Submission Template

This template is provided to assist in the structuring of responses to the Consultation Paper.

There are 11 Topic Areas, around which we request that Submissions be structured. These are supported by guiding questions that may assist you to structure your input.

You may also wish to provide a cover note highlighting key issues – if you do so, please ensure this is no more than 2 pages.

If you wish to attach additional supporting material please do so, but please indicate in the body of your response what is attached.

You need only address those Topics on which you wish to comment. There is no expectation that all submissions address all Topics, although you are of course welcome to do so.

The deadline for submissions is **14 October 2024**.

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TOPIC 1: Evidence and Issues

Guiding Questions

1. **Are there any aspects of the information provided on the issues and challenges discussed in section 2 of the Consultation Paper that you wish to comment on or add to? If so, please provide a page reference for the content on which you are commenting and also provide any supporting information that you consider relevant.**

   The work underway to address health workforce shortages is outlined in dot points on page 14 of the consultation paper. However, the consultation paper fails to acknowledge how the development of the National Allied Health Workforce Strategy[1] can be intertwined into a whole-of-system approach. Additionally, section 1.1 on page 20 of the consultation paper refers to the National Medical Workforce Strategy, which is only specific to the medical workforce. Ahpra regulates 16 National Boards most of which are allied health professionals. Similarly, the consultation paper's first paragraph on page 30 outlines Australia's Health Workforce report, highlighting health workforce shortages with no mention of allied health.

[1] Department of Health and Aged Care. National Allied Health Workforce Strategy [Internet]. 2024. Available from: https://www.health.gov.au/our-work/national-allied-health-workforce-strategy

Likewise, page 20 of the consultation paper outlines medical and nursing training and accreditation requirements, which are referenced several times throughout the paper. However, there is very little if any acknowledgement of allied health throughout the consultation paper, let alone the training and accreditation requirements.

Page 22 of the consultation paper outlines that Ahpra protects the health and safety of the community while attempting to maintain light-touch regulatory oversight and should focus more on proactive, whole-of-systems regulation.

Osteopathy Australia agrees and notes that Ahpra generally only operates reactively, and we would go as far as to say has actively avoided acting proactively, even when presented with external risk data. For example, techniques such as dry needling are used frequently in osteopathy, physiotherapy, chiropractic and by others. Dry needling sits outside of the regulation of acupuncture but carries all the same risks. Currently, there are no minimum training standards or obligations beyond generic Ahpra codes and guidelines. Dry needling can be incredibly safe when used by highly qualified health professionals and if adequately trained, an effective technique. However, dry needling can have a serious impact if a needle penetrates the lung field resulting in a potentially life-threatening pneumothorax. Osteopathy Australia, in the absence of any standards, has developed its own guidelines and recommendations, but they are not enforceable.

Osteopathy Australia has raised our concerns, over numerous years, with Ahpra about several incidences of pneumothorax per year, within osteopathy. Some of these result in hospitalisation. We have flagged that our professional indemnity insurer has indicated this is similar in other professions such as physiotherapy and chiropractic. As such, we asked if the regulator could consider a clear statement or standard on minimum training expectations for invasive needling practices. On each occasion, it has been met with a sentiment that if they are not receiving Ahpra notifications, they do not see the need to act.

2. **Are there additional issues and challenges of concern to you that are not covered in Section 2 of the Consultation Paper?**

While Osteopathy Australia agrees that NRAS can have a larger role in workforce, consumer participation, broader inter-agency complaints coordination or policy development, it must be recognised that currently, the NRAS is a user's pays scheme, *funded by registrants*.

Increasingly, Ministers and Governments want more from the scheme beyond regulation. The consultation paper lacks some analysis, recommendations or suggestions on how government(s) will need to fund such additional whole of systems changes and functioning, over unfairly adding additional financial burdens on the 900,000+ registered health workforce.

Similarly, the paper needs more focus on issues that result in Minister(s) or Government(s) intervention for additional regulation (as a blunt tool) when the development of training, practice or procedural standards and/or oversight within their clinical institutions, hospitals or Departments would be both more appropriate and effective. It appears increasingly, in times of political pressure, NRAS is a default solution when proper internal clinical governance (or lack thereof) may actually be a better option.

~~3. If so, please provide details and attach any relevant supporting information or data.~~

TOPIC 2: Governance and Stewardship – Strategic connection

Guiding Questions

4. **Do you think that a stronger strategic connection between workforce planning / strategy and health practitioner regulation is an important reform priority?**

Osteopathy Australia believes a strong connection between workforce planning/strategy and health practitioner regulation is pivotal to the reform priorities. Strategically planning for workforce shortages forecast for the coming years is essential to ensure the public receives access to the care they need. Currently beyond workforce mobility (though National registration), some data and the development of capability standards, Ahpra has achieved little with respect to workforce planning, sustainability or capacity. The reform priorities must be intertwined with existing workforce strategy activities, including the National Allied Health Workforce Strategy. As outlined above, the consultation paper makes no mention of the Allied Health Workforce Strategy[1]; however, it references the National Medical Workforce Strategy several times (on pages 14, 20 and 21).

Ahpra has indicated during its Professions Reference Group (PRG) meetings that work is underway to support parental leave fee arrangements under the National Scheme. There are concerns about access to fee relief for practitioners taking leave from practice, which must be consistent cross-professionally. The consultation paper fails to acknowledge this work, which is critical for workforce planning activities. The National Scheme fails to acknowledge that practitioners may have absences from practice for reasons such as going on maternity leave. Additionally, it does not have any flexibility to modify fees, continuing professional development (CPD) or recency of practice (ROP) hours for osteopathy specifically. Despite maternity leave legislation, protections or allowances being present in all other industries, NRAS offers little consistency nor flexibility. Failing to acknowledge that practitioners may go on maternity leave from time to time does a disservice to all professions regulated under the Scheme leading to unplanned absences from practice and further contributing to workforce shortages and maldistribution.

Professions such as optometry and medical radiation practitioners have an exemption process in place for maternity leave. The majority of healthcare professions are female dominated, particularly in younger demographics and increasingly so. For regulated health workers wanting to raise a family, NRAS places additional regulatory barriers to maintaining their place within the health workforce. 54.1% of registered osteopaths are female, and just under 70% of registered osteopaths are of childbearing age[3]. It is unfair and inequitable to provide different exemption processes for some professions and not others. With a largely female-dominated profession, osteopathy should arguably have the same privileges as others.

Registrants fund and give their time each year to collect comprehensive workforce data. Ahpra collects that workforce data, which is provided to the Australian Institute of Health and Welfare (AIHW), and unfortunately, that data is rarely available before three years, by which time it offers little relevance to inform workforce planning strategies. For this data to be current and inform best-practice workforce planning solutions, it must be released more often. Osteopathy Australia recommends the release of workforce planning data (even as unanalysed data cubes) annually to inform best-practice solutions. If registrants participate

and fund the collection of this data each year, it is Ministers and Government(s) responsibility to ensure AIHW releases it in a timely manner.

Currently, student data is not published in any timely, meaningful or useful form and is often only released as a collective number of total students enrolled. Student workforce data is not granular enough to determine how many students are forecast to graduate per year per profession. Access to data on the number of students enrolled per year of study, and per state is pivotal to informing workforce planning arrangements and providing solutions to addressing workforce maldistribution. Osteopaths are mostly concentrated within metropolitan Melbourne and scarcely scattered in other areas across the country. To better plan for existing workforce shortages, access to student graduate data is essential to ensure new graduates have better opportunities to work in areas of need.

Page 33 of the consultation paper discusses the development of KPIs based on the NRAS Strategy 2015-2020. KPIs should be made publicly available, especially to practitioners who are paying for the scheme to operate. KPIs should be developed in collaboration with regulated professions and must be reasonable in relation to their scope of practice. Osteopathy Australia recommends that Ahpra works in alignment with the recent scope of practice review[2] to ensure KPIs are tangible and achievable.

Page 35 of the consultation paper discusses Ministerial responsibilities. A core issue with NRAS has always been that is accountable to all but none, i.e. it is accountable to whole the Ministerial Council but effectively not accountable to any one Minister. Lines of accountability must be clearly outlined, as no Minister can act without the direction of the Ministerial Council. For example, it took several years for a review of non-surgical cosmetic procedures. Yet, on the flipside, often confirmation or appointments to National Boards are delayed due to the infrequency of Ministerial Council meetings, especially with election cycles.

Table 3 on pages 46-47 outlines reform areas that have commenced their review period. However, the implementation of previous review outcomes or recommendations are incomplete or unclear. More transparency and accountability on existing activities that have occurred is required to ensure previous review outcomes are finalised and communicated to stakeholders.

5. **Do you have a perspective on how this could be achieved?**

As indicated above, Ahpra must work collaboratively with the Department of Health and Aged Care to implement changes resulting from the National Allied Health Workforce Strategy[1]. Ahpra should also work closely with peak body associations and various allied health professionals to ensure the right skill level and experience of the workforce is available. As outlined above, access to student data is crucial for workforce planning purposes.

Ahpra operates consultations in a perfunctory and procedurally fair way; however, fails to undertake open group consultation at the initial stages to scope concerns, issues and cross-

[2] Department of Health and Aged Care. Unleashing the Potential of our Health Workforce – Scope of Practice Review [Internet]. 2024. Available from: https://www.health.gov.au/our-work/scope-of-practice-review

professional input. The Ahpra PRG operates as an Ahpra-controlled 'show and tell' rather than a collaborative opportunity for both sides to learn from each other. As the reviewers are aware, great value can be achieved, for both the Scheme and the professions, by initial open, collective and collaborative discussion on the issues for any code, guidelines or standard, before the initial drafting of the consultation papers. Yet this simple, cost-effective technique is rarely used.

There must be transparency in the work Ahpra is undertaking, including parental leave fee arrangements in the National Scheme. As indicated above, 54.1% of registered osteopaths are female, and just under 70% of registered osteopaths are of childbearing age[3]. Osteopathy Australia strongly recommends that work continues in this space to ensure equitable access to practitioner fee relief for osteopaths choosing to take parental leave. Ahpra must be held accountable for outlining the progress of ongoing matters and public awareness is encouraged going forward.

Fairness and transparency should underpin the National Scheme, and this applies when setting registration standards cross-professionally. As outlined above, it is unfair to grant different privileges to different professions such as those outlined in your own recent professional association's consultation regarding significant differences across recent consultations on ROP or CPD standards.

Despite the principles of the NRAS Scheme being risk-based and data-driven, this information is not publicly available. Ahpra claims that data systems are in place to review return to practice and determine the length of absence, however, types of complaints are not correlated with this information, nor are they publicly available.

Ahpra regularly conducts literature reviews and refreshes its guidelines after these reviews. However, the findings and analysis from the literature reviews may not be publicly released or on release highlight a lack of evidence to reinforce regulatory decisions. Lessons learned about a return to work, for example, are never publicly released; therefore, the way Ahpra and its Boards determine return-to-practice outcomes and conditions on registration is unclear. Our recent response to the confidential preliminary consultation on the ROP registration standards for osteopathy discussed that if the literature review could not find a clear consensus on the period of elapsed time after which a competency assessment should be completed, Ahpra must explain the strategies behind why they have chosen both the 150 hours in 12 months and 450 hours in three-year periods. Additionally, the review identified a range of 'protective factors' but provided no clarity on the evidence (or lack thereof) regarding the effectiveness of these. These findings are significant and must be communicated with registrants and members of the public to instil faith that Ahpra is acting in the best interest of public safety.

We also wish to highlight that Ahpra often does not produce evidence-informed policy but seeks out evidence to support existing policies, such as what can be seen in the ROP or CPD reviews as indicated above. As such, several policies and standards in force are outdated and not fit for purpose, like the professional capabilities framework, which is currently slated for review for osteopathy and many other professions.

[3] Australian Health Practitioner Regulation Agency. Annual report 2022/23. [Internet]. https://www.ahpra.gov.au/documents/default.aspx?record=WD23/33329&dbid=AP&chksum=HAMa0wv3ezKx%2bjMGWOjydw%3d%3d

Page 30 of the consultation paper highlights workforce shortages and the sustainability of the workforce. While Ahpra conducts regular workforce surveys, workforce attrition data is not accessible or rarely published. Ahpra has the records (but not the systems) to precisely calculate workforce attrition, over the last decade, across the Schemes' professions. Attrition data is vital for good workforce planning. One of the few exceptions is the Osteopathy Board of Australia published report in 2020; yet it cannot be compared to other professions as that data is not available. If National Boards and Ahpra are placing registrants' fees aside for research or data, why is it not being used to produce data of use to workforce planning? Again, there is no reference to the development of the National Allied Health Workforce Strategy[1].

Again, as highlighted in the previous sections, increasingly Minister(s) and Government(s) want more from the NRAS that requires clarification on how government(s), not registrants, will need to fund such additional whole of systems changes and functioning, beyond regulation.

6. ~~Do you have a view on what success would look like if reforms to strengthen strategic connection occurred?~~

TOPIC 3: Governance and Stewardship - Regulatory Connection

Guiding Questions

1. **Do you think there is a need for the National Scheme to work more closely with other regulators and agencies?**

   Osteopathy Australia agrees that jurisdictions, NRAS, consumers and registrants would greatly benefit from better coordination, open communication and consistent processes with other regulators or agencies. Minister(s) and Government(s) must accept individual accountability and fund the ongoing creation and maintenance of the complexity and confusion as a result of federation and ongoing individual jurisdictional idiosyncrasy.

   Further, as highlighted above, Minister(s) and Government(s) must accept the limitations of the scheme and accept interventions for additional regulation (as a blunt tool) when the development of training, practice or procedural standards and/or oversight within their jurisdictional clinical institutions, hospitals or Departments would be both more appropriate and effective in protecting the public. It appears increasingly, in times of political pressure, NRAS is a default solution when proper internal clinical governance (or lack thereof) would be a more appropriate option and directly within each jurisdictions control.

2. **If so, which regulators or agencies do you think should be involved?**

   All federal or jurisdictional health complaints, regulatory and/or standards bodies.

3. **Do you have a view about what structure or process should be used for this purpose?**

   Again, as highlighted in the previous sections, increasingly Minister(s) and Government(s) want more from the NRAS including regulatory connection or coordination with other bodies, particularly State bodies, which require clarification on how government(s), not registrants, will need to fund such additional whole of systems changes and functioning, beyond regulation.

If consumers would benefit from a single front door for complaints, support, direction and/or education, each jurisdiction should fund that consumer-focused service, similar to current healthcare complaints entities. Again, it would be unfair that additional financial burdens are placed on the 900,000+ registered health workforce to better coordinate various jurisdictional complexities across their entities and structures.

4. ~~Do you have a view on what success would look like if reforms to build connection across regulators were implemented?~~

TOPIC 4: Governance and Stewardship – Community Voice

Guiding Questions

1. **Do you see the need to strengthen the community input in setting strategic direction and priorities for the National Scheme.**

   A community voice and input into strategic directions and priorities such as responses to the identification of areas of risk and harm to the public is important. However, the National Scheme is user-funded. If community involvement and consultation are to be implemented, funding to facilitate this must be sourced through alternative routes. As highlighted in the previous section, increasingly Ministers and Governments want more community involvement in the Scheme, which requires clarification on how government(s) will need to fund such additional whole of systems changes and functioning, over unfairly adding additional financial burdens on the 900,000+ registered health workforce.

2. **If yes, how do you think this could be done.**

   Changing the composition of National Boards and working on consumer and practitioner parity plus similar in all other Ahpra committees, boards etc.

   Having a community representative as Chair on all National Boards.

   Ensuring consumer promotion and awareness raising budget and engagement tracking KPIs are allocated within the Ahpra budget.

TOPIC 5. Operational accountability and efficiency - Scheme wide objectives and priorities

Guiding Questions

1. **Do you have a view about methods that could be used to ensure that there is balanced consideration of workforce, health service access, and public safety in the National Scheme, as envisaged in the statutory objectives?**

   Minister(s) and Government(s) need to confirm the priority of statutory objectives, clearly with some priority given to the core functions of healthcare registration, regulation and complaint handling. Osteopathy Australia understands why this component of the Scheme should be user pay and funded by registrants; however, if other priorities and/or services need equal focus or resourcing, it would be unreasonable for registrants to fund other government priorities.

   Beyond healthcare registration, regulation and complaint handling, we would consider the functions for data collection, collaborative capability development and accreditation processes are equally important.

   As discussed earlier, referencing existing and new Workforce Strategies is crucial for a balanced workforce. The consultation paper refers to the National Medical Workforce Strategy on several occasions, however, it fails to acknowledge the National Allied Health Workforce Strategy[1]. Given Ahpra has more allied health Boards than medical and nursing, Osteopathy Australia strongly suggests harmonisation and collaboration with existing workforce strategy activities across the sector.

   Development of the National Allied Health Workforce Strategy[1] has quickly highlighted the limited (*or complete lack of*) resources, data or understanding, in both State or Federal jurisdictions or their departments, have in regard to the broader allied health workforce, data or planning beyond hospitals. This review must consider what is a responsibility or objective of Ahpra and equally what should remain a planning responsibility for or funded by Government(s).

2. **Do you think the priorities and strategic direction of the National Scheme are clear to all of the entities within the Scheme?**

   Neither the priorities nor the strategies are truly clear, or more accurately, they may be clearly stated but it is difficult to understand how they are operationalised or the outcomes achieved beyond the functions involved with healthcare accreditation, registration, regulation and complaint handling. The consultation paper does not refer to the fact that Ahpra is a practitioner-funded scheme. It is unclear to readers of the consultation paper that it is user-paid, however, there is reference to consumer voices in several sections. Given practitioners are paying for the National Scheme, government must fund any expectations it may have of the scheme outside of registration and complaints handling.

   In New South Wales (NSW), osteopaths pay more for their registration costs than in other states and territories due to co-regulation. Increased costs for registrants each year do not necessarily translate into public protection. Co-regulation is not addressed in the consultation paper. The review must address the inconsistencies that exist across NSW and

Queensland (QLD) and the Ministers should be responsible for this. Addressing the inconsistencies will help to simplify a complex regulatory scheme.

3. **Do you think that there are appropriate processes and structures to ensure that actions and decisions taken by entities align with the strategy direction and priorities for the Scheme.**

   Osteopathy Australia has seen a variety of outcomes and conditions placed on registrants, for similar matters, across jurisdictions which is of concern, nor can we highlight any tangible benefits achieved for consumer safety from current co-regulation models.

   Osteopathy Australia considers all administrative functions, plus all functions that can be verified by evidence independently should be delegated to Ahpra over waiting on National Board decisions. Otherwise, the National Boards should make decisions out-of-session, so decision-making is timely rather than potentially waiting 4-6 weeks until the next Board meeting.

~~4. Do you have a view about the functions that are delivered or should be delivered by the Ahpra Board?~~

~~5. Are there additional areas that the Aphra Board may need to focus on?~~

TOPIC 6: Operational accountability and efficiency - Boards and Committees

Guiding Questions

1. **Do you see opportunities to reduce the number of Boards within the National Scheme. If so, can you provide detail.**

   Each registrant contributes money to cover the costs of the Boards, which is not equitable expenditure of practitioner fees. If Ahpra is looking at reducing the costs of the scheme and utilising practitioner fees effectively, perhaps it should investigate Board and committee sitting fees. As indicated in Ahpra's most recent annual report[3], payments to Board Chairs alone cost nearly $1million of practitioner fees each year. Boards sit approximately four to six times per year, which is expensive to fund especially if Board members travel interstate and require overnight accommodation. Further, in a user pays scheme, NRAS should not be funding business class flights at any time, including overseas travel. It is unacceptable that a minority of National Boards can fund a practitioner support program when dealing with notifications but can afford to send individuals on $8,000-$14,000 international business class flights.

2. **Do you see opportunities to reduce the number of Committees within the National Scheme. If so, can you provide detail.**

   The Osteopathy Board of Australia operates without any state committees or councils. Other Boards operate with numerous committees, which begs the question of why complexity exists if there is no risk to the public. Other professions such as nursing and midwifery and medicine are the only professions that operate with state committees and councils. The cost of registration could be reduced if these committees and councils are disbanded.

3. **Do you see any risks in any proposed adjustments to the number of National Boards and/or Committees, and if so, what are those risks?**

   No.

4. **Do you think that the National Boards have too much operational focus?**

   Yes, as highlighted above, Osteopathy Australia considers all administrative functions, plus all functions that can be verified by evidence independently should be delegated to Ahpra over waiting on National Board decisions. Otherwise, the National Boards should make decisions out-of-session, so decision-making is timely rather than potentially waiting four to six weeks until the next Board meeting.

5. **Do you think the National Boards have sufficient scope to focus on higher level policy issues and risks and to provide input to the Ahpra Board and ministers on these issues? If not, what changes would you suggest?**

   Osteopathy Australia believes that the National Boards should be taking a proactive approach to regulation and policy issues. Currently, National Boards function under a reactive model where they are not involved in certain policy issues or regulation until significant harm has already occurred and a subsequent high volume of complaints have been received.

   This reactive nature can clearly be seen with the National Boards not regulating or providing guidance in the cosmetics industry until significant harm had occurred and national media interest was involved. As outlined above, other examples include practice such as dry needling, which is unregulated by National Boards due to receiving a limited number of complaints. Instead, Ahpra and its National Boards should review the potential risk of harm to the public rather than being responsive to the result of harm.

   National Boards should be the leading authority in ensuring patient safety and must be proactive rather than reactive in their risk and policy analysis and regulation development. Furthermore, the Ahpra Board and Ministers should utilise the expertise of each professional Board and associated professional peak body within policy development. It is evidently clear that most higher-level policy issues or risk decisions, plus any strategy or planning are led by Ahpra, not the National Boards.

6. **Do you think cross profession decision making and collaboration in one or more functions across the National Scheme should be prioritised. If so, can you suggest where this might be most required and how this might be achieved?**

   Osteopathy Australia supports the need to promote cross-professional decision-making and collaboration. As outlined in Consultation Paper 1, having profession-specific Boards and decision-making is important to ensure appropriate regulatory decisions are made for a profession. However, all National Boards should be working together to promote consistent standards, accountability, responsibility and alignment.

   Cross-professional collaboration could be prioritised within areas such as the development of national codes of conduct and shared professional capabilities. For example, it is not clear why only 12 of the 16 registered professions share a code of conduct. A shared code of conduct could be developed across all registered professions to ensure a consistent

professional approach to practice and solidify professional expectations. All professions should hold the same basic professional capabilities that underpin practice.

Furthermore, cross-professional collaboration is essential in ensuring a consistent approach to complaints handling, registration and re-registration processes. The current approach of 16 independent National Boards for decision-making is cumbersome and unsustainable.

Osteopathy Australia would also like to highlight the need for better consultation processes that emphasises cross-professional collaboration. For example, the recent consultation on CPD and ROP registration standards could have provided an opportunity for cross-professional collaboration rather than being profession-specific. Consultations often consist of online submissions only without the opportunity for stakeholders to collaborate and discuss key issues. There are better methodologies for ensuring meaningful consultation is conducted, including for the opportunity to talk through key issues and inform policy development activities before they open for consultation. As such, we call for Ahpra to facilitate a more collaborative process via consultation workshops and meetings.

7. **Do you think National Boards should be constituted with equal numbers of practitioner members and community members? If yes, why? If not, why not?**

   Yes, to ensure balance. Further, the current legislative makeup of the National Boards can be a disadvantage in smaller or maldistributed professions, due to designated seats for various jurisdictions. For example, in osteopathy, practitioner members are required from around three States, two which have less than 40 and another which has 70 practitioners.

8. **Do you think Health Ministers should have the flexibility to appoint a community member to the Chairperson role on a National Board? If yes, why? If no, why not?**

   Yes, if they are appointed on a skills basis with aims to optimise the running, discussion and output of the National Board, being a practitioner or community member is irrelevant.

~~9. Do you have a view as to what top line KPIs and associated reporting would be most effective?~~

TOPIC 7: Operational accountability and efficiency – Accreditation Functions

Guiding Questions

1. **Do you think that additional measures are required to make sure that accreditation functions support workforce strategy and planning priorities? If so, what measures do you suggest being considered?**

   It is worth noting that Ahpra has recently started a consultation process on shared capabilities, and this was a recommendation in the Independent Accreditation Systems Review conducted by Professor Michael Woods in 2017 (seven *years ago*) and to date has not been implemented beyond this recent consultation commencing. Osteopathy Australia supports having shared professional capabilities across all healthcare professions, in fact, we believe that all healthcare professions should share a range of base common competencies/capabilities, that ensure they are safe for the public.

Capabilities (or Standard or Competencies) are the backbone of accreditation and workforce. Currently, almost half of the NRAS capability documents are over five years old, which probably means they are sufficiently out-of-date and may pose a risk to the public by promoting obsolete or supplanted information, competencies or capabilities.

The fact that some NRAS capability documents will be nearly a decade old before being updated would shock most consumers. As has been quoted in the media 'yesterday's "Gold Standard" can be tomorrow's "Malpractice"'.

It is generally accepted that by 2010 the doubling time of healthcare knowledge shrunk to 3.5 years and by 2020, the doubling time of healthcare knowledge was as little as 0.2 years. Further, the healthcare fact 'half-life' is now accepted as 12-24 months. Many healthcare students entering the workforce do so with information that is already incorrect by the time they graduate. If the course they have completed was assessed/accredited against a five-year-old capability document, the information they are taught is not current. For example, how many of those older capabilities documents address artificial intelligence (AI) in healthcare or contain out-of-date competencies or capabilities?

All these frameworks or capabilities documents would be greatly improved by more frequent review, which we suggest occurs at least every three years to ensure currency, to protect the public and industry readiness. A more frequent review period will reduce the number of major updates, maintain currency with healthcare knowledge, capabilities and industry changes or expectations.

TOPIC 8: Coherent and Effective Complaints handling - Simplifying structures and processes.

Guiding questions

1. **Do you think it is necessary to simplify complaints handling?**

Osteopathy Australia supports the need to simplify the complaints handling process. Currently, complaints handling processes differ from State to State and is difficult to navigate for consumers who may not know which entity is the appropriate one to lodge their complaint with.

Health Complaints Entities (HCEs) and their ability to negatively license are outlined as types of occupational regulation on pages 19, 73 and 75 of the consultation paper. In Australia, title protection is regulated, however, this does not prevent Ahpra from placing the public at risk.

While Osteopathy Australia agrees that simplifying complaints handling will be beneficial, we also suggest that the financial costs of managing complaints should be considered. The costs for managing all complaints should not be the responsibility of regulated professions. For example, it is inequitable for practitioner fees to fund every single complaint that is not exclusive to practitioner conduct or behaviour.

2. **Do you support a single front door for lodging complaints within each State and Territory Health Complaints Entities?**

Yes, a single front door approach will benefit consumers by simplifying the current confusing complaints lodgement system. Locating the correct complaints-handling entity is currently seen as a hurdle for many consumers so providing a single front door approach simplifies the complaints process and ensures that they are handled promptly.

If consumers would benefit from a single front door for complaints, support, direction and/or education, each jurisdiction should fund that consumer-focused service, similar to current healthcare complaints entities. Again, it would be unfair that additional financial burdens are placed on the 900,000+ registered health workforce to better coordinate various jurisdictional complexities across their entities and structures.

~~3. If not, do you have other suggestions for simplifying the processes for lodging and assessing complaints?~~

4. **Do you have suggestions about what would be required to make this single front door model of complaints handling work?**

Appropriate funding must be obtained, and operational policies and procedures established. National Boards operate on a user-based funding model. As highlighted above, Osteopathy Australia is therefore concerned that a single front door approach to complaints handling will result in some professions subsidising other professions with higher rates of complaints. As such, alternative funding must be sourced.

Strong policies and procedures must also be established and implemented consistently nationwide to ensure complaints are handled appropriately and efficiently.

5. **Do you see risks in a single front door approach and if so, what are those risks?**

Risks of complaint mishandling or delays in handling could occur if the single front door is not appropriately staffed or if there is inadequate staff training in complaints triaging and dissemination. Appropriate practices, policies and protocols must be established and implemented if a single-door approach is taken.

6. **Do you have a view on how joint decisions would be made between the health complaints entity and Ahpra about those complaints that should be referred to Ahpra as a Professional Standards breach?**

75% of complaints end in no further action and consumers do not feel heard when receiving this advice. Often, complaints outcomes are more punitive in NSW than for other jurisdictions operating under the Scheme. There are consequences and costs associated for registrants because of this. If government is committed to making improvements to the complaints handling process and the Scheme, then they should be funding this part of the Scheme.

TOPIC 9: Coherent and Effective Complaints handling - high-risk notifications

Guiding questions

1. **What do you see as the problems if any, with the way high-risk notifications are currently managed? If you think there is a need for reform what should this look like?**

   Page 15 of the consultation paper outlines that healthcare complaints continue to rise. Osteopathy Australia reminds Ahpra that it received six complaints about osteopaths in 2021-22[3]. Osteopaths are a low-risk profession, which is indicated by the small number of complaints received over the 2022-23 period. In comparison to medical practitioners from which Ahpra received 130 complaints, osteopaths pose a very low risk to the public.

2. ~~Do you think the current division of responsibilities between National Boards and Ahpra in the management of high-risk complaints is working well. If yes, why? If no, why not? What changes would you suggest?~~

3. ~~Do you think that a stronger regulatory decision-making role for Ahpra would be beneficial and if so in what way?~~

4. ~~Do you think that a stronger regulatory decision-making role for Ahpra would be risky, and if so in way?~~

5. ~~Do you think the arrangements for providing clinical input to regulatory decision making are working well? If yes, why? If no, why not? What changes would you suggest?~~

6. ~~Do you think the arrangements for hearing serious misconduct matters through state and territory tribunals are working well? If yes, why? If no, why not? What changes would you suggest?~~

7. ~~Have you observed significant inconsistency in the outcomes in tribunal decisions and if so, can you provide further detail and examples?~~

8. **What do you think of the idea of a single national health practitioner tribunal to replace the current 8 separate state and territory tribunals?**

   Unless separate tribunals are going to apply some consistency in ruling and consequences, practitioners are being denied equal and fair natural justice across Australia. If that is not possible, then a single national health practitioner tribunal would be advantageous.

9. ~~Do you believe that there is more that the National Scheme could do to strengthen performance on serious and high-risk complaints and if so, can you provide detail?~~

TOPIC 10: Scope and Expansion of the National Scheme

Guiding Questions

1. **Do you think the current two staged assessment process is appropriate for considering adding professions to the National Scheme and if not, what changes would you recommend?**

   Osteopathy Australia recommends a tiered approach to the registration Scheme. The tiered approach may include categories for low-risk professions and high-risk professions. The tiered approach may include additional professions proposed to be added to the National Scheme. As mentioned in the section above, osteopaths are a low-risk profession, which is indicated by the small number of complaints received over the 2022-23 period. In comparison to medical practitioners from which Ahpra received 130 complaints, osteopaths pose a very low risk to the public. A tiered approach to registration offers professions the opportunity to pay a reduced registration fee based on a lower risk to the public.

   The risk criteria and how it applies to practitioners is an area that should also be addressed and changed. We have questions about the risk criteria and:
2. A professions capacity to cause harm
3. Harm itself (how is it defined or assessed)
   - Procedures that have the capacity to cause harm.

4. **Do you have a view as to whether an additional pathway into the National Scheme based on the United Kingdom Accredited Voluntary Register Model would be a useful reform?**

   Ahpra operates a profession-by-profession scheme, however, the examples provided across the globe indicate different ways of working and co-regulatory models. Osteopathy Australia is noncommittal toward the current or alternative models.

5. **Do you see any risks and challenges with an additional pathway into the national Scheme via an Accredited Register Model?**

   Health or care workes who require direct supervision, such as allied health assistants, the care workforce etc should not be included in the scheme. Regulated allied health professions, like osteopaths, will face additional burdens and supervisory responsibilities if allied health assistants are regulated under the National Scheme. Allied health professionals such as osteopaths are already burdened with completing administrative tasks relating to their clinical practice and do not have the time or capacity to supervise allied health assistants. Adding the supervisory component to an already burdened workforce adds a dimension of complexity and responsibility for regulatory complaints handling processes.

6. **Do you have a view about the importance of the National Code of Conduct for non-registered practitioners in the broader regulatory framework?**

   The National Code of Conduct should be consistently implemented across all jurisdictions with resourcing to ensure consumers and practitioners are aware of their obligations. While it is important, it is poorly understood, and awareness is low.

7. ~~Do you see a need for additional focus on implementation of the National Code of Conduct for non-registered practitioners and if so, what would that involve?~~

8. **Should there be a regular cycle of review of the professions in the National Scheme or is the flexibility for professions to bring forward proposals at any time preferable?**

   Osteopathy Australia recommends a review period of at least every three years to ensure currency, protect the public and provide industry readiness. A more frequent review period will reduce the number of major updates, and maintain currency with healthcare knowledge, capabilities and industry changes or expectations.

9. ~~Do you think that there should be any avenue or process for considering removing a profession from the National Scheme (e.g. if evidence shows that there are very few complaints, the costs of registration outweigh the benefits, or it is established that alternative registration methods are adequate to protect the public).~~

TOPIC 11: Possible Reform Concepts

Guiding Questions

10. ~~Do you have any other comments or suggestions in relation to Reform Concept 1 (Repositioning the National Scheme- applying a Stewardship Model)~~

11. ~~Do you have any other comments or suggestions in relation to Reform Concept 2 (Resetting Accountabilities within and Alongside Ahpra)~~

12. ~~Do you have any other comments or suggestions in relation to Reform Concept 3 (A fully integrated 3- tier model of health practitioner regulation))~~

13. ~~Do you wish to put forward any reform concepts for consideration – if so please attach detail~~