

**INTERGOVERNMENTAL AGREEMENT**

**FOR A**

**NATIONAL REGISTRATION AND ACCREDITATION SCHEME**

**FOR THE HEALTH PROFESSIONS**

**1. PARTIES**

1.1 AN AGREEMENT made on the twenty sixth day of March 2008, between

The Commonwealth of Australia;

The State of New South Wales;

The State of Victoria;

The State of Queensland;

The State of Western Australia;

The State of South Australia;

The State of Tasmania;

The Australian Capital Territory; and.

The Northern Territory of Australia.

**2. PREAMBLE**

2.1 In 2005, the Commonwealth Government asked the Productivity Commission to undertake a research study to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals and propose solutions to ensure the continued delivery of quality healthcare over the next 10 years. The report was delivered in January 2006.

2.2 The report recommended that there should be a single national registration board for health professionals, as well as a single national accreditation board for health professional education and training; to deal with workforce shortages/pressures faced by the Australian health workforce and to increase their flexibility, responsiveness, sustainability, mobility and reduce red tape.

2.3 At its meeting of 14 July 2006, the Council of Australian Governments (COAG) agreed to establish a single national registration scheme for health professionals, beginning with the nine professional groups then registered in all jurisdictions.

2.4 COAG further agreed to establish a single national accreditation scheme for health education and training, in order to simplify and improve the consistency of current arrangements.

2.5 COAG has subsequently agreed to establish a single national scheme, with a single national agency encompassing both the registration and accreditation functions. The national registration and accreditation scheme will consist of a Ministerial Council, an independent Australian Health Workforce Advisory Council, a national agency with an agency management committee, national profession-specific boards, committees of the boards, a national office to support the operations of the scheme, and at least one local presence in each State and Territory.

2.6 At its meeting of 26 March 2008, COAG agreed to establish the scheme by 1 July 2010.

2.7 Stakeholders have been extensively consulted in the development of the scheme. In addition to ad hoc meetings, there have been a number of formal consultations with key stakeholders. Stakeholders were also asked to make a number of submissions on the proposed scheme, including on their preferred regulatory model. This feedback has been crucial in informing the final scope, structure and functions of the new scheme.

2.8 This Agreement identifies the objectives, scope and governance, legislative, administrative and financial arrangements for the scheme.

### **3. DEFINITIONS AND INTERPRETATION**

3.1 In this Agreement, unless the context appears otherwise:

- (a) 'Advisory Council' means the Australian Health Workforce Advisory Council;
- (b) 'Agreement' means this Intergovernmental Agreement;
- (c) 'AHMC' means the Australian Health Ministers' Conference;
- (d) 'AHMAC' means the Australian Health Ministers' Advisory Council;
- (e) 'board' means a national profession-specific board covered by the scheme;
- (f) 'COAG' means the Council of Australian Governments;
- (g) 'jurisdiction' means one of the Parties to this Agreement;
- (h) 'Ministerial Council' means the Australian Health Workforce Ministerial Council to be established as part of the scheme pursuant to part 7 of this agreement and comprising the Commonwealth Health Minister and the Ministers with responsibility for Health from each State and Territory;
- (i) 'national agency' is the entity defined in 1.16 of Attachment A;
- (j) 'Party' means a party to this Agreement; and
- (k) 'scheme' or 'national scheme' means the national registration and accreditation scheme.

## **4. OPERATION OF THE AGREEMENT**

4.1 This Agreement commences upon signature by all of the Parties.

4.2 All disputes between the Parties will be resolved in accordance with this Agreement.

## **5. OBJECTIVES**

5.1 To establish a single national registration and accreditation scheme for health professionals, beginning with the nine professions currently registered in all jurisdictions. That is, physiotherapy, optometry, nursing and midwifery, chiropractic care, pharmacy, dental care (dentists, dental hygienists, dental prosthetists and dental therapists), medicine, psychology and osteopathy.

5.2 As agreed by COAG on 26 March 2008, all professionals in these nine groups will be covered by the national scheme as of 1 July 2010.

5.3 The objectives of the national scheme, to be set out in the legislation, are to:

- (a) provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
- (b) facilitate workforce mobility across Australia and reduce red tape for practitioners;
- (c) facilitate the provision of high quality education and training and rigorous and responsive assessment of overseas-trained practitioners;
- (d) have regard to the public interest in promoting access to health services; and
- (e) have regard to the need to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and enable innovation in education and service delivery.

5.4 The scheme will operate under the following principles, to be set out in the legislation:

- (a) it should operate in a transparent, accountable, efficient, effective and fair manner;
- (b) it should ensure that fees and charges are reasonable; and
- (c) it should recognise that restrictions on the practice of a profession should only occur where the benefits of the restriction to the community as a whole outweigh the costs.

5.5 The legislation will provide that all bodies within the scheme will have regard to the objectives of the national scheme.

5.6 The Parties to this Agreement confirm that they do not intend the proposed national registration and accreditation scheme to have any role in regulating employment conditions, rates of pay or other employment matters with regard to the health professions proposed to be regulated.

5.7 The Parties to this Agreement further confirm that they do not intend the proposed national registration and accreditation scheme to have any role in relation to resourcing, management or governance of State and Territory health institutions.

## **6. IMPLEMENTATION**

6.1 For the purpose of ensuring a national registration and accreditation scheme, the States and Territories undertake to use their best endeavours to submit to their respective Parliaments whatever Bill or Bills that have the effect of achieving a national scheme from 1 July 2010.

6.2 The structure and functions of the national scheme will be set out in the legislation establishing the scheme. The legislation will establish a single scheme covering both the registration and accreditation functions and will be framed in such a way to encompass this Agreement.

6.3 The State of Queensland will host the substantive legislation to give effect to the national scheme, which will be subject to the approval of the AHMC. Once approved by the AHMC, the State of Queensland will take the lead in enacting the primary legislation to establish the scheme.

6.4 The State of Western Australia will, as soon as reasonably practicable, enact corresponding legislation, substantially similar to the agreed model, so as to permit the scheme to be established on 1 July 2010. The States of New South Wales, Victoria, South Australia and Tasmania and the Australian Capital Territory and the Northern Territory will, as soon as reasonably practicable following passage of the Queensland legislation, use their best endeavours to enact legislation in their jurisdictions applying the Queensland legislation as a law of those jurisdictions, so as to permit the scheme to be established on 1 July 2010.

6.5 Each of the States and Territories will use their best endeavours to repeal their existing registration legislation which covers the health professions that are subject to the new national scheme. This will have the effect of abolishing the current State and Territory based registration boards for those health professions.

6.6 Each of the Parties will use its best endeavours to repeal, amend or modify any other legislation which is inconsistent with or alters the effect of the legislation to establish the national registration and accreditation scheme.

6.7 Except as agreed by AHMC, a Party will use its best endeavours not to submit a Bill to its legislature which would be inconsistent with, or alter the effect of the legislation to implement the national registration and accreditation scheme, or this Agreement.

6.8 The States and Territories will use their best endeavours to ensure legislation as appropriate provides for entities in their jurisdiction to investigate and hear serious disciplinary matters and the hearing of appeals against less serious disciplinary matters arising from the registration function. Each State and Territory will be responsible for deciding which entity will be responsible for that function in their jurisdiction, in accordance with national criteria agreed by AHMC.

6.9 In the interests of facilitating a smooth transition to the national scheme, the AHMC will administratively establish the national agency, with an interim Chief Executive Officer, as soon as possible to commence the implementation of the scheme. The interim Chief Executive Officer will report every six months to AHMC until the establishment of the scheme.

6.10 To further ensure a smooth transition to the scheme, all existing members of jurisdictional boards and supporting hearing panels for the nine professions will, if they agree, be appointed to a list of persons from which national boards may form committees for a period of two years from commencement of the operation of the scheme.

6.11 A mechanism will also be developed to give first consideration to existing jurisdictional registration board staff to operate the State and Territory presence of the national office of the national agency.

6.12 The responsibility for the implementation of the proposed framework will transition to AHMC upon signature of this Agreement. Until legislation establishes the Ministerial Council, AHMC will be responsible for the implementation of the scheme, including the resolution of any unsettled matters so as to bring it into effect on 1 July 2010. After the establishment of the Ministerial Council, the Ministerial Council will be responsible for the scheme as per part 7 of this agreement, including the resolution of any unsettled matters. AHMC and the Ministerial Council will continue to consult with stakeholders in the development of the scheme.

## **7. THE MINISTERIAL COUNCIL**

7.1 The Parties shall establish in legislation the Ministerial Council to be known as the Australian Health Workforce Ministerial Council and will comprise the Commonwealth Health Minister and the Ministers with responsibility for health from each State and Territory.

7.2 The Ministerial Council will meet from time to time, as required.

7.3 The relevant quorum requirements will be that all jurisdictions should be represented by the Minister responsible for health.

7.4 Agreement by the Ministerial Council for the purpose of decisions relating to this scheme will be by consensus. In circumstances where the Ministerial Council is unable to come to an agreement and a decision must be made, there will be a transparent process of review in order to assist it to reach an agreement. This review will be undertaken by the Advisory Council (described in Attachment A).

7.5 Under the proposed legislation for the scheme, the Ministerial Council will be responsible for:

- (a) providing policy direction;
- (b) agreeing on the inclusion of new professions in the scheme;
- (c) proposing legislative amendments through processes of governments, which are consistent with this Agreement;
- (d) providing funding as appropriate in the set up phase of the scheme;
- (e) appointing members to the Advisory Council, subject to clause 1.10 of Attachment A making appointments to the management committee of the national agency;
- (f) appointing members of boards;

- (g) approving profession-specific registration, practice, competency and accreditation standards and continuing professional development (CPD) requirements provided by the boards;
- (h) requesting boards to review approved profession-specific registration, practice, competency and accreditation standards and CPD requirements;
- (i) maintaining a reserve power to intervene on budgets and fees, with any intervention to be transparent; and
- (j) initiating an independent review following three years of the scheme's operation.

7.6 In respect to the Advisory Council, the Ministerial Council will:

- (a) have the power to refer matters relating to the scheme to the Advisory Council for advice; and
- (b) have regard to advice provided by the Advisory Council when making decisions under the scheme, including advice provided by the Advisory Council in accordance with clauses 1.8 (b) and (c) of Attachment A.

7.7 Following the approval of standards and requirements as set out in 7.5 (g) above, these standards and requirements will be publicly available.

7.8 To clarify, the Ministerial Council will not seek to insert itself into the day-to-day operations of the national agency. In particular, the Ministerial Council will not have any power to intervene in registration, examination or disciplinary decisions relating to individuals, or decisions relating to the accreditation of specific courses.

## **8. THE STRUCTURE AND FUNCTIONS OF THE SCHEME**

8.1 For details of the structure and functions of the national registration and accreditation scheme refer to Attachment A.

## **9. THE COMPLAINTS AND REVIEW PROCESS UNDER THE NATIONAL SCHEME**

9.1 For details of the complaints and review process under the national scheme refer to Attachment A.

## **10. REPORTING REQUIREMENTS**

10.1 Each of the Parties will notify AHMC in writing when they have secured the entry into force of the relevant legislation to give effect to the scheme.

10.2 The national agency will submit an annual report to the Ministerial Council. As soon as reasonably practicable, and within two months of receipt, each of the Parties will table the annual report in their respective Parliaments.

10.3 In its first two years of operation, the agency will submit six monthly reports to the Ministerial Council, outlining in reasonable detail the progress that has been made in implementing the scheme.

## **11. THE INCLUSION OF OTHER HEALTH PROFESSIONS**

11.1 For details relating to the inclusion of other health professions in the national scheme refer to Attachment B.

## **12. FUNDING**

12.1 The resources of the scheme will comprise fees received for registration functions and accreditation functions, appropriate resources of the registration boards, current Commonwealth, State and Territory contributions to registration, accreditation and related workforce functions and a contribution of \$19.8 million to the establishment of the new scheme agreed by COAG.

12.2 The Commonwealth will not reduce its contributions and subsidies to the scheme for the first two years of its operation.

12.3 The Parties will meet the initial costs of establishing the national registration and accreditation scheme, but it is intended that in the longer term the scheme will be self-funding.

12.4 There will be a single national set of fees for each profession in the scheme. These fees will:

- (a) be agreed between the boards and the national agency; and
- (b) where agreement is unable to be reached the matter will be referred to the Ministerial Council.

12.5 The overarching principle is that the process of setting fees will be equitable and transparent to registrants.

12.6 Where appropriate, registration fees will continue to contribute to the accreditation function and transitional arrangements will apply as necessary.

12.7 The Advisory Council will be funded directly by governments according to the AHMAC cost-sharing formula.

## **13. ALTERATION OF THE SCHEME AND AMENDMENTS TO THE LEGISLATION**

13.1 Any of the Parties may propose amendments to the national scheme by communicating the proposed amendments to the other Parties and the justification for seeking them.

13.2 The Ministerial Council will consider any proposed amendments and agree to such amendments as it sees fit.

13.3 If the changes agreed at 13.2 require legislative amendment, the State of Queensland will:

(a) submit to its Parliament a bill in a form agreed by the Ministerial Council which has the effect of amending the legislation in the manner agreed; and

(b) take all reasonable steps to secure the passage of the bill and bring it into force in accordance with a timetable agreed by the Ministerial Council.

13.4 If the amendment is passed through the Queensland Parliament, legislation of the States of New South Wales, Victoria, South Australia and Tasmania and the Australian Capital Territory and the Northern Territory will incorporate the changes by applying the amendment as a law of those jurisdictions. In the State of Western Australia, agreed amendments to the legislation will be carried out via changes to the corresponding Western Australian legislation. The State of Western Australia will use its best endeavours to secure the passage of any agreed amendments and bring them into force to ensure ongoing consistency with the national scheme.

## **14. REVIEW OF THE SCHEME**

14.1 For the purposes of the scheme, an independent review will be initiated by the Ministerial Council following three years of the scheme's operation.

14.2 The Parties note that COAG agreed on 14 July 2006 to request the Commonwealth Treasurer to task the Productivity Commission to undertake a further review of the health workforce by July 2011.

## **15. DISPUTE RESOLUTION IN RELATION TO THIS AGREEMENT**

15.1 Where a dispute arises in relation to this Agreement, AHMC or the Ministerial Council, as appropriate, will work cooperatively in an endeavour to resolve it.

## **16. WITHDRAWAL AND CESSATION**

16.1 The Parties agree that withdrawal from the scheme will be a measure of last resort.

16.2 A Party that proposes to withdraw from this Agreement will notify each of the other Parties by giving at least 12 months written notice.

16.3 In the event of withdrawal from this Agreement by any one of the Parties, this Agreement will be rendered null and void except as otherwise agreed by the Ministerial Council (or in the event that the Ministerial Council has not been established, by AHMC).

16.4 In circumstances where a Party fails to comply with any of its obligations under this Agreement, the Agreement shall be rendered null and void except as otherwise agreed by the Ministerial Council (or in the event that the Ministerial Council has not been established, by AHMC).



16.5 In circumstances where this Agreement is rendered null and void, responsibility for the registration and accreditation of the health professions covered by the scheme will revert to individual States and Territories.

16.6 This Agreement may be terminated at any time by agreement in writing of all of the Parties.

IN WITNESS WHEREOF this Agreement has been executed as at the day and year first written above.

SIGNED by:

The Honourable Kevin Rudd MP )  
Prime Minister of the Commonwealth of Australia )

The Honourable Morris Iemma MP )  
Premier of the State of New South Wales )

The Honourable John Brumby MP )  
Premier of the State of Victoria )

The Honourable Anna Bligh MP )  
Premier of the State of Queensland )

The Honourable Alan Carpenter MLA )  
Premier of the State of Western Australia )

The Honourable Michael Rann MP )  
Premier of the State of South Australia )

The Honourable Paul Lennon MHA )  
Premier of the State of Tasmania )

Mr Jon Stanhope MLA )  
Chief Minister of the Australian Capital Territory )

The Honourable Paul Henderson MLA )  
Chief Minister of the Northern Territory )

**ATTACHMENT A****THE STRUCTURE AND FUNCTIONS OF THE SCHEME**

1.1 The national registration and accreditation scheme for health professionals will consist of a Ministerial Council, an independent Australian Health Workforce Advisory Council (the 'Advisory Council'), a national agency with an agency management committee, national profession-specific boards ('boards'), committees of the boards, a national office to support the operations of the scheme, and at least one local presence in each State and Territory.

1.2 The role of the independent Advisory Council will be to provide authoritative advice to assist the Ministerial Council in exercising its responsibilities under the scheme. In making decisions in relation to the scheme, the Ministerial Council must take into account any advice provided by the Advisory Council.

1.3 The national agency will ensure that the scheme operates consistently with the legislation and the directions of the Ministerial Council.

1.4 There will be boards for each of the professions covered by the scheme (nine professional groups initially). The boards will be responsible for both the registration and accreditation functions.

1.5 The boards will establish committees, as required, to carry out functions on their behalf, including dealing with disciplinary matters related to registrants.

1.6 There will be a national office to support the operations of the scheme and at least one local presence in each State and Territory.

1.7 The Australian Health Ministers' Advisory Council will provide advice to the Ministerial Council on matters relating to the scheme.

**Australian Health Workforce Advisory Council**

1.8 The independent Advisory Council will provide advice to the Ministerial Council on matters relating to the scheme, as established by the legislation. It will provide independent and transparent advice to the Ministerial Council, taking into account the objects of the legislation, on:

- (a) matters which are referred to the Advisory Council by the Ministerial Council;
- (b) matters for review where the Ministerial Council has not been able to reach a decision by consensus; and
- (c) any other matters which the Advisory Council considers appropriate and which are consistent with the objects of the legislation.

1.9 The Advisory Council will comprise:

- (a) an independent, eminent chair, who is not a current or recent health practitioner; and
- (b) six other members of whom three should have appropriate health and/or education expertise.

1.10 Members of the Advisory Council will in the first instance be appointed by COAG and thereafter by the Ministerial Council. Appointments will initially be for three years, with membership and terms of reference reviewed by the Ministerial Council after that time.

1.11 To initiate the COAG appointment process, the Queensland senior official will consult with other senior officials and put a proposal through senior officials to COAG in the six months prior to the commencement of the scheme.

1.12 The advice provided by the Advisory Council to the Ministerial Council will be public and transparent with all advice published.

1.13 Where the Ministerial Council has reached a decision on a matter on which the Advisory Council has provided advice, that advice will be published as soon as possible.

1.14 Where the Ministerial Council has not been able to reach a decision on a matter, on which the Advisory Council has provided advice, that advice will be published no later than 15 days after the Ministerial Council has considered the advice.

1.15 The Advisory Council will be funded directly by governments and supported by an independent secretariat.

## **The National Agency**

1.16 The national agency will administer the scheme and the agency will be governed by an agency management committee.

1.17 The role of the national agency will be to:

- (a) maintain up-to-date and publicly accessible national lists of accredited courses and registered practitioners with entries relating to individuals to include any conditions or restrictions on professional practice;
- (b) administer the resources of the scheme and ensure the scheme is as efficient as possible;
- (c) act in accordance with any policy directions from the Ministerial Council;
- (d) report annually to the Ministerial Council;
- (e) following agreement with the boards, set fees, and where there is no agreement, this will be referred to the Ministerial Council;
- (f) at its discretion, contract or delegate functions, excluding registration and accreditation functions, with any delegations reported to the Ministerial Council;
- (g) in consultation with the boards, develop and administer procedures and business rules for the efficient and quality operation of the registration and accreditation functions and the operation of the boards and their committees, consistent with ministerial policy direction and the objects of the legislation;
- (h) in accordance with the objects of the legislation and any policy directions of Health Ministers, set frameworks and requirements for the development of registration,

accreditation and practice standards by the national boards to ensure that good regulatory practice is followed;

- (i) advise the Ministerial Council on issues relevant to the scheme; and
- (j) establish a national office.

1.18 The national office will have the following functions:

- (a) maintain the national registers of health practitioners and lists of accredited courses;
- (b) provide secretariat and administrative support for the agency management committee and boards, and any other committees constituted under the scheme; and
- (c) establish at least one presence ('one-stop-shop') in each State and Territory, which will be responsible in each jurisdiction for:
  - (i) receipt and management of local enquiries regarding registration and registered practitioners;
  - (ii) receipt of applications for registration and renewal of registration and management of local processes associated with these;
  - (iii) receipt and processing of complaints against registered practitioners;
  - (iv) monitoring of conditions on registration and management of impaired practitioners; and
  - (v) providing administrative support as needed for local committees set up by the boards.

### **The Agency Management Committee**

1.19 The agency management committee will comprise members appointed by the Ministerial Council, including:

- (a) one independent chair, who must be an eminent person and not currently or recently practising in the health professions;
- (b) at least two people with relevant health and/or education and training expertise; and
- (c) at least two people who are not current or former practising health professionals and who have business or administrative expertise.

1.20 The agency management committee will appoint a Chief Executive Officer.

1.21 Members of the agency management committee will be provided with appropriate statutory immunities.

## **The Profession Specific National Boards ('the Boards')**

1.22 Members of the relevant profession will form the majority of each board. The size of each board may vary between each profession. The size and composition of each board will be decided by the Ministerial Council, following consultation with the relevant profession.

1.23 All boards will comprise:

- (a) a chair who is a member of the relevant profession;
- (b) at least 50 per cent of the remaining members must be from the relevant profession, with no more than two-thirds of the board including the chair being members of the relevant profession; and
- (c) at least two community members.

1.24 Board members will be appointed by the Ministerial Council and:

- (a) appointments will be based on skills and experience relevant to the registration and accreditation functions;
- (b) appointments will be made following an open and transparent process, where nominations are sought from individuals and professional bodies;
- (c) the administration of the appointments process will be undertaken by the agency management committee;
- (d) board members will be appointed from a pool of eligible applicants through the instrument of appointment specified in legislation;
- (e) board members will not represent any professional body or organisation; and
- (f) board members will be provided with appropriate statutory immunities.

1.25 The role of the boards will be to:

- (a) establish local and national committees as required to enable the delivery of a board's functions in relation to registration, investigation of conduct, competence or impairment matters, conduct of disciplinary hearings, course of study accreditation and assessment of overseas trained practitioners, in a manner that provides effective and timely local responses;
- (b) manage the development of registration, practice, competency and accreditation standards and CPD requirements for approval by the Ministerial Council that comply with the objects of the legislation, any policy directions of the Ministerial Council and the framework and requirements for standards developed by the agency management committee;
- (c) approve a list of accredited courses of study that meet the qualifications required for general registration;
- (d) oversee the assessment of the knowledge and clinical skills of overseas trained practitioners whose basic qualifications are not recognised in the list of approved courses of study and determine the suitability of an applicant's knowledge and clinical skills for registration in Australia;

- (e) oversee the registration functions for that profession, including decisions on individual applications for registration, and impose conditions on a grant of registration if necessary;
- (f) oversee the receipt and investigation of complaints about registered practitioners and the determination of matters following investigation, including referral of serious matters for hearing by the relevant external tribunal;
- (g) oversee disciplinary processes in relation to less serious matters, including the conduct of disciplinary hearings and settlement of matters by consent and determine less serious disciplinary matters relating to individual practitioners;
- (h) oversee the management of impaired registrants, including the monitoring of conditions and suspensions imposed through disciplinary processes;
- (i) provide an internal merits review of decisions made in relation to registration, conditions on registration, complaints investigation and management, and management of impaired registrants upon application from a practitioner, notifier, or on its own motion;
- (j) provide an internal merits and process review of decisions made in relation to the accreditation of education courses and institutions;
- (k) refer matters as appropriate to police and criminal justice systems;
- (l) refer the hearing of serious matters (those which may result in suspension or cancellation of registration) to an entity (determined by each State and Territory) external to the agency (which will also be responsible for hearing of appeals against less serious disciplinary matters determined by the board);
- (m) receive complaints made to other bodies as appropriate;
- (n) make representations regarding an individual practitioner to the entity that is hearing a serious matter or reviewing a decision made by the board in relation to that practitioner; and
- (o) provide advice to the Ministerial Council on issues relating to the scheme.

## **Committees of the Boards**

1.26 In relation to any committees established by a board to carry out its functions:

- (a) committee members will be drawn from a process approved by the Ministerial Council;
- (b) committee members will be provided with appropriate statutory immunities relevant to the function; and
- (c) the legislation will specify the minimum number of committee members and their composition that is required for statutory decision making.

## **Registration**

1.27 Stakeholders have provided substantive and valuable comment to assist in the formulation of the model for registration categories and title and practice restrictions.

1.28 The substantive legislation to establish the national registration and accreditation scheme will have the following features to ensure the appropriate protection of the public:

- (a) nine separate professional registers, with divisions of registers as listed in Table 1;
- (b) the primary basis for regulation will be ‘protection of professional title’, with statutory offences to prevent unregistered or unauthorised persons using professional titles, which in the first instance will be those listed in Table 2, with further titles to be determined by the Ministerial Council (or in the event that the Ministerial Council has not been established, by AHMC);
- (c) practice restrictions will be applied where they are currently adopted across all jurisdictions as follows:
  - i) two professions, dentistry and optometry, will be subject to legislative definitions of core practices and offences to prevent practice by unregistered or unauthorised persons;
  - ii) elements of the practice of spinal manipulation may also require legislative protection, and further work will be undertaken to define these for this purpose;
- (d) general exemptions from title and practice offence will apply to regulated professionals undertaking their usual activities, students, assistants working under supervision, businesses employing registered practitioners and persons assisting in emergencies; and
- (e) any special purpose or additional categories of registration will be determined by AHMC, following consultation with stakeholders during implementation of the scheme.

1.29 The Ministerial Council, in consultation with stakeholders, may determine further modifications to registration categories and practice restrictions within the parameters of clause 1.28.

1.30 Jurisdictions will continue to have discretion to regulate additional core practices through local public health, drugs and poisons, and radiation safety legislation or through other funding or administrative mechanisms.

1.31 The recognition of specialist qualifications (for example, medical and dental specialties) will be achieved by:

- (a) the relevant board being empowered to ‘endorse’ or ‘notate’ the registration of a suitably qualified practitioner, with this information entered on an integrated register against that practitioner’s name;
- (b) public identification and communication of recognised specialties, specialist titles and approved qualifications, identified through the public registers and via guidelines issued by the relevant board (rather than via an extensive list of specialties and associated specialist qualifications listed in regulation under the legislation);
- (c) general statutory offences that prevent unregistered or unauthorised persons from using any title that could induce a belief that the person is endorsed as a specialist, or from holding themselves out as a specialist in one of the established specialties (rather than offences for use of the separate specialist titles); and



- (d) recognition of new specialties or specialty areas of practice on professional registers to be subject to the approval of the Ministerial Council.

1.32 State and Territory drugs and poisons legislation will, at the discretion of States and Territories, provide a mechanism through which suitably qualified registrants of the nursing and allied health professions may be authorised to possess, administer and prescribe scheduled medicines, with:

- (a) responsibility for determining qualification requirements and endorsing qualified individuals residing with the relevant board; and
- (b) authorisation for particular professions (or sub-groups within professions) to obtain, possess, use, sell or supply (administer or prescribe) medicines to be granted under State and Territory drugs and poisons legislation.

1.33 This Agreement does not cover the licensing of pharmacy premises and pharmacy ownership restrictions. These matters will continue to be the responsibility of the States and Territories.

## **Accreditation**

1.34 As a transitional measure, the Ministerial Council (or in the event that the Ministerial Council has not been established, by AHMC) will assign accreditation functions to existing accreditation bodies, with the requirement that within the first 12 months of the new scheme they meet standards and criteria set by the national agency for the establishment, governance and operation of external accreditation bodies, which will include:

- (a) processes for assessing individual qualifications and courses of training that are rigorous, open, transparent and fair, consistent with government policy, and include adequate arrangements for review of accreditation decisions;
- (b) governance arrangements that provide for community input and promote input from education providers and the professions but provide independence in decision-making;
- (c) financial viability, reporting and accountability requirements, quality assurance and audit and risk management plans;
- (d) mechanisms to foster collaboration and consistency of processes across all profession-specific accreditation committees; and
- (e) processes for developing and reviewing codes and guidelines that impact on the nature, scope or duration of education and training requirements for registration purposes or specialist accreditation that are open, transparent and fair and include sufficient consultation.

1.35 Where it has been determined that an existing accreditation body will be assigned the accreditation functions of a board, the accreditation body will:

- (a) assess courses of study and determine whether they meet the approved accreditation standards and advise the relevant board;

- (b) assess accrediting authorities in other countries to determine whether courses of study that those authorities accredit provide practitioners with the required knowledge and clinical skills to practise in Australia and advise the relevant board;
- (c) provide an internal merits and process review of decisions made in relation to the accreditation of education courses and institutions;
- (d) oversee the assessment of the knowledge and clinical skills of overseas trained practitioners whose basic qualifications are not recognised in the list of approved courses of study and make recommendations to the board's registration committee regarding the suitability of an applicant's knowledge and clinical skills for registration in Australia and advise the relevant board in respect to an individual's application for registration; and
- (e) be permitted to undertake other functions outside the scope of the national scheme as long as there is no conflict of interest between the assigned functions and any other function carried out by the accreditation body in its own right.

1.36 Where there is an existing accreditation body and it has been determined that this body will be assigned the accreditation functions of a board, within three years, in consultation with the relevant accreditation body and the profession, the relevant board will review this assignment and the future arrangements and make a recommendation to the Ministerial Council on the best future arrangements for its profession.

1.37 Ongoing decisions about whether external bodies should continue to perform accreditation functions will be taken by the Ministerial Council following consultation with the boards.

1.38 Where there is no existing body to perform the accreditation functions outlined in clause 1.35 above, the relevant board will undertake consultations with the profession, education and training providers, consumers and governments, before determining the composition of an appropriate accreditation committee.

1.39 An accreditation committee so established will comprise members who bring expertise from the profession, education and from health policy including:

- (a) registered practitioners;
- (b) persons with education and training expertise;
- (c) persons who are not members of the relevant profession; and
- (d) at least two persons who are also members of the respective professional registration board of the agency.

1.40 An accreditation committee established under clause 1.38 will be required to meet the standards set by the national agency including those processes described in 1.34(a) above.

## **EXTERNAL COMPLAINTS AND REVIEW PROCESSES UNDER THE NATIONAL SCHEME**

2.1 The hearing of serious disciplinary matters (those which may result in suspension or cancellation of registration) will be undertaken by an entity external to the agency, which will also be responsible for the hearing of appeals against less serious disciplinary matters where internal review has not resolved the matter.

2.2 It will be the responsibility of each State and Territory to determine which entity in their particular jurisdiction (in accordance with national criteria agreed by AHMC) will be responsible for the hearing of these matters.

2.3 However, to ensure national consistency, the legislation to establish the national scheme will specify common processes, findings and determinations that can be made.

2.4 Access to the courts will be available as under current arrangements.

**TABLE 1****PROPOSED REGISTERS AND DIVISIONS OF REGISTERS**

<b>Profession</b>	<b>Proposed Register</b>	<b>Proposed Divisions of the Register</b>
Chiropractic	'Register of chiropractors'	Nil
Dental	'Register of dental care providers'	<ul style="list-style-type: none"> <li>• Dentists</li> <li>• Dental therapists</li> <li>• Dental hygienists</li> <li>• Dental prosthetists</li> </ul>
Medical	'Register of medical practitioners'	Nil
Nursing and Midwifery	'Register of nurses and midwives'	<ul style="list-style-type: none"> <li>• Registered nurses</li> <li>• Enrolled nurses</li> <li>• Midwives</li> </ul>
Optometry	'Register of Optometrists'	Nil
Osteopathy	'Register of Osteopaths'	Nil
Pharmacy	'Register of Pharmacists'	Nil
Physiotherapy	'Register of Physiotherapists'	Nil
Psychology	'Register of Psychologists'	Nil

**TABLE 2**

**PROFESSIONAL TITLES PROPOSED TO BE RESTRICTED UNDER  
THE NATIONAL SCHEME**

<b>Profession</b>	<b>Titles to be protected</b>
Chiropractic	<ul style="list-style-type: none"> <li>• 'chiropractor'</li> <li>• catchall provision along the lines of 'any other title, name, symbol, description, et cetera which given the circumstances could be reasonably understood to indicate the person is a registered chiropractor'</li> </ul>
Dental	Titles restricted to those registered in the relevant division of the register: <ul style="list-style-type: none"> <li>• 'dentist'</li> <li>• 'dental therapist'</li> <li>• 'dental hygienist'</li> <li>• 'dental prosthetist'</li> <li>• 'oral health therapist'</li> <li>• catchall provision as above</li> </ul>
Medical	<ul style="list-style-type: none"> <li>• 'medical practitioner'</li> <li>• catchall provision as above</li> </ul>
Nursing and Midwifery	Titles restricted to those registered in the relevant division of the register: <ul style="list-style-type: none"> <li>• 'nurse'</li> <li>• 'nurse practitioner'</li> <li>• 'enrolled nurse'</li> <li>• 'midwife'</li> <li>• catchall provision as above</li> </ul>
Optometry	<ul style="list-style-type: none"> <li>• 'optometrist'</li> <li>• 'optician'</li> <li>• catchall provision as above</li> </ul>
Osteopathy	<ul style="list-style-type: none"> <li>• 'osteopath'</li> <li>• catchall provision as above</li> </ul>
Pharmacy	<ul style="list-style-type: none"> <li>• 'pharmacist'</li> <li>• 'pharmaceutical chemist'</li> <li>• catchall provision as above</li> </ul>
Physiotherapy	<ul style="list-style-type: none"> <li>• 'physiotherapist'</li> <li>• 'physical therapist'</li> <li>• catchall provision as above</li> </ul>
Psychology	<ul style="list-style-type: none"> <li>• 'psychologist'</li> <li>• catchall provision as above</li> </ul>

**ATTACHMENT B****THE INCLUSION OF OTHER HEALTH PROFESSIONS**

1.1 The COAG Communiqué of 14 July 2006 confined the first tranche of national registration to the nine health professions currently registered in all jurisdictions. However, it was envisaged that other health professions would be added over time.

1.2 The Ministerial Council will determine those additional professions that should enter the scheme, but this will not occur prior to the commencement of the scheme on 1 July 2010.

1.3 In 1995, the Australian Health Ministers' Advisory Council established a process for determining whether to regulate any currently unregulated health profession, involving assessment against six criteria. Under this process, statutory registration would only be introduced where:

- (a) it was supported by a majority of jurisdictions; and
- (b) it could be demonstrated that the occupation's practice presents a serious risk to public health and safety which could be minimised by regulation.

1.4 It has been determined that these criteria are appropriate for assessing the inclusion of partially regulated and unregulated health professions in the national registration and accreditation scheme. These criteria are set out below.

1.5 In the first instance, partially regulated occupations, except for podiatry, will be assessed for inclusion in the scheme. On March 2007, AHMC noted that Aboriginal Health Workers will be given further consideration as a priority in this work. Following this, any proposals for the inclusion of unregulated health occupations in the national registration scheme will be assessed.

1.6 It has been decided that podiatry is a special case, and accordingly it will automatically be included in the national registration scheme as soon as practicable post-1 July 2010. This is warranted because the only jurisdiction in which podiatrists are not registered is the Northern Territory, and the only reason that they have not been regulated is because there are insufficient numbers of podiatrists in the Northern Territory to make registration viable. In any case, all of the podiatrists practising in the Northern Territory are registered in other jurisdictions.

1.7 In addition to being able to demonstrate that they meet the relevant criteria, those professions seeking inclusion in the scheme will also be required to develop their own nationally-consistent registration proposal for consideration by the Ministerial Council.

1.8 Consideration has also been given to how partially regulated professions who are not recommended for inclusion in the scheme should be treated. It has been decided that jurisdictions will individually determine whether these professions should continue to be regulated.

## **CRITERIA FOR ASSESSING THE NEED FOR STATUTORY REGULATION OF UNREGULATED HEALTH OCCUPATIONS**

### **GUIDING PRINCIPLES**

*While it is acknowledged that occupational regulation may have a number of benefits, both for the occupation and for its individual practitioners, for the development of the criteria the following principles were adopted:*

- the sole purpose of occupational regulation is to protect the public interest; and
- the purpose of regulation is not to protect the interests of health occupations.

*Using these guiding principles six criteria were developed in the form of questions to address the issue of registration. Where appropriate, information to assist in addressing each criterion is also provided.*

*Note: It is considered that the occupation must meet all six criteria to be considered for registration.*

### **THE CRITERIA**

#### **Criterion 1:**

**It is appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?**

#### **Criterion 2:**

**Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?**

The following should be considered when assessing whether there is significant risk of harm to the health and safety of the public:

- the nature and severity of the risk to the client group;
- the nature and severity of the risk to the wider public; and
- the nature and severity of the risk to the practitioner.

Areas which could be explored to identify a risk to public health and safety are:

- to what extent does the practice of the occupation involve the use of equipment, materials or processes which could cause a serious threat to public health and safety;
- to what extent may the failure of a practitioner to practice in particular ways (that is, follow certain procedures, observe certain standards, or attend to certain matters), result in a serious threat to public health and safety;
- are intrusive techniques used in the practice of the occupation, which can cause a serious, or life threatening danger;
- to what extent are certain substances used in the practice of the occupation, with particular emphasis on pharmacological compounds, dangerous chemicals or radioactive substances; and
- is there significant potential for practitioners to cause damage to the environment or to cause substantial public health and safety risk.

Epidemiological or other data, (for example, coroners' cases, trend analysis, complaints), will be the basis for determining the demonstration of risk/harm.

**Criterion 3:****Do existing regulatory or other mechanisms fail to address health and safety issues?**

Once the particular health and safety issues have been identified, are they addressed through:

- other regulations, for example, risk due to skin penetration addressed via regulations governing skin penetration and/or the regulation of the use of certain equipment, or industrial awards;
- supervision by registered practitioners of a related occupation; and
- self regulation by the occupation.

**Criterion 4:****Is regulation possible to implement for the occupation in question?**

When considering whether regulation of the occupation is possible, the following need to be considered:

- is the occupation well defined;
- does the occupation have a body of knowledge that can form the basis of its standards of practice;
- is this body of knowledge, with the skills and abilities necessary to apply the knowledge, teachable and testable;
- where applicable, have functional competencies been defined; and
- do the members of the occupation require core and government accredited qualification.

**Criterion 5:****Is regulation practical to implement for the occupation in question?**

When considering whether regulation of the occupation is practical the following should be considered:

- are self regulation and/or other alternatives to registration practical to implement in relation to the occupation in question;
- does the occupational leadership tend to favour the public interest over occupation self-interest;
- is there a likelihood that members of the occupation will be organised and seek compliance with regulation from their members;
- are there sufficient numbers in the occupation and are those people willing to contribute to their costs of statutory regulation;
- is there an issue of cost recovery in regulation; and
- do all Governments agree with the proposal for regulation.

**Criterion 6:****Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?**