Harnessing self-regulation to support safety and quality in healthcare delivery

A comprehensive model for regulating all health practitioners

Proposal by the National Alliance of Self-Regulating Health Professions
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This proposal is a collaborative document prepared by representatives of NASRHP with input from Kandie Allen-Kelly and Karl Charikar, Consultants.
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Executive summary

The National Alliance of Self-Regulating Health Professions (NASRHP) currently consists of eight self-regulating allied health professional associations. This paper is submitted to the Australian governments as a resource for use during the development of an improved regulatory framework for Australian health practitioners.

The issue

There is a community expectation that Australian healthcare delivery meets a governed standard, with established public protection processes in place. This expectation is met for a quarter of recognised health professions through the National Registration and Accreditation Scheme (NRAS) for Health Professions, which commenced under National Law in July 2010. The remainder of practitioners operate outside of a formalised framework, with public protection offered only through practitioner voluntary membership of a self-regulating professional association.

It is estimated that 20 health professions have submitted proposals for inclusion in the NRAS which have not progressed. These proposals have addressed the six benchmarking criteria of the Intergovernmental Agreement for National Registration and Accreditation Scheme for the Health Professions¹, highlighting the public benefit of improved practitioner regulation. Additionally, the Australian Health Ministers’ Advisory Council (AHMAC) is awaiting the outcome of the 2011 consultation into ‘Unregistered Health Professions’, before proceeding with further regulation development. This situation, however, runs contrary to public expectation that a formal regulation structure exists which provides recognition of qualifications, minimum entry standards, assurance of practice standards, a code of conduct and ethics, and an avenue for complaints.

The professional associations that constitute the NASRHP administer functions equivalent to those of the NRAS boards. Many manage or contribute to the following processes and functions on a national scale:

- accreditation of tertiary courses which grant entry to the profession
- entry level practice standards (alternatively known as competency standards)
- assessment of the qualifications of international health practitioners
- codes of ethics (or conduct) and complaints systems
- continuing professional development (CPD) and recency of practice.

The primary concern of a robust health regulatory system is public safety through the assurance of quality service provision. Unfortunately, self-regulation in its current form is not sufficiently far-reaching because it cannot mandate standards beyond entry level, nor ensure that all practitioners submit to a code of ethics/conduct and a complaints management system. Current self-regulatory systems only regulate members or those who seek voluntary accreditation. Most self-regulated professions have examples of serious public complaints in which the practitioner was either not a member or chose to resign membership, providing no avenue to pursue the complaint and ensure public safety. This highlights the gaps in the current health practitioner regulatory system in which there is a high level of regulation for the professions partnering with AHPRA in NRAS, but no enforceable public protection for the other three-quarters of Australia’s health professions.
The NASRHP proposes that the Australian Health Practitioner Regulation Agency (AHPRA), a single national body, should be responsible for managing a framework that regulates all health practitioners. This framework should include three components:

- nationally registered professions via NRAS boards
- authorised self-regulating professions via a Health Professions Panel
- negative licensing.

The proposed model for authorised self-regulating professions detailed in this paper calls for the Australian governments, through AHPRA, to:

- authorise the self-regulation of designated health professions
- implement reserved/protected title legislation
- require all practitioners working under the reserved title of a profession to meet standards for practice set by the self-regulated profession.

This model of regulation will provide numerous benefits to both the public and governments. Importantly, it will ensure all practitioners are held accountable against enforceable profession-specific standards of practice supported by a complaints handling process. It will address current consumer expectations and provide assurance of consistently safe and high quality standards in healthcare from a greater proportion of health professions. The model will also provide a minimum qualification standard for each of the professions, ensuring the most appropriate level of skill and expertise is available to the consumer. Further to this, the implementation of mandated continuing professional development will ensure oversight and greater certainty about the quality and currency of practice of those who are not currently members of a professional association.
The model represents benefits to both the consumer and governments. The Australian governments will benefit from a reduction in the inconsistencies between self-regulating professions with respect to the quality and coverage of standards. A clear definition of ‘health practitioner’ under the ‘authorised self-regulation’ model will mark a boundary between evidenced-based health practitioners and unregulated health workers. The current lack of clarity leads to confusion – for consumers, government departments, agencies and employers. Finally, the authorised self-regulation model will alleviate concerns regarding imposing regulation which has the level of administrative burden associated with NRAS boards.

The next steps

This proposed model is submitted to the Australian governments for careful consideration. The NASRHP is committed to working with the Council of Australian Governments (COAG), AHMC, AHPRA, the Department of Health and Ageing (DoHA) and all jurisdiction health departments, and other self-regulated and unregulated professions around this model. The NASRHP seeks a working partnership with AHPRA in a way that is congruent with AHPRA’s partnership with NRAS boards, and is available as an expert reference group for the Government during this period of health reform.

The NASRHP requests that:

- this proposal for a single regulatory system and model of authorised self-regulation is tabled at the next meeting of AHMAC
- the Australian governments actively participate in open dialogue with NASRHP about the proposed model of authorised self-regulation
- it be engaged to work with the Australian governments on this as the expert reference group
- a roundtable be developed as soon as possible to discuss the next steps, including a broad consultation process.
Introduction

Allied Health Professions Australia (AHPA) is the peak body and national voice of allied health in Australia with a membership of 14 different professions. This voice represents a collaborative mix of registered and self-regulated professions. Australia has 116,800\(^2\) allied health practitioners, who work alongside doctors and nurses to provide optimum healthcare for all Australians (AIHW, 2010: 448). Allied health practitioners account for 18% of the country’s healthcare workforce, which is a proportion that continues to grow. Together with doctors and nurses, allied health practitioners are regarded as the third pillar of healthcare providers in Australia.

The National Alliance of Self-Regulating Health Professions (NASRHP) was formed in 2007 and came under the auspices of AHPA in 2010. It currently consists of eight professional associations, each of which is the peak body for their allied health profession:

- Audiological Society of Australia, trading as Audiology Australia
- Australian Diabetes Educators Association (ADEA)
- Australian & New Zealand College of Perfusionists (ANZCP)
- The Australian Orthotic Prosthetic Association (AOPA) Inc.
- Australian Sonographers Association (ASA)
- Dietitians Association of Australia (DAA)
- Exercise & Sports Science Australia (ESSA)
- Speech Pathology Australia (SPA).

The NASRHP’s core objective is to provide a forum for allied health professions that are not nationally registered to:

- seek clarity regarding regulation for their respective professions
- benchmark their self-regulatory environment
- advocate on behalf of the public for an improved health regulatory environment
- address the challenges and consequences for the professions and health agencies of the current fragmentation in health practitioner regulation.

The NASRHP contends that to protect the interests and safety of the public a single national authority, such as AHPRA, should be responsible for managing the regulation of all health practitioners. This will involve a framework covering the registered professions (NRAS), authorised self-regulating professions and negative licensing of those practitioners who do not otherwise fit within the regulation processes. Authorised self-regulation, with reserved/protected title legislation, will require practitioners utilising the protected title to meet standards for practice set by the professional association. All regulation will be managed by AHPRA and the framework will be fluid, such that on AHPRA's recommendation a profession may move out of or into the NRAS should its demonstrated risk profile change.
Solving the dilemma of health practitioner regulation in Australia

Background

Public safety and quality practice is the cornerstone of health practitioner regulation. The regulation of health practitioners in Australia has been contentious for the past decade or more. In 2004 the Council of Australian Governments (COAG) recognised the health workforce as a priority issue and commissioned a report from the Productivity Commission. The Commission identified approximately 90 registration bodies and 20 professional associations that were involved in the regulation and accreditation of health practitioners. Significant variations in the accreditation of university programs and hence the graduate entry level across jurisdictions within single professions were identified. These variations limited workforce movement due to varying requirements of the registration boards and the need to register in every jurisdiction. The report proposed the establishment of a consolidated national registration and accreditation regime to integrate the system.

In 2009 legislative change led to the introduction of AHPRA, a single national regulatory body. AHPRA’s primary function was to implement the NRAS across Australia by 1 July 2010, through ten profession-specific boards. The ten initial professions were those that were previously registered in every state and territory. Partially registered professions were required to lodge a submission in response to the six criteria outlined in the Intergovernmental Agreement (IGA). These submissions were assessed and four additional professions will be included in the NRAS from 2012 according to the level of public risk. It is understood that in the last two years, up to 20 additional health professions have provided submissions seeking inclusion in NRAS. The NASRHP believes there has been a lack of clarity surrounding the assessment of these submissions. Many of the well-known allied health professions were excluded from the scheme, such as dietitians, speech pathologists, diabetes educators, audiologists, exercise physiologists, orthotist/prosthetists, sonographers and perfusionists. Each profession has practitioners working with clients with complex and/or acute conditions, often involving areas of advanced practice. More than 50,000 practitioners in the self-regulating health professions fall outside the current framework, along with many other unregulated practitioners.

In February 2011 the Australian Health Ministers’ Advisory Council (AHMAC) released a consultation paper ‘Options for the regulation of unregistered health practitioners’, and subsequently conducted state-based consultations. A total of 181 submissions were received. In August 2011, AHMAC released a communiqué stating that ‘Ministers have commissioned work on unregistered professions and future directions for national registration . . . Ministers agreed to defer consideration of the inclusion of additional professions into the NRAS . . . until this work has been completed . . . ’

It is anticipated that AHMAC and the Australian Health Ministers’ Conference (AHMC) will consider the options for self-regulating professions more thoroughly at their meetings in February and March 2012. The proposed framework in this paper is in response to this consultation. In the absence of NRAS inclusion for other health professions, the NASRHP proposes a model of authorised self-regulation for increased protection of the public.
The impact of fragmented regulation of Australia’s health practitioners

Many issues have arisen due to restricted inclusion in the NRAS, including confusion for consumers, practitioners, employers and various health agencies. The UK Council for Healthcare Regulatory Excellence (CHRE) asserts that regulation touches the point between the public and the personal. Over regulation ‘is seen as an interference in personal conduct; under regulation is seen as an abdication of public responsibility’ (CHRE, 2010). Governments across Australia have a responsibility to provide the public with quality and safety when accessing healthcare. Practitioner regulation promotes public trust and consumer confidence in the service quality of their provider and the healthcare system. The fragmented regulation of health practitioners exposes the public to an unacceptable risk.

NRAS, the current regulatory framework, covers less than a quarter of the fifty plus health professions operating in Australia, as defined in the Health Professionals and Support Services Award 2010. There is an absence of public knowledge regarding the limited coverage of the NRAS and many consumers assume that those providing healthcare services have the appropriate qualification and competency, and practise within a regulated environment. For three-quarters of health professions, this is not necessarily the case and consumers are mostly unaware they must satisfy themselves as to the competency and qualifications of the health practitioner. In the absence of statutory regulation many allied health professional associations have taken responsibility for setting and enforcing standards, quality, accreditation and disciplinary measures. However, while most of the self-regulating professional associations perform the activities of a registration and accreditation board to a high standard, these activities are only applicable to their members. Furthermore, there is no method for ensuring consistency and an appropriate standard of self-regulation across the self-regulated professions.

Non-regulated health practitioners include those who choose not to engage with their self-regulating professional association and those practitioners whose profession is not regulated at all. The risks associated with the provision of health services by these practitioners are significant. Each of the members of the NASRHP has provided evidence of inherent risks or unsafe practice examples in their recent submissions for inclusion in the NRAS and/or their response to the AHMAC options paper. Those who fall outside the registered and self-regulated professions are not the focus of this proposal. Should they meet the definition of a health practitioner, the NASRHP contends that they should move towards authorised self-regulation in the future.

The perception of consumers and other stakeholders is that the difference between the registered and self-regulating professions extends further than simply the degree of public risk. Those professions which are not nationally registered have had limited access to funding to improve quality, whilst there
has also been a decrease in cross-profession collaboration. For example, recognised self-regulating professions have been excluded from some Medicare Local membership opportunities.

Workforce planning continues to be a major challenge for the health sector. The self-regulated professions can currently only collect accurate membership and accredited practitioner data, with the remainder of the profession inaccessible. Collection of data against a prescribed dataset by the self-regulated professions has historically been overlooked, with the consequential impacts on workforce planning. The professions within the NRAS now have complete data collection processes and prescribed datasets allowing for much improved workforce planning. The standing committee for health professions to advise Health Workforce Australia (HWA) is trying to identify and resolve workforce issues in the non-registered professions due to lack of data availability.

The NASRHP has identified shortcomings in the current Australian health regulatory framework that include:

- limited public awareness of the lack of breadth in the current NRAS
- an absence of public knowledge regarding the lack of coverage of NRAS as many consumers assume that those providing healthcare services have the appropriate qualification and competency, and practise within a regulated environment
- the self-regulating processes implemented by professional associations are not enforceable across the entire profession nor are they standardised
- limited avenues for complaints management, prevention of practice and subsequent public protection for those practitioners outside of the NRAS, the self-regulatory professional associations memberships and those who practise in non-regulated professions
- fragmented or ad hoc regulation of health professions creating an inconsistent administrative burden, with government agencies and authorities having to approach each sector in a different manner and independently.
The UK has recently developed a right-touch model of health profession regulation that examines the effective methods of providing quality and safety without excessive cost to the UK Government or practitioners. The Australian governments are asked to consider the UK approach when addressing the issues facing self-regulated health professions in the Australian context.

With right-touch regulation, the UK Government seeks the balance between the extremes of under and over regulation. They assert that six key principles should be applied to regulation:

1. Proportionate: Regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised.
2. Consistent: Rules and standards must be joined up and implemented fairly.
3. Targeted: Regulation should be focused on the problem, and minimise the side effects.
4. Transparent: Regulators should be open, and keep regulations simple and user friendly.
5. Accountable: Regulators must be able to justify decisions, and be subject to public scrutiny.
6. Agile: Regulators must look forward to anticipate change rather than looking back to prevent the last crisis from happening again (CHRE, 2010).

Right-touch regulation is based on a thorough evaluation of risk and is proportionate and outcome focused. It has mandatory registration and assured voluntary register components and a decision tree is used to determine whether a profession is registered (mandatory registration) or self-regulated (assured voluntary registers). This decision is based on the type of risk, the level of risk, and whether the problem can be resolved locally.

The recently renamed Assured Voluntary Registers Scheme has ‘new powers to accredit voluntary registers’, commencing July 2012. Features of this scheme include:

4.2 Accreditation means that the organisation holding the voluntary register is well governed in respect of its arrangements for voluntary registers; that its register is reliable and that its requirements for registrants enable good outcomes for consumers.

4.3 Their scheme is open to applications from organisations that hold registers for practitioners:

- who practise a defined discipline (or related disciplines) within health and social care, which requires a specific body of knowledge, accredited training and the acquisition of particular skills
- meet the Authority’s standards including governance, management of its register and criteria for registrants (CHRE, 2011).

The scheme focuses on the promotion of good quality care rather than the avoidance of harm. The UK has proposed that movement between statutory registration and voluntary regulation is essential. The Council of Healthcare Regulatory Excellence UK (CHRE) has discretionary power to recommend a group for statutory registration in the interests of public protection or to recommend a particular group cease registration and become self-regulated instead.

While the UK framework goes further than the current Australian approach to the self-regulated professions, it does not provide protection of title or manage the public risk associated with non-member practice. It is the view of the NASRHP that an Australian self-regulatory model must cover all practising health practitioners via mandatory participation.
The NASRHP contends that AHPRA should act as the single national regulatory authority for all health practitioners, including managing a self-regulatory framework. This will provide a public guarantee for health service quality whilst minimising duplication of functions and high administrative expenses. The self-regulating professions wish to partner with AHPRA to assure quality and sustainability in regulation across the health sector. The development of criteria for self-regulation will provide those professions that have under-developed processes with the necessary guidance and assistance for improvement. The diagram below outlines the proposed structure of an all-encompassing regulatory framework for all Australian health practitioners.

It is proposed that AHPRA will act as the governing body for all health practitioner regulation. This will involve the management of the following key aspects:

- nationally registered professions (NRAS)
- authorised self-regulating professions
- negative licensing for those practitioners who fall outside the above categories.

KEY FEATURES OF THE PROPOSED NATIONAL HEALTH PRACTITIONER REGULATION

- AHPRA is responsible for regulation of all health practitioners.
- AHPRA regulation will protect the public against poor practice, inappropriate advice, intervention and exploitation from registered (statutory regulation), self-regulated and unregulated health practitioners.
- AHPRA collects and utilises evidence to determine the level of risk a health profession poses to the public and recommends the most appropriate level of regulation.
- AHPRA determines the criteria of quality self-regulation and assesses self-regulating professional associations against those criteria to determine authorised self-regulation status.
- All health practitioners can be subject to negative licensing for non-compliance with the quality and safety standards (conduct, health and performance matters).
- As national evidence is gathered, AHPRA may recommend that a profession move into or out of statutory registration.
- Unregistered practitioners are encouraged to collaborate with similar practitioners and work towards meeting AHPRA criteria for authorised self-regulation, if appropriate.
Proposed model: Authorised self-regulation

The NASRHP proposes that the Australian governments authorise the self-regulation of designated health professions through the relevant national professional associations, thereby requiring practitioners working under professional titles to meet accreditation standards for practice.

The proposed model is similar to the planned extension of powers of the UK Health regulatory authority being introduced in July 2012. Any model developed for the self-regulated professions must address the obvious gaps in the current regulatory system, as previously outlined. Of most importance is the need for improved consumer protection.

The most significant difference between the UK model and this proposed model is the proposal for legislative change. Legislation must enable the authority to require credentialing for all health practitioners, not just those with membership of the self-regulated profession. The NASRHP member professional associations vary from covering 98% to 50% of their profession. The public risk posed by so many practitioners working outside of a regulatory environment is unacceptable. The proposed model demonstrates how practitioners in the self-regulated professions can be captured in a sensible regulatory framework. This model assumes that the public risk, whilst deemed medium to low, can be further minimised and managed through authorised self-regulation.

Legislative change is essential as the *Competition and Consumer Act 2010* (Cth) dictates that membership of a professional association cannot be mandatory. The NASRHP advises the Australian governments of the necessity to require all graduated practitioners seeking professional employment to be accredited or credentialed and abide by the standards required by their professional associations. These standards being:

- completion of a tertiary qualification that is accredited by the professional association to meet the standards for entry to the profession
- commitment to the defined scope of practice, generic practice standards and any specific practice standards that will apply to their setting
- participation in an accredited CPD and/or certification scheme
- commitment to work within the profession’s code of ethics/code of professional practice
- compliance with recency of practice standards for the profession
- compliance with criminal history check, advertising and professional indemnity insurance requirements
- any that may be required for practice in a particular setting (e.g. working with children, mental health, accreditation for government programs).

There are current examples of authorised self-regulation in Australia. Assessments of the qualifications of international health practitioners to work in Australia are mostly undertaken by the relevant professional associations under authority from the Department of Education, Employment...
DEEWR authorises professional associations to conduct the credentialing process for the purpose of skilled migration. Other examples of authorised self-regulation include private practitioner standards for Medicare schemes (e.g., Better Access, Helping Children with Autism and the Better Start program), DVA-funded programs, and some state workers compensation schemes. These instances provide working, effective, inexpensive methods to achieve quality and safety standards without registration. The proposed model for authorised self-regulation is not dissimilar, with the Government encouraged to review and formalise authority for this work to extend to other areas of practitioner regulation.

It is recommended that AHPRA create a Health Professions Panel. This panel will be responsible for assessing the standards for the professions to ensure they meet AHPRA guidelines. For most professions these standards already exist and are broadly in line with those of registered professions. Therefore, the panel’s primary task will be to determine the assessment criteria for accrediting/assuring that the authorised self-regulator’s professional standards meet AHPRA standards, and that any gaps in standards are rectified. AHPRA will not be asked to create a range of standards for each profession, but rather the benchmarks for these standards.

KEY ELEMENTS OF THE AUTHORISED SELF-REGULATION MODEL

- Legislative change will be sought to enable AHPRA to authorise self-regulation.
- AHPRA will manage authorisation of professional associations through the appointment of a Health Professions Panel, including representatives of the self-regulated professions and community members.
- The criteria for the authorised self-regulatory body should include that they are a single, national member-based association with a key objective and appropriate mandate for advancing their profession through the setting of standards. Extending and formalising the current role of these professional associations within guidelines rather than duplicating processes or encouraging disparate regulatory models is an important element of this model.
- Professional associations cannot mandate that all practitioners in their profession become members. They will, however, be authorised to regulate every member of that profession working in Australian healthcare against its professional standards.
- All regulated professions must have a code of ethics or conduct that meets at minimum a broad criteria code of conduct set by AHPRA (profession-specific codes preferred), and includes enforceable complaints handling processes.
- Professional associations will be authorised to register every student of that profession before they commence field placements.
- Protection of title, such that only those practitioners or students of the profession credentialed through the authorised self-regulation process can use the title of the profession/credential.
- AHPRA will promote those self-regulation credentials and the authorised agencies to government agencies, committees, employers, practitioners, and the public.
- The scheme should commence with those professions that have a self-regulatory authority which already meets all or most of the NRAS board functions and AHPRA legal requirements and is prepared to work within the model as designed.
Key elements of the proposed model

AHPRA’s role
In consultation with the professions, AHPRA will draw up the criteria against which the professional associations will be assessed to determine their suitability as an authorised self-regulated organisation.

Health Professions Panel (HPP)
This multi-disciplinary panel will also include community and legal representatives. It will assess the capability, capacity and systems so that they can approve, authorise, and accredit the regulatory standards and processes of one national self-regulatory professional association per profession using existing AHPRA guidelines, and to remove authorisation, suspend or impose conditions on the self-regulatory organisation.

Authorised self-regulating professional association’s role
The role of the self-regulating professional association is to continue to set accreditation and practice standards and additionally to assess all individual health practitioners in their profession against those standards. The role will mirror the functions of the NRAS boards.

Protection of title
Protection of title (reservation of title) is an essential element of this model. The use of title must be limited by legislation to include the credential requirement of the authorised self-regulated profession. Only those practitioners or students of the profession credentialed through the authorised self-regulation process can legally use the appropriate level title of the profession/credential.

Managing students under the authorised self-regulation model
It is proposed that all students will be regulated under this model in the same manner as those in the NRAS. The NASRHP considers that as students are attending courses accredited by their bodies and are working with consumers, therefore constituting a level of risk, they should also be regulated by them so that the professional body can support them into and through the profession. Appendix 1 shows that many self-regulating professions already have large student member numbers.

Scope of practice: Health support workers/allied health assistants
Whether allied health assistants ultimately fall under the proposed authorised self-regulation model depends on the outcomes of the work currently being commenced by HWA and AHPRA. This work will consider extended practice and scope of practice for support workers and practitioner assistants, which will conclude with a recommendation regarding regulation options.
Defining allied health professions

No singular agreed definition exists for allied health in Australia, although international literature demonstrates that all of the NASRHP are included in the varying interpretations. Health professions use a range of indicators to demonstrate that they are a profession, based on the defining elements of professions commonly used internationally in health practice.

In 2009 Turnbull and colleagues explicated a new way of defining allied health, a Model of Allied, Scientific and Complementary (ASC) health practitioners. They argued that the ‘health reform agenda in Australia requires a clear approach to grouping “allied health” services in terms of what they do, who they do it to, why they do it, and how they integrate with other health services, so that appropriate workforce decisions can be made for the future’ (Turnbull, et al, 2009:27). The Australian governments will need to determine which professions should be included in an authorised self-regulation scheme which should be included in NRAS in the future, and those that will not participate. The NASRHP proposes the following elements for inclusion when considering Australian health practitioner regulation.

An allied health profession is a national health profession with recognised and enforceable standards for university accreditation and credentialing, robust and enforceable regulatory mechanisms, evidence-based practice and an internationally recognised body of knowledge. It has a defined core scope of practice developed through competency-based training and a university qualification at Australian Qualifications Framework (AQF) Level 7 or higher. An allied health practitioner works in an interdisciplinary model to provide health services, including direct individual patient care (inpatient and outpatient), healthcare to groups in the community, public health programs, research and education in the defined profession. Medicine, nursing and midwifery are not included in the definition.

Determining authorised self-regulating associations

In an authorised self-regulatory model, criteria will need to be established for assessing the appropriateness of an association to self-regulate. The criteria should be based on the elements of the health profession definition, which also reflect NRAS functions. Consideration should also be given to whether the professional association has the governance and administration infrastructure to regulate all members of their profession. Whilst some professions are further progressed regarding self-regulation, all members of the NASRHP agree to this common set of elements. For a full summary of the self-regulating professions’ current capabilities, mapped against the NRAS, refer to Appendix 1: Mapping comparison with AHPRA. All members of the NASRHP meet the elements as outlined below:

Recognised health profession

There are many definitions of ‘health profession’. The self-regulating professions party to this proposal are identified in various contexts, including in the Health Practitioner Regulation Act (2009), by Health Workforce Australia (HWA) through its Standing Advisory Committee for Health Professions, through recognition to provide health services under Medicare and in the Health Professionals and Support Services Award 2010.
National profession
Each of the NASRHP members operates nationally. Each has a single, national membership-based professional association that currently performs self-regulatory functions for the profession.

Recognised and enforceable standards for university accreditation and credentialing
Each of the professions has, or is working towards, accreditation standards that apply to all entry level qualifications at Australian universities and for assessing internationally trained health practitioners.

Robust and enforceable regulatory mechanisms
While regulatory mechanisms are inherently weakened by the lack of regulation and voluntary membership, failure to comply with the profession’s code of ethics, practice standards or scope of practice, or CPD program, can all result in membership/credentialing ineligibility.

Evidence-based practice and an internationally recognised body of knowledge
Each profession is party to an academic journal and a significant body of scientific research that supports clinical practice.

Defined core scope of practice
The core scope of practice for each profession is either published (developed by the professional association) or is inherent in the accreditation standards and practice standards of the profession.

Competency-based training
Each profession has clinical placements that are an essential part of the accreditation standards for entry level qualifications.

University qualification at AQF Level 7 or higher
Each profession’s qualification meets this requirement.

Advantages of the proposed model
Public safety
The primary advantage of this proposed model is that it embraces a right-touch regulatory methodology focused on patient and consumer safety and quality healthcare. It fills the gap in the current regulatory environment that is silent on the quality and safety of healthcare provided by 75% of health professions. This model addresses the public need for safety, and minimises risk with the least administrative impact. Through protection of title the public can be assured that their treating practitioner has the appropriate qualifications, competency, and meets other credentialing requirements. Further to this, the proposed model is proactive and seeks to identify and prevent risk through the promotion of quality. Other models, such as legislated codes of conduct, are reactive models, reliant on an adverse event, its reporting, and the subsequent discipline procedure outcome.

Communication
Managing all health practitioner regulation under the ambit of AHPRA will facilitate processes and standards development and improve cross professional and government communication. Communication with professional bodies should be simplified, as there will be a direct connection through the Health Professions Panel overseeing authorised self-regulation.
Workforce planning

At present, workforce data on the self-regulated professions is poor. The proposed authorised self-regulatory model will improve data collection processes and the capacity to capture accurate workforce data, such as the numbers of practitioners, applications to practise that are refused or withdrawn, complaints against practitioners and audit outcomes. The development of reporting mechanisms between the self-regulating professional associations and AHPRA will assist in assessing health professions against NRAS criteria and identifying the appropriate level of regulation. All parties, including the consumer, governments and the professions, will benefit from accurate workforce data and the ability to plan and tailor resources appropriately.

Ease of administration

The proposed model of authorised self-regulation provides Australian governments with a less burdensome option for increased regulation than extending the current NRAS model. AHPRA will not be required to establish new national boards to register practitioners or develop course accreditation processes. As with the NRAS scheme, all health practitioners under this model will be required to pay a fee and the program of standards development, accreditation and complaints management will be covered by those fees. Individual professional associations will determine whether their membership will include accreditation application and/or a renewal fee or whether it will remain completely separate.

Challenges for the proposed model

As is identified in the summary document in Appendix 1, self-regulating professional associations are working towards consistency in standards. There are also two areas where all professions require further policy development, being criminal record checking and mandatory reporting, particularly with respect to fitness to practise issues. The size and developmental stages between professions means that some will require transition arrangements or provisional authorised self-regulation to enable them to reach the necessary standards. This allows for a staged approach to the authorisation of professional bodies to self-regulate, which will promote growth and improved excellence within professional groups currently struggling to address gaps in their self-regulatory models.

Amelioration of risk for government of an authorised self-regulation model

The ‘right-touch’ regulation model creates risk for the Australian governments associated with not directly overseeing the registration of health practitioners. Although AHPRA and AHMAC have assessed many of these professions as medium to low risk, there is still a risk in applying a self-regulation model with indirect oversight that needs to be ameliorated. Decisions regarding amelioration strategies will depend on governments weighing up cost effectiveness against the risk. Possible strategies are:

- reporting by each professional body to AHPRA on a 6- or 12-monthly basis the significant data and results of audits of at least 5% of practitioners
- panel audit of policies, procedures, complaints management systems on a triennial timetable.
Conclusion and recommendations

This proposal calls for the Australian Health Practitioner Regulation Agency (AHPRA) to work in partnership with NRAS boards and a newly established Health Professions Panel to deliver best practice regulation to ensure all Australians have access to safe, high quality health practitioners.

The NASRHP contends that it is unacceptable for almost three quarters of Australia’s health professions to remain outside a regulated environment and that it is the responsibility of Australian governments to establish a framework that will ensure the safety of Australians and provide them with access to high quality health services.

The framework should include the current capacity for national registration of practitioners whose profession could demonstrate a high risk to consumers; authorised self-regulation for practitioners whose risk is determined to be of a medium level; and negative licensing where the right to practise has been withdrawn from registered or regulated practitioners or poor practice is exhibited by unregulated practitioners.

The proposed framework and model of authorised self-regulation outlined builds on current knowledge and structures, satisfies community expectations of healthcare quality and safety and supports the growth of health professions in Australia.

The NASRHP contends that many existing national professional associations currently act in loco as a board of registration for their profession, undertaking a significant proportion of the functions undertaken by national registration boards. This includes setting standards for their professions, enforcing a code of ethics or conduct, requiring continuing professional development and demonstrating strong governance structures.

The opportunity for Australian governments to continue the reform of the Australian Health system is demonstrated through this proposal. The NASRHP is committed to working with Australian governments to enable the development and implementation of an environment that will ensure all Australians have access to safe, high quality health care.

Recommendations

Consequently, the NASRHP looks forward to working with stakeholders to ensure that:

- this proposal for a single regulatory system and model of authorised self-regulation is tabled at the next meeting of AHMAC
- the Australian governments actively participate in open dialogue with NASRHP about the proposed model of authorised self-regulation
- it be engaged to work with the Australian governments on this as the expert reference group
- a roundtable be developed as soon as possible to discuss the next steps, including a broad consultation process.
References


2. Hodges, C (2011). *Australia’s views on regulatory requirements of counsellors and qualified therapists*.


## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHPA</td>
<td>Allied Health Professions Australia</td>
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<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
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<tr>
<td>AHMAC</td>
<td>Australian Health Ministers Advisory Council</td>
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<tr>
<td>AHWMC</td>
<td>Australian Health Workforce Ministerial Council</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>CHRE</td>
<td>Council of Healthcare Regulatory Excellence (UK)</td>
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<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
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<tr>
<td>HPP</td>
<td>Health Professions Panel</td>
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<td>HWA</td>
<td>Health Workforce Australia</td>
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<tr>
<td>NASRHP</td>
<td>National Alliance of Self-Regulating Health Professions</td>
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<tr>
<td>NRAS</td>
<td>National Registration and Accreditation Scheme</td>
</tr>
</tbody>
</table>
Appendix 1: Mapping the self-regulated professions against AHPRA functions and the NRAS
Summary

How the self-regulating professions meet and manage standards

All of the self-regulated health professions who make up the National Alliance of Self-Regulating Health Professions (NASRHP) currently perform significant aspects of the role played by AHPRA and the NRAS boards in respect of the registered health professions. They manage the professional standards, safety and quality, continuing professional development, and enforcing a code of conduct, including complaints handling processes in line with that required under NRAS.

In all cases these professional associations represent a clear, distinguishable profession. Each profession has a single, identifiable national professional association dedicated to their cause and perform many of the regulatory functions currently prescribed under NRAS. Where there are other professional bodies doing different aspects of regulatory activity, the profession is working to integrate this.

Size of the population

Due to the lack of mandatory regulation, it is difficult to accurately assess the size of the self-regulated professions. Some professions have better data than others due to the commitment of their professionals to membership or accreditation. All NASRHP members are currently working with each other and Health Workforce Australia to build a more accurate database. The following summary data covers the professions in the NASRHP currently.

**Audiology**

The profession of audiology in Australia is just over 2000 practitioners. Ninety-eight per cent of those are members of Audiology Australia. Approximately 280 students are enrolled in audiology programs.

**Diabetes Educators**

There are around 3000 diabetes educators practising in Australia. The Australian Diabetes Educators Association has a membership of approximately 1800, or 60% of the profession.

**Dietetics**

There are around 5000 dietitians practising in Australia, 75-80% of whom are members of DAA. University programs are currently graduating 500+ per year and this is expected to increase to around 600 shortly.

**Exercise Physiology**

There are 2200 Accredited Exercise Physiologists and ESSA estimates that there are another 2000 in the industry. ESSA has 700 student members.

**Orthotist/Prosthetists**

There are 320 orthotist/prosthetists nationally, of which approximately 75% are AOPA members.

**Perfusionists**

There are approximately 120 perfusionists (non-medical) practising in Australia. There are about 8 students in training.
Sonography
There are 4800 accredited sonographers, including almost 600 students (data from ASAR, collected on behalf of Medicare Australia). Seventy per cent of sonographers are members of ASA.

Speech Pathology
There are approximately 7000 practising speech pathologists. These estimates are based on the SPA practising membership level of 4200, and extrapolating from the registrant data from the Speech Pathologists Board of Queensland and the number of practising SPA members in Queensland. Student enrolment is approximately 800.

It is estimated there are an additional 25,000 (including students) in other self-regulated professions.

TOTAL NASRHP – 24,540 professionals (approximately) and 3,048 students
OTHER known SELF-REGULATED – 19,000 professionals and 6,000 students

Why these bodies constitute the responsible authority for their health profession
Most of the members of NASRHP have been setting standards for their professions since inception of the profession in Australia and are the Australian body in the international equivalent. For example, the DAA is the Australian member of the International Confederation of Dietetic Associations (ICDA) and has been accrediting educational programs in dietetics and assessing overseas trained dietitians since the 1960s. The AOPA has been the peak professional body for orthotist/prosthetists since 1975 and serves a similar function to other associations internationally, such as the British Association for Prosthetists and Orthotists (BAPO). Speech Pathology Australia is a society member of the International Association of Logopaedics and Phoniatrics (IALP).

Mapping the self-regulated professions against AHPRA functions and the NRAS

1. Registration of suitably qualified and competent persons in the health profession, and if necessary, to impose conditions on the registration of persons in the profession

All members of the National Alliance of Self-Regulating Health Professions (NASRHP) act in loco as a board of registration for their profession. Each is responsible for the standards that determine if a professional is eligible for membership of the association and/or accreditation program, which, in the absence of registration, acts as a system of self-regulation for the profession.

There is a great similarity between the standards required for self-regulation. All require evidence of CPD; all are required to abide by a code of ethics or code of conduct and all set (or delegate or are developing) single national standards for both education and practice.

However, it must be noted that membership of the relevant professional association is voluntary. Two of the self-regulating professions have established their practice standards accreditation as the accepted industry standard, thus achieving close to universal membership, while others are moving towards this.
2. Development or approval of standards, codes and guidelines for the health profession

All of the professional bodies have developed (or are in the process of developing) national standards for professional practice, codes of ethics and other professional guidelines. There is a shared recognition that these documents form the basis for professional practice, and a willingness to further develop standards.

3. Approval of accredited programs of study as providing qualifications for registration or endorsement in the profession

The professional associations’ model of self-regulation for accreditation is consistent with that used by AHPRA.

Some of the professional bodies are solely responsible for the accreditation of courses for entry to the profession. Others delegate this authority to a body of experts separate to their association; however, this is not dissimilar to arrangements for registered professions, such as occupational therapy, where the Board of Registration has authorised another body (the Occupational Therapy Council) to accredit courses on its behalf. The Australian Sonographers Association is a stakeholder of the Australian Sonographer Accreditation Registry (ASAR) – the accrediting body. The AOPA currently does not accredit courses as there is only one tertiary course in Australia.

In all cases, only courses at AQF Level 7 or higher are accredited.

4. Oversight of the assessment of the knowledge and clinical skills of overseas-trained applicants for registration in the health profession whose qualifications are not approved qualifications for the profession, and determine the suitability of the applicants for registration in Australia

DEEWR authorises a body to assess overseas-qualified professionals for practice in Australia. For all NASRHP self-regulated professions, except sonography, this is the professional association. For sonography, due to historical reasons, DEEWR currently authorises the Australian Institute of Radiography to perform this function.

The model of authorised self-regulation already exists in relation to the assessment of overseas-qualified practitioners and is well developed. DEEWR has not reported any weaknesses in the systems and processes developed by the self-regulating health professions.

Medicare Australia also uses a model of authorised self-regulation whereby the professional association assures the accreditation of practitioners whose services are rebateable under the Medicare Benefits Scheme. Exercise physiologists, dietitians, audiologists, speech pathologists and diabetes educators are accredited this way.

5. Development or approval of standards, codes and guidelines for the profession, including the development of registration standards for approval by the Ministerial Council; and the development and approval of codes and guidelines that provide guidance to health practitioners registered in the profession

All of the self-regulating professions have a body of knowledge that defines their practice, and codes and guidelines to assist professionals to develop safe, high quality practice.

All the professional bodies place a strong priority on the development of these standards, and are willing to develop any additional documents that will assist this proposal.
6. Make recommendations to the Ministerial Council about the operation of specialist recognition in the health profession and the approval of specialties for the profession

Some of the self-regulated professions have developed bodies of knowledge around specialist fields of practice, and have developed criteria to assist the public in recognising professionals with advanced standards of practice in particular disciplines.

The National Alliance of Self-Regulating Health Professions (NASRHP) is aware that AHPRA has made recommendations to the Ministerial Council regarding specialist registration for certain registered professions, and would welcome a discussion with AHPRA about this matter as part of this proposal.

7. Professions registered by AHPRA must undertake discipline-specific minimum CPD hours, recorded as points or hours. Declaration signed by individual health practitioner at membership renewal time

All of the professions operate a CPD program that is mandatory for members, and those seeking accredited status (where this status exists). The programs are set by the profession and are in line with the quantity and range of acceptable activities required of registered professionals. CPD requirements, including reflective practice, workplace focus, clinical aspirations, promotion, prevention, contribution to the profession and set hours are similarly held by all of the NASRHP professional bodies.

Each of the self-regulated professions undertakes a random audit of a percentage of participants in their CPD programs each period. Most professional bodies audit more members than are currently undertaken by AHPRA boards.

The CPD programs do not apply to non-members except those seeking accredited status where this exists e.g. Accredited Practising Dietitians’ accreditation and sonography.

8. Oversight of the management of health practitioners and students registered in the health profession, including monitoring conditions, undertakings and suspensions imposed on the registration of the practitioners are all carried out within the self-regulating professions

Most of the self-regulated professions have resumption-of-practice policies and requirements. All the professions in this group have a requirement for professionals to undergo additional training, supervision or coursework if they lack professional practice for a period of time (commonly 3 years or 5 years). This duration of absence from practice, and the measures required to retain rights to practise, are broadly in line with those expected of registered professions.

9. Student memberships

Each of the professions has a distinct membership category for students, with the exception of audiology, where all students in its accredited courses are required to be working part time as interns in the profession. For all the others, eligibility for student membership is enrolment in an accredited entry level course of study.

10. Oversight of the receipt, assessment and investigation of notifications about persons who are or were registered as health practitioners in the health profession under this law or a corresponding prior Act

Each of the professional bodies is responsible for the development, distribution and enforcement of a code of ethics and/or code of professional conduct that guides professional practice. Each is
responsible for complaints made against professionals for breach of this code. Each has a detailed
and comprehensive system in place to support this process, with senior staff designated to liaise
with complainants and the professional involved, an expert panel to take evidence and adjudicate on
cases, and a range of measures which can be taken against a professional found to have breached
their code of ethics. Each can bar a professional from membership of the association (and accredited
membership, where such a category exists).

11. Keep up-to-date and publicly accessible national registers of registered health practitioners
for the health profession

Each of the professional associations has, or is developing, a publicly accessible database of
members (and accredited members, where such a status exists). The public (including employers)
can find name, location and membership status.

Except in the case of sonography, where the register is held and made publicly available by ASAR,
the search tool does not apply to professionals who choose to be non-members (or non-accredited
members) of their association.

12. Public indemnity insurance

All of the self-regulating professional bodies recommend PI insurance; some mandate it and most
offer it either as part of their membership package or under a separate scheme.

13. Governance

Most board members of the self-regulated professions are from that profession. Increasingly,
the NASRHP professional bodies are expanding or changing their boards to include independent
directors. Most of the accreditation groups include external members. All ethics or conduct
committees have panels which are separate to their boards or councils. Many have other
professionals or consumers on their panels.

In the following pages two mapping documents are provided. The first summarises the current
functions of the self-regulating professional associations mapped against the national law, the
functions of AHPRA and the functions of the national boards. The second is a complete mapping of
the NASRHP associations against the AHPRA, NRAS functions.
Table 1: Summary – Mapping the functions of AHPRA and NRAS against current activities of the self-regulated professions

<table>
<thead>
<tr>
<th>National Law establishes</th>
<th>Functions of AHPRA</th>
<th>Functions of National Boards</th>
<th>Functions of Self-Regulating Professional Associations</th>
</tr>
</thead>
</table>
| National registration standards and processes, including identity and criminal history checking, English language competence and recency of practice requirements to ensure a consistently high quality of registration occurs nationally | To provide administrative assistance and support to the National Boards, and the Boards’ committees, in exercising their functions | To register suitably qualified and competent persons in the health profession and, if necessary, to impose conditions on the registration of persons in the profession – ensure:  
- identity and criminal history checks  
- English language competence  
- recency of practice | - Develop and assess eligibility for membership of the association which often doubles as the requirement for professional recognition  
- All have standards and processes for determining eligibility  
- Those who assess overseas qualified applicants assess English language competence and profession-specific competence testing  
- Recency of practice and criminal history checks not currently done |
| National requirements for registered health practitioners to only practice with appropriate professional indemnity insurance arrangements in place and to complete the continuing professional development requirements for their profession | In consultation with the National Boards, to develop and administer procedures for the purpose of ensuring the efficient and effective operation of the National Boards | To decide the requirements for registration or endorsement of registration in the health profession, including the arrangements for:  
- supervised practice in the profession  
- continuing professional development  
- appropriate professional indemnity insurance | - The self-regulated professional associations cannot demand professional indemnity insurance but they strongly encourage members to have it and many assist members to source it  
- Mandatory CPD requirements are in place for all members or those who maintain accredited status |
| National accreditation standards & functions (largely independent of governments) are set, and will ensure a consistently high standard of accreditation occurs nationally | To establish procedures for the development of accreditation standards, registration standards and codes and guidelines approved by national boards, for the purpose of ensuring the NRAS operates in accordance with good regulatory practice | To develop or approve standards, codes and guidelines for the health profession, including—  
i. the approval of accreditation standards developed and submitted to it by an accreditation authority; and  
ii. the development of registration standards for approval by the Ministerial Council;  
iii. the development and approval of codes and guidelines that provide guidance to health practitioners registered in the profession All self-regulated associations develop or approve standards, codes and guidelines for their profession. The association boards approve standards and codes developed by expert committees |
<p>| To keep an up-to-date and publicly accessible list of approved programs of study for each health profession | To approve accredited programs of study as providing qualifications for registration or endorsement in the health profession | All of the self-regulated professional bodies currently maintain an up-to-date list of programs accredited by them or for their profession on their websites |</p>
<table>
<thead>
<tr>
<th>National Law establishes</th>
<th>Functions of AHPRA</th>
<th>Functions of National Boards</th>
<th>Functions of Self-Regulating Professional Associations</th>
</tr>
</thead>
<tbody>
<tr>
<td>To establish and administer an efficient procedure for receiving and dealing with applications for registration as a health practitioner and other matters relating to the registration of registered health practitioners</td>
<td>To oversee the assessment of the knowledge and clinical skills of overseas-trained applicants for registration in the health profession whose qualifications are not approved qualifications for the profession, and to determine the suitability of the applicants for registration in Australia</td>
<td>Most of the NASRHP professional associations are authorised by DEEWR to assess overseas-qualified professionals. Those that are not are a key stakeholder of the professional body that does the assessments</td>
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<tr>
<td>In conjunction with the National Boards, to keep up-to-date national registers of students for each health profession</td>
<td>To establish an efficient procedure for receiving and dealing with notifications against persons who are or were registered health practitioners and persons who are students, including by establishing a national process for receiving notifications about registered health practitioners in all professions</td>
<td>All of the self-regulating professions have student membership but cannot mandate it</td>
<td></td>
</tr>
<tr>
<td>To establish an efficient procedure for receiving and dealing with notifications about persons who – i. are or were registered as health practitioners in the health profession under this Law or a corresponding prior Act; or ii. are students in the health profession</td>
<td>To oversee the receipt, assessment and investigation of notifications about persons who – i. health and performance and professional standards matters in relation to persons who are or were registered in the health profession under this Law or a corresponding prior Act; and ii. health matters in relation to students registered by the Board</td>
<td>All of the self-regulating professions have a national complaints management system in place. Some are more developed than others. Without authorised self-regulation, complaints are, by law, unable to be heard against professionals who do not join or are not accredited by their professional association</td>
<td></td>
</tr>
<tr>
<td>To do anything else necessary or convenient for the effective and efficient operation of the NRAS</td>
<td>To establish panels to conduct hearings about – i. health and performance and professional standards matters in relation to persons who are or were registered in the health profession under this Law or a corresponding prior Act; and ii. health matters in relation to students registered by the Board</td>
<td>Members of the professional body are encouraged to notify harmful practices, however, this cannot be mandated without authority from government</td>
<td></td>
</tr>
<tr>
<td>To oversee the management of health practitioners and students registered in the health profession, including monitoring conditions, undertakings and suspensions imposed on the registration of the practitioners or students; at the Board’s discretion, to provide financial or other support for health programs for registered health practitioners and students</td>
<td>As above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functions of AHPRA</td>
<td>Functions of National Boards</td>
<td>Functions of Self-Regulating Professional Associations</td>
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<tr>
<td>To refer matters about health practitioners who are or were registered under this Law or a corresponding prior Act to responsible tribunals for participating jurisdictions</td>
<td>All will be engaged with the ACCC Act. Some of the self-regulated professions have agreements with certain jurisdictional authorities or are informally called upon to provide expert evidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privacy protections to ensure a nationally high standard of protection is provided to information related to functions under the scheme</td>
<td>In conjunction with the National Agency, to keep up-to-date and publicly accessible national registers of registered health practitioners for the health profession</td>
<td>All self-regulated professional bodies have privacy policies in place and most provide regular staff training to minimise breaches of privacy</td>
<td></td>
</tr>
<tr>
<td>Transitional arrangements for existing registrants to transition to the National Scheme while maintaining the protection of the public and continuity of health services</td>
<td>To negotiate in good faith with, and attempt to come to an agreement with each National Board on the terms of a health profession agreement</td>
<td>Not applicable at present</td>
<td></td>
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<tr>
<td>To provide advice to the Ministerial Council in connection with the administration of the NRAS If asked by the Ministerial Council, to give to the Ministerial Council the assistance or information reasonably required by the Ministerial Council in connection with the administration of the NRAS</td>
<td>To give advice to the Ministerial Council on issues relating to the NRAS for the health professions If asked by the Ministerial Council, to give to the Ministerial Council the assistance or information reasonably required by the Ministerial Council in connection with the NRAS Make recommendations to the Ministerial Council about the operation of specialist recognition in the health profession and the approval of specialties for the profession</td>
<td>Not applicable at present</td>
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</table>
Table 2: Detailed mapping - How self-regulated professional associations perform the roles of AHPRA and the registration boards

<table>
<thead>
<tr>
<th>AHPRA/board function</th>
<th>Speech Pathology</th>
<th>Sonography</th>
<th>Audiology</th>
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</thead>
<tbody>
<tr>
<td>1. Registration of suitably qualified and competent persons in the health profession, and if necessary to impose conditions on the registration of persons in the profession</td>
<td>Practising membership of Speech Pathology Australia: Suitably qualified and competent persons eligible for membership include graduates from an SPA accredited training program or those with overseas qualifications who have satisfied the skills recognition assessment of SPA in accordance with DEEWR requirements</td>
<td>Ordinary (full) membership of ASA: Suitably qualified, competent and accredited persons eligible for membership include graduates from training programs accredited by ASAR or those with overseas qualifications who have satisfied the skills recognition assessment conducted by AIR in accordance with DEEWR requirements</td>
<td>CCP (Certificate of Clinical Practice) credentialing program: Suitably qualified and competent persons are eligible to join the program i.e. graduates of Audiology Australia accredited training courses in Australia or audiologists trained overseas who satisfy the skills recognition process for DEEWR i.e. have passed the Audiology Australia equivalence Theory Exam for Overseas Trained Audiologists Ongoing competency is supported by compliance with continuing professional development requirements</td>
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<tr>
<td></td>
<td>SPA Certification program (professional self-regulation) Suitable qualified persons who are practising members or full-time postgraduate student members of SPA are eligible to earn Certified Practising Speech Pathologist (CPSP) status through participation in SPA’s Professional Self-Regulation program which has mandatory CPD requirements</td>
<td>All Ordinary members are required to retain accredited sonographer status Ongoing competency is supported by compliance with triennial continuing professional development requirements Members are also bound by the ASA’s Competency Standards and the Code of Professional Conduct All ASA ordinary members are eligible to use the designation ‘ASA Certified Sonographer’</td>
<td></td>
</tr>
<tr>
<td>2. Development or approval of standards, codes and guidelines for the health profession</td>
<td>Speech Pathology Australia has been responsible for standards, codes and guidelines for accreditation of training courses and for standards of practice of the profession since 1949 Standards: Competency Based Occupational Standards (CBOS) 2011 Code of Ethics 2010 Scope of Practice 2003 (under current review) Parameters of Practice 2007 Principles of Practice 2001 Clinical guidelines Position statements</td>
<td>ASA has made significant progress towards developing a full suite of standards, codes and guidelines for the profession. Once complete, this work will include clinical guidelines and position statements on specific topics. Anticipated completion is 2013 The ASA Code of Professional Conduct was adopted in 2010 and the Competency Standards for the Entry Level Sonographer were published in 2011</td>
<td>The Federal Executive Council (FEC) of Audiology Australia and CCP Review Committee and Education Committee are responsible for standards, codes and guidelines until 2011. In line with other health professions, it is proposed that in 2012 an ‘Audiology Credentialing Committee’ be established to advise the FEC on the CCP program and qualifications issues The board has approved: Professional Standards of Practice for Audiologists Recommended Standards for Clinical Practice (undergoing revision at this time)</td>
</tr>
</tbody>
</table>
### Dietetics

- **APD (Accredited Practising Dietitian) credentialing program:**
  - Suitable qualified and competent persons are eligible to join the program i.e. graduates of DAA accredited training courses in Australia or dietitians trained overseas who satisfy the skills recognition process for DEEWR
  - Ongoing competency is supported by compliance with continuing professional development requirements

<table>
<thead>
<tr>
<th>Dietetics</th>
<th>Exercise Physiology</th>
<th>Orthotics &amp; Prosthetics</th>
<th>Perfusion</th>
<th>Diabetes Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>APD (Accredited Practising Dietitian) credentialing program:</td>
<td>Exercise Physiology accreditation program:</td>
<td>Certified Member of the AOPA (CPO):</td>
<td>Fellow of the College (FANZCP) – members who have passed the college certification exam and are re-certified</td>
<td>Suitable qualified and competent persons eligible to be credentialled are:</td>
</tr>
<tr>
<td>Suits a dual stream Bachelor of Prosthetics and Orthotics qualification from La Trobe University Melbourne, or equivalent</td>
<td>Suitably qualified and competent persons are eligible to become accredited as an accredited exercise physiologist through: graduating from a NUCAP accredited training course in Australia or individual application (until 1/1/14)</td>
<td>Eligibility assessed according to tertiary qualification. Must have a dual stream Bachelor of Prosthetics and Orthotics qualification</td>
<td>Clinical trainee, a student employed by a hospital or institution doing the Swinburne Master’s degree course or from 2012 the new ABCP course</td>
<td></td>
</tr>
<tr>
<td>From 1/1/2014 only graduates from a NUCAP-accredited exercise physiology training course will be accredited</td>
<td>Ongoing competency is supported by compliance with annual continuing professional development requirements</td>
<td>Renewal of membership is dependent on completion of the CPD program. Members are also bound by the Competency Standards and the Ethical Code and Professional Conduct By-law</td>
<td>Associate includes overseas perfusionists (non FANZCP), corporate members, students doing the Swinburne Master’s degree and others</td>
<td></td>
</tr>
<tr>
<td>Ongoing competency is supported by compliance with annual continuing professional development requirements</td>
<td></td>
<td>A Perfusion Registration Certificate indicates to employers, health insurance companies and patients that you are an appropriately qualified registered perfusionist</td>
<td>A Perfusion Registration Certificate indicates to employers, health insurance companies and patients that you are an appropriately qualified registered perfusionist</td>
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The Dietetic Credentialing Council with 3 external members administers the APD program and advises the board on standards and credentialing matters
The DAA board approves all standards and policies, APD by-law and associated policies, including return to practice requirements, CPD requirements and audit processes

The ESSA board is responsible for standards, codes and guidelines for AEPs, which are developed by ESSA’s accreditation and curriculum (EAC) committee
ESSA has:
- Code of professional practice and ethical practices
- Scope of practice
- AEP knowledge and skills criteria

The AOPA currently has a set of Competency Standards (2003) which are under review. We have an ethical code in place
We are currently looking to develop a set of standards of practice, scope of practice and position statements
We currently accredit training courses as part of the CPD program

The ANZCP is the only professional body, sole educator and trainer of clinical perfusionists
The Board of Cardiovascular Perfusion (ABC) certification exam consists of a 3-hour written paper, a 2-hour multiple choice and 2 x 30 minute oral sessions. They must pass all 3 sections to be accredited
Re-certification is on a 3-yearly rotation

The Credentialling Committee is responsible for advising the Board on credentialling, CPD programs and qualifications matters, and accredits training courses as part of CPD
The Board approves Position Statements and Clinical Recommendations developed by the Clinical Practice Committee, as well as standards for accreditation of courses reviewed by the Course Accreditation and Standards of Practice Committee
The code of conduct was reviewed and approved in 2010
### Approval of accredited programs of study as providing qualifications for registration or endorsement in the profession

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<tr>
<td>SPA acts as the accreditation authority for university training courses</td>
<td>ASAR acts as the accreditation authority which oversees accreditation processes for training courses. ASA is a stakeholder in ASAR</td>
<td>Audiology Australia has accredited training courses on a national basis since 2008</td>
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<td>Fifteen programs are currently accredited (including Bachelor and Graduate Entry Master’s programs) across 10 universities. There are also 2 new university programs awaiting accreditation</td>
<td>Entry level training is competency based</td>
<td>The Audiology Credentialing Committee of the Audiology Australia will act as an accreditation authority to oversee accreditation processes with representation from professionals and community members</td>
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<td>Entry level training is competency based. The Competency Based Occupational Standards (CBOS) was developed in 1994 with 2 revisions in 2001 and 2011</td>
<td>The ASA’s Competency Standards for the profession were published in October 2011 and adopted as the minimum standard for accredited courses by ASAR in December 2011</td>
<td>Entry level training is competency based. Competencies were developed in 2008 and are being reviewed in 2012</td>
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<td>The SPA university accreditation process does not prescribe clinical placement hours; rather a student’s final year assessment must be achieved against all profession-specific units (of CBOS) and a range of generic competencies</td>
<td>The ASA has also developed a set of guiding principles that aim to transition the profession from historical methods of education and training to a more sustainable model that acknowledges sonography as a discrete profession</td>
<td>Entry level training is generalist and supported by the Clinical Internship program</td>
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<td>Graduates of accredited programs are able to work anywhere in Australia Speech pathology is a registered profession in Queensland. The registration board accepts accreditation of courses by SPA</td>
<td>At present, all entry level courses are at Graduate Diploma or higher through the Higher Education sector, with the exception of a professional qualification (accredited as equivalent); however, it is envisaged that the advanced body of knowledge required for the profession will see the requirement transition to Master’s level</td>
<td>There are currently 5 Schools of Audiology with approved programs</td>
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<td>Graduates of accredited programs are able to work anywhere in Australia. They are also highly regarded internationally</td>
<td>Graduates are able to work anywhere in Australia, thus ensuring workforce mobility</td>
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<td>Accredited courses are completed part time, generally over 2 years (graduate diploma) whilst holding a paid student sonographer position of at least 0.6 EFT. No post-qualification requirement</td>
<td>Students are required to do, within their qualifying studies, a range of clinical placements covering various aspects of clinical work as per the Core Knowledge and Competencies mandatory for graduation. This is based on 200 hours of client interface and 300 hours of clinical support tasks</td>
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<td>Upon successful completion of their Master’s degree they then go on to complete a competency-based Clinical Internship to achieve a Certificate of Clinical Practice (CCP), which is effectively required by all health sector agencies as a quality ‘benchmark’ mechanism in the absence of licensing or registration</td>
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Harnessing self-regulation to support safety and quality in healthcare delivery

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<td>DAA has accredited training courses on a national basis since 1984</td>
<td>ESSA has accredited training courses on a national basis since 2005</td>
<td>The AOPA does not accredit programs of study. It is the known authority for consultation when courses and training programs at the TAFE level (technician) are developed</td>
<td>Eligibility to become a clinical trainee: practitioner must have a science degree, be employed by a hospital or medical institution and be sitting or have passed the Swinburne Master's Degree in Perfusion Science (2006–2011)</td>
<td>ADEA currently acts as the accreditation authority for university training courses. The Course Accreditation and Standards of Practice Committee administers and advises the Board on these processes. Currently, five postgraduate courses are accredited. All courses are at the Graduate Diploma level or higher. Students are required to complete a clinical placement as part of their qualifying studies. Upon successful completion of their qualification, diabetes educators are required to complete the ADEA credentialling process to achieve credentialed status. This includes supervised placements, covering the core competencies, and attainment of CPD points. Graduates are able to work anywhere in Australia</td>
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<td>The Australian Dietetic Council acts as an accreditation authority that oversees accreditation processes and has professional and community members</td>
<td>ESSA acts as an accreditation authority to oversee accreditation processes. The National University Course Accreditation Program (NUCAP) committee of ESSA comprises academic and practitioner members. The exercise physiology accreditation is comprised of knowledge and skill criteria. The exercise physiology accreditation was established in 2002 and a revised version occurred in 2008. It is anticipated a revision will occur in 2012–2013</td>
<td>This lack of accreditation process is due to there being only one university degree in Australia and currently no formal technician training programs. Due to an influx of IHP applicants for membership and difficulties with assessing 'equivalency', this process is under review. The LTU Orthotics and Prosthetics program is a 4-year Clinical Master's in Prosthetics and Orthotics. This qualification is internationally recognised, is classified as ISPO (the International Society for Prosthetics and Orthotics) category 1, and graduates have a qualification recognised by every country in the world.</td>
<td>Only students who were employed as trainees in a clinical hospital were eligible to sit the ABCP certification exams. The students had to have independently completed 200 cases and have the approval of their supervisor to sit the board exams. The student is also expected to attend a perfusion simulation course run twice a year by the College, where they are challenged with adverse event scenarios to manage during simulated surgery. ANZCP education committee, the Board of Cardiovascular Perfusion (ABCDEP) is responsible for overseeing education and training.</td>
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<td>Dietitians must complete a minimum 20-week (800 hrs) professional practicum, including at least two different hospital sites and one community health placement.</td>
<td>The exercise physiology accreditation is comprised of knowledge and skill criteria. The exercise physiology accreditation was established in 2002 and a revised version occurred in 2008. It is anticipated a revision will occur in 2012–2013.</td>
<td>The LTU Orthotics and Prosthetics program is a 4-year Clinical Master's in Prosthetics and Orthotics. This qualification is internationally recognised, is classified as ISPO (the International Society for Prosthetics and Orthotics) category 1, and graduates have a qualification recognised by every country in the world.</td>
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<td>SPA has been responsible for administering the processes of recognition of overseas-trained speech pathologists from the early 1970s onwards, and as the recognised ‘Assessing Authority’, provides reports to DEEWR on a 6-monthly basis. SPA has successfully negotiated mutual recognition programs with overseas associations viz. ASHA (USA), CASLPA (Canada) and RCSLT (UK), IASLT (Ireland) and NZSTA (New Zealand). The Queensland Registration Board defers to the Association’s assessment of those with overseas qualifications.</td>
<td>There are very few applicants under this scheme. An average of 7 professionals enter the profession through this avenue annually (2005-2010 data). Due to historical connections throughout the evolution of sonography, and a lack of regular assessment of the appropriateness of appointments as ‘Assessing Authority’, the AIR has been and continues to be responsible for administering the processes of recognition of overseas-trained sonographers and is the only recognised ‘Assessing Authority’ through DEEWR. The fragmentation of this area of regulation for sonography generates confusion for potential applicants and detailed outcomes are not regularly communicated to all stakeholders. To the ASA’s knowledge there are no mutual recognition programs in place.</td>
<td>Audiology Australia is responsible for administering the processes of recognition of overseas-trained audiologists in the hearing healthcare sector. Eligibility for membership of Audiology Australia is the benchmark for employment in Australia.</td>
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4. **Oversight of the assessment of the knowledge and clinical skills of overseas-trained applicants for registration in the health profession whose qualifications are not approved qualifications for the profession, and determine the suitability of the applicants for registration in Australia**
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<td>DAA is responsible for administering the processes of recognition of overseas-trained dietitians and provides reports to DEEWR on an annual basis</td>
<td>ESSA is responsible for administering the process of recognising overseas-trained exercise physiologists</td>
<td>AOPA is looked to by Australian employers to assess and/or recognise overseas-trained practitioners. We currently do not have a course accreditation process or competency-based assessment in place</td>
<td>College is working on improved guidelines to support employing overseas perfusionists depending upon their education background, and their originating country, to either sit a modified course or the full course</td>
<td>ADEA is responsible for administering the process of recognition of overseas-trained diabetes educators, through its Credentialling Committee</td>
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<td>DAA has received research funding from DEEWR to develop alternative formats for examinations</td>
<td>ESSA is looking to develop a relationship with DEEWR to be recognised as the assessor of overseas-trained exercise physiologists</td>
<td>Orthotist/prosthetists has recently been removed from the Skilled Occupations List (SOL) for skilled migration. We have recently made a submission into the 2012 review for inclusion.</td>
<td>DEEWR does not have a position on overseas perfusionists</td>
<td>Currently ADEA has no mutual recognition of credentials with other international registering organisations</td>
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<tr>
<td>DAA has successfully negotiated mutual recognition programs with overseas national dietetic associations, including New Zealand and more recently Canada, to support international workforce mobility. This work has been used as a model by other professions, including Federal Treasury looking for advice on mutual recognition of auditors. It is also the basis for the DEEWR ‘How to ...’ guide on mutual recognition</td>
<td>Currently ESSA has no mutual recognition of credentials with other international registering organisations</td>
<td>Currently DEEWR appears to have no assessing authority in place</td>
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<tr>
<td>College is working on improved guidelines to support employing overseas perfusionists depending upon their education background, and their originating country, to either sit a modified course or the full course</td>
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<td>Interested in establishing mutual recognition, especially with the HPC, which manages the registration of orthotist/prosthetists in the UK</td>
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<td>5. Development or approval of standards, codes and guidelines for the profession, including the development of registration standards for approval by the Ministerial Council; and the development and approval of codes and guidelines that provide guidance to health practitioners registered in the profession.</td>
<td>SPA’s Professional Self-Regulation (PSR) program leading to Certified Practising Speech Pathologists (CPSP) status has been in place since 2000. PSR is designed around the principle of self-regulation. PSR participants complete professional development that enhances professional practice skills. A range of designated activity types are logged through the year and across a triennium. SPA has a code of ethics (revised 2010) by which all members must abide. There are no conferred specialist titles; however, certain practice areas are considered to be advanced areas of practice, some of which may require workplace credentialing. Criteria for provider eligibility for certain government programs i.e. the FaHCSIA Working with Children with Autism program (sole providers) and the Better Start for Children with Disabilities program requires speech pathologists to be a Practising Member and Certified Practising Speech Pathologist (CPSP) (or earning eligibility to be a CPSP in the initial 12-month qualifying period).</td>
<td>ASA has made significant progress towards developing a full suite of standards, codes and guidelines for the profession. This work will include practice guidelines and position statements on specific topics to be completed by 2013. Membership of ASA is dependent on compliance with the ASA Code of Professional Conduct, updated in 2010. The Competency Standards for the Entry Level Sonographer were published in October 2011 and adopted as the minimum standard for accredited courses by ASAR in December 2011. ASAR’s scope extends to the accreditation of education programs and individual sonographers who are then listed on the register of accredited medical sonographers. Accreditation is the requirement for sonographic practice, as is complying with continuing professional development requirements. It also manages recency of practice requirements for practitioners returning to sonography. ASAR does not develop practice standards, codes or guidelines. The ASA’s Certified Sonographer standard sets a more rigorous level of self-regulation, as it also requires practitioners to operate within a code of professional conduct. At a minimum, the ASA believes that all practitioners should be required to demonstrate eligibility to the ASA’s Certified Sonographer program. The ASA Competency standards for the entry level sonographer identify discipline-specific competencies across four disciplines. Although they have been identified as such in the past, these are not specialties, as there is less breadth of knowledge required than for a general sonographer and they do not require the completion of an initial general sonography program. There is the scope for discipline-specific accreditation from ASAR.</td>
<td>A CCP credentialing program has been in place since 1972 and currently supports entry level practice – a review of the current CCP is considering processes to introduce an advanced practice CCP. Audiology Australia entry level training is generalist. Entry level practitioners must satisfy mentoring and CPD requirements for a minimum of 12 months before they are awarded the Certificate of Clinical Practice (CCP). Advanced credentials i.e. Advanced CCP (and the specialist identification), would be competency based, and would require additional CPD requirements to that of retaining the generalist CCP. To provide services for the Federal Better Start program (FaHCSIA) an audiologist must be a full &amp; CCP member and have specific expertise, experience and the resources to provide diagnostic, and frequently, paediatric services. Audiology Australia has developed a range of guidelines and position papers on advertising, internet sales, tinnitus, etc.</td>
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<td>APD credentialing program has been in place since 1994 and supports both entry level practice and advanced practice</td>
<td>ESSA’s accreditation program has been in place since 2002</td>
<td>The AOPA supports the use of standards and codes to guide the professional conduct of its membership. Currently the AOPA has published competency standards (2003) and a code of ethical practice (updated 2010) in place</td>
<td>The course is unaccredited on national or state levels due to the high cost of registering the 4 or less students that are trained each 2 years within Australia and New Zealand. The Royal College of Surgeons and Anaesthetists were involved and assisted us with setting the earlier education program. ANZCP perfusionists can be employed anywhere in Australia and New Zealand. The Fellows of the ANZCP support the College Guidelines and Regulations and employ only board-eligible clinical trainees and certified perfusionists. However, the hospital is under no obligation to do so unless the Director of Perfusion has specified it as a pre-requisite for employment.</td>
<td>ADEA’s credentialing program commenced in 1986 with two formal reviews since undertaken. The credentialing program supports advanced practice in diabetes education. Practitioners must satisfy supervised placement, mentoring and CPD requirements before recognition of credentialled status. The ADEA has a code of professional conduct to guide diabetes educators. The ADEA has Clinical Recommendations and Position Statements on a range of clinical and education matters.</td>
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<td>DAA entry level training is generalist</td>
<td>The accreditation program requires professionals to meet all of the knowledge and skills criteria, plus 500 hours of clinical training. Annual professional development is required to help achieve personal development plans for each AEP</td>
<td>The AOPA is committed to developing a full suite of guidelines for the profession and this process is currently underway. The Competency Standards are also currently under review. International practice and publications provide for an extensive range of documents relating to scope of practice, extended practice and professional guidelines, which the AOPA will consider in its review. AOPA members are bound by the Statement of Rules and Purpose (2011) of the Association, as well as the Competency Standards (2003) and By-laws (2010). Within the By-laws the restriction of membership renewal according to CPD status is outlined. CPD is a mandatory process which allows the practitioner to use the title AOPA certified Orthotist/Prosthetist. The AOPA has no ‘specialist recognition’ or advanced credentialing in place.</td>
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<td>Entry level practitioners must satisfy mentoring and CPD requirements for a minimum of 12 months in the provisional phase before full status is achieved. Advanced credentials i.e. Advanced APD and Fellow, are competency-based, generalist in nature and consider five aspects of practice. This has been pursued rather than specialist credentials</td>
<td>ESSA has developed AEP scope of practice document, delineation of roles document with Dietitians Association of Australia and a number of position statements on a range of clinical conditions. Currently there is no specialist recognition of exercise physiologists</td>
<td>International practice and publications provide for an extensive range of documents relating to scope of practice, extended practice and professional guidelines, which the AOPA will consider in its review. AOPA members are bound by the Statement of Rules and Purpose (2011) of the Association, as well as the Competency Standards (2003) and By-laws (2010). Within the By-laws the restriction of membership renewal according to CPD status is outlined. CPD is a mandatory process which allows the practitioner to use the title AOPA certified Orthotist/Prosthetist. The AOPA has no ‘specialist recognition’ or advanced credentialing in place.</td>
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<td>DAA has a code of professional conduct and statement of ethical practice to guide APDs</td>
<td>ESSA has a code of professional conduct to guide all members, including AEPs</td>
<td>The AOPA is committed to developing a full suite of guidelines for the profession and this process is currently underway. The Competency Standards are also currently under review. International practice and publications provide for an extensive range of documents relating to scope of practice, extended practice and professional guidelines, which the AOPA will consider in its review. AOPA members are bound by the Statement of Rules and Purpose (2011) of the Association, as well as the Competency Standards (2003) and By-laws (2010). Within the By-laws the restriction of membership renewal according to CPD status is outlined. CPD is a mandatory process which allows the practitioner to use the title AOPA certified Orthotist/Prosthetist. The AOPA has no ‘specialist recognition’ or advanced credentialing in place.</td>
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<td>AED has a constitution and by-laws which provide clear processes for investigating complaints. ESSA is currently developing a guideline on recency of practice and another on English literacy skills</td>
<td>ESSA has a code of professional conduct to guide all members, including AEPs</td>
<td>AOPA members are bound by the Statement of Rules and Purpose (2011) of the Association, as well as the Competency Standards (2003) and By-laws (2010). Within the By-laws the restriction of membership renewal according to CPD status is outlined. CPD is a mandatory process which allows the practitioner to use the title AOPA certified Orthotist/Prosthetist. The AOPA has no ‘specialist recognition’ or advanced credentialing in place.</td>
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<td><strong>7. Professions registered by AHPRA must undertake discipline-specific minimum CPD hours, recorded as points or hours. Declaration signed by individual health practitioner at membership renewal time. Audit conducted.</strong></td>
<td>To be a Certified Practising Speech Pathologist (CPSP), professional development activities must be undertaken</td>
<td>To remain an accredited sonographer, continuing professional development is mandatory</td>
<td>CP program requires 50 hours CPD per 2 years, and has desktop auditing of all who hold a CCP</td>
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<td>CPSP status requires a minimum total of 60 points in three years, with a minimum of 15 points each year, including a minimum of 10 points in activities related to clinical practice and a ceiling of 12 points for each activity type</td>
<td>A minimum of 40 points per triennium must accrue, across a broad range of activities, many of which have caps</td>
<td>Auditing of 30% of logs of eligible CCPs occurs biennially</td>
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<td>Activities must be relevant and extend professional practice, skills and knowledge. A diverse range of relevant activities is recognised</td>
<td>At the end of each practitioner’s triennium, a desktop audit is conducted to ensure they have logged sufficient points. Penalties apply for non-compliance</td>
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<td>Declaration of points and completion of an activity log sheet are required at the annual membership renewal</td>
<td>A minimum of 10% of the practitioners completing their triennium are randomly selected for a full audit annually. These practitioners are required to furnish evidence of the activities they have undertaken. Penalties apply for non-compliance. Activities must be relevant and extend professional practice skills and knowledge. A diverse range of relevant activities is recognised</td>
<td>The ASAS operates a recognised CPD program that fulfils the minimum requirements as determined by ASAR and extends these with two additional programs that require either 15 or 40 points in every year. This extension is viewed by ASAS as a positive way members can re-cast undertaking CPD from a requirement to a vital component of the sonographers’ professionalism</td>
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<td>Random auditing of at least 5% occurs</td>
<td>The PD-asa program conducts full audits of 10% of each category</td>
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<td>Penalties apply for non-compliance</td>
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<td>Current consideration is being given to requiring Certified Practising Speech Pathologist status (including mandatory CPD) for eligibility for practising membership of Speech Pathology Australia</td>
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<td>Resumption-of-practice requirement: Audiologists who have not practised from more than three years and less than five – and have previously held a CCP – must undertake a structured program, and complete the required number of hours in CPD and engage a mentor. This is known as a ‘Fast Track’ Internship</td>
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<td><strong>8. Oversight of the management of health practitioners and students registered in the health profession, including monitoring conditions, undertaking and suspensions imposed on the registration of the practitioners. Professions registered by AHPRA have discipline-specific resumption-of-practice requirements</strong></td>
<td>Recency of practice requirements apply: Speech pathologists previously eligible for practising membership with SPA who have practised for less than 1000 hours during the previous five years, must undertake a re-entry program to be eligible for practising membership</td>
<td>All ASA members are eligible to use the designation ‘ASA Certified Sonographer’ or ‘ASA Certified Student Sonographer’</td>
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<td>New graduates retain eligibility for practising membership for up to three years. New graduates who remain non-practising for more than three years but less than 12 years are required to undertake a a re-entry program to regain eligibility. Those who graduated more than 12 years ago and have not practised do not qualify for re-entry and are guided to study selected coursework through a university</td>
<td>ASA members must comply with the ASA code of professional conduct and can be deemed ineligible for membership</td>
<td>Audiologists who have not practised for more than five years must undertake the full 12-month Clinical Internship</td>
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<td>ASAR does not have the capacity to impose suspensions on the right to practise for breaches of a code of conduct or criminal activity</td>
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<td></td>
<td>ASA considers this to be a significant risk to the health, wellbeing and safety of consumers</td>
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<td></td>
<td>A recency of practice policy applies and is managed by ASAR. All accredited sonographers returning to the profession after more than 5 years absence are required to undertake a re-entry program</td>
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</tr>
</tbody>
</table>

Note: The above information is a summary of the requirements and processes for various health professions in Australia. The details presented are based on the information available and may not be exhaustive.

Source: [Australian Health Practitioner Regulation Agency (AHPRA)](https://www.ahpra.gov.au/)

<table>
<thead>
<tr>
<th>Dietetics</th>
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<th>Diabetes Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>APD program requires 30 hours CPD per year, and has an auditing component</td>
<td>AEPs are required to complete 20 hours CPD per year, and has an auditing component</td>
<td>For renewal of membership, a member must adhere to the CPD program, which is mandatory. This is a discipline-specific program consisting of weighted hours, which is submitted online. It requires a minimum of 30 points over one financial year. The audit process involves the auditing of 5% of CPD logs annually</td>
<td>A minimum clinical practice of 150 cases and 45 CEU points are required. Points from 3 categories: (1) Accredited perfusion meetings, seminars and other perfusion activity; (2) Non-accredited perfusion and other medical meetings; (3) Individual educational and self-study activities</td>
<td>Attainment of continuing professional development points in a range of areas is mandatory to remain a Credentialled Diabetes Educator. While diabetes educators retain their credentialing status for three years annual submission of CPD portfolio is required. The minimum total of points is 40 per year</td>
</tr>
<tr>
<td>APDs are required to record CPD for a minimum of 30 hours per year, and active learning activities are encouraged</td>
<td>A minimum of 15 hours must be undertaken in further education</td>
<td>Activities must be relevant and extend professional practice, skills and knowledge. A diverse range of relevant activities are recognised</td>
<td>At the end of a three-year cycle a perfusionist submits a record of continuing education activities undertaken in the last three years. If sufficient continuing professional education points have been accrued and verified a Certificate of Registration will also be issued</td>
<td>There are three core categories for points allocation. The number of points required from each category varies and is determined by the diabetes educator’s role and scope of practice</td>
</tr>
<tr>
<td>Auditing of 5% of logs of eligible APDs occurs annually. Penalties apply for non-compliance</td>
<td>Auditing of 15% of logs of AEPs occurs annually</td>
<td>Auditing of 15% of logs of AEPs occurs annually</td>
<td>5% of applicants are audited which involves a member of the College visiting their institution and checking the hospital records (without compromising patient privacy)</td>
<td>Declaration of points and an activity log are required at the time of renewal. Random auditing of 10% occurs</td>
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<tr>
<td>CPD consists of:</td>
<td>Penalties apply for non-compliance</td>
<td>Penalties apply for non-compliance</td>
<td></td>
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<tr>
<td>- Professional education – non assessed (20 hours per year cap)</td>
<td>CPD accredited areas are: professional development further education self-directed learning community services</td>
<td>CPD accredited areas are: professional development further education self-directed learning community services</td>
<td>Long-term education points are required. Points from 3 categories: (1) Accredited perfusion meetings, seminars and other perfusion activity; (2) Non-accredited perfusion and other medical meetings; (3) Individual educational and self-study activities</td>
<td></td>
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<tr>
<td>- Professional education – assessed</td>
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<td>At the end of a three-year cycle a perfusionist submits a record of continuing education activities undertaken in the last three years. If sufficient continuing professional education points have been accrued and verified a Certificate of Registration will also be issued</td>
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<td>- Self-study activity (20 hours per year cap)</td>
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<td>5% of applicants are audited which involves a member of the College visiting their institution and checking the hospital records (without compromising patient privacy)</td>
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<tr>
<td>- Evidence-based activity</td>
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<tr>
<td>- Mentee/mentor activity</td>
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<td>- Quality improvement activity</td>
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<td>- DAA strategic activity</td>
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**Dietitian**

- ESSA is currently addressing the requirements of resumption-of-practice requirements
- These requirements will be in place by July 2012

**Orthotist & Prosthetist**

- The AOPA has no resumption-of-practice process in place or policy on recency of practice

**Perfusionist**

- Scope of practice policy, rules and a well-developed process for regulation
- Well-developed practice guidelines and a self-regulation program advertised via our website www.anzcp.org for practitioners and the public to report a perfusionist voluntary perfusion incident reporting system for adverse events on our website, which is reported via our biannual gazette

**Diabetes Educator**

- To resume practice, diabetes educators who have not practised for more than three years and have previously been credentialled must undertake a structured Home Study program and complete a mentorship and the required CPD points
<table>
<thead>
<tr>
<th>AHPRA/board function</th>
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<th>Sonography</th>
<th>Audiology</th>
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</thead>
<tbody>
<tr>
<td><strong>9. Student membership</strong></td>
<td>Students in accredited courses can join as student members</td>
<td>Students in accredited courses can join ASA as student members</td>
<td>Students in Audiology Australia accredited Master’s courses can join as student members</td>
</tr>
<tr>
<td><strong>10. Oversight of the receipt, assessment and investigation of notifications about persons who are or were registered as health practitioners in the health profession under this law or a corresponding prior Act</strong></td>
<td>SPA has formal complaints handling mechanisms and disciplinary procedures. An appointed Ethics Board that can convene investigation panels investigates formal complaints regarding members of the Association. Complaints are considered with respect to a breach of the code of ethics. SPA has a delegated officer – Senior Advisor Professional Issues – who coordinates the work of the board and is the first point of contact for complaints.</td>
<td>A disciplinary committee investigates formal complaints to the ASA. The committee has an extensive set of procedures and processes that apply once a written complaint is received and it is determined that there may be a breach of the code. ASA has a delegated officer who coordinates this work and is the first point of contact for complaints. Formal complaints handling mechanisms and disciplinary procedures are in place. This code only applies to ASA members – currently around 70% of the profession. The committee is completely separate from the board and includes members of the profession and others.</td>
<td>Audiology Australia has a code of ethics and is developing an aligned code of professional conduct and statement of professional ethics to guide all members including CCPs. Audiology Australia has a constitution and by-laws that provide clear processes for investigating complaints.</td>
</tr>
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<tr>
<td>Students in accredited courses can join as student members</td>
<td>Students in accredited courses can join as student members</td>
<td>Students enrolled in the LTU program can join as student members</td>
<td>All students who have a BSC or higher qualification and are employed clinically within a perfusion department are eligible to enter the ABCP Perfusion Education and Training course. They are offered free membership to the College during their 1st year as student members but can remain members upon payment of a fee until they are accredited</td>
</tr>
</tbody>
</table>

Complaints and disciplinary procedures in place, and tested:
- DAA has a constitution and by-laws that provide clear processes for investigating complaints
- Code of Professional Conduct
- Complaints and Disciplinary Procedures By-law
- Statement of ethical practice (for guidance)

ESSA has complaints and disciplinary procedures in place

- ESSA has a constitution and by-laws that provide clear processes for investigating complaints

The AOPA has a national council that adheres to our constitution, including our code of ethics and professional conduct. The rules and statement of purposes includes an article addressing complaints, disputes and mediation, discipline, suspension and expulsion

- This procedure is managed by the president, secretary or a nominated complaints manager. A complaint is assessed against the code of ethics and professional conduct and competency standards. Therefore, only the complaints relating to practising orthotist/prosthetists with AOPA membership can be managed

ANZCP has a well-established code of ethics and code of conduct

- Perfusionists Regulation Board sets up a Standards and Complaints Committee to manage the complaints and administer any recommendations. An external lawyer is included in this committee

ADEA has formal complaints handling mechanism and disciplinary procedures. The procedures are contained in the ADEA Constitution. The Complaints Committee comprises consumer and health professional members and reports to the ADEA Board. ADEA also has a code of conduct
## AHPRA/board function

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<tr>
<td>11. Keep an up-to-date and publicly accessible national registers of registered health practitioners for the health profession</td>
<td><strong>Up-to-date database records details of all members of SPA and supports member services and generates reports</strong>&lt;br&gt;<strong>An online ‘Find a Speech Pathologist’ search allows check on CPSP status and Medicare provider status as well as areas of clinical interest</strong>&lt;br&gt;<strong>SPA is able to analyse current data to provide information across all practice settings relevant to workforce data collections</strong>&lt;br&gt;<strong>Additional data collection could be undertaken to contribute to workforce data pool if required</strong></td>
<td><strong>An up-to-date ASA web-based database records details of all members and supports the provision of member services</strong>&lt;br&gt;<strong>ASA is able to analyse current data to provide information across practice settings relevant to workforce data collections. ASAR database holds minimal information on each accredited practitioner. It provides a publicly accessible search function to enable checks on accredited status</strong></td>
<td><strong>Audiology Australia maintains a listing of all clinics where its members offer audiological services. Members of the public are able to make enquiries about a member’s clinical status and practice location</strong>&lt;br&gt;<strong>Audiology Australia is able to analyse current data to provide information across a range of practice settings relevant to workforce data collections</strong>&lt;br&gt;<strong>Additional data collection would be undertaken to contribute to workforce data pool as required e.g. HWA</strong></td>
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<tr>
<td>12. Professional Indemnity</td>
<td><strong>SPA recommends the PI policies but it is not mandatory. Forty-five per cent of practising members have taken up PI cover with SPA’s recommended provider. Additional members will have taken up PI through other insurance programs (union or other brokers). It is estimated that approximately 60–70% of members carry PI policies</strong></td>
<td><strong>There is no obligation for practitioners to hold PI and legal benefits insurance. ASA provides PI insurance as an optional part of membership and strongly recommends members hold insurance independent of their employer. About 88% of eligible (full or student) members have insurance coverage through ASA, the status of the other 12% and ASA non-members is not established</strong></td>
<td><strong>All audiologists in private practice, anyone doing contract work or sessional work must have PI – it’s also a significant requirement for doing work for any agency such as the Office of Hearing Services, DVA, Workcover, etc., and a current policy must be provided annually</strong></td>
</tr>
<tr>
<td>13. Governance arrangements</td>
<td><strong>Currently only members form the board of SPA</strong>&lt;br&gt;The Ethics Board has three consumer representatives</td>
<td><strong>Up to 2 non-sonographer directors are appointed by the board to enhance the skill set</strong></td>
<td><strong>Only audiologists who are members of Audiology Australia are eligible for positions on the Federal Executive Council and State Branch Executive Councils. Audiology Australia is in the process of restructuring their Ethics Committee which oversees the codes of ethics and conduct and complaints management procedures to incorporate consumer representation</strong></td>
</tr>
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<tr>
<td>Up-to-date database supports members’ service and generates reports Online service allows check on APD status, and for any who are sanctioned under the code DAA is able to analyse current data to provide information across all practise settings relevant to workforce data collections Additional data collection could be undertaken to contribute to workforce data pool if required</td>
<td>Up-to-date database supports members service’ and generates reports ESSA's database supports an online service to check on AEP status to AEPs who wish to be promoted on our website</td>
<td>Up-to-date database records of all AOPA members Online 'find an orthotist/prosthetist' function Database allows for checking of CPD status</td>
<td>A list of registered and certified perfusionists is available to the public on our website <a href="http://www.anzcp.org">www.anzcp.org</a> and is updated on a yearly basis</td>
</tr>
</tbody>
</table>

Approximately 25% of all dietitians have PI insurance through DAA's scheme with Guild: all the consultants and private practitioners Many in the public system have insurance through their union, estimated to be another 30% PI insurance is required for all practising exercise physiologists, whether accredited or not ESSA is uncertain what proportion of all exercise physiologists holds PI insurance as not all purchase PI from our preferred provider Guild AOPA supports the PI policies through Guild Insurance but it is not mandatory ANZCP does not offer indemnity insurance due to the membership size. The union (MSAV) has a $5 million indemnity insurance policy for members and not all perfusionists are members. All perfusionists who work in private practice do so as a part of a group and they must have insurance Professional indemnity insurance is mandatory for practising diabetes educators. ADEA offers insurance to members, and many have insurance through their relevant union |

All directors are DAA members but the ADC, DCC and Complaints Committees all have substantial external representation ESSA has non-profession members on its Board of Directors The National Council is made up only of practising orthotist/prosthetists Only FANZCP and those who are also life or honorary fellows (holding FANZCP) are entitled to vote and thus make decisions about standards setting. In the past, the Australian and New Zealand College of Surgeons and the College of Anaesthetists have been members of our Education Board ADEA has 11 directors on its Board. All are required to be ADEA members. Eight are required to be practising diabetes educators. The other three of the positions can be skills-based |