Boards being attributed to the administrative operations of AHPRA.

Conclusion

89. Under NRAS, any person applying for registration is subject to nationally consistent registration standards and codes for the professions. Registration details on each practitioner are maintained on a single register where it can easily be verified whether any limitations or conditions apply to their registration. The element of risk to the public is minimised and the public can be assured that no matter where they may receive treatment the practitioners have been assessed against the same registration standards.

90. The introduction of a national scheme represented a significant change in the manner that health practitioners are regulated in Australia. It involved the setting up of a large new organisation, the transfer of large numbers of staff from predecessor organisations, the transfer of large numbers of records and the education of practitioners and employers on new arrangements.

91. In the face of these challenges, a cooperative working relationship has developed between all agencies and organisations involved, particularly AHPRA, the Boards themselves and jurisdictions, and there has been a willingness on the part of all parties to address issues and make the Scheme a success.

92. Whilst it is clear that there have been some operational difficulties in the establishment of NRAS, these have largely been the result of bringing 10 professions across eight jurisdictions into a system that was to be operational from day one without any interruption to service provision.

93. At the February 2011 AHWMC meeting Ministers discussed some of the issues that had been occurring with the move to a national system of registration. Jurisdictions noted that implementation varied, with some states identifying few problems, and others citing more substantial issues as state systems moved to the national system. AHWMC agreed it was important to continue to keep a close watch on the new Agency in the coming months as it became fully operational. AHWMC committed to: providing additional short term assistance to AHPRA to assist with upcoming major re-registration rounds; and to continue to receive regular feedback from AHPRA on how it was performing to ensure that any further start up problems were appropriately managed.

94. Any difficulties in bringing these systems together should not overshadow the importance of this key health workforce reform and the role of AHPRA in achieving a national scheme with a focus on the health and safety of the public and nationally consistent standards for health practitioners. The Scheme has significant potential to deliver improved public protection, improved professional standards, greater workforce mobility and better quality education and training and AHPRA is well placed to play the key support role in delivery of these benefits.