RESPONSE TO CONSULTATION - 29 SEPTEMBER 2014

for the

Review of the National Registration and Accreditation Scheme (NRAS) for Health Professions

Monday 6 October 2014
Review of the National Registration and Accreditation Scheme for Health Professions

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. The College is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees and International Medical Graduates. There are nine surgical specialties in Australasia being: Cardiothoracic surgery, General surgery, Neurosurgery, Orthopaedic surgery, Otolaryngology Head-and-Neck surgery, Paediatric surgery, Plastic and Reconstructive surgery, Urology and Vascular surgery. RACS also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research.

Concerns about consultation process

RACS has carefully assessed the consultation paper distributed for this review and believes it to be inadequate from a number of viewpoints. Given the complexity of the task that initially confronted the Australian Health Practitioner Regulation Agency (AHPRA) in the creation of a national scheme, the review questions should now reflect the areas where its effectiveness and efficiency can be improved in order to deliver a national system capable of matching the unique structures within Australia to the advantage of the community.

The focus should be on ensuring a high and uniform standard across the country with systems and processes that are streamlined and clearly structured to meet established benchmarks. The principles of the national scheme include transparency, accountability and fairness in its processes. These should have been evaluated within the review. Equally, given the current Federal Government’s emphasis on reducing the red tape of regulators, there needed to be a heightened emphasis on reducing layers, complexity and double handling of issues between the regulator of health professionals and other stakeholder groups.

Unfortunately, the consultation paper appears to reflect a ‘pre-determined outcome’ suggesting that a ‘regulator of the regulator’ with additional committees of unspecified powers would provide solutions to some of the challenges that have confronted AHPRA. Equally there appears to be an ongoing desire to replicate processes and entities that first surfaced in the United Kingdom over ten years ago, but without recognising two key issues.

Firstly, that United Kingdom health services are profoundly different from its Australian counterpart. The presence of the National Health System (NHS) is overwhelming it is the service provider for health in the United Kingdom. Any regulatory activities works with the health system and many of the regulatory activities are funded from within the structure and with the resources of the NHS. Secondly, the United Kingdom has suffered from significant health-related scandals over the past 20 years, from the Bristol infirmary to the more recent Staffordshire Hospital. It has come from a very difficult and dissimilar past. Although Australia has had its own health scandals, understanding the reason for these is crucial. Service delivery is extremely different from the United Kingdom, with variations between states and territories as well as between the public and a very prominent private sector. History is full of politically driven, short term reforms that responded to urgent crises. It is crucial that this implementation review of the national system in Australia does not succumb to this but is instead focused on ways to improve the system that we have introduced. It should not complicate, fragment or undo some of the benefits derived from a nationally consistent scheme. It should not merely add committees to the structure. In brief, we need to first define the problems, rather than simply apply solutions that are ideologically driven and with limited perspective.
Objectives

Four key points were established from within the objectives of the national scheme.

1. Protection of public safety
2. Facilitation of workforce mobility and high quality education and training
3. Promotion of access to health services

Concerns were raised at the time and continue to be raised today that the key and principal purpose of the regulator should be protection of the public by ensuring the registration of all health practitioners who are suitably trained and qualified to practise in a competent and ethical manner. This is consistent with international standards. Australia is an exception where AHPRA and the various boards are now also asked to balance issues of access and flexibility of workforce. There is a fundamental conflict of interest where an access issue may identify a solution involving a random practitioner but protection of public safety would not involve a specific practitioner. This issue should have received careful consideration by the review and it is disappointing that this is neither explored nor quantified in the review.

RACS does not believe that reliance on the system of protection of title is adequate protection for the public. RACS continues to profile the significance carried by the title of surgeon. The public has confirmed through surveys and research that surgeons should have medical qualifications and additional training to justify the standards required to be safe in undertaking surgery. Unfortunately the title system that has been introduced does not provide this certainty. Although ‘specialist surgeon’ is protected, this is not generally understood by the public, who continue to attach equivalent meaning to the word surgeon. Consideration should be given to protecting and restricting the title of surgeon to those who have received specific training from a recognised surgical educational program. The standards for the surgery performed need to be at a required level from these programs.

Workforce and related scopes of practice provide some of the key concerns to the health sector and the various government health departments. This will only be accentuated when funding to Health Workforce Australia is cut and some of the functions are absorbed into the Commonwealth Department of Health. It appears that workforce issues will again be addressed from a state / territory perspective and not as a systemic issue in other words, returning to the older model. It does need to be highlighted however, that the regulator of standards is not the appropriate body to be dealing with the challenges of sustainable workforce and workforce reform. This should be the responsibility of a separate body.

The Key Activities

The following key activities should be addressed by the regulator:

1. Setting standards of practice for the health profession
2. Assessing practitioners for registration against those standards
3. Setting accreditation standards for education and training programs
4. Assessing education and training providers against those standards.

Indeed that discussion paper outlines the broad areas of expenditure by AHPRA, which are:

1. Registration. 36%
2. Notifications 36%
3. Professional standards 8%
4. Accreditation 6%
5. Compliance 5%
In the first four years of its operation, AHPRA has brought into place a uniform approach to registering health practitioners. It has been highly successful in establishing quite a stable system, understanding the complexity and lack of comparability that existed prior to creation of the National Body. AHPRA needs to be congratulated for this work. It has addressed the issue where 100 per cent of all the professions interact with the regulator. It was the appropriate prioritisation. This also gives strong emphasis to the capability of managing complex processes and systems that do exist within AHPRA. It is now time to address the issues where less than two per cent of the practitioners interact with the system but are more complex.

Handling notifications and complaints

Of key concern to RACS is the handling of complaints against practitioners. Our responses to the individual questions below will highlight that we do not have a national system for the handling of complaints. Unfortunately political imperatives have provided complexity to this structure and this has resulted in more expensive co-regulatory systems being developed that are lacking in national uniformity. Consequently practitioners can be trained and registered in a comparable manner across the country but complaints and investigations are increasingly being handled via a fragmented, jurisdictionally-varied framework.

Unfortunately the discussion paper appears to support this approach and in fact encourages ongoing fragmentation. The major concerns about the system continue to be transparency, natural justice, timeliness and better communication and support to all parties. It is noted in the discussion paper that the international benchmark for resolving complaints is Ontario, Canada where 150 days is allowed for finalisation. It is disgraceful that AHPRA and the co-regulatory processes struggle to achieve resolution of cases after 365 days or longer. It is the strongest recommendation of RACS that all appropriate methods of resolving complaints in a timely manner, are assessed and implemented on a national basis to achieve the international benchmark set by the Ontario system.

Costs – they appear comparable

The discussion paper appears to focus dominantly on costs and uses comparisons to the United Kingdom to justify a position. As stated previously, comparisons to the United Kingdom need to be viewed in context. The dominant role of the NHS cannot be overstated. The specific challenges for the two health sectors are different. Notwithstanding these comments, RACS was impressed by the comparability of the fees, given the very different cost drivers that exist. The figures do not seem to support any substantial change to the structure and governance of AHPRA. RACS disputes the conclusions of the independent reviewer. However this does highlight a strong requirement on achieving cost efficiencies and ensuring that back-office functions provide for support across the health professional areas without being replicated.

Costs are always of significant concern and this scheme is funded directly by the practitioners and not by government. Consequently sensible areas of cost reduction when identified must be actioned. The substantial cost of handling notifications and complaints needs to be streamlined on a nationally consistent basis. On further analysis it appears that the co-regulatory model is more expensive with more funds being channelled to support the NSW investigatory processes, compared to other states. The Queensland model is yet to stabilise to understand the true impact. Equally, the cost for compulsory criminal record check of practitioners is almost $1.5 million for 60,000 practitioners with only a handful of registrations being affected.
The cost-effectiveness of this ‘accepted’ practice would surely see it modified, or funded from government funds and not from the practitioners.

Scope of Practice

Some of the decisions made by AHPRA have been appropriately questioned. There are valid concerns, particularly in the area of extended scope of practice. The more prominent ones include the current legal action between the College of Ophthalmologists and the Optometry Board of Australia. Resolving these issues in the courts would be one of the more difficult paths.

Unfortunately, there appears to be little in the public domain on the criteria for the consideration to be given to changes in scopes of practice. Some of these may be legitimate and some may support flexible work-practices and work reform. However, there are no agreed criteria that RACS can determine. Surely public safety would be of the prime concern and if changes in scope of practice did occur then an emphasis on appropriate education and accreditation, delivery of services within a multi-disciplinary team, collaboration with delegation of accountabilities and responsibilities would be clearly outlined.

It is critical that in consideration of these issues the standards of the clinical service and patient safety are paramount. There should be no ‘drop in standard’ if a different profession delivers the service. Other concerns around scopes of practice have occurred in areas of nurse endoscopy, podiatric surgery of the foot and ankle and extension of physiotherapy roles. RACS believes that the principles required for broad consultation should be clearly agreed and appropriately overseen by AHPRA. RACS does not believe the changing scope of practice is the domain of a separate board. Health care is always interrelated and co-dependent. RACS believe this is an issue upon which AHPRA has the capacity to manage and make appropriate recommendations to the Australian Health Ministers Council. It does not require an additional layer of bureaucracy to resolve.

Remember who is paying

Government and the independent reviewer must be mindful of the fact that this regulatory scheme is funded from the health practitioners themselves, who are a vital component of the success of the scheme. Although the primary aim of protecting the safety of the public is strongly supported, and it is crucial that consumers and the various political bodies and departments of health have full confidence in the system, the inclusion of additional requirements, committee structures and key functions (such as workforce reform) should not be considered as justified from this specific funding.

Having previously referred to ‘additional tasks’, it is important to highlight the activities of the Doctors Health Program that was run successfully in Victoria and is now being funded nationally. In an era where health issues are increasingly profiled and recognised, the importance of providing access to support is critical, particularly at the regulatory interface. The profession is highly supportive of this and the ongoing funding for its activities out of registration fees.

Response to Questions raised by the Reviewer

Question 1. Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?
Response. No. If there is any additional reporting required then this should be clarified and the scope of that reporting, including measures and frequency, should be clearly defined. That should then be the responsibility of AHPRA to fulfil. There is no point in creating a redundant committee structure and supporting bureaucracy that is the regulator of a regulator.

**Question 2.** Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?

Response. No. There is no need for an additional and legislated body. What is required is clarity of the principles for scope of practice issues discussions so that decisions can be made against these. This could easily be achieved by the AHPRA board or via a designated sub-committee with experts from within the clinical area, to set the standards required and ongoing monitoring for those standards. The principles need to be clearly articulated but must include aspects of collaboration with other health practitioners, delegation of accountability and responsibility, training and educational requirements and also detail how costs to the health system can be lowered.

**Question 3.** Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions?

Response. No. There is no requirement to increase the complexity of the AHPRA structure. What do need to be defined are the criteria to be a health professional group with regulatory requirements. Then profession-specific issues need to be addressed by its specific board. At this point the concerns about scope of practice creep are arising from the nine, low-regulatory workload professions and this needs to be more fully considered. Placing all these professional issues in the one board, away from the other professions, would make it much more difficult to have them appropriately considered.

Furthermore, greater efficiencies (and less cost) need to be achieved through better back-office integration in supporting these boards.

**Question 4.** Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service?

Response. Each profession should have its own clearly defined professional board. However, as stated in the response to question 3, increased efficiencies in ‘back-office’ functions could be highly beneficial in regard to costs. Some regulatory functions could be shared but further details would be required.

**Question 5.** Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?

Response. Yes. The fees should always be structured to simply cover the costs of the scheme within that profession. Regulation is not a profit-making activity.

**Question 6.** Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?

Response. Possibly. The criteria for including health professionals in the Regulatory scheme are not evident. The number of practitioners, educational requirements, risk to the public and cost-benefit analysis that supports inclusion of the health professionals at the moment are not clear. This needs to be defined by AHPRA, approved by the Australian...
Health Ministers and promulgated. Many groups would welcome regulatory requirements as it is an achievement to be regarded in a category of ‘health professional’.

However, the issue is one of risk to the public. NSW, SA, QLD and VIC (assuming legislation currently before Parliament is passed) have a system where health practitioners not covered through AHPRA have a code of conduct. The Code covers issues around delivery of services, false claims, infection control, record keeping and information provided to patients. For public protection it includes prohibition orders for breach, public warnings and naming, if considered to be of serious risk. This approach should be consistent nationally.

**Question 7.** Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory mechanisms?

**Response.** No. As stated in question 6, the state-based health care complaints entities can offer protection for dissatisfied consumers.

**Question 8.** Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measure for entry to the National Scheme to the Health Workforce Ministerial Council?

**Response.** No. The principles of this should be developed by AHPRA and approved by the Australian Health Ministers.

**Question 9.** What changes are required to improve the existing complaints and notifications system under the National Scheme?

**Response.** Substantial improvements are required within the complaints and notifications system. These relate to clarity of purpose, communication and support for the complainant, but importantly the professional about whom the complaint is made, a requirement to be able to resolve the concern through more than one avenue and dominantly through conciliation / mediation rather than an adversarial system and particularly timeliness.

To the general public, the ability to differentiate on how complaints are made is very difficult. In response to this, RACS is a supporter of one common ‘entry’ point for complaints about the health system. However, it is then imperative that the ‘complaints entry function’ is capable of being able to rapidly assess, align possibilities with expectations and then communicate as fully as possible, back to the person raising the complaint. There will always be multiple systems behind the entry point as complaints can be system-based, organisationally based or professionally-based. It is critical that the appropriate review and complaint mechanism is activated and this may involve multiples at the one time.

Communication and support are vital - both for the public who have raised the concern and the practitioner about whom the concern is made. Complaints are often devastating to both parties and everything possible should be done to reduce this stress and the time over which any investigation transpires.

There needs to be a substantial move away from the adversarial and legally-based system that is currently evident to one focused on conciliation and rapid resolution wherever possible. There is no doubt that the concerns, aggravation and anguish of complaints are compounded by extended delays and an adversarial approach.

It is noted in the Reviewer’s consultation document that Ontario, Canada appears to achieve the benchmark in resolving complaints with a required completion at 150 days. Extensions can be allowed but only in specific circumstances. None of the complaint mechanisms within
Australia, whether they are state-based, co-regulatory or through AHPRA, come close to achieving this type of benchmark. This is substantially increasing the costs of the system and is the one area that with proper reform, will significantly reduce costs. RACS strongly recommends that substantial reform is required in the complaints area with KPIs that are closely monitored and are reported to the professional groups, the public and the Ministers of Health.

**Question 10.** Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?

**Response.** No. RACS views it as highly regrettable that politically driven alternatives are now fracturing the national approach to the Registration and Accreditation scheme. Rather than creating alternatives, it is crucial to define the key issues. In response to question 9, RACS has outlined key areas to be addressed. The dominant one is timeliness. There is no doubt that lack of resolution is the dominant concern and cost driver to complaint handling. It would be far better to define the parameters of success rather than proposing a separate model where neither the problem nor the solution are clearly defined.

**Question 11.** Should there be a single entry point for complaints and notifications in each State and Territory?

**Response.** Yes. RACS believes this would be an advantage to the public, but would need to be supported by a substantially superior triage, communication and support methodology.

**Question 12.** Should performance measures and prescribed timeframes for dealing with complaints and notification be adopted nationally?

**Response.** Yes. However, these KPIs need to meet international benchmarks. Currently this appears to be Ontario, Canada with resolution of complaints within 150 days. The KPIs and their monitoring need to be reported to the professions as the funding body, the Australian Health Ministers and also the public.

**Question 13.** Is there sufficient transparency for the public and for notifiers about the processes and outcomes of disciplinary processes? If not, how can this be improved?

**Response.** No. Clearer guidelines need to be produced that clearly set out the requirements, expectations and the support provided to the person making the complaint and also to the professional about whom the complaint is made. This document should also clearly set out the requirements for all AHPRA staff in handling any investigation with appropriate and due process.

**Question 14.** Should there be more flexible powers for the National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

**Response.** Yes. RACS believes the dominant concerns about the current complaint / notifications approach are timeliness and the adversarial approach. Both of these lead to increased costs. It is well established that having flexible dispute resolution leads to a more effective and efficient use of the legal system.

**Question 15.** At what point should an adverse finding and the associated intervention recorded against a practitioner be removed (from the public register)?

**Response.** For medical practitioners, adverse findings in relation to matters proven on the basis of rules of evidence, a rigorous evidence base and due process, comparable to
those applying in court proceedings can be permanently published. Allegations and unproven matters should not be published. Disciplinary sanctions should be published while they are current but removed when no longer current.

**Question 16.** Are the legislative provisions on advertising working effectively or do they require change?

**Response.** The Reviewer’s consultation paper provides no analysis on this issue from which to respond. Advertising will always be contentious. However, the key for the regulator is to fully enforce its standards and to inform the health professionals about this. Communication is the most effective ‘persuader’.

**Question 17.** How should the National Scheme respond to differences in States and Territories in protected practices?

**Response.** Unless there are critical geographical reasons, all States and Territories should move to uniform practices across the regions. It is a core function of being able to improve workforce mobility and appropriately train / orientate international medical graduates who are moving to this country. Areas of difference between the regions should be highlighted to the Health Ministers with a commitment by them to progressively align the legislation.

**Question 18.** In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

**Response.** No. The report on the consultation on the National Code of Conduct should identify what legislation is needed to support the proper implementation of the Code to protect the public. It does not need to be considered within changes to the National Law.

**Question 19.** Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

**Response.** There should be national consistency in as many aspects of the law as possible. There is no demonstrable or published benefit from having the mandatory reporting arising from the treating practitioner – health professional interaction. It appears appropriate to adopt the West Australian and Queensland provision.

**Question 20.** To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsible and sustainable health workforce and innovation in education and service delivery?

**Response.** RACS does not agree that a regulator charged with the requirements of protecting the public, should have a large or dominant role in health workforce reform.

**Question 21.** Should a reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service gaps?

**Response.** RACS does not agree that AHWAC should be reconstituted. It should not have a role as a regulator of the regulator. RACS does not agree with the premise of this question that the regulator has responsibility to address workforce priorities. The AHPRA responsibility is to protect the public through defining standards of the profession and the educational bodies and ensuring that all participants maintain them.
Other processes are required to address these. At the moment the function of Health Workforce Australia appears to be incorporated into the Commonwealth Department of Health. Other processes involving the department are required to assess and advise on solutions.

**Question 22.** To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accredited processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?

Response. This question is very difficult to understand especially in regard to its purpose. Very little analysis of this is undertaken in the discussion paper. RACS is placing increasing emphasis on teamwork, leadership within health teams as well as communication and collaboration within its training programs. The Australian Medical Council is progressively highlighting these areas.

**Question 23.** What relationship, if any is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

Response. Accreditation of medical courses undergraduate and postgraduate as well as vocational training through the various Colleges is undertaken through the Australian Medical Council. There should be no acceptable premise that standards at any level should be minimised and lowered. It is the history of health care that standards and the educational requirements to achieve and maintain them are increasing. This is to the benefit of the public.

**Question 24.** How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

Response. The processes relating to International Medical Graduates are one of the most frequently reviewed areas of regulatory activity, whether it be by the ACCC, Senate Committee process or the courts of law. The current arrangements have recently been revised following the release of the ‘Lost in the Labyrinth Report’. The changes are yet to be assessed.

RACS continues to have substantial concerns around the high use of International Medical Graduates within Australia. Australia and New Zealand rank amongst the highest importers of medical expertise globally. Literally these skilled individuals are being ‘stolen’ from countries where the health need is significantly greater and where the original country’s investment in health professional training is literally migrating to Australia. It is in essence, ‘overseas aid in reverse’ and it is not acceptable. In assessing surgeons from other countries, RACS continues to highlight that one of the most effective ways of undertaking assessment is through designated assessment posts in major hospitals where skill levels can be determined and networks of colleagues established, before any attachment is attempted in regional or rural areas.

RACS continues to have concerns about how ‘Area of Need’ posts are approved through various departments of health. Often positions are not tenable from the perspective of a surgical practice in regard to operative practice opportunities or after hours (safe-hours) requirements. ‘Area of Need’ posts need to be assessed by the relative professional group before being declared.

Unfortunately, AHPRA continues to demonstrate fragmented and inconsistent approaches at the management level to requirements of overseas surgeons coming to Australia to train in
supernumerary positions and then return to their home-country. This needs to be either handled centrally or more consistently across the various States as requirements such as the English language skills standard are misinterpreted, incurring delays of many months in some instances. This is another area of AHPRA function that would benefit from clear KPIs and measures.

**Question 25.** Should the appointment of Chairperson of a National Board be on the basis of merit?

Response. All appointments should be on the basis of merit and as such, should be defensible. RACS confirms its confidence in the Chair of MBA and the Chair of AHPRA. Both are outstanding individuals, incredibly gifted and experienced in their roles with outstanding international profiles.

**Question 26.** Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?

Response. RACS is highly appreciative of the world-leading work undertaken by the Australian Medical Council over many years. Initially through a highly collegiate process, it has oversought both the University Medical Schools and then Medical College activities. Given the increased regulation now required, it is moving more fully into an accreditation model with clearer requirements and capacity to enforce the standards. RACS would not support the development of a committee structure within the various professional boards to handle this. There should be a clearly separated function.

**Question 27.** Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?

Response. RACS believes that oversight of these bodies is appropriate in the current structure. A separate entity like the AMC, rather than sub-committees of the boards – is well positioned for its work. Equally the degree of oversight by Medical Board of Australia is appropriate and there should not be further committees or regulators interposed. However the standards required, need to be clearly available and open to both comment and challenge. They should be reviewed periodically by an international group that understands the requirements for accreditation and make reports available broadly. A report of the AMC was undertaken in the last two years; however RACS believes this report has only been released internally. Making these reports available more broadly will allow any concerns to be addressed openly and transparently.

**Summary**

The National Registration and Accreditation Scheme was introduced to achieve the following four key objectives:

1. Protection of public safety
2. Facilitation of workforce mobility and high quality education and training
3. Promotion of access to health services

RACS strongly believes that this review needs to clarify the primary purpose of the regulator, which is to protect the safety of the public. Nothing could be more important. It believes any focus on access and development of a sustainable workforce could provide a key conflict of interest in the deliberations of AHPRA and its Boards. It is important that workforce reform is
identified as the principal activity of another group, following the abolition of Health Workforce Australia.

The challenges for this review are to clearly identify the areas where improvements should be made and not to identify possible solutions that are bureaucratic and reflective of overseas systems and have key differences from the health sector within Australia. The capacity to change things purely because of political drivers or bureaucratic control needs to be resisted. Instead the improvement areas need clarity to be followed by the development of key measures of success. AHPRA as the responsible entity should embrace these as the areas in which it must improve. Although cost is an important aspect of the functioning of AHPRA, the health professionals who are the funders of the scheme are more concerned about effectiveness. The main concern of excessive cost relates to the adversarial aspects of the complaints systems.

AHPRA has been highly successful in providing the registration capacity across all health professionals. Its major challenges now lie within the areas of notification and complaint. An emphasis towards national uniformity and a consistent process is critical as are a transparency of activities, natural justice and timeliness. Most of the concerns raised from the complaints approach are greatly magnified when prompt resolution is not achieved. The College believes this should be one of the key areas of focus of this review.

Having substantially established itself, AHPRA and its associated Boards are now in the process of ‘bedding down’ a complex structure within the additional complexity of the health sector. AHPRA needs to clearly articulate the principles that guide its decision making and ensure these are broadly communicated and understood. RACS believes this will mitigate a number of ongoing concerns. There is no justification for making wholesale changes, increasing the fragmentation of the system or introducing more bureaucratic requirements.