



**Ahpra  
& National  
Boards**

# Annual report 2022/23

## **Growing a safe workforce**

The Australian Health Practitioner Regulation Agency and the National Boards, reporting on the National Registration and Accreditation Scheme



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This report provides Ahpra data, unless stated otherwise. Due to rounding (to one decimal place), percentages may not add to exactly 100%. Data from 2019/20 to 2022/23 include practitioners on the temporary pandemic sub-registers. This affects some percentages.

We refine our data collection and reporting each year so data may not directly correlate across annual reports.

The report's supplementary data tables, available online at [www.ahpra.gov.au](http://www.ahpra.gov.au), are the source for some of the statistics cited. Some other statistics are drawn from internal reports.

The 'Most common types of complaint' graphs in the National Board reports are based on the main reason for a notification.

For definitions of words and phrases, refer to the list of common abbreviations and the glossary. Throughout the report, the term 'podiatrist' refers to both podiatrists and podiatric surgeons unless otherwise specified.

The appendices are available online; they contain more information about Boards and committees.

You will see photos of some of the health practitioners who serve our community, some photos of students and graduates, and some of Board and committee members and staff. We thank everyone who agreed to be photographed for this report.

# Tables and figures

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# A growing workforce

## 2022/23 highlights

# 877,119

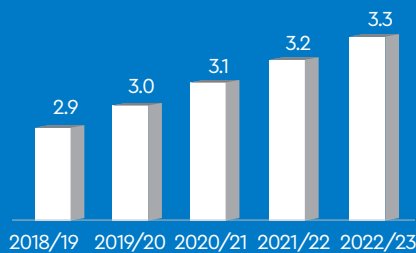
**registered health practitioners**

2.9% more than last year

# 3.3

**registered health practitioners for every 100 Australians**

Number of practitioners per 100 people



# 14.3%

**more applications for registration**  
than last year

- 96,136 applications finalised
- 42,565 from new graduates

# 92.5%

**more new overseas-qualified practitioners**

- 147.6% more nurses and midwives
- 41.1% more medical practitioners
- 50.3% more allied health practitioners

# 800,943

**practitioner renewals**

- 35,865 (4.7%) more than last year

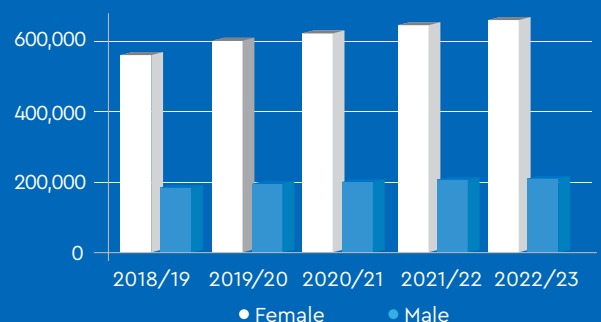
# 10,813

health practitioners identify as  
**Aboriginal and/or Torres Strait Islander**

# 183,900

**health students**

### A predominantly female workforce



Practitioners can also be registered as neither female nor male, though these numbers are too low to be represented in the figure.

■ ■  
We placed more senior Ahpra staff on the frontline assessing applications at their earliest stage to ensure complete applications and reduce delays  
■ ■

■ ■  
More Australian and internationally trained practitioners have sought to work in the nation's health systems than ever before – we responded to get them practising safely, sooner  
■ ■

# A safer workforce

## 2022/23 highlights

### Notifications

17,096 notifications were made about 13,584 practitioners nationally

- 1.5% of all registered health practitioners had a notification
- 9,706 notifications about 7,970 practitioners dealt with by Ahpra
- The most common concern was clinical care



**Ahpra can use its own and external data to identify potential risks and emerging issues – having an evidence-based approach provides a solid basis for informed regulatory decision-making and proactive management of risk**



### Aboriginal and Torres Strait Islander participation

Eight Aboriginal and/or Torres Strait Islander people were appointed to Boards and committees, bringing the current total to 33

Nine Aboriginal and/or Torres Strait Islander staff members were hired at Ahpra, bringing the total to 15



**Cultural safety for Aboriginal and Torres Strait Islander Peoples was enshrined as a new objective and guiding principle in the National Law**



### Cosmetic surgery

315 calls to cosmetic surgery hotline

157 cosmetic surgery concerns actioned

69 cosmetic surgery audits for advertising compliance

- 65 cases of non-compliance



**Major reforms have increased the safeguards for those considering cosmetic surgery, as well as clearer guidelines for medical practitioners performing and advertising cosmetic services**



### Legal action

Matters involving 129 practitioners (relating to 200 notifications) finalised at tribunal

- 98.0% resulted in disciplinary action
- disqualification periods up to 25 years imposed

140 appeals finalised

442 criminal complaints received

- 75.1% about title protection



**In May, Ahpra completed its 100th criminal prosecution**



### Compliance

4,759 cases involving 4,750 practitioners monitored by Ahpra at 30 June

- 1,342 cases were about health, performance and/or conduct
- 380 advertising complaints assessed

### Accreditation

More than 802 approved programs of study delivered by more than 130 education providers



# Introduction

Australia, like most of the world, is experiencing a health workforce shortage, affected by population growth, social changes and the lingering effects of the COVID-19 pandemic.

This year, we advanced a comprehensive program of work to ensure the numbers of registered practitioners can keep growing to meet these demands.

## Expanding the workforce

The number of registered health practitioners increased by 2.9%, to 877,119. We continue to focus our efforts on registering suitably qualified practitioners so they are available to work in the areas they are needed. This year, our initiatives to streamline registration processes included increasing engagement with employers and further reducing timeframes to assess applications. Registration applications were 14.3% higher than last year, and the average time taken to assess an application was almost two-thirds faster than last year.

A raft of significant changes was put in place to improve the registration process for international applicants. This work accelerated in line with National Cabinet commissioning the *Independent review of overseas health practitioner regulatory settings*, led by Ms Robyn Kruk AO, which is looking at ways to ease health workforce shortages by smoothing the pathways for international practitioners to come and work in Australia. We have cut the time it takes to assess applications, boosted exam places for internationally qualified nurses and consulted on making English language requirements more flexible. There was a dramatic increase in the number of overseas-qualified practitioners being registered (147.6% more nurses and midwives, 41.1% more international medical graduates and 50.3% more allied health practitioners). We will continue to work on improving their application experience, while maintaining our high quality and safety standards.

## Ensuring safety

We worked in several areas to strengthen safety, the most notable being cosmetic surgery reforms and improved management of sexual boundary violations.

- To respond to the rising risk in the cosmetics sector, we established a Cosmetic Surgery Enforcement Unit with specialist investigators, conducted a targeted audit of advertising and established a telephone hotline for members of the public and practitioners.
- We released a blueprint to better protect patients from sexual misconduct, with a range of measures underway, including a review of the criminal history registration standard and employing more specialist investigators and social workers to support notifiers.

## Cultural safety

Cultural safety for Aboriginal and Torres Strait Islander Peoples is a new objective and guiding principle of the National Scheme. It is one of the more than 30 reforms to the National Law aiming to strengthen protections for the public that were passed in October. In the third year of our Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy, we began developing a culturally safe notification process and established a new Aboriginal and Torres Strait Islander Engagement and Support team to assist registrants. Seventeen Aboriginal and/or Torres Strait Islander people were appointed to Boards, committees and staff positions.

## Regulatory insights

We consulted on a data strategy, which takes into consideration our unique access to health practitioner data and its potential use. In this consultation, stakeholders, practitioners and the public considered opportunities to use and share some of these data to inform health workforce policy and planning and to improve public safety. We continue to assess the regulatory insights found in our data to help us understand emerging issues and manage risk.

In this report, we are pleased to share our work to make healthcare safer for every Australian. We thank Ahpra staff and National Board and committee members, who have navigated a year of great change, for their efforts and achievements. And we would like to thank the registered practitioners around Australia for their continued dedication to safe, high-quality healthcare.



**Mr Martin Fletcher**

Chief Executive Officer,  
Ahpra



**Ms Gill Callister PSM**

Co-convenor, Forum of  
National Registration and  
Accreditation Scheme Chairs  
Chair, Ahpra Board



**Mr Brett Simmonds**

Co-convenor, Forum of  
National Registration and  
Accreditation Scheme Chairs  
– to 3 Feb  
Chair, Pharmacy Board  
of Australia



**Ms Rachel Phillips**

Co-convenor, Forum of  
National Registration and  
Accreditation Scheme Chairs  
– from 4 Feb  
Chair, Psychology Board  
of Australia

# About us

## Our purpose

Safe and professional health practitioners for Australia

## Our vision

Our communities have trust and confidence in regulated health practitioners

## Our values

Integrity

Respect

Collaboration

Achievement

## What we do

Working in partnership with 15 National Boards, the Australian Health Practitioner Regulation Agency (Ahpra) implements the National Registration and Accreditation Scheme (the National Scheme). The National Scheme regulates 16 health professions.

Public safety is our priority. Every decision we make is guided by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

**Ahpra has five core functions.**

### Professional standards

National Boards establish registration standards, codes and guidelines for health practitioners.

### Accreditation

We work with accreditation authorities and committees to ensure that graduating students are suitably qualified and skilled to apply for registration as health practitioners.

### Notifications

We manage complaints and concerns raised about the health, performance and conduct of individual health practitioners on behalf of the National Boards, except in New South Wales. In Queensland, we jointly consider notifications with the Office of the Health Ombudsman and manage those referred to us.

### Compliance

We monitor and audit registered health practitioners to make sure they are complying with Board requirements.

### Registration

We ensure that only health practitioners with the skills and qualifications to provide competent and ethical care are registered to practise. We manage registration and renewal processes for local and overseas-qualified health practitioners and we manage student registration. We publish the national *Register of practitioners* (at [www.ahpra.gov.au](http://www.ahpra.gov.au)) so that important information about individual health practitioners is available to the public.

For more information visit [www.ahpra.gov.au](http://www.ahpra.gov.au) and the linked National Board websites.

# Health practitioner regulation in Australia

## The National Scheme

The National Scheme operates Australia-wide to regulate individual health practitioners. It is a vital part of the Australian health system. The scheme is governed by a nationally consistent law passed by each state and territory parliament – the National Law. A Ministerial Council made up of all of Australia's health ministers oversees the scheme.

## Ahpra and the National Boards

Fifteen National Boards are responsible for the regulation of 16 health professions. They set standards that practitioners must meet to be registered, develop regulatory policy and guidance, and make regulatory decisions about concerns raised about registered health practitioners.

Ahpra supports the Boards to implement the National Scheme. Together, Ahpra and the National Boards are responsible for the registration of every practitioner in the registered health professions across Australia.

## Regulation around the country

If someone wants to make a complaint or raise a concern about a registered health practitioner in most states and territories, they should come to Ahpra. However, in New South Wales and Queensland the process is different.

Ahpra has a national role in ensuring that, across Australia, all notifications and their outcomes are recorded and that the national *Register of practitioners* is accurate and complete.

### New South Wales

The National Boards don't handle notifications in New South Wales. Instead, 15 health professional councils – supported by the Health Professional Councils Authority (HPCA) and working with the Health Care Complaints Commission (HCCC) – assess and manage complaints about registered and unregistered health practitioners' conduct, health and performance.

Ahpra has a role in accepting mandatory notifications in NSW and referring them to the HCCC.

### Queensland

The Office of the Health Ombudsman (OHO) receives concerns in Queensland. All concerns about registered health practitioners are jointly considered by OHO and Ahpra and a portion of them are referred to Ahpra to manage.

## Other states and territories

Health complaints entities (HCEs) handle some types of complaints about health practitioners, and can provide outcomes that Ahpra and the National Boards cannot, such as:

- an apology or explanation
- access to health records
- compensation or a refund
- an improvement for a hospital, clinic, pharmacy or community health service.

Ahpra and the National Boards work with the HCEs to decide which organisation should take responsibility for, and manage, a complaint or concern.

The HCEs are:

### Australian Capital Territory

Health Services, Discrimination, Disability and Community Services Commissioner

### Northern Territory

Health and Community Services Complaints Commission

### South Australia

Health and Community Services Complaints Commission

### Tasmania

Health Complaints Commissioner

### Victoria

Health Complaints Commissioner

### Western Australia

Health and Disability Services Complaints Office

## Accreditation authorities

Each registered profession has an accreditation authority – either an external council or a committee established by a National Board – that accredits programs of study.

## Independent ombudsman

The National Health Practitioner Ombudsman (NHPO) provides an independent ombudsman, privacy and freedom of information oversight of the National Scheme, the work of Ahpra and the National Boards, and the administrative processes experienced by practitioners and the public.



# Regulatory principles for the National Scheme

These regulatory principles underpin the work of the National Boards and Ahpra in regulating Australia's registered health practitioners in the public interest. They shape our thinking about regulatory decision-making and have been designed to encourage a culturally safe and responsive, risk-based approach to regulation across all professions. The regulatory principles consider community expectations and reflect ministerial directions.

1. The National Boards and Ahpra administer and comply with the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The scope of our work is defined by the National Law.
2. Public protection is our paramount objective in the National Registration and Accreditation Scheme. We act to support safe, professional practice and the safety and quality of health services provided by registered health practitioners.
3. We protect the health and safety of the public by ensuring that only registered health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.
4. In all our work we:
  - a. identify the risks that we need to respond to
  - b. assess the likelihood and possible consequences of the risks
  - c. respond in ways that are culturally safe, proportionate and consistent with community expectations, and manage risks so we can adequately protect the public
  - d. take timely and necessary action under the National Law.
5. The primary purpose of our regulatory response is to protect the public and uphold professional standards in the regulated health professions. When we learn about concerns regarding registered health practitioners, we apply the regulatory response necessary to manage the risk, to protect the public.
6. Our responses consider the potential risk of the registered health practitioner's health, conduct or performance to the public including:
  - people vulnerable to harm, and
  - Aboriginal and Torres Strait Islander Peoples.
7. When deciding on regulatory responses, we are fair and transparent, and consider the importance of maintaining standards of professional practice that support community confidence in regulated health professions.
8. We work with our stakeholders, including patient safety bodies, healthcare consumer bodies and professional bodies, to protect the public. We do not represent the health professions, registered health practitioners or consumers. However, we work with practitioners and their representatives and consumers to achieve outcomes that protect the public.

This applies to all our regulatory decision-making, the development of standards, policies, codes and guidelines as well as the way we regulate individual registered health practitioners.



# Ahpra Board

The Ahpra Board is the governing board for Ahpra. Its members are appointed by the Ministerial Council.

The Ahpra Board was formerly called the Agency Management Committee; its name changed on 13 October as a result of a change to the National Law.

The board ensures that Ahpra performs its functions in a proper, effective and efficient way. It is responsible for determining Ahpra policies, setting the strategic direction for the National Scheme and assuring its performance.

We thank outgoing member Adjunct Professor Karen Crawshaw PSM.



**Ms Gill Callister PSM**  
Chair



**Emeritus Professor  
Arie Freiberg AM**



**Mr Jeff Moffet**



**Mr Lynton Norris**



**Honorary Associate  
Professor Carmen Parter**



**Ms Jenny Taing OAM**



**Ms Barbara Yeoh AM**



**Dr Susan Young**

# National Boards



The National Boards work to ensure safe, quality healthcare by practitioners across Australia. Each of the registered health professions is regulated by a National Board.

All Chairs are registered health practitioners in their profession. The other Board members are a mix of practitioner and community members. All are appointed by the Ministerial Council.

This section comprises reports from each of the National Boards.



Aboriginal and Torres  
Strait Islander Health  
Practice Board  
Ahpra



Chinese Medicine Board  
Ahpra



Chiropractic Board  
Ahpra



Dental Board  
Ahpra



Medical Board  
Ahpra



Medical Radiation  
Practice Board  
Ahpra



Nursing and  
Midwifery Board  
Ahpra



Occupational  
Therapy Board  
Ahpra



Optometry Board  
Ahpra



Osteopathy Board  
Ahpra



Paramedicine Board  
Ahpra



Pharmacy Board  
Ahpra



Physiotherapy Board  
Ahpra



Podiatry Board  
Ahpra



Psychology Board  
Ahpra



# Aboriginal and Torres Strait Islander Health Practitioners



## Issues this year

Despite regular annual growth in the profession, there are a significant number of Aboriginal and Torres Strait Islander Health Practitioners who do not renew their registration with the Aboriginal and Torres Strait Islander Health Practice Board of Australia each year. Both the Board and Ahpra understand there can be challenges with both obtaining and maintaining registration, particularly for Aboriginal and Torres Strait Islander Peoples. In response, Ahpra has established an Aboriginal and Torres Strait Islander engagement liaison team to provide registration support to Aboriginal and Torres Strait Islander practitioners across all health professions, especially Aboriginal and Torres Strait Islander Health Practitioners. This special support network will hopefully enable more Aboriginal and Torres Strait Islander Health Practitioners to become, and remain, registered to provide care to their communities.

## Policy updates

The Board participated in the ongoing cross-professional reviews of registration standards and continues to routinely review and update other published materials to ensure they are up to date, clear and accurate.

## Accreditation

The Board acknowledges the excellent ongoing work of the Aboriginal and Torres Strait Islander Health Practice Accreditation Committee and the accreditation support team. The committee continues to engage with its key stakeholders, including education providers, around a range of topics relating to Aboriginal and Torres Strait Islander Health Practice education and accreditation, and this is an important pillar in the effective work of the committee. The committee developed and endorsed guidelines for risk-based accreditation decision-making in conjunction with the Chinese medicine, medical radiation practice, paramedicine and podiatry accreditation committees. These guidelines were supported by the Board and took effect on 1 July 2022.

## UN Permanent Forum

In April, I had the privilege of attending the United Nations Permanent Forum on Indigenous Issues in my role as Board Chair. The Permanent Forum serves as an advisory body to the Economic and Social Council (ECOSOC), with a mandate to discuss Indigenous issues relating to economic and social development, culture, environment, education, health and human rights. Attending this auspicious event and sharing my experiences with Indigenous peoples from across the world was fantastic. It reminded me that this profession is the only dedicated and regulated Indigenous health profession in the world and that being part of this profession is something we should all be very proud of.

## Stakeholder engagement

The Board continues to optimise Board meeting times with stakeholder engagement activities across the jurisdictions where each meeting is held. This includes visits to local communities and health services, which also helps with cultural immersion for non-Indigenous Ahpra staff as well as Board and committee members.

The Board continues to engage widely with employers and stakeholders to inform them of the potential that Aboriginal and Torres Strait Islander Health Practitioners have to enhance the care provided to their communities. The Board acknowledges the ongoing support of local and regional health networks in its work, particularly in facilitating high-quality, hands-on clinical training for student practitioners.

## Other news

As Board Chair, I must offer my personal thanks to all Board and committee members whose efforts and contributions enable the Board to continue its important work. On behalf of the Board, I thank Ahpra for the continued support it provides to our work and, on the occasion of her retirement from Ahpra, special thanks must go to Ms Jill Humphreys, the Board's Executive Officer, for all her hard work and dedication over the years.

**Ms Renee Owen, Chair**



## Board members

**Ms Renee Owen (practitioner), Chair**

Mr Bruce Brown (community)

Mrs Danielle Martin (practitioner) – from 23 Mar

Ms Margaret McCallum (community)

Mr Christopher O'Brien (practitioner)

Ms Leanne Quirino (practitioner)

Ms Iris Raye (practitioner)

Ms Abbey Shillingford (community)

Ms Jill Humphreys was the Executive Officer, Aboriginal and Torres Strait Islander Health Practice, to 31 May. Mr Paul Fisher is the Executive Officer, Aboriginal and Torres Strait Islander Health Practice, from 1 June.

For more information, see the online appendices and [www.atsihealthpracticeboard.gov.au](http://www.atsihealthpracticeboard.gov.au).

## Registration

**887** Aboriginal and Torres Strait Islander Health Practitioners

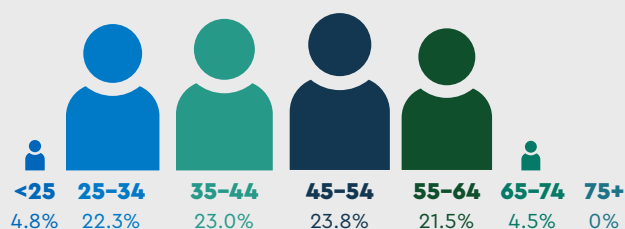
- Up **0.1%** from 2021/22
- **0.1%** of all registered health practitioners

**110** first-time registrants (including new graduates)

**100%** are Aboriginal and/or Torres Strait Islander

**77.0%** female; **23.0%** male

**Figure 1. Age**



## Regulation

**3** notifications lodged with Ahpra about **3** Aboriginal and Torres Strait Islander Health Practitioners

**6** notifications about **3** Aboriginal and Torres Strait Islander Health Practitioners made Australia-wide, including HPCA and OHO data

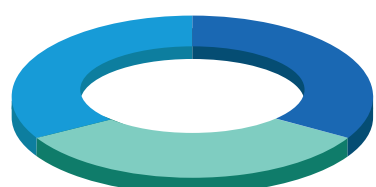
- **0.3%** of the profession Australia-wide

**Figure 2. Sources of notifications**



- **66.7%** patient, relative or member of the public
- **33.3%** ombudsman

**Figure 3. Most common types of complaints**



- **33.3%** communication
- **33.3%** behaviour
- **33.3%** offence against other law

**Figure 4. Notifications closed**



**3** notifications closed

- **100%** cautioned or reprimanded

**No** immediate actions taken

**No** mandatory notifications received

**3** practitioners monitored for health, performance and/or conduct during the year

**No** criminal offence complaints made

**No** notifications finalised at tribunal

**No** matters decided by a panel

**No** appeals lodged



## Highlights this year

The Chinese Medicine Board of Australia held a pilot of the clinical component that forms part of the Board's new regulatory examinations. This completed the project phase of the development of the regulatory examinations. Work was ongoing to hold the first clinical examination, including the appointment of registered Chinese medicine practitioners as examiners. Establishing the regulatory examination is an important milestone and enables the Board to assess whether relevant overseas-trained practitioners have the knowledge, clinical skills and professional attributes needed to safely and competently practise as an acupuncturist or Chinese herbal medicine practitioner in Australia.

## Policy updates

The Board concluded its review of two guidelines, *Guidelines on safe Chinese herbal medicine practice* and *Guidelines on infection prevention and control for acupuncture and related practices*. The Board considered the valuable feedback it received from consultations and finalised both guidelines for publication.

The Board began the review of the *Patient health records guidelines* and conducted the annual review of the *Nomenclature compendium*.

## Stakeholder engagement

In February, the Board met with representatives from the six national professional associations:

- Australian Acupuncture and Chinese Medicine Association (AACMA)
- Australian Natural Therapists Association (ANTA)
- Australian Traditional Medicine Society (ATMS)
- Chinese Medicine and Acupuncture Society of Australia Ltd (CMASA)
- Chinese Medicine Industry Council (CMIC)
- Federation of Chinese Medicine and Acupuncture Societies of Australia (FCMA).

There was robust discussion on several profession-specific issues. The Board published a communiqué following the meeting.

The Board was pleased to be able to meet face to face with the Chinese Medicine Council of New South Wales. The joint meeting was a great opportunity for the Board and the council to exchange experiences and views.

In May, the Board visited education providers in Sydney. It was an opportunity to see their centres and clinical facilities and learn more about practitioners' and students' clinical experiences in Chinese medicine practice and education. They visited:

- Endeavour College of Natural Health
- NICM Health Research Institute
- Sydney Institute of Traditional Chinese Medicine
- Western Sydney University.

The Chair and Executive Officer met with the Chair and Deputy Chair of the Chinese Medicine Council of New Zealand and discussed the regulation of the profession. This provided an opportunity for the Chair to share the experience of regulation in Australia as the council works towards regulating Chinese medicine practitioners in New Zealand.

## Other news

The Board was delighted to learn that Ms Stephanie Campbell was re-appointed for a second term on the Board, and welcomed Professor Hui Chen to the Board's Policy, Planning and Communications Committee in January.

**Adjunct Professor Danforn Lim, Chair**



## Board members

**Adjunct Professor Chi Eung Danforn Lim (practitioner), Chair**

Ms Sophy Athan (community)

Mr David Brereton (community)

Ms Stephanie Campbell (community)

Mr Luke Hubbard (practitioner)

Mr Roderick Martin (practitioner)

Dr Johannah Shergis PhD (practitioner)

Ms Bing Tian (practitioner)

Ms Dina Tsiopelas (practitioner)

Ms Samanta Salvaneschi was the Executive Officer, Chinese Medicine, to November. Ms Kirsten Hibberd is the Executive Officer, Chinese Medicine, from November.

For more information, see the online appendices and [www.chinesemedicineboard.gov.au](http://www.chinesemedicineboard.gov.au).

## Registration

**4,823** Chinese medicine practitioners

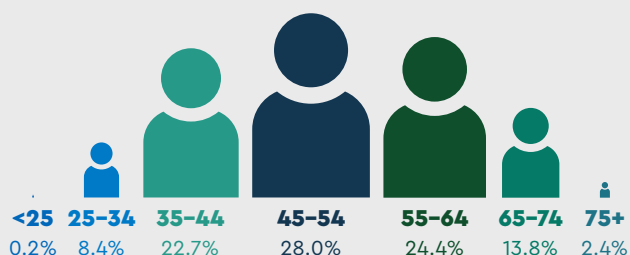
- Down **0.3%** from 2021/22
- **0.5%** of all registered health practitioners

**380** first-time registrants (including new graduates)

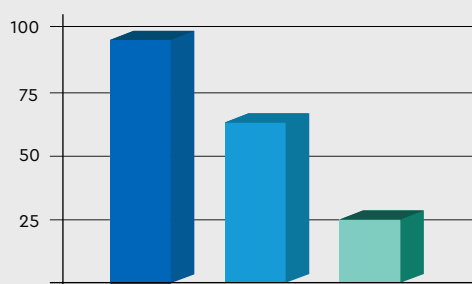
**0.4%** identified as Aboriginal and/or Torres Strait Islander

**58.4%** female; **41.6%** male

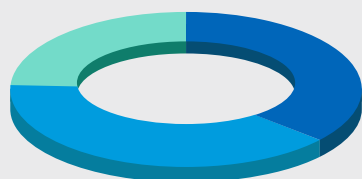
**Figure 5. Age**



**Figure 6. Divisions**



- **98.2%** acupuncturist
- **64.6%** Chinese herbal medicine practitioner
- **25.4%** Chinese herbal dispenser



- **36.2%** registered in one division
- **39.5%** registered in two divisions
- **24.3%** registered in three divisions

## Regulation

**14** notifications lodged with Ahpra about **12** Chinese medicine practitioners

**41** notifications about **33** Chinese medicine practitioners made Australia-wide, including HPCA and OHO data

- **0.7%** of the profession Australia-wide

**Figure 7. Sources of notifications**



- **78.6%** patient, relative or member of the public
- **14.3%** government department
- **7.1%** ombudsman

**Figure 8. Most common types of complaints**



- **28.6%** breach of non-offence provision – National Law
- **21.4%** behaviour
- **14.3%** communication
- **7.1%** clinical care
- **28.6%** other

**Figure 9. Notifications closed**



**32** notifications closed

- **18.8%** conditions imposed on registration
- **6.3%** cautioned or reprimanded
- **3.1%** referred to another body
- **71.9%** no further regulatory action

**1** immediate action taken

**1** mandatory notification received

- About professional standards

**16** practitioners monitored for health, performance and/or conduct during the year

**16** criminal offence complaints made

**No** notifications finalised at tribunal

**No** matters decided by a panel

**No** appeals lodged

## Policy updates

The Chiropractic Board of Australia began a review of its *Statement on paediatric care*, which provides important guidance to chiropractors in caring for children. The Board also began a review of its *Guidelines for clinical record keeping for chiropractors*.

The Melbourne Centre for Behaviour Change, at the University of Melbourne, conducted research on behalf of the Board exploring chiropractors' understanding of their advertising obligations. All chiropractors were invited to attend focus groups and participate in a survey. The Board thanks participants for their willingness to contribute and the valuable feedback received.

## Stakeholder engagement

Face-to-face information forums were held in Perth and Adelaide, giving chiropractors an opportunity to engage with the Board.

The program of presentations by the Board to final-year students continued throughout the year to welcome them to the profession and to help them understand the expectations and requirements of registration. The Board recorded a video presentation welcoming new graduates to the profession, which was published on the Board's website.

## Safety and quality standards

The Board built on planned initiatives to ensure the public continues to receive safe, competent and ethical care from chiropractors, and supported chiropractors to provide safe care. The Board was pleased to hold a forum for all chiropractors and key stakeholders in July on the National Safety and Quality Primary and Community Healthcare Standards.

Ms Kim Packham from the Australian Commission on Safety and Quality in Health Care addressed the forum and gave an overview of the new standards. Ms Packham then talked about clinical governance in the health system more broadly, its inception and its drivers; and spoke in more detail about some of the standards. Following the presentation, a panel of health practitioners and a consumer representative took questions from forum attendees on topics including accreditation of clinical governance frameworks in the professions where the accreditation exists; the potential financial costs of accreditation; and the importance of partnering with consumers. Videos and resource materials were published on the Board's website.

The Board met regularly with its stakeholders and regulatory partners, including professional associations, the Chiropractic Council of New South Wales and the Council on Chiropractic Education Australasia. The Chair and Executive Officer visited with the New Zealand Chiropractic Board, which was an opportunity to exchange information about regulating the profession and discuss shared experiences.

## Other news

The Board was pleased to announce a 15% reduction in the annual registration fee for chiropractors. Registration fees support the Board's regulatory obligations and its continuing efforts to support and develop a safe and mobile Australian chiropractic workforce. The Board was able to significantly reduce fees while maintaining the standards that will ensure the community's trust and confidence in the profession.

The Board farewelled Ms Kim Barker, community member of the Board, in April. We thank Ms Barker for her contribution and commitment to the regulation of the chiropractic profession during her time on the Board.

**Dr Wayne Minter AM, Chair**



## Board members

**Dr Wayne Minter AM (practitioner), Chair**

Ms Kim Barker (community) – to 14 Apr

Dr Abbey Chilcott (practitioner)

Mrs Colleen Papadopoulos (community)

Mr Ken Riddiford (community)

Professor Anna Ryan (practitioner)

Dr Michael Shobbbrook AM (practitioner)

Dr Arcady Turczynowicz (practitioner)

Dr Ailsa Wood (practitioner)

Ms Kirsten Hibberd is the Executive Officer, Chiropractic.

For more information, see the online appendices and [www.chiropracticboard.gov.au](http://www.chiropracticboard.gov.au).

## Registration

**6,345** chiropractors

- Up **3.2%** from 2021/22
- **0.7%** of all registered health practitioners

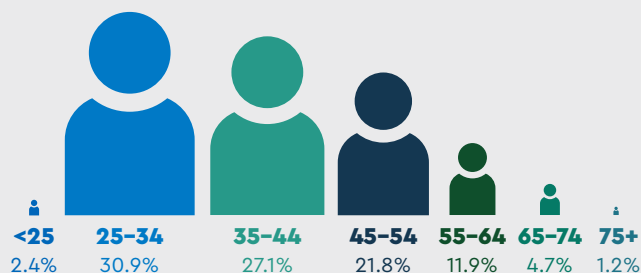
**325** first-time registrants

- **282** domestic (including new graduates)
- **43** international

**0.6%** identified as Aboriginal and/or Torres Strait Islander

**42.0%** female; **58.0%** male

**Figure 10. Age**



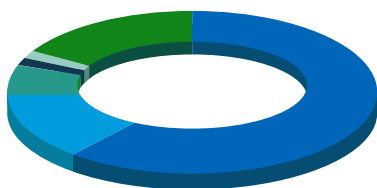
## Regulation

**67** notifications lodged with Ahpra about **60** chiropractors

**123** notifications about **106** chiropractors made Australia-wide, including HPCA and OHO data

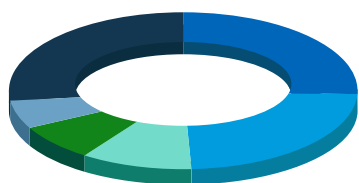
- **1.7%** of the profession Australia-wide

**Figure 11. Sources of notifications**



- **61.2%** patient, relative or member of the public
- **13.4%** other practitioner
- **6.0%** health complaints entity
- **1.5%** Board initiated
- **1.5%** employer
- **16.4%** other

**Figure 12. Most common types of complaints**



- **25.4%** clinical care
- **23.9%** boundary violation
- **10.4%** breach of non-offence provision – National Law
- **7.5%** offence against other law
- **6.0%** confidentiality
- **26.9%** other

**Figure 13. Notifications closed**



**103** notifications closed

- **15.5%** conditions imposed on registration or an undertaking accepted
- **14.6%** cautioned or reprimanded
- **2.9%** registration suspended
- **9.7%** referred to another body or retained by a health complaints entity
- **57.3%** no further regulatory action

**2** immediate actions taken

**5** mandatory notifications received

- **4** about sexual misconduct
- **1** about impairment

**42** practitioners monitored for health, performance and/or conduct during the year

**15** criminal offence complaints made

**6** notifications finalised at tribunal

**No** matters decided by a panel

**No** appeals lodged

# Dental practitioners

The Dental Board of Australia achieves its role of protecting the public by setting standards for entering and maintaining registration in the dental profession, and by supporting practitioners to practise professionally. We focused on achieving these goals by working collaboratively and consultatively with the profession, our stakeholders and the public.

## Highlights this year

The Board continued its focus on stakeholder engagement through regular meetings of the Dental Stakeholder Liaison Group and collaboration with its co-regulators, the Dental Council New South Wales and the Office of the Health Ombudsman (OHO). In November, the Board published its position statement on the Minamata Convention on Mercury, alerting practitioners to actions they can take to phase down the use of dental amalgam. In May, the Board travelled to Wellington to meet with New Zealand's Dental Council and discuss matters of mutual interest.

The Board updated the list of approved qualifications from overseas jurisdictions for the first time since the National Scheme began. Practitioners with qualifications from New Zealand, Ireland and the United Kingdom will now have an easier process to demonstrate they are qualified for registration in Australia.

## Dental practitioner support

This was the third year of operation of the Dental Practitioner Support Service, the first 24/7, free, confidential, nationwide telephone and online service for all dental practitioners and students. Following a review of the service's operation, the Board committed to funding this service into the future.

## Cultural safety

Revisions to the National Law acknowledge the National Scheme's role in developing a culturally safe and respectful health workforce, one that is responsive to Aboriginal and Torres Strait Islander Peoples and that contributes to the elimination of racism in the provision of health services. Members of the Board and its national committees completed cultural safety training and have reaffirmed their commitment to building a culturally safe workforce free of racism.

In November, the Board's Chair and Executive Officer attended the first Indigenous Dental Association of Australia conference in Canberra. Board members also visited the Dalarinji Aboriginal Oral Health Clinic in Sydney to further their understanding of how to provide culturally safe oral healthcare. The Board's May visit to New Zealand provided an opportunity to visit Takapūwāhia Marae and learn more about Ora Toa Health Services and Te Tiriti o Waitangi (the Treaty of Waitangi).

## Accreditation

The Board continued to work closely with its accreditation authority, the Australian Dental Council, to oversee accredited programs of study that, when approved by the Board, lead to registration as a dental practitioner. The Board consulted on the current accreditation arrangements to inform its decisions on arrangements for the next period.

## Policy updates

Following targeted consultations, the Board released a range of updated guidance for practitioners, including new resources regarding infection prevention and control following retirement of the Board's guidelines, and updated fact sheets on teeth whitening and on obligations regarding use of title.

## Registration standards, guidelines and codes

The Board's review of its *Specialist registration standard* has progressed, and work is underway to review the Board's registration standards for conscious sedation and general registration for overseas-qualified dental practitioners. The Board is also participating in the multiprofession review of its *Continuing professional development standard*, *Recency of practice standard* and its limited registration standards.

**Dr Murray Thomas, Chair**



## Board members

**Dr Murray Thomas (practitioner), Chair**

Mr Robin Brown (community)

Dr Penelope Burns (practitioner)

Mrs Julia Christensen (community)

Ms Jacqueline Gibson-Roos (community)

Mrs Kim Jones (community)

Professor Richard Logan (practitioner)

Mr Tan Nguyen (practitioner)

Mrs Janice Okine (practitioner)

Dr Kate Raymond (practitioner)

Dr Simon Shanahan (practitioner)

Ms Carolynne Smith (practitioner)

Ms Maja Doma was the Executive Officer, Dental, to 16 December. Mr Mark Ford is the Executive Officer, Dental, from 19 December.

For more information, see the online appendices and [www.dentalboard.gov.au](http://www.dentalboard.gov.au).



## Registration

**26,692** dental practitioners

- Up **2.5%** from 2021/22
- **3.0%** of all registered health practitioners

**1,505** first-time registrants

- **1,025** domestic (including new graduates)
- **480** international

**0.6%** identified as Aboriginal and/or Torres Strait Islander

**55.3%** female; **44.7%** male

Figure 14. Age

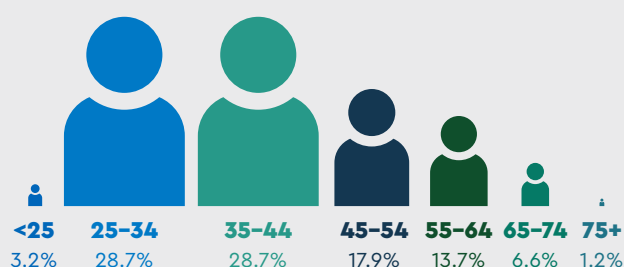
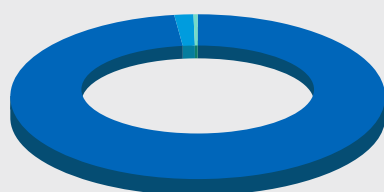
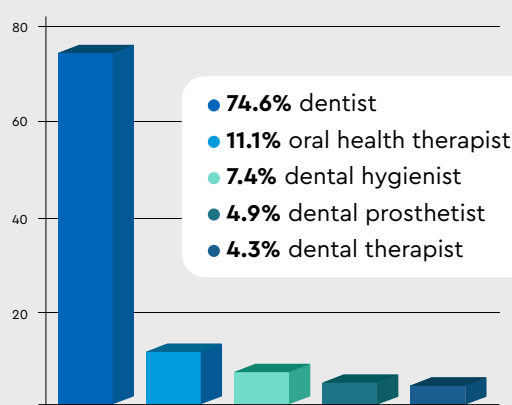


Figure 15. Divisions



- **98.0%** registered in one division
- **1.7%** registered in two divisions
- **0.3%** registered in three divisions

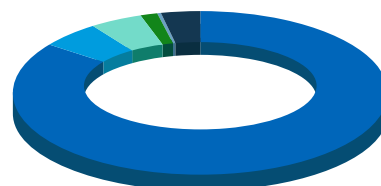
## Regulation

**610** notifications lodged with Ahpra about **517** dental practitioners

**1,074** notifications about **903** dental practitioners made Australia-wide, including HPCA and OHO data

- **3.4%** of the profession Australia-wide

Figure 16. Sources of notifications



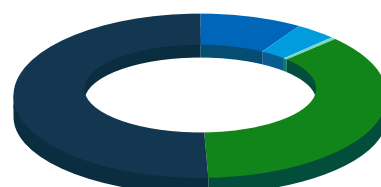
- **84.9%** patient, relative or member of the public
- **5.2%** health complaints entity
- **4.6%** other practitioner
- **1.5%** employer
- **0.3%** Board initiated
- **3.4%** other

Figure 17. Most common types of complaints



- **63.6%** clinical care
- **7.5%** communication
- **3.1%** documentation
- **2.3%** behaviour
- **2.3%** breach of non-offence provision – National Law
- **21.1%** other

Figure 18. Notifications closed



**750** notifications closed

- **8.9%** conditions imposed on registration or an undertaking accepted
- **3.6%** cautioned or reprimanded
- **0.4%** registration suspended or disqualified from applying
- **36.4%** referred to another body or retained by a health complaints entity
- **50.7%** no further regulatory action

**3** immediate actions taken

**15** mandatory notifications received

- **10** about professional standards
- **4** about impairment
- **1** about sexual misconduct

**166** practitioners monitored for health, performance and/or conduct during the year

**13** criminal offence complaints made

**16** notifications finalised at tribunal

**No** matters decided by a panel

**2** appeals lodged

# Medical practitioners



The Medical Board of Australia had a particularly busy year. Much of our work was high profile and contentious, but we held our focus on public safety. Key achievements include reform of the cosmetic surgery industry and strengthening telehealth guidelines. Workforce issues have emerged as a significant, ongoing challenge.

## Cosmetic practice

Ahpra and the Board commissioned Mr Andrew Brown to conduct an independent review of the regulation of medical practitioners who perform cosmetic surgery. We were appalled by media reports that raised concerns about the alleged conduct of some doctors, including alleged serious hygiene breaches, patient safety issues, poor patient care, unsatisfactory surgical outcomes and aggressive and inappropriate advertising.

The review's final report was published in September. The Board and Ahpra accepted all 16 recommendations. Our work this year was dominated by cosmetic practice, and by developing a package of reforms aimed at increasing public safety, improving practice, lifting standards and ensuring better information is accessible to foster safer consumer choices.

The Board took the following actions:

1. Created an area of practice endorsement to help consumers know who is trained and qualified to perform cosmetic surgery safely. Demand for cosmetic surgery already outstrips supply by surgeons. The area of practice endorsement aims to provide a safe alternative for patients who will continue to seek cosmetic procedures by doctors who are not surgeons. It creates a high standard, where there has been none. The work to create an area of practice endorsement has included:
  - a. developing a registration standard that defines requirements for endorsement of registration, which has been approved by Ministerial Council
  - b. approving accreditation standards developed by the Australian Medical Council that set the standards for accreditation of cosmetic surgery programs for endorsement.
2. Developed revised *Guidelines for medical practitioners who perform cosmetic surgery and procedures*.
3. Developed new guidelines for cosmetic surgery advertising.
4. Advised ministers on who should be able to call themselves 'surgeon'.
5. Encouraged practitioners to report concerns about patient safety, through guidance.
6. Centralised the management and decision-making of all cosmetic practice complaints.

With Ahpra, we have also:

1. Established a hotline for enquiries and complaints about cosmetic practice.

2. Proactively audited advertising compliance.
3. Published an advertising hub with information for practitioners and consumers.

The new guidelines took effect from 1 July 2023. For more on cosmetic surgery regulation, see page 85.

## Telehealth guidelines

The Board updated its telehealth guidelines to close the gap that has sprung up between online healthcare business models, including prescribing, and good medical practice.

Under the revised guidelines:

- telehealth consultations will continue as an important feature of healthcare in Australia
- real-time doctor–patient consultations remain key to safe prescribing
- providing healthcare, including prescribing, issuing certificates and referring, via questionnaire-based asynchronous web-based tools in the absence of a real-time patient–doctor consultation, is not considered good practice.

The new guidelines will be effective from 1 September 2023.

## Medical Training Survey

In 2022, 23,000 doctors in training (56.6% response rate) completed the Medical Training Survey (MTS), helping build a robust national dataset to drive improvements in medical training.

The results were broadly consistent with previous years, with some small but statistically significant variations in year-on-year results. Changes included an increase in trainee workload, a dip in the quality of teaching, a drop in the number of trainees who would recommend their current training position or organisation, and an increase in the number of trainees considering a future career outside medicine.

The culture of medical training is a continuing concern, with 55% of Aboriginal and Torres Strait Islander trainees reporting that they have experienced and/or witnessed bullying, harassment, discrimination and racism, compared with 34% of all trainees who have.

Fault lines in the culture of medicine revealed by the MTS warrant ongoing, collaborative solutions from agencies across the health sector. The Board will continue the policy and professional standards work that will underpin sector-wide action, in collaboration with the frontline organisations that hold the keys to lasting cultural change.

The MTS results are published in static reports and are accessible through an online reporting tool on the MTS website at [www.medicaltrainingsurvey.gov.au](http://www.medicaltrainingsurvey.gov.au).

## CPD homes

The Board's *Continuing professional development* (CPD) registration standard requires medical practitioners to have a CPD home to help them with their CPD. All Australian Medical Council-accredited specialist medical colleges have been approved as CPD homes, so all practitioners doing college CPD will be compliant with the Board's standard.

CPD homes are accredited by the Australian Medical Council (AMC) and approved by the Board. An additional CPD home, Doctorportal Learning, which can provide quality-assured CPD programs to doctors, was approved in 2022.

Prospective CPD homes can apply to the AMC for accreditation and must meet robust accreditation standards.

Practitioners will be required to have a CPD home by 1 January 2024.

## Workforce

Medical workforce shortages were a key issue for governments in December. To help chart a course, Ms Robyn Kruk AO was appointed in December to lead an independent review of Australia's health regulatory settings. The review's interim report was published and recommended:

- cutting assessment red tape, allowing more international practitioners to enter and work in Australia safely and sooner
- fast-tracking some approvals, through greater recognition of international qualifications from comparable health systems
- reviewing current standards, including English language and recency of practice requirements.

The Board has started to consider how it can fast-track practitioners to registration while maintaining public confidence and safety. This is likely to include a review of the specialist international medical graduate pathway, which will be a feature of the Board's 2023 work.

## Accreditation

The Australian Medical Council is the appointed external accreditation authority for the medical profession. It has a range of functions, including to accredit medical schools and their programs of study, specialist colleges and their programs of study, intern training accreditation authorities and CPD homes.

After a program of study has been accredited by the AMC, the Board decides whether to approve the accredited programs as providing qualifications for registration.

In 2022/23, the Board approved the following:

Medical school programs of study	12
Specialist medical college programs of study	7
Intern training accreditation authorities	2

The Board also approved revised accreditation standards for primary medical programs.

## New registration standards, codes or guidelines

As well as the regulatory reforms in cosmetic practice and telehealth, the Board also consulted on and recommended that ministers approve a revised registration standard for *Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of postgraduate year one training*.

This revised standard defines the requirements that Australian and New Zealand medical graduates must meet to become eligible for general registration. This includes the requirement to complete a period of supervised practice and puts the National Framework for Prevocational (PGY1 and PGY2) Medical Training into effect. It removes mandatory rotations in medicine, surgery and emergency medical care and replaces them with a range of broad-based experiences.

Over this year, the Board, with other National Boards, consulted on the English language registration standard and approved a range of additional tests.

## Stakeholder engagement

### Newsletters and media

The Board published 11 editions of the regular *Medical Board Update*.

The Board responded to many media requests for comment on a range of issues. We also received requests for comment about individual practitioners but, guided by law, provided limited information.

### Meetings with stakeholders

The Board has an active program of stakeholder engagement that includes regular meetings with the:

- Australian Medical Association (AMA)
- Australian Medical Council (AMC)
- Medical Council of New South Wales
- Medical Council of New Zealand
- specialist colleges through the Council of Presidents of Medical Colleges
- professional indemnity providers
- Drs4Drs – the Board provides about \$2m funding annually for state-based health services for all medical practitioners and students.

### Internal engagement

The Board has a program of internal stakeholder engagement to promote consistency in decision-making and respond to feedback from our decision-makers, including:

- regular meetings with the chairs of state and territory boards
- the MBA annual conference for all members of the Board and Ahpra staff.

## Medical school education packages

The Board published new education resources on regulation and professionalism for medical students in Australia.

The educational resources aim to dispel myths and misconceptions about regulation and to help medical students understand the regulation of medical practitioners in Australia. They are an optional resource for medical schools and align with the medical school 'Professionalism and leadership' curriculum. They are published on the Board's website. See page 97 for more information about these resources.

## New fields and specialties

The Board consulted on a proposal to recognise genetic pathology as a new field of specialty practice within pathology.

## COVID-19

While the Australian community is learning to live with COVID-19, there continue to be impacts on our healthcare services. The Board agreed to provide some additional flexibility to interns who have had to take leave for COVID-19 illness or to isolate, reducing their service requirements to 45 weeks.

**Dr Anne Tonkin AO, Chair**



## Board members

**Dr Anne Tonkin AO (practitioner), Chair**

Associate Professor Stephen Adelstein (practitioner)

Mr Mark Bodycoat (community)

Dr Kerrie Bradbury (practitioner)

Ms Jayde Geia (community) – to 30 Nov

Dr Samuel Goodwin (practitioner)

Dr Daniel Heredia (practitioner)

Ms Eileen Jerga AM (community)

Dr Andrew Mulcahy (practitioner)

Dr Debra O'Brien (practitioner)

Dr Susan O'Dwyer (practitioner)

Ms Fearn (Michelle) Wright (community)

Dr Joanne Katsoris is the Executive Officer, Medical.

For more information, see the online appendices and [www.medicalboard.gov.au](http://www.medicalboard.gov.au).

## Registration

**136,742** medical practitioners

- Up **3.6%** from 2021/22
- **15.6%** of all registered health practitioners

**8,357** first-time registrants

- **4,146** domestic (including new graduates)
- **4,211** international

**0.6%** identified as Aboriginal and/or Torres Strait Islander

**45.9%** female; **54.1%** male

Figure 19. Age

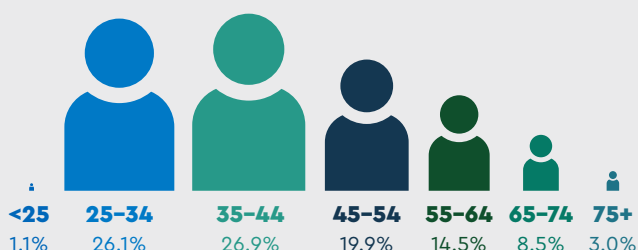


Table 1. Specialties

Addiction medicine	199
Anaesthesia	5,919
Dermatology	657
Emergency medicine	3,326
General practice	34,934
Intensive care medicine	1,164
Medical administration	354
Obstetrics and gynaecology	2,280
Occupational and environmental medicine	294
Ophthalmology	1,093
Paediatrics and child health	3,811
Pain medicine	405
Palliative medicine	473
Pathology	2,362
Physician	13,161
Psychiatry	4,540
Public health medicine	450
Radiation oncology	472
Radiology	3,044
Rehabilitation medicine	626
Sexual health medicine	134
Sport and exercise medicine	163
Surgery	6,484
<b>Total</b>	<b>86,345</b>

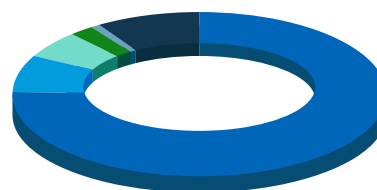
## Regulation

**5,615** notifications lodged with Ahpra about **4,494** medical practitioners

**9,938** notifications about **7,761** medical practitioners made Australia-wide, including HPCA and OHO data

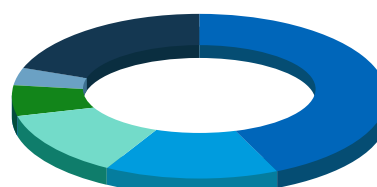
- **5.7%** of the profession Australia-wide

Figure 20. Sources of notifications



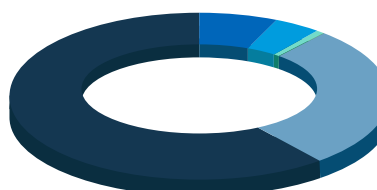
- **75.5%** patient, relative or member of the public
- **7.2%** other practitioner
- **5.3%** health complaints entity
- **2.2%** employer
- **0.8%** Board initiated
- **9.1%** other

Figure 21. Most common types of complaints



- **43.2%** clinical care
- **15.0%** communication
- **12.9%** medication
- **6.0%** documentation
- **3.4%** behaviour
- **19.5%** other

Figure 22. Notifications closed



**6,087** notifications closed

- **6.6%** conditions imposed on registration or an undertaking accepted
- **3.9%** cautioned or reprimanded
- **0.7%** registration suspended or cancelled or disqualified from applying
- **0.1%** fined
- **27.9%** referred to another body or retained by a health complaints entity
- **60.8%** no further regulatory action

**148** immediate actions taken

**305** mandatory notifications received

- **139** about impairment
- **100** about professional standards
- **50** about sexual misconduct
- **16** about alcohol or drugs

**872** practitioners monitored for health, performance and/or conduct during the year

**127** criminal offence complaints made

**78** notifications finalised at tribunal

**3** matters decided by a panel

**85** appeals lodged



# Medical radiation practitioners

## Issues this year

Following from the global effects of COVID-19 and its impacts on the global health workforce, the main focus for the Medical Radiation Practice Board of Australia was the availability of medical radiation practitioners and the pipeline for new registrants.

## Accreditation

The Board worked with the Medical Radiation Practice Accreditation Committee on funding and fee structures, with the aim of balancing the costs of accreditation between education providers and practitioners.

## Policy and project updates

### Post-implementation review of professional capabilities

The revised *Professional capabilities for medical radiation practice* were published by the Board in November 2019. The Board started a post-implementation review to investigate any safety or unintended consequences arising from the professional capabilities. The report and outcomes from the review were published in June 2023. Interprofessional practice and workplace culture are now future focus points for the Board.

### Supervised practice framework

Following a multiprofession review of supervised practice arrangements in 2020 and 2021, the Board agreed to recommend to health ministers that the *Supervised practice registration standard* be retired on 30 March 2023. The multiprofession *Supervised practice framework* for medical radiation practitioners came into effect on 1 April.

### Statement on artificial intelligence

To support practitioners with the continual evolution of artificial intelligence (AI), the Board published a statement on the role of AI in medical radiation practice. The statement identified that patient safety was paramount when AI and related technologies are used in practice.

## Recognition of overseas qualifications

Since 2016, the Board has assessed and maintained an equivalent status for qualifications approved in a number of overseas jurisdictions, including the United Kingdom and New Zealand. In October, the Board assessed qualifications approved by the Irish regulator for medical radiation practice as equivalent to Australian qualifications. The Board also accepts a number of examination results used as the basis of safe practice in overseas jurisdictions.

## Facilitating research

Through its newsletter, the Board continued to support ethics-approved research in medical radiation practice. Recent research projects include attitudes to scheduled medicines, attitudes to evidence-based practice and work-related musculoskeletal issues.

## Stakeholder engagement

The Board continued to meet with national and international stakeholders including the New Zealand Medical Radiation Practice Board, the Canadian Association of Medical Radiation Technologists, Medical Radiations Australia, the Australian Society of Medical Imaging and Radiation Therapy (ASMIRT), the Australian and New Zealand Society of Nuclear Medicine (ANZSNM), the Australian Sonographers Association and others to discuss emerging issues in medical radiation practice, with a focus on workforce availability, educational pipelines and capabilities necessary for professional practice.

The Board has developed a closer working relationship with the NSW Medical Radiation Practice Council and looks forward to further collaboration on joint projects and presentations.

Representatives of the Board also attended the ASMIRT national conference in Sydney in April and the ANZSNM annual conference in Adelaide in May.

**Ms Cara Miller, Chair**



## Board members

**Ms Cara Miller (practitioner), Chair**

Mr Richard Bialkowski (community)

Ms Joan Burns (community)

Mr Anthony Buxton (practitioner)

Ms Lucy Galloway (practitioner) – from 28 Mar

Dr Susan Gould PhD (community) – to 31 Jan

Mr James Green (practitioner)

Ms Renea Hart (community) – to 1 Jul

Mr Brendan McKernan (practitioner)

Mr Travis Pearson (practitioner)

Mrs Amber Summers (practitioner) – to 22 Feb

Mr Roger Weckert (practitioner)

Associate Professor Caroline Wright (practitioner)

Mr Adam Reinhard is the Executive Officer, Medical Radiation Practice.

For more information, see the online appendices and [www.medicalradiationpracticeboard.gov.au](http://www.medicalradiationpracticeboard.gov.au).

## Registration

**18,976** medical radiation practitioners

- Up **2.0%** from 2021/22
- **2.2%** of all registered health practitioners

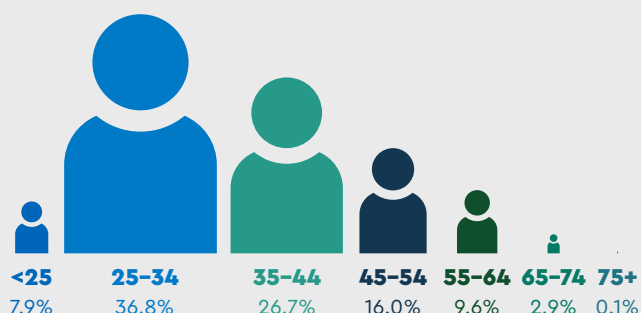
**1,146** first-time registrants

- **854** domestic (including new graduates)
- **292** international

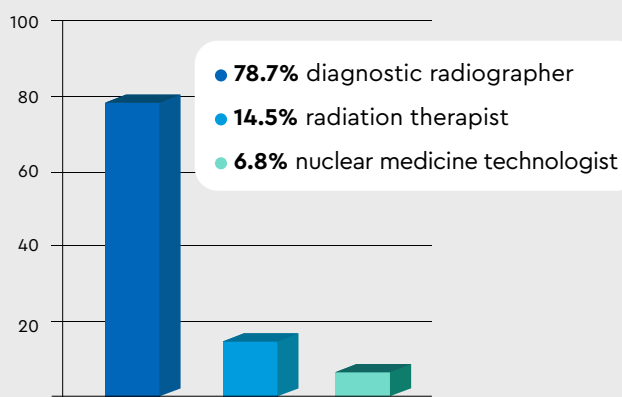
**0.6%** identified as Aboriginal and/or Torres Strait Islander

**68.9%** female; **31.1%** male

**Figure 23. Age**



**Figure 24. Divisions**



**99.9%** registered in one division

**0.1%** registered in two divisions

## Regulation

**34** notifications lodged with Ahpra about **28** medical radiation practitioners

**53** notifications about **43** medical radiation practitioners made Australia-wide, including HPCA and OHO data

- **0.2%** of the profession Australia-wide

**Figure 25. Sources of notifications**



- **55.9%** patient, relative or member of the public
- **11.8%** employer
- **8.8%** ombudsman
- **5.9%** Board initiated
- **5.9%** other practitioner
- **11.8%** other

**Figure 26. Most common types of complaints**



- **29.4%** clinical care
- **20.6%** offence against other law
- **8.8%** behaviour
- **8.8%** communication
- **2.9%** health impairment
- **29.4%** other

**Figure 27. Notifications closed**



**35** notifications closed

- **11.4%** conditions imposed on registration
- **8.6%** cautioned or reprimanded
- **8.6%** referred to another body or retained by a health complaints entity
- **71.4%** no further regulatory action

**3** immediate actions taken

**7** mandatory notifications received

- **6** about impairment
- **1** about professional standards

**17** practitioners monitored for health, performance and/or conduct during the year

**5** criminal offence complaints made

**No** notifications finalised at tribunal

**No** matters decided by a panel

**No** appeals lodged

## Reflections on the year

*Adjunct Professor Veronica Casey AM, Chair of the Nursing and Midwifery Board of Australia (NMBA), reflects on an important year for the Board as it slowly returned to face-to-face engagements and maintained the steady growth of the professions.*

It was great to meet with nurses and midwives across Australia again. Representatives of the NMBA and I were fortunate to attend or speak at a number of national and international conferences, including the Australian College of Midwives' National Conference, Australian College of Nursing National Nursing Forum, CRANaplus, Australian College of Nurse Practitioners' National Conference, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) National Conference and many more. We were also able to host the NMBA's national conference once again to support the professional development of Board members and Ahpra staff, and to improve the regulation of the nursing and midwifery professions. I find events such as these incredibly important as we get to engage with colleagues, nurses and midwives. I also want to acknowledge the incredible commitment of nurses and midwives to deliver safe and quality care to the public.

This year we've hit the ground running with the start of several projects to support the growth of safe and competent nursing and midwifery workforces. This can be seen through our commitment to a full review of the policy on re-entry to practice, facilitating the assessment of internationally qualified nurses and midwives through the outcomes-based assessment model, improving our engagement with employers, and creating a high-level scope-of-practice document for the professions and those working with and being treated by nurses and midwives.

## Re-entering the workforce

An update was made to the *Re-entry to practice policy*, which provides nurses and midwives who have been out of practice for between 10 and 15 years the opportunity to complete an NMBA-approved re-entry-to-practice program based on an assessment of their application. This interim solution was put in place while a full review of the policy identifies what works with the current approach and what opportunities there are to amend re-entry strategies to improve the timeliness of the process and the quality of nurses and midwives re-entering the workforce.

## International applicants

With the borders well and truly open, we are seeing larger numbers of internationally qualified nurses and midwives (IQNMs) interested in getting registered and working in Australia. This has seen more IQNMs progressing through the online self-checks, portfolio creation and examinations. Fortunately, we have been able to maintain a steady assessment of IQNMs, with qualification assessments averaging 10 business days and waiting lists for Objective Structured Clinical Exams (OSCE) effectively cleared. The NMBA has also committed to the establishment of a second OSCE site and the development of an accessible and affordable online OSCE preparatory course for internationally qualified registered nurses (IQRNs), which will provide critical information about safe and quality practice in the Australian healthcare context and support IQRNs through the OSCE process.

## Engaging employers

We worked with consultants at Nous Group to conduct a survey and workshops with employers of nurses and midwives across the country, which assessed the current level of engagement that the NMBA and Ahpra have with employers of practitioners. The project reviewed our current methods of communicating with employers and also assessed the understanding of roles and expectations the

NMBA, Ahpra and employers have of each other. Nous developed an engagement strategy to improve trust and engagement between employers, the NMBA and Ahpra, and to create an opportunity for the three to work together to support an environment for safe and competent care by nurses and midwives.

## Standardising conditions

The NMBA requested a review of education conditions being imposed on nurses' and midwives' registration following a notification. The review found that the education topics varied, including the number of hours and topics, and the timeframe for completion, even though the issues raised in the notifications were similar. The review further identified significant challenges for nurses and midwives in sourcing appropriate education, in terms of both a provider and relevant or 'fit for purpose' topic content.

The NMBA has approved a third party to develop and host standardised education topics. The units will be targeted, flexible, fit for purpose and provide profession-specific education modules that address the main deficits identified in the notifications review process.

## What nurses and midwives do

In response to continuing feedback from employers, the professions and public who were unsure of what to expect from the differing roles and education of nurses and midwives, the NMBA released two fact sheets: *Scope of practice and capabilities of nurses and midwives* and *What do nurses and midwives do?* The fact sheets provide an overview of the varying roles and core activities of midwives, registered nurses, enrolled nurses and nurse practitioners, and provide information for practitioners, employers and the general public on the different education, knowledge, skills and responsibilities expected of each group. The fact sheets outline the foundational aspects of what nurses and midwives do – throughout their careers, their scope continues to develop, based on their ongoing education, training and competence.

## Health and wellbeing

In addition to extended pandemic services, the NMBA has worked with Nurse & Midwife Support to develop a new suite of resources to support nurses and midwives. These services include the Notification Navigator and the Graduate mentorship pilot program. The Notification Navigator provides nurses and midwives who are the subject of a notification with accessible, professional, confidential, compassionate and individualised assistance throughout the notification process. The mentorship program focuses on building nurturing and collaborative relationships to support new graduates during their initial phase of entering the workforce. The program aims to enhance early career wellbeing, ultimately improving retention, which will help us maintain stable nursing and midwifery workforces. More information about these services is available at Nurse & Midwife Support on 1800 667 877.

## Working with other practitioners

The Aboriginal and Torres Strait Islander Health Practice Board and the NMBA agreed to a joint project to explore and develop strategies to better inform and educate nurses and midwives about the role of Aboriginal and Torres Strait Islander Health Practitioners.

To inform the development of the draft guidance document, workshops were held at the NMBA National Conference in October. A series of focus groups identified the areas where nurses, midwives and Aboriginal and Torres Strait Islander Health Practitioners work in partnership.

## Culturally safe care

In early June, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) and the NMBA committed to a landmark agreement to strengthen our commitment to improve the quality and safety of contemporary nursing and midwifery practice to further influence culturally safe care for Aboriginal and Torres Strait Islander Peoples.

The NMBA and CATSINaM signed a partnership investment agreement that will support the delivery of the strategies and recommendations made in the *Gettin' em and keepin' em and growin' em* report (GENKE II). This includes addressing systemic racism and enhancing cultural safety, as well as empowering the next generation of Aboriginal and Torres Strait Islander nurses and midwives, engagement with education providers, an analysis of pathways and strengthening community.

The agreement is designed to create systemic, lasting change, and will enable collaboration, innovation and shared decision-making to achieve this.

**Adjunct Professor Veronica Casey AM, Chair**



## Nurses and midwives

**Table 2. Divisions, dual registration and endorsements**

Nurses by division	
Enrolled nurse	71,494
Enrolled nurse and registered nurse	11,519
Registered nurse	370,502
<b>Total</b>	<b>453,515</b>
Dual-registered nurses and midwives	
Enrolled nurse and midwife	107
Enrolled nurse and registered nurse and midwife	104
Registered nurse and midwife	26,344
<b>Total</b>	<b>26,555</b>
Endorsements	
Nurses	
Nurse practitioner	2,656
Scheduled medicines	1,258
Midwives	
Midwife practitioner	1
Scheduled medicines	1,089
<b>Total</b>	<b>5,004</b>

## Dual registered

**26,555** registered as both nurse and midwife

- Down **5.5%** from 2021/22
- **3.0%** of all registered health practitioners

**98.4%** female; **1.6%** male

## Board members

**Adjunct Professor Veronica Casey AM (practitioner), Chair**

Mrs Theresa Best (community) – from 28 Mar

Mr David Carpenter (practitioner)

Professor Catherine Chamberlain (practitioner) – to 31 Oct

Dr Christopher Helms PhD (practitioner)

Ms Sonja Ilievskia (community)

Ms Penelope Marshall (practitioner) – from 27 Mar

Mrs Gemma Martin (community) – to 23 Jan

Dr Jessica (Jessa) Rogers PhD (community)

Ms Catherine Schofield (practitioner)

Associate Professor Linda Starr (practitioner)

Ms Annette Symes (practitioner)

Mrs Jennifer Wood (practitioner)

Ms Tanya Vogt is the Executive Officer, Nursing and Midwifery.

For more information, see the online appendices and [www.nursingmidwiferyboard.gov.au](http://www.nursingmidwiferyboard.gov.au).

## Snapshot nurses

**480,070** nurses (including those dual registered as midwives)

- Up **2.1%** from 2021/22
- **54.7%** of all registered health practitioners

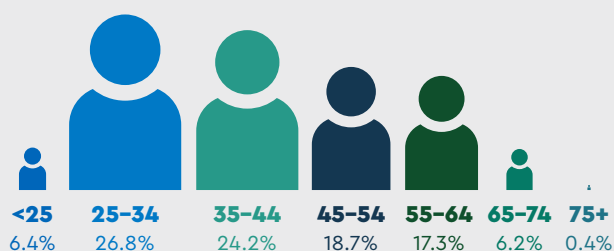
**34,593** first-time registrants

- **23,405** domestic (including new graduates)
- **11,188** international

**1.5%** identified as Aboriginal and/or Torres Strait Islander

**88.1%** female; **11.9%** male

Figure 28. Age



## Nurse regulation

**1,791** notifications lodged with Ahpra about **1,521** nurses

**2,884** notifications about **2,365** nurses made Australia-wide, including HPCA and OHO data

- **0.5%** of the profession Australia-wide

Figure 29. Sources of notifications



- **32.8%** patient, relative or member of the public
- **28.8%** employer
- **15.0%** other practitioner
- **1.8%** Board initiated
- **1.8%** health complaints entity
- **19.8%** other

Figure 30. Most common types of complaints



- **20.7%** clinical care
- **14.2%** health impairment
- **11.5%** offence against other law
- **9.7%** medication
- **8.7%** behaviour
- **35.3%** other

## Policy for nursing

### Cosmetic medical procedures

Recent updates have been made to the NMBA's position statement *Nurses and cosmetic medical procedures*. These aim to ensure that arrangements are in place for post-procedural care and that nurses comply with the requirements of the Therapeutic Goods Administration to use products only for their intended and approved use.

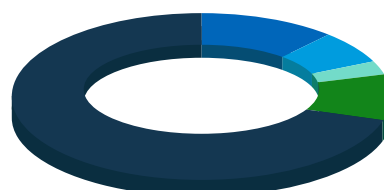
### Nurse practitioner review

A comprehensive review and revision of the nurse practitioner (NP) regulatory framework has begun, including an internal analysis, external literature review and input from expert stakeholders. This has informed the revision of the NP registration standard and guidelines, which will soon be consulted on.

### Proposed registration standard

The NMBA has undertaken a preliminary consultation on a proposed registration standard, *General registration for internationally qualified registered nurses*. This proposes two new pathways designed to streamline processes for eligible internationally qualified registered nurses, who have already been registered and have practised as a registered nurse in an NMBA-approved comparable international regulatory jurisdiction.

Figure 31. Notifications closed



**1,919** notifications closed

- **11.7%** conditions imposed on registration or an undertaking accepted
- **6.4%** cautioned or reprimanded
- **2.6%** registration suspended or cancelled or disqualified from applying
- **9.0%** referred to another body or retained by a health complaints entity
- **70.4%** no further regulatory action

**111** immediate actions taken

**512** mandatory notifications received

- **234** about impairment
- **191** about professional standards
- **50** about alcohol or drugs
- **37** about sexual misconduct

**638** practitioners monitored for health, performance and/or conduct during the year

**79** criminal offence complaints made

**63** notifications finalised at tribunal

**3** matters decided by a panel

**20** appeals lodged



## Snapshot midwives

**34,238** midwives (including those dual registered as nurses)

- Down **2.9%** from 2021/22
- **3.9%** of all registered health practitioners

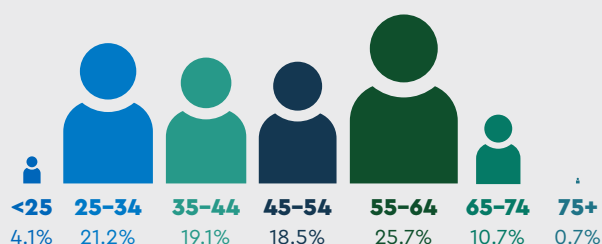
**1,655** first-time registrants

- **1,382** domestic (including new graduates)
- **273** international

**2.3%** identified as Aboriginal and/or Torres Strait Islander

**98.7%** female; **1.3%** male

Figure 32. Age



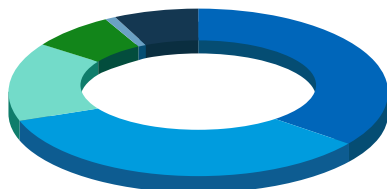
## Midwife regulation

**99** notifications lodged with Ahpra about **80** midwives

**168** notifications about **135** midwives made Australia-wide, including HPCA and OHO data

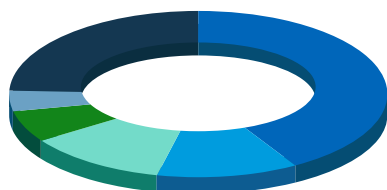
- **0.4%** of the profession Australia-wide

Figure 33. Sources of notifications



- **35.4%** other practitioner
- **34.3%** patient, relative or member of the public
- **15.2%** employer
- **7.1%** government department
- **1.0%** health complaints entity
- **7.1%** other

Figure 34. Most common types of complaints



- **41.4%** clinical care
- **12.1%** breach of non-offence provision – National Law
- **12.1%** communication
- **6.1%** behaviour
- **4.0%** medication
- **24.2%** other

## Policy for midwifery

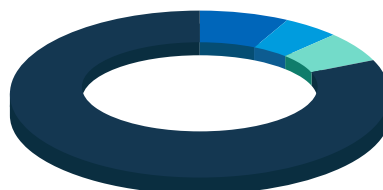
### Privately practising midwives

We conducted a full review of the *Safety and quality guidelines for privately practising midwives*, which ensures they remain contemporary and reflect the current safety and quality expectations for privately practising midwives (PPMs). Once an advance copy of the updated guidelines was published, we supported several educational webinars for PPMs to learn about any changes and how they may affect their practice.

### A workforce for the future

We have committed to leading a comprehensive review of the Australian midwifery workforce, which will deliver a full report and includes broad stakeholder consultation. It will also include a review of the registration standard *Endorsement for scheduled medicines for midwives*, to ensure it aligns with current public and practitioner expectations. Our aim for this project is to enable the continuous development of a flexible, responsive and sustainable Australian midwifery workforce that can meet the needs of our communities.

Figure 35. Notifications closed



**103** notifications closed

- **7.8%** conditions imposed on registration or an undertaking accepted
- **4.9%** cautioned or reprimanded
- **5.8%** referred to another body or retained by a health complaints entity
- **81.6%** no further regulatory action

**10** immediate actions taken

**24** mandatory notifications received

- **19** about impairment
- **5** about professional standards

**18** practitioners monitored for health, performance and/or conduct during the year

**4** criminal offence complaints made

**1** notification finalised at tribunal

**No** matters decided by a panel

**No** appeals lodged

# Occupational therapists

## Accreditation

The Occupational Therapy Board of Australia continued to approve the accreditation of programs undergoing their scheduled reviews during the year. There are now 48 occupational therapy programs of study delivered by 24 education providers across Australia.

## Policy updates

In April, the Board published:

- Easy English information about the shared *Code of conduct*, which is aimed at the public
- new record-management resources for practitioners, including a summary of the guidance about record management given in the shared *Code of conduct*
- a self-reflective tool to help occupational therapists assess the adequacy of their record-keeping and management practices.

## Stakeholder engagement

The Board met with a number of key stakeholders, including:

- Occupational Therapy Australia (the national professional association)
- Occupational Therapy Council of Australia
- Occupational Therapy Council of NSW
- Occupational Therapy Board of New Zealand
- NDIS Quality and Safeguards Commissioner.

## Growing the workforce

Responding to workforce pressures has been a major focus of the Board this year. Growing a safe workforce involves responding to the current acute shortage and maldistribution of registered occupational therapists, while ensuring that the public continues to receive safe care.

The Board published a new webpage with consolidated information for overseas-qualified practitioners who are considering seeking, or who have decided to seek, registration as an occupational therapist in Australia. The Board also collaborated with the Occupational Therapy Council of Australia to streamline the application and assessment process for overseas-qualified practitioners and to reduce duplication and administrative burden.

Further responses to workforce pressures are being developed by the Board and will be implemented in 2023/24.

These meetings provided the chance to discuss emerging issues and to look for opportunities to enhance collaboration on activities that are being carried out across the respective organisations.

In September, the Board hosted a live webinar, *Graduating soon?*, for upcoming and recent graduates. The webinar was attended by more than 300 students and provided information about registering as an occupational therapist for the first time and information about the role of Ahpra and the Board, and included a live Q&A throughout the session.

## Other news

In March, we said farewell to Ms Sally Cunningham, our practitioner member from Victoria. Our sincere thanks to Sally for all her valuable contributions to the regulation of occupational therapists. Also in March, we were pleased to welcome Ms Kate Andrews, our newest practitioner member from Victoria.

**Ms Julie Brayshaw, Chair**



## Board members

**Ms Julie Brayshaw (practitioner), Chair**

Ms Kate Andrews (practitioner) – from 28 Mar

Mr Darryl Annett (community)

Ms Sally Cunningham (practitioner) – to 15 Mar

Ms Roxane Marcelle-Shaw (community)

Ms Jennifer Morris (community)

Dr Claire Pearce PhD (practitioner)

Associate Professor Justin Scanlan (practitioner)

Ms Rebecca Singh (practitioner)

Ms Angela Thynne (practitioner)

Ms Vathani Shivanandan was the Executive Officer, Occupational Therapy, to 24 July. Dr Vanessa Oelkers PhD is the Executive Officer, Occupational Therapy, from 25 July.

For more information, see the online appendices and [www.occupationaltherapyboard.gov.au](http://www.occupationaltherapyboard.gov.au).

## Registration

**29,742** occupational therapists

- Up **7.5%** from 2021/22
- **3.4%** of all registered health practitioners

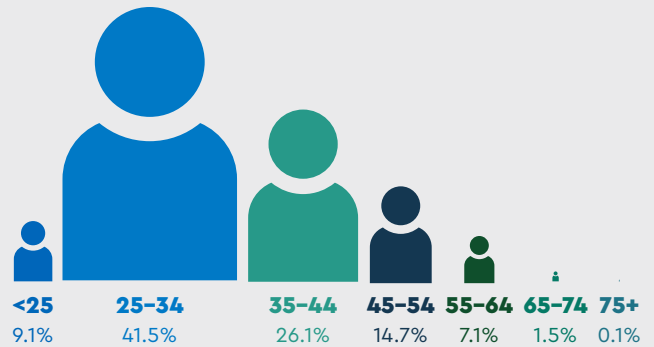
**2,545** first-time registrants

- **2,023** domestic (including new graduates)
- **522** international

**0.6%** identified as Aboriginal and/or Torres Strait Islander

**89.5%** female; **10.5%** male

**Figure 36. Age**



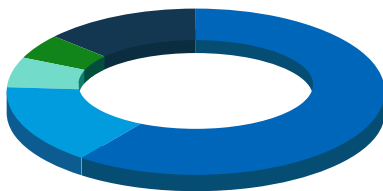
## Regulation

**83** notifications lodged with Ahpra about **76** occupational therapists

**149** notifications about **132** occupational therapists made Australia-wide, including HPCA and OHO data

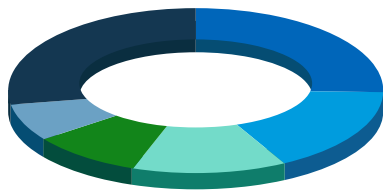
- **0.4%** of the profession Australia-wide

**Figure 37. Sources of notifications**



- **60.2%** patient, relative or member of the public
- **15.7%** other practitioner
- **6.0%** employer
- **4.8%** Board initiated
- **13.3%** other

**Figure 38. Most common types of complaints**



- **25.3%** clinical care
- **16.9%** communication
- **13.3%** documentation
- **9.6%** breach of non-offence provision - National Law
- **7.2%** confidentiality
- **27.7%** other

**Figure 39. Notifications closed**



**66** notifications closed

- **13.6%** conditions imposed on registration or an undertaking accepted
- **6.1%** cautioned or reprimanded
- **19.7%** referred to another body or retained by a health complaints entity
- **60.6%** no further regulatory action

**No** immediate actions taken

**8** mandatory notifications received

- **4** about impairment
- **2** about professional standards
- **1** about alcohol or drugs
- **1** about sexual misconduct

**20** practitioners monitored for health, performance and/or conduct during the year

**16** criminal offence complaints made

**No** notifications finalised at tribunal

**No** matters decided by a panel

**No** appeals lodged

# Optometrists

## Stakeholder engagement

In October, the Optometry Board of Australia hosted its annual meeting of the Optometry Regulatory Reference Group in Melbourne, with stakeholders in the optometry profession.

In September, the Board conducted a webinar on professional obligations aimed at final-year optometry students graduating from Board-approved courses. The webinar, called *Ready to work: your obligations as an optometrist*, aimed to help graduates understand what is required of them in their professional role as they prepare to start work. It focused on Board requirements such as the *Code of conduct*, registration standards and guidelines.

Representatives of the Board attended the Indigenous Allied Health Australia National Conference in November and the National Aboriginal and Torres Strait Islander Eye Health Conference in May, gaining further culturally safe eye-care understanding that will inform future policies.

## Trans-Tasman relationships

The Chair attended the Optometrists and Dispensing Opticians Board of New Zealand's meeting in Wellington, New Zealand, in September. This was a great opportunity to strengthen Trans-Tasman relationships.

## Policy updates

The Board, along with other National Boards, developed new resources to support the shared *Code of conduct*. These included a self-reflective tool to support optometrists in managing health records, a one-page summary of guidance about health record management, and Easy English information about the shared *Code of conduct* for the public.

The Board also consulted on the English language skills registration standards, along with other National Boards and Ahpra.

## Accreditation

In May, the Board approved the Optometry Council of Australia and New Zealand's (OCANZ) revised standards for the accreditation of Board-approved programs of study in ocular therapeutics. These standards will come into effect in 2024 and include greater emphasis on the integration of Aboriginal and Torres Strait Islander cultural safety into ocular therapeutics programs.

Along with Ahpra and the other National Boards, the Board also consulted on a scheduled review of National Scheme accreditation arrangements.

## Other news

The Board bade farewell to Associate Professor Ann Webber, the practitioner member for Queensland, in December. In March, we farewelled the previous Chair and practitioner member for New South Wales, Mrs Judith Hannan (Irvine).

The health ministers appointed Professor Sharon Bentley in March as the new practitioner member for Queensland. Mrs Judith Hannan was Presiding Member of the Board until December, when she was appointed as Chair. On her departure, Mr Stuart Aamodt became Presiding Member, a position that will be in place until the health ministers appoint a new Chair.

### Mr Stuart Aamodt, Presiding Member



## Board members

Mrs Judith Hannan (Irvine) (practitioner),  
Presiding Member – to 1 Dec, Chair – 2 Dec to 30 Mar

Mr Stuart Aamodt (practitioner),  
Board member – to 29 Mar, Presiding Member –  
from 30 Mar

Dr Carla Abbott PhD (practitioner)

Professor Sharon Bentley (practitioner) – from 27 Mar

Mr Anthony Evans (community)

Mr Benjamin Graham (community)

Associate Professor Rosemary Knight (community)

Mr Martin Robinson (practitioner)

Miss Renee Slunjski (practitioner)

Associate Professor Ann Webber (practitioner) –  
to 14 Dec

Ms Lynda Pham is the Executive Officer, Optometry.

For more information, see the online appendices and [www.optometryboard.gov.au](http://www.optometryboard.gov.au).

## Registration

**6,762** optometrists

- Up **4.0%** from 2021/22
- **0.8%** of all registered health practitioners

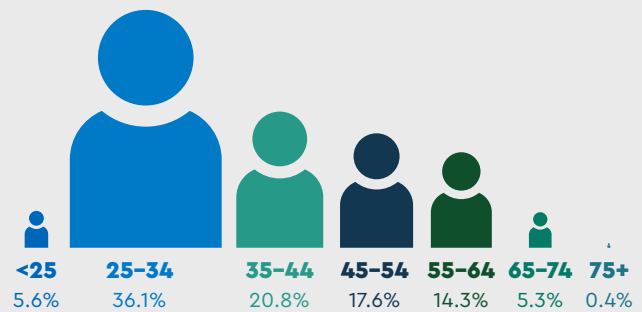
**403** first-time registrants

- **380** domestic (including new graduates)
- **23** international

**0.2%** identified as Aboriginal and/or Torres Strait Islander

**58.6%** female; **41.4%** male

**Figure 40. Age**



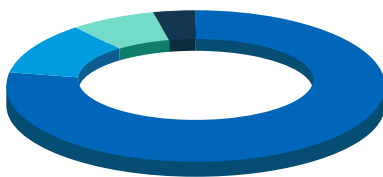
## Regulation

**27** notifications lodged with Ahpra about  
**26** optometrists

**63** notifications about **57** optometrists made Australia-wide, including HPCA and OHO data

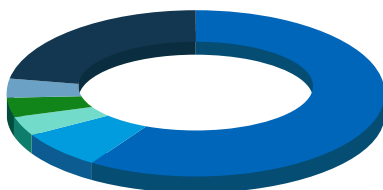
- **0.8%** of the profession Australia-wide

**Figure 41. Sources of notifications**



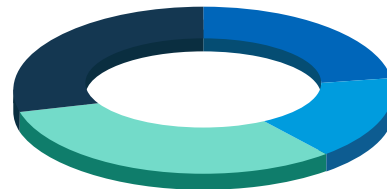
- **77.8%** patient, relative or member of the public
- **11.1%** government department
- **7.4%** other practitioner
- **3.7%** health complaints entity

**Figure 42. Most common types of complaints**



- **59.3%** clinical care
- **7.4%** breach of non-offence provision – National Law
- **3.7%** confidentiality
- **3.7%** documentation
- **3.7%** medication
- **22.2%** other

**Figure 43. Notifications closed**



**31** notifications closed

- **22.6%** conditions imposed on registration
- **16.1%** cautioned or reprimanded
- **32.3%** referred to another body or retained by a health complaints entity
- **29.0%** no further regulatory action

**No** immediate actions taken

**2** mandatory notifications received

- **1** about impairment
- **1** about professional standards

**10** practitioners monitored for health, performance and/or conduct during the year

**No** criminal offence complaints made

**No** notifications finalised at tribunal

**No** matters decided by a panel

**No** appeals lodged



## Issues this year

The Osteopathy Board of Australia saw a return to pre-COVID engagement levels as well as continued multiprofession collaboration with other Boards.

The Boards together continued the review of registration standards common to all health professions, including the English language skills standard. They also collaborated on publication of new Easy English information about the shared *Code of conduct*, which applies to osteopaths. With some of the other professions, the Board developed and published new resources to support practitioners to manage health records. Ahpra conducted a proactive advertising audit and shared the results with stakeholders.

## Stakeholder engagement

### Local

The Chair participated in the quarterly Osteopathy Think Tank organised by Osteopathy Australia (OA), which is focused on education, workforce issues, research, data and information sharing, plus the current consultations and reviews within the National Scheme. The Chair continued to attend Osteopathic Research Alliance, which comprises academic and individual osteopathy researchers in Australia.

Regular virtual meetings were held with the Australian Osteopathic Accreditation Council (AOAC), the Osteopathy Council of NSW (OCNSW) and OA.

The Chair presented information in an online presentation on regulation and Board requirements for registration to final-year students. Three newsletters were sent to registered osteopaths and students.

All these local engagements remind students and registrants of their obligations and allow discussion of emerging issues such as the audit of advertising and the rise in professional indemnity insurance (PII) notifications.

### International

The Board met in Wellington on 30 March and held a joint stakeholder meeting with the Osteopathy Council of New Zealand (OCNZ) on 31 March. The joint

meeting provided valuable information-sharing on current and emerging issues, and shared approaches to the regulation of osteopathy. The Chairs, Executive Officer, Registrar and OCNZ had met regularly throughout the year, but this was an opportunity for all the practitioner and community members to have a wide-ranging discussion, and was important for succession purposes.

The Board Chair is a member of the Public Relations Committee of the Osteopathic International Alliance, which organises World Osteopathic Healthcare Week, celebrated in April 2023.

## Accreditation

The Chair and CEO of the AOAC and the Board met every two months for a liaison meeting.

The Board reviewed and consulted on the assignment of the accreditation function for the osteopathy profession, which involves program accreditation and practitioner assessment, ahead of the end of the current assignment to AOAC in June 2024. An expression of interest process started in May.

## Other news

The Board returned to the pre-COVID mix of face-to-face and virtual monthly Board and committee meetings.

Mrs Marcella Lazarus joined the Board as a community member in March.

### Dr Nikole Grbin, Chair



## Board members

**Dr Nikole Grbin (practitioner), Chair**

Ms Robyn Davis (community)

Dr Pamela Dennis (practitioner)

Dr Julia Duffy PhD (community)

Mrs Marcella Lazarus (community) – from 27 Mar

Dr Rebecca Malon (practitioner)

Dr Timothy McNamara (practitioner)

Associate Professor Paul Orrock (practitioner)

Dr Andrew Yaksich (practitioner)

Dr Cathy Woodward PhD is the Executive Officer, Osteopathy.

For more information, see the online appendices and [www.osteopathyboard.gov.au](http://www.osteopathyboard.gov.au).

## Return to engagement

The Osteopathy Board met in Brisbane in July and in Sydney in September. On both occasions it was an opportunity to meet with the respective co-regulators in each state (OHO and OCNSW) and with Ahpra senior staff.

The Board held a breakfast forum for osteopathy registrants at the Adelaide Hilton on 24 February, with a third of registrants from South Australia attending. Ahpra staff attended to provide technical information on registration and notification questions. This was the first forum since 2019 and planning for future events has begun.

## Registration

**3,325** osteopaths

- Up **5.7%** from 2021/22
- **0.4%** of all registered health practitioners

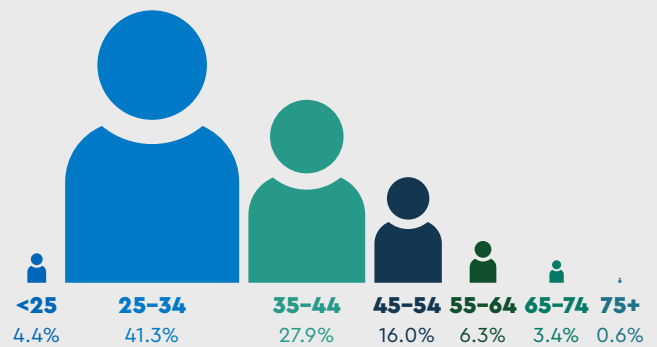
**256** first-time registrants

- **241** domestic (including new graduates)
- **15** international

**0.8%** identified as Aboriginal and/or Torres Strait Islander

**54.1%** female; **45.9%** male

**Figure 44. Age**



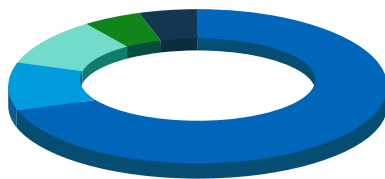
## Regulation

**20** notifications lodged with Ahpra about **20** osteopaths

**29** notifications about **29** osteopaths made Australia-wide, including HPCA and OHO data

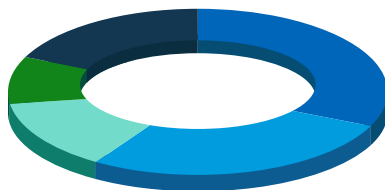
- **0.9%** of the profession Australia-wide

**Figure 45. Sources of notifications**



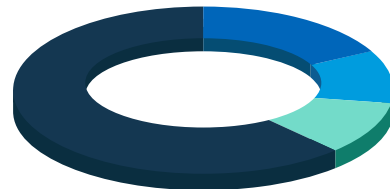
- **70.0%** patient, relative or member of the public
- **10.0%** government department
- **10.0%** police
- **5.0%** employer
- **5.0%** other

**Figure 46. Most common types of complaints**



- **35.0%** clinical care
- **20.0%** boundary violation
- **15.0%** communication
- **10.0%** breach of non-offence provision – National Law
- **20.0%** other

**Figure 47. Notifications closed**



**29** notifications closed

- **17.2%** cautioned or reprimanded
- **10.3%** conditions imposed on registration
- **10.3%** referred to another body or retained by a health complaints entity
- **62.1%** no further regulatory action

**No** immediate actions taken

**1** mandatory notification received

- About impairment

**6** practitioners monitored for health, performance and/or conduct during the year

**1** criminal offence complaint made

**2** notifications finalised at tribunal

**No** matters decided by a panel

**No** appeals lodged

# Paramedics

## Issues this year

The number of notifications about paramedicine practitioners believed to be practising unsafely or acting unprofessionally continues to grow, as does the number of paramedics. The Paramedicine Board of Australia continued to engage with the profession on ethical and professional issues related to the types of notifications received about paramedics. The Board is committed to its role in ensuring public protection and will continue to take necessary and appropriate regulatory action including taking matters to tribunals when required.

## Policy updates

The Board participated in the ongoing cross-profession reviews of registration standards including those related to criminal history, English language skills, recency of practice and continuing professional development. It continued to routinely review and update other published material to ensure it was up to date, clear and accurate.

## Accreditation

The Board joined in the whole-of-scheme approach to reviewing accreditation arrangements. The Paramedicine Accreditation Committee developed and endorsed guidelines for risk-based accreditation decision-making in conjunction with the Chinese medicine, medical radiation practice, Aboriginal and Torres Strait Islander Health Practice and podiatry accreditation committees. These guidelines were supported by the Board and took effect on 1 July 2022.

## Stakeholder engagement

The Board implemented an enhanced communications and engagement strategy for the profession. As part of this, the Board has established private and public sector employer-based reference groups to provide a stronger two-way connection with registered paramedics. The Board hopes to be able to connect and engage widely with practitioners through these reference groups.

## Focusing on cultural safety

After several years spent successfully embedding the paramedicine profession into the National Scheme (1 November marked five years since paramedics entered the scheme), the focus of the Board's work turned to development, advancement and review. The Board reinforced its commitment to actively support, promote and enhance the cultural safety of Aboriginal and Torres Strait Islander Peoples in a number of ways, including sponsoring work related to improving the cultural safety of the notifications process.

## Other news

We are very pleased to welcome Ms Kate Griggs to the Board as a community member. Kate comes to the Board with a strong background as a health consumer representative and has served several terms on Ahpra's Community Advisory Council. We were also delighted that Ms Tiina-Liisa Sexton was re-appointed to the Board for a second term as a community member. We look forward to the strong, ongoing role community members have in the work of the Board.

My personal thanks must go to the Board and committee members for their ongoing work and support. And the Board notes its gratitude for the support of key stakeholders in its work, including professional bodies, educators, employers and health departments across Australia.

**Professor Stephen Gough ASM, Chair**



## Board members

**Professor Stephen Gough ASM (practitioner), Chair**

Ms Clare Beech (practitioner)

Mr Keith Driscoll ASM (practitioner)

Ms Kate Griggs (community) – from 29 Mar

Associate Professor Ian Patrick ASM (practitioner)

Ms Linda Renouf (community)

Ms Tiina-Liisa Sexton (community)

Mr Howard Wren ASM (practitioner)

Ms Angela Wright (practitioner)

Mr Paul Fisher is the Executive Officer, Paramedicine.

For more information, see the online appendices and [www.paramedicineboard.gov.au](http://www.paramedicineboard.gov.au).

## Registration

**24,164** paramedics

- Up **4.8%** from 2021/22
- **2.8%** of all registered health practitioners

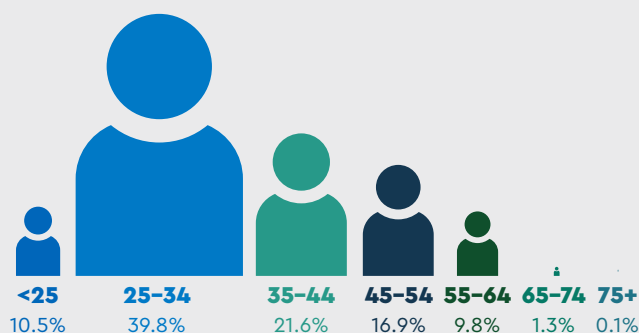
**1,947** first-time registrants

- **1,878** domestic (including new graduates)
- **69** international

**2.0%** identified as Aboriginal and/or Torres Strait Islander

**49.1%** female; **50.8%** male

**Figure 48. Age**



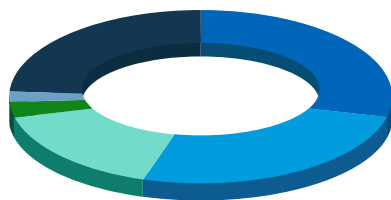
## Regulation

**104** notifications lodged with Ahpra about **88** paramedics

**216** notifications about **175** paramedics made Australia-wide, including HPCA and OHO data

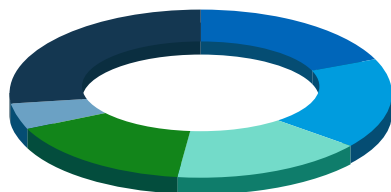
- **0.7%** of the profession Australia-wide

**Figure 49. Sources of notifications**



- **28.8%** patient, relative or member of the public
- **26.0%** employer
- **16.3%** other practitioner
- **2.9%** Board initiated
- **1.9%** health complaints entity
- **24.0%** other

**Figure 50. Most common types of complaints**



- **18.3%** clinical care
- **17.3%** health impairment
- **16.3%** behaviour
- **16.3%** offence against other law
- **4.8%** medication
- **26.9%** other

**Figure 51. Notifications closed**



**140** notifications closed

- **14.3%** conditions imposed on registration or an undertaking accepted
- **7.9%** cautioned or reprimanded
- **1.4%** registration cancelled
- **2.9%** referred to another body or retained by a health complaints entity
- **73.6%** no further regulatory action

**3** immediate actions taken

**19** mandatory notifications received

- **8** about impairment
- **6** about alcohol or drugs
- **3** about sexual misconduct
- **2** about professional standards

**38** practitioners monitored for health, performance and/or conduct during the year

**13** criminal offence complaints made

**2** notifications finalised at tribunal

**No** matters decided by a panel

**1** appeal lodged

# Pharmacists

## Response to COVID-19

To further support the health system, the Pharmacy Board of Australia invited pharmacists who were on the pandemic sub-register and practising, to transition to the main *Register of practitioners* and maintain their registration beyond the closure of the sub-register. Those pharmacists who transitioned to the main register will then be eligible to apply for renewal of general registration to keep practising.

## Review of registration standards and guidelines

A consultation paper on the review of the *Guidelines on compounding of medicines* was published on the Board's website following extensive stakeholder engagement. The guidelines apply to pharmacists compounding medicines to meet the unique needs of a patient. The review will identify opportunities to clarify the guidance for pharmacists and ensure safety of compounding.

To prepare for a review of its registration standard on the supervised practice requirements for intern pharmacists holding provisional registration, the Board surveyed interns and supervising preceptors about their experiences. Their feedback will be used to develop a stakeholder forum on supervised practice to capture further insights about the internship year. Revised proposals for supervised practice of interns will be tested with stakeholders during future public consultation.

The Board continued to collaborate with other National Boards in reviewing registration standards common to all health professions. This included the registration standard on English language skills and publication of Easy English information about the shared *Code of conduct*.

## Accreditation standards for pharmacist prescribing

To complement its past work exploring opportunities for pharmacist prescribing, the Board agreed to fund the development of accreditation standards for education programs for pharmacist prescribing. Program providers would need to ensure that pharmacists completing their programs meet the prescribing competencies set out in the National Prescribing Service (NPS) Prescribing Competencies Framework.

Completion of accredited education programs would qualify and equip pharmacists to prescribe in accordance with any authorisations set out in state and territory medicines and poisons legislation that required pharmacists to qualify for an endorsement for scheduled medicines. The draft accreditation standards developed by the Australian Pharmacy Council were open to initial public consultation and will undergo further development and further public consultation.

## Assignment of accreditation function

The Board reviewed and consulted on the assignment of the accreditation function for the pharmacy profession. Accreditation involves two processes: program accreditation and practitioner assessment. The current assignment, to the APC, will end in June 2024.

The Board reviewed performance and progress of current accreditation priorities and confirmed the priorities and measurement of progress for the next period. It considered the consultation feedback and the APC's expression of interest to continue to deliver accreditation functions, and confirmed its ongoing assignment to the APC.

## Supporting professional practice

The Board continued to provide annual funding to the Pharmacists' Support Service. This long-established service is staffed by volunteer pharmacists who provide crisis telephone counselling, and offers valuable health support services to pharmacists and students across Australia.

The Board continued its face-to-face engagement with pharmacists and stakeholders by holding stakeholder meetings in Adelaide and Melbourne. This enabled it to hear first-hand about local issues affecting pharmacists and their practice, and to discuss the Board's role in protecting the public.

**Mr Brett Simmonds, Chair**



## Board members

**Mr Brett Simmonds (practitioner), Chair**

Mrs Elise Apolloni (practitioner)

Ms Melissa Cadzow (community)

Dr Alice Gilbert PhD (practitioner)

Mr Mark Kirschbaum (practitioner)

Ms Hannah Mann (practitioner)

Dr Suzanne Martin (veterinarian) (community)

Dr Amy Page PhD (practitioner)

Dr Cameron Phillips PhD (practitioner)

Dr Janet Preuss PhD (community)

Mr Rodney Wellington (community)

Mr Laurence (Ben) Wilkins (practitioner)

Mr Joe Brizzi is the Executive Officer, Pharmacy.

For more information, see the online appendices and [www.pharmacyboard.gov.au](http://www.pharmacyboard.gov.au).



## Registration

**36,425** pharmacists

- Up **3.0%** from 2021/22
- **4.2%** of all registered health practitioners

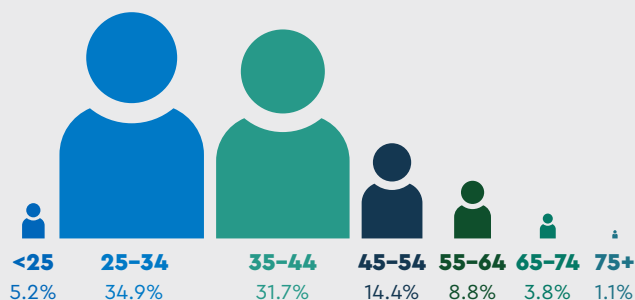
**2,177** first-time registrants

- **1,398** domestic (including new graduates)
- **779** international

**0.3%** identified as Aboriginal and/or Torres Strait Islander

**64.1%** female; **35.9%** male

**Figure 52. Age**



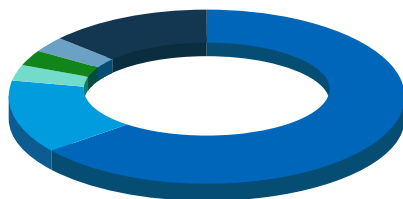
## Regulation

**379** notifications lodged with Ahpra about **327** pharmacists

**830** notifications about **599** pharmacists made Australia-wide, including HPCA and OHO data

- **1.6%** of the profession Australia-wide

**Figure 53. Sources of notifications**



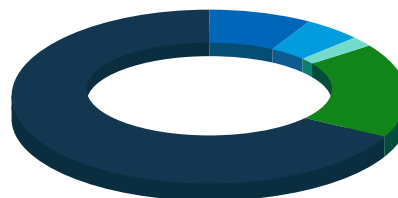
- **64.4%** patient, relative or member of the public
- **13.7%** other practitioner
- **2.9%** Board initiated
- **2.9%** employer
- **2.9%** health complaints entity
- **13.2%** other

**Figure 54. Most common types of complaints**



- **52.8%** medication
- **9.2%** communication
- **6.3%** offence against other law
- **6.1%** clinical care
- **4.5%** behaviour
- **21.1%** other

**Figure 55. Notifications closed**



**449** notifications closed

- **8.5%** cautioned or reprimanded
- **4.7%** conditions imposed on registration or an undertaking accepted
- **1.8%** registration suspended, cancelled, surrendered or disqualified from applying
- **17.6%** referred to another body or retained by a health complaints entity
- **67.5%** no further regulatory action

**16** immediate actions taken

**33** mandatory notifications received

- **22** about impairment
- **11** about professional standards

**72** practitioners monitored for health, performance and/or conduct during the year

**10** criminal offence complaints made

**10** notifications finalised at tribunal

**No** matters decided by a panel

**4** appeals lodged

# Physiotherapists

## Workforce

The Physiotherapy Board of Australia made progress on its strategic work, and an important focus was workforce and getting a better understanding of the attrition of physiotherapists in Australia. In January, the Board agreed to collaborate with the Australian Physiotherapy Association (APA) on research into physiotherapist attrition rates. The aims of this research are to help understand why physiotherapists are leaving the profession and what factors contribute to this decision. Practitioners will be surveyed in an effort to ascertain the reasons for changing careers or moving away from clinical practice.

The Board has also been involved in scheme-wide responses to increasing the workforce by reviewing the process for assessing overseas practitioners to register for practice in Australia and facilitating more efficient ways of supporting overseas-trained practitioners.

## Physiotherapy practice thresholds

The Board continued to work with the Physiotherapy Board of New Zealand on a first review of the two countries' national practice thresholds, with a focus on updating the wording about cultural safety and digital competence. The proposed amendments include updating key competencies to incorporate providing culturally safe care, communicating in a culturally safe way, and having awareness and understanding of any cultural biases. Another change includes the requirement for digital competency, reflecting the increasing use and reliance on technology to deliver services remotely. The consultation closed in June and the physiotherapy practice thresholds are being finalised for implementation.

## Assessing physiotherapy prescribing

The Board held a forum in July on physiotherapy prescribing in Australia. The forum aimed to discuss with key stakeholders the public value of physiotherapy prescribing, and to get the practitioner perspective. The forum was well attended and has led to the formation of a national working group, which is made up of physiotherapy practitioners from various clinical settings and expertise, representatives from the APA and the Board, as well as a number of prescribers and consumers. The working group is focused on developing a position on physiotherapy prescribing, assessing its potential public value and determining the clinical settings that would be suitable.

## Strategic projects

The Board has been involved in multiple professional policy developments and the review of several registration standards. The English language standard, recency of practice standard and continuing professional development standard are all under review.

The Board continues its commitment to cultural safety and eliminating racism in healthcare by participating in Aboriginal and Torres Strait Islander engagement. We continue to seek to understand the challenges for Aboriginal and Torres Strait Islander Peoples in both working in and receiving healthcare. And we continue our efforts to identify ways that the Board can support the eradication of racism in healthcare.

**Ms Kim Gibson, Chair**



## Board members

**Ms Kim Gibson (practitioner), Chair**

Ms Sally Adamson (practitioner)

Mrs Janet Blake (community)

Mr David Cross (practitioner)

Dr Paula Harding PhD (practitioner)

Ms Cherie Hearn (practitioner)

Emeritus Professor Sheila Lennon (practitioner)

Ms Rosemary Mathlin (community)

Mr Allan Renouf (community)

Ms Elizabeth Trickett (practitioner)

Ms Katherine Waterford (community)

Mr Simon Watt (practitioner)

Ms Alison Abud is the Executive Officer, Physiotherapy.

For more information, see the online appendices and [www.physiotherapyboard.gov.au](http://www.physiotherapyboard.gov.au).

## Registration

**42,098** physiotherapists

- Up **5.2%** from 2021/22
- **4.8%** of all registered health practitioners

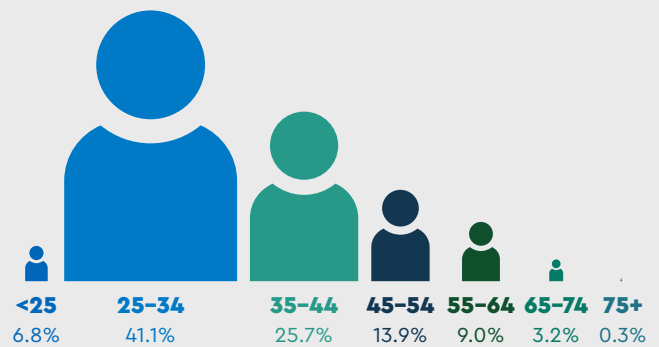
**3,329** first-time registrants

- **2,220** domestic (including new graduates)
- **1,109** international

**0.7%** identified as Aboriginal and/or Torres Strait Islander

**64.0%** female; **36.0%** male

**Figure 56. Age**



## Regulation

**140** notifications lodged with Ahpra about **124** physiotherapists

**224** notifications about **191** physiotherapists made Australia-wide, including HPCA and OHO data

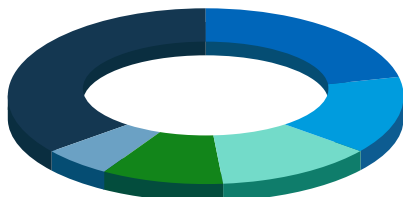
- **0.5%** of the profession Australia-wide

**Figure 57. Sources of notifications**



- **50.7%** patient, relative or member of the public
- **14.3%** other practitioner
- **7.9%** employer
- **4.3%** health complaints entity
- **2.9%** Board initiated
- **20.0%** other

**Figure 58. Most common types of complaints**



- **21.4%** clinical care
- **14.3%** boundary violation
- **12.9%** breach of non-offence provision – National Law
- **10.0%** behaviour
- **5.7%** communication
- **35.7%** other

**Figure 59. Notifications closed**



**135** notifications closed

- **13.3%** cautioned or reprimanded
- **11.9%** conditions imposed on registration or an undertaking accepted
- **2.2%** disqualified from applying for registration
- **13.3%** referred to another body or retained by a health complaints entity
- **59.3%** no further regulatory action

**9** immediate actions taken

**15** mandatory notifications received

- **6** about impairment
- **5** about professional standards
- **4** about sexual misconduct

**36** practitioners monitored for health, performance and/or conduct during the year

**30** criminal offence complaints made

**4** notifications finalised at tribunal

**No** matters decided by a panel

**1** appeal lodged

# Podiatrists

The Podiatry Board of Australia's new professional capabilities for podiatrists and podiatric surgeons<sup>1</sup> describe the minimum level of professional capability needed to practise safely. The new *Code of conduct* sets the Board's expectations about professional behaviour and conduct.

Our messaging and engagement with the profession aimed to support practitioners to practise safely. This includes reminders about professional obligations under the *Code of conduct*, maintaining competence through professional development, effective infection prevention and control, and advertising obligations.

We also encouraged practitioners to use the professional capabilities to reflect on their practice, identify areas for improvement and seek professional development to address any gaps. We pointed to Board resources developed to support safe practice. Examples of these include the self-assessment tools for infection prevention and control, health records and advertising.

## Registration standard approved

The Board's revised registration standard for specialist registration for the specialty of podiatric surgery was approved by the Ministerial Council on 23 April.

The review of the registration standard included consultation with key stakeholders. No substantive changes were made to the requirements for specialist registration. Minor editorial and structural changes improve readability and clarity.

## Resources to support practitioners

The Board worked with Ahpra to review our resources to support practitioners using Pathway B of the registration standard to obtain endorsement for scheduled medicines.

We published new and updated resources, including a checklist, a user-friendly clinical study template, a guidance document for clinical studies, a sample portfolio of evidence and FAQs.

Together with other National Boards and Ahpra we developed new resources, including a summary of the guidance in the *Code of conduct* about record management and a self-reflective tool to help practitioners assess their record-keeping practice.

In partnership with Ahpra, we also audited the advertising of a random sample of registrants and shared lessons from the audit with the profession.

## Accreditation

On 1 July 2022, two new and four re-appointed members started a three-year term on the Podiatry Accreditation Committee.

The Board considered reports from the committee on monitoring of podiatry programs and on accreditation decisions to decide whether to approve the accredited program of study as providing a qualification for registration.

## Stakeholder engagement

The Board published three newsletters and held quarterly meetings with the Australian Podiatry Association (APoDA), Podiatry Council of New South Wales and Podiatry Accreditation Committee. A meeting was also held with the Podiatrists Board of New Zealand.

Face-to-face engagement resumed, which included meeting with local stakeholders in Brisbane, hosting a booth at the APoDA national conference and giving a presentation to registrants. We welcomed the opportunity to meet registrants at the booth and answer questions about the Board's work, including requirements for registration and endorsement.

**Associate Professor Cylie Williams, Chair**



## Board members

**Associate Professor Cylie Williams (practitioner), Chair**

Mr Andrew van Essen (practitioner)

Ms Raelene Harrison (community)

Ms Julia Kurowski (practitioner)

Dr Kristy Robson PhD (practitioner)

Mr Anthony Short (practitioner)

Ms Shellee Smith (community)

Mrs Kathryn Storer (Shonk) (practitioner)

Professor Andrew Taggart (community)

Ms Jenny Collis is the Executive Officer, Podiatry.

For more information, see the online appendices and [www.podiatryboard.gov.au](http://www.podiatryboard.gov.au).

1 Throughout this report, the term 'podiatrist' refers to both podiatrists and podiatric surgeons unless otherwise specified.

## Registration

**6,038** podiatrists

- Up **0.8%** from 2021/22
- **0.7%** of all registered health practitioners
- **41** are podiatric surgeons

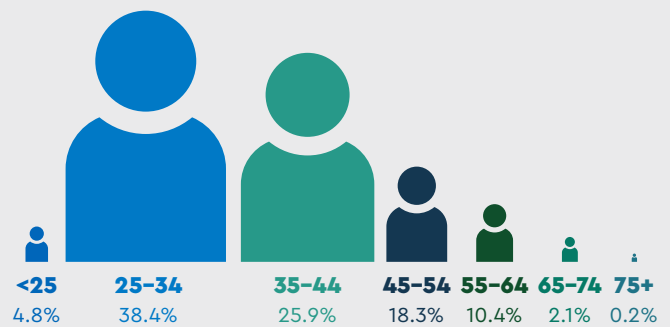
**277** first-time registrants

- **229** domestic (including new graduates)
- **48** international

**0.6%** identified as Aboriginal and/or Torres Strait Islander

**59.0%** female; **41.0%** male

**Figure 60. Age**



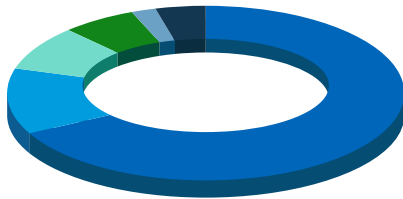
## Regulation

**49** notifications lodged with Ahpra about **41** podiatrists

**90** notifications about **71** podiatrists made Australia-wide, including HPCA and OHO data

- **1.2%** of the profession Australia-wide

**Figure 61. Sources of notifications**



- **67.3%** patient, relative or member of the public
- **12.2%** government department
- **8.2%** other practitioner
- **6.1%** employer
- **2.0%** Board initiated
- **4.1%** other

**Figure 62. Most common types of complaints**



- **24.5%** clinical care
- **16.3%** breach of non-offence provision – National Law
- **8.2%** communication
- **8.2%** documentation
- **6.1%** behaviour
- **36.7%** other

**Figure 63. Notifications closed**



**56** notifications closed

- **21.4%** conditions imposed on registration
- **12.5%** cautioned or reprimanded
- **1.8%** registration suspended
- **16.1%** referred to another body or retained by a health complaints entity
- **48.2%** no further regulatory action

**1** immediate action taken

**4** mandatory notifications received

- **3** about professional standards
- **1** about impairment

**21** practitioners monitored for health, performance and/or conduct during the year

**7** criminal offence complaints made

**1** notification finalised at tribunal

**No** matters decided by a panel

**1** appeal lodged



# Psychologists

## Education and training reform

The Psychology Board of Australia publicly consulted on updated competencies for general registration as a psychologist in Australia, as part of the broader program of work on education and training reform.

By updating the core competencies for registration, we can ensure they are contemporary and we can be confident that psychologists are properly trained and qualified to safely and effectively deliver services into the future.

Our consultation proposed the following improvements:

- updating the eight core competencies to ensure they continue to be relevant, contemporary and aligned with the current Australian accreditation standards and international best practice
- placing a greater emphasis on professional reflexivity, deliberate practice and self-care
- emphasising culturally safe care with Aboriginal and Torres Strait Islander Peoples, families and communities
- better addressing the diversity in the Australian community by requiring psychologists to show sensitivity and respect when working with diverse clients, colleagues and other people they encounter.

During the consultation period we hosted two national webinars and attended several events hosted by professional psychology associations that aimed to help the profession and public to understand the changes.

We would like to thank the many individuals, organisations and professional associations who provided feedback on our public consultation paper. Once we have reviewed and incorporated the feedback, we will publish an advance copy of the *Professional competencies for psychologists* on our website at least 12 months before they come into effect.

### Developing a code of conduct

Our expert advisory group prepared a preliminary draft of the Board's *Code of conduct* for psychologists. This draft incorporated research and development from the past year, including user testing, and the expert group's advice on issues specific to psychological practice.

We also carried out preliminary consultation with targeted stakeholders. Following this, we will release the draft code for public consultation, and invite psychologists, stakeholders and the community to provide feedback.

## National committees

In December, the Board established national committees to support the management of registration and notifications. The committees replace the regional board structure that has been in place since the start of the National Scheme.

These national committees are:

- Psychology Registration and Compliance Committee
- Psychology Notifications Committee: Assessment
- Psychology Notifications and Compliance Committee
- Psychology Immediate Action Committee.

The Board delegates functions to the national committees so they can make decisions about individual practitioners. This includes deciding whether a practitioner is suitable to be registered and whether to take action against a practitioner when a notification is made about them.

The Board would like to acknowledge the work of Ahpra staff and committee members to ensure the transition to the new structure went smoothly.

**Ms Rachel Phillips, Chair**



### Board members

**Ms Rachel Phillips (practitioner), Chair**

Ms Miranda Bruyniks (community)

Professor Petrina Coventry (community)

Ms Marion Hale (community)

Ms Vanessa Hamilton (practitioner)

Mr Christopher Joseph (community)

Mr Timothy Ridgway (practitioner)

Professor Jennifer Scott (practitioner)

Dr Jennifer Thornton PhD (practitioner)

Professor Kathryn von Treuer (practitioner)

Dr Robyn Vines PhD (practitioner)

Ms Angela Smith is the Executive Officer, Psychology.

For more information, see the online appendices and [www.psychologyboard.gov.au](http://www.psychologyboard.gov.au).

## Registration

**46,347** psychologists

- Up **3.2%** from 2021/22
- **5.3%** of all registered health practitioners

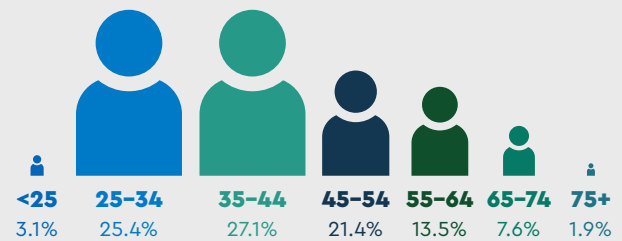
**2,986** first-time registrants

- **2,750** domestic (including new graduates)
- **236** international

**0.7%** identified as Aboriginal and/or Torres Strait Islander

**80.5%** female; **19.5%** male

**Figure 64. Age**



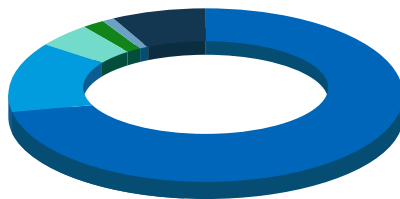
## Regulation

**671** notifications lodged with Ahpra about **553** psychologists

**1,208** notifications about **981** psychologists made Australia-wide, including HPCA and OHO data

- **2.1%** of the profession Australia-wide

**Figure 65. Sources of notifications**



**Figure 66. Most common types of complaints**



**Figure 67. Notifications closed**



**721** notifications closed

- **13.2%** conditions imposed on registration or an undertaking accepted
- **7.1%** cautioned or reprimanded
- **0.7%** registration suspended or cancelled or disqualified
- **13.3%** referred to another body or retained by a health complaints entity
- **65.7%** no further regulatory action

**28** immediate actions taken

**60** mandatory notifications received

- **27** about impairment
- **21** about professional standards
- **7** about sexual misconduct
- **5** about alcohol or drugs

**197** practitioners monitored for health, performance and/or conduct during the year

**106** criminal offence complaints made

**17** notifications finalised at tribunal

**4** matters decided by a panel

**7** appeals lodged

# Supporting the Boards

## Appointments

National Board members are appointed by the Ministerial Council, and state and territory board members are appointed by the relevant health minister in each jurisdiction.

Our regulatory work is not possible without the right people serving on boards and committees. Ahpra provided administrative support for 503 statutory appointments made within the year (Table 3).

**Table 3. Statutory appointments**

National Boards	13
National Board committees and panels	313
State and territory boards	40
State and territory committees	137
<b>Total</b>	<b>503</b>

We have been working to increase the participation of Aboriginal and Torres Strait Islander Peoples and people from diverse backgrounds through advertising and engagement strategies (Table 4).

**Table 4. Board and committee diversity**

	Appointed in 2022/23	Currently in National Scheme
Aboriginal and/or Torres Strait Islander	8	33
Culturally and/or linguistically diverse	25	177
Identified with disability	3	21
Rural and/or regional	14	163

## Supporting good governance

Ahpra develops, manages and delivers a coordinated and integrated governance program, which responds to the needs of board and committee members.

The program has four key areas, which are aligned to the three-year regulatory 'life cycle' of members and boards:

- orientation and induction of new members
- professional development, including member skills development
- board effectiveness reviews
- documentation for good governance practice.

### Orientation and induction

During the year, 22 new board members attended our orientation program, which included a face-to-face or video conference introduction and three self-paced online learning modules focusing on key governance concepts. An information management and cybersecurity training module was introduced, which provided all board, committee and panel members with an overview of their statutory obligations for the management of protected information and the risks posed by cybercrime to the security of our data.

## Professional development

To support board effectiveness and strengthen the partnership between Ahpra and the National Boards, Ahpra collaborated with an external partner, Board Matters, to develop a refreshed governance professional development program for board members. The program has two key components:

- an online self-directed learning program
- face-to-face, scenario-based workshops to supplement the online content.

This blended learning approach to regulatory professional development offers the following benefits:

- a consistent baseline regulatory governance learning experience
- content that can be accessed at a time and a place that suits the members' needs
- content linked to the board effectiveness review outcomes, building capacity and capability where needed
- content that can be made available to other statutory appointees.

## Board effectiveness reviews

Board effectiveness reviews are conducted annually over a rolling three-year cycle.

The agreed approach to reviews is a triennial program of both informal (check-in) and formal (in-depth) reviews, using a combination of surveys and interviews, conducted confidentially through Board Matters.

An informal, check-in review was completed in October. The 2023 in-depth effectiveness review, incorporating a peer survey component, began in May.

## Governance documentation

These documents were developed, reviewed or updated:

- guidelines for board and committee members with respect to duty of confidentiality
- a new framework for the administration of payments to Chairs
- business rules for the payment of sitting fees.

## Payments to Board Chairs

Board members are entitled to remuneration, including travel and subsistence allowances, within the framework determined by the Ministerial Council. In addition to sitting fees for scheduled board and committee meetings, Chairs may also be remunerated for the additional work that is required.

**Table 5. Payments to Board Chairs**

Range	Number of Chairs <sup>1</sup>	2022/23 total payments <sup>2</sup>
\$0–\$20,000	2	\$31,096
\$20,001–\$40,000	4	\$122,684
\$40,001–\$60,000	5	\$266,234
\$60,001–\$80,000	2	\$130,654
\$80,000 plus	4	\$434,166
<b>Total</b>	<b>17</b>	<b>\$984,834</b>

1 One new Chair was appointed to replace a Chair who resigned.

2 Payments to Board Chairs, including the Ahpra Board, under the approved remuneration framework.

# Accreditation



**Accreditation helps ensure that people seeking registration are suitably trained, qualified and competent to practise as health practitioners.**

National Boards and accreditation authorities have separate but complementary functions. For example, an accreditation authority accredits a program of study and the relevant National Board approves it as a basis for registration. The accreditation authority for each profession can be an external council or committee. As well, the Ahpra Board has an independent Accreditation Committee.

Figure 69 (on page 49) outlines how the accreditation process works.

## The year in summary

- **183,900** registered students were enrolled in approved programs.
- More than **802** programs of study were accredited and approved.
- More than **130** education providers delivered accredited and approved programs of study.

Approved programs of study can be searched on our website.

## Accreditation Committee

The Accreditation Committee provides independent and expert advice on accreditation reform and other accreditation matters to National Boards, accreditation authorities and Ahpra. Other external entities performing accreditation roles as part of the National Scheme, such as specialist colleges and postgraduate medical councils, take account of the committee's advice, where relevant.

The committee met four times; Professor Andrew Wilson AO is its independent chair. Its priority areas of work are supporting the future health workforce and strengthening accreditation systems. Specific deliverables reflect areas referred to the committee in the health ministers' response to the independent review of accreditation systems in the health system, *Australia's health workforce: strengthening the education foundation*.

The committee released public consultation proposals on two of its first priorities: a statement of intent for interprofessional collaborative practice (IPCP) and a glossary of accreditation terms that will enhance shared understanding and consistent interpretation of the committee's advice. Achieving IPCP is fundamental to effective team-based and coordinated care. The committee is working towards embedding IPCP in the 16 registered health professions by gaining a joint commitment from stakeholders across the health and education sectors to take action. The glossary of terms will support interpretation and implementation of the committee's future advice.



## Oversight

The Ahpra Board provides a whole-of-scheme perspective on accreditation governance, accountability and transparency issues. This includes oversight of financial arrangements and performance reporting, and the accreditation arrangements established by agreements and terms of reference for accreditation authorities.

The current accreditation arrangements end on 30 June 2024 for all professions except paramedicine, which ends on 30 November 2023. Ahpra and all National Boards started the third scheduled review of accreditation arrangements in late 2022 to prepare for the next period to mid-2029. The review will inform the priorities for accreditation during the next period and how progress on these priorities will be measured.

The Ahpra Board oversees the review process as part of its role in whole-of-scheme oversight and accountability. The review will end later in 2023, when all National Boards make decisions on the accreditation authorities to exercise functions for the next period.

## New collaborative approaches

In October, the Forum of National Registration and Accreditation Scheme Chairs (FoNC), Health Professions Accreditation Collaborative Forum (HPAC Forum) and Ahpra agreed to discontinue the Accreditation Liaison Group and replace it with an integrated approach to collaboration on accreditation issues using existing structures, including expanding FoNC membership to include accreditation.

This highlights the commitment between National Boards, accreditation authorities and Ahpra to share information and work collaboratively. The intent of building specific consideration of accreditation, and facilitating cross-scheme collaboration on accreditation and related issues, is being achieved by dedicated discussions with HPAC Forum representatives at the FoNC, and attendance by Ahpra and National Board representatives at meetings of the HPAC Forum. In addition, HPAC Forum, FoNC and Ahpra hold an annual meeting to discuss accreditation issues relevant to the National Scheme strategy.

## Funding

Nine National Boards exercise accreditation functions through external councils.

Five National Boards – Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine, Medical Radiation Practice, Paramedicine and Podiatry – exercise accreditation functions through a committee established by their Boards.

One National Board – Nursing and Midwifery – exercises accreditation functions related to education programs through an external council, and exercises functions related to assessment of internationally qualified nurses and midwives (IQNM) through a committee established by the Board.

The National Boards contributed over \$10.8 million of funding to these accreditation authorities and committees (see Table 6).

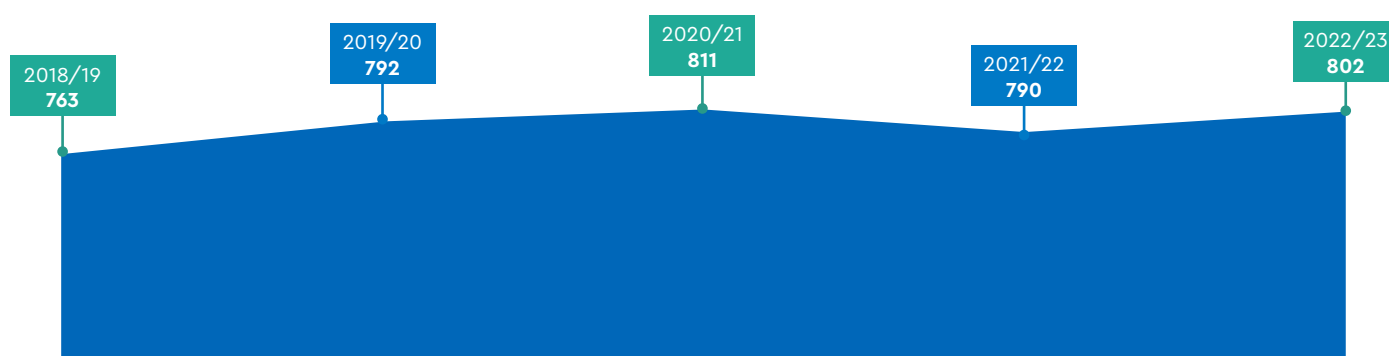
**Table 6. National Board funding contributions**

Board	2022/23 \$'000 <sup>1</sup>	2021/22 \$'000 <sup>1</sup>
Aboriginal and Torres Strait Islander Health Practice	187	131
Chinese Medicine	133	108
Chiropractic	257	250
Dental	470	483 <sup>2</sup>
Medical	3,368 <sup>3</sup>	3,409 <sup>3</sup>
Medical Radiation	196	164
Nursing and Midwifery	3,078 <sup>3</sup>	2,938 <sup>3</sup>
Occupational Therapy	0	0
Optometry	353	343
Osteopathy	199	203 <sup>2</sup>
Paramedicine	90	111
Pharmacy	893 <sup>2</sup>	749 <sup>2</sup>
Physiotherapy	331	331
Podiatry	188	134
Psychology	1,091	1,064
<b>Total</b>	<b>10,834</b>	<b>10,418</b>

- 1 Actual amounts. Requirements of the accounting standards may result in differences between these and the amounts in our financial statements.
- 2 Includes funding for accreditation-related projects.
- 3 Includes funding for the review of accreditation standards.

**Figure 68. Number of accredited programs 2018/19 to 2022/23**

The data in this diagram differ from those in previous reports due to updated data reported by accreditation authorities.





# The work of the committees

Ahpra supported the accreditation committees for Aboriginal and Torres Strait Islander Health Practice, Chinese medicine, medical radiation practice, paramedicine and podiatry to:

- assess and accredit programs of study
- monitor approved programs of study
- develop and/or review accreditation standards for paramedicine and podiatry
- develop and implement consistent guidelines for accreditation of education and training programs in these five professions.

We also supported the nursing and midwifery (assessment of IQNM) accreditation committee to oversee the outcomes-based assessment of the knowledge, clinical skills and professional attributes of internationally qualified nurses and midwives who want to register in Australia.

This work across six professions supports our multiprofession approach to accreditation functions.

## Accrediting and monitoring programs

We supported the accreditation committees to assess, accredit and monitor programs of study:

- 14 for Aboriginal and Torres Strait Islander Health Practice
- 9 for Chinese medicine
- 35 for medical radiation practice
- 26 for paramedicine
- 16 for podiatry and 2 for podiatric surgery.

## Policy and process

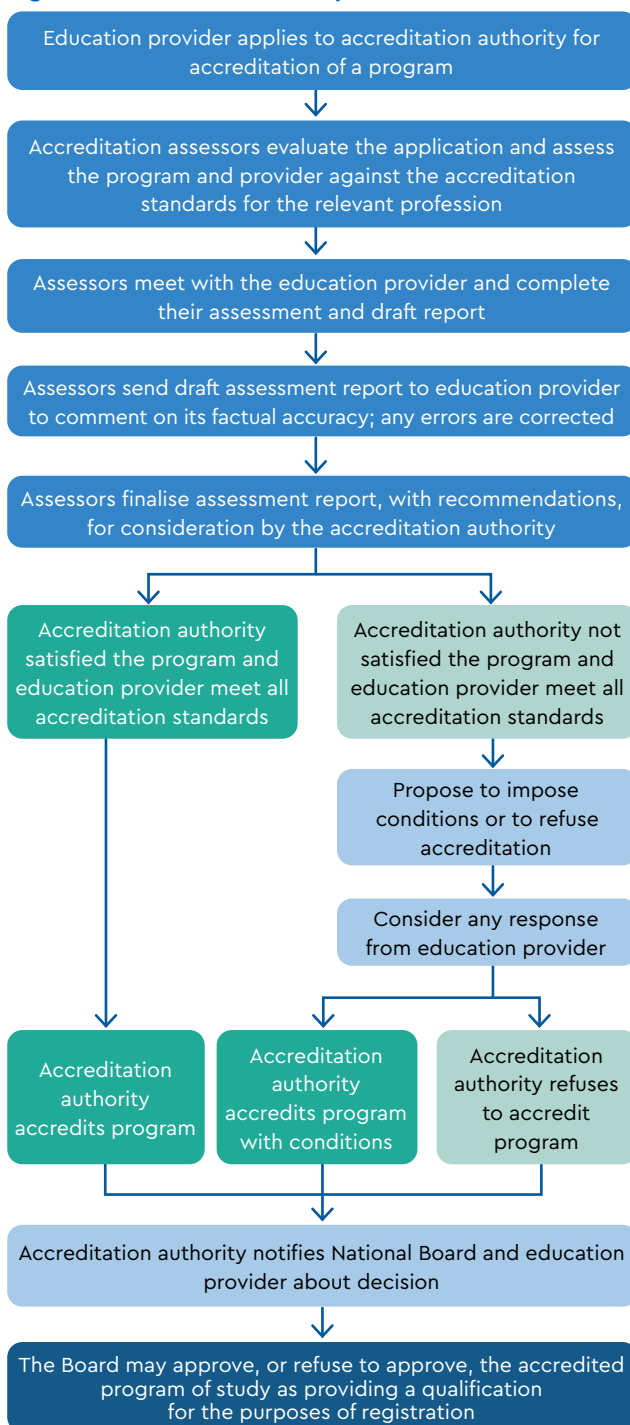
We also supported the accreditation committees to:

- continue to implement specific monitoring to assure the relevant National Boards that students are achieving the capabilities required for safe and competent practice before graduation, despite ongoing changes to program delivery under the COVID-19 public health orders
- continue to apply a flexible approach to monitoring education providers' compliance with accreditation standards, based on specific issues and risk profile – this flexible, risk-based model continued to enable responsive and proportionate regulatory approaches to assessment and monitoring activities
- implement consistent cross-profession guidelines for accreditation, complemented by profession-specific processes (such as establishing assessment teams)
- collaborate to implement consistent cross-profession processes and tools to collect data from 44 education providers delivering more than 100 approved programs across the five professions
- start to implement the *Guidelines for risk-based decision making*.

## Cultural safety training

We began to develop Aboriginal and Torres Strait Islander cultural safety training specifically for accreditation assessors. The five accreditation committees and Ahpra collaborated on this with the other 10 accreditation authorities through the HPAC Forum. Following a procurement process, the forum appointed ABSTARR Consulting to develop, implement and evaluate the training. It will be designed for accreditation assessors within the National Scheme to support their assessment of programs and providers against relevant accreditation standards. The first training session will be delivered later in 2023.

**Figure 69. The accreditation process**



# Registration



**Responding to the increasing pressure on Australia's health workforce was a priority across much of our work.**

We strengthened our engagement with employers to ensure registration requirements are clearly understood, improved timeframes to assess applications for registration, and created a new information hub for international applicants on our website.

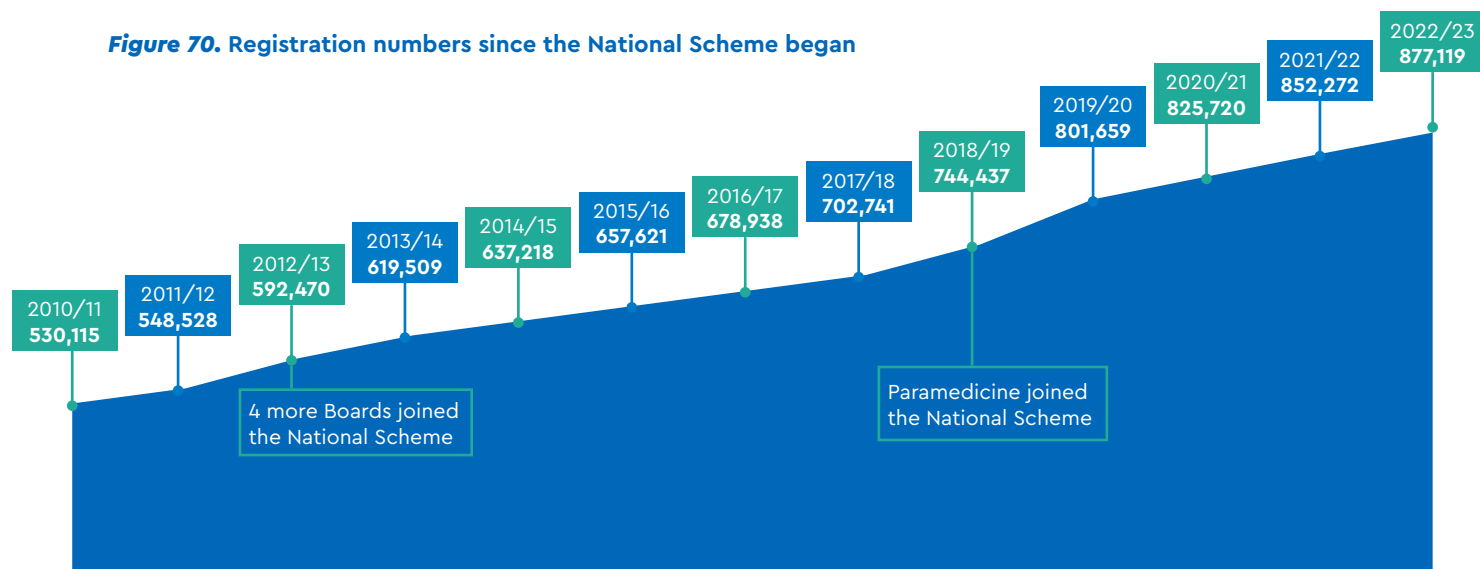
The new hub and other changes are helping international applicants find information about getting registered in Australia quickly and easily.

These initiatives were well aligned to the findings from the interim report of the *Independent review of overseas health practitioner regulatory settings* (referred to as the Kruk review), which was released in April.

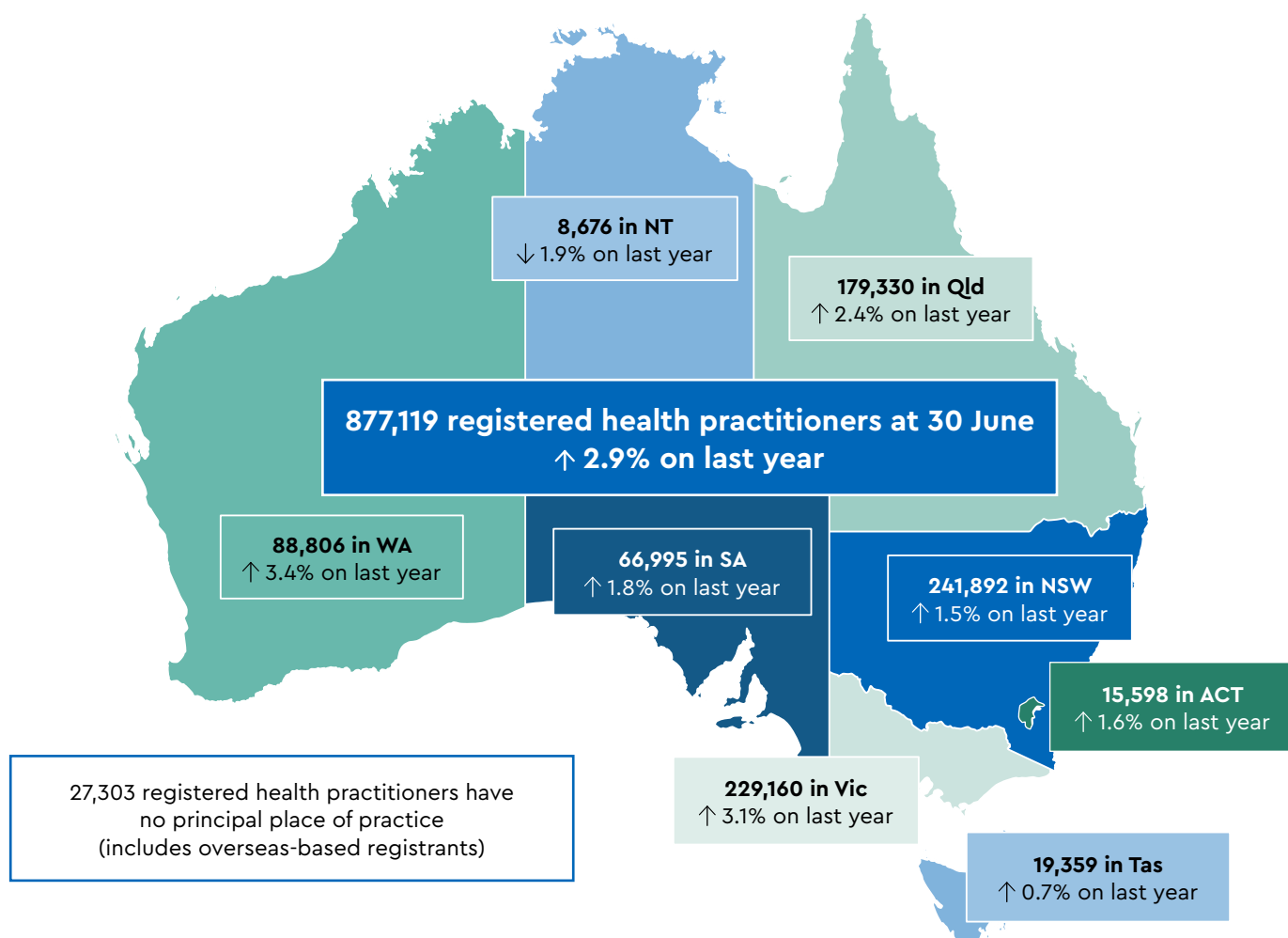
## The year in summary

- The number of registered health practitioners grew by **2.9%** this year to **877,119**.
- **96.6%** of all registered practitioners hold some form of practising registration.
- **88,318** practitioners hold specialist registration in an approved specialty.
- **27,156** practitioners hold endorsement to extend their scope of practice in a particular area because of an additional approved qualification.
- The temporary pandemic sub-register was closed on 8 June 2023 and any practitioners who remained on it were transitioned to ongoing registration.

**Figure 70. Registration numbers since the National Scheme began**



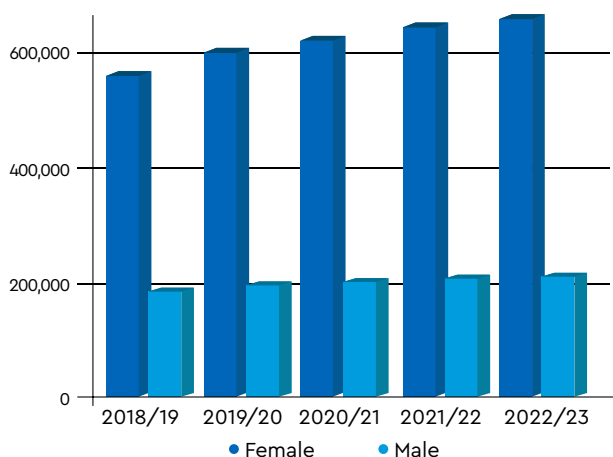
**Figure 71. Health practitioners by state and territory**



## Gender of the health workforce

The registered health practitioner workforce is predominantly female. Over the past five years, there has been a steady increase in both female and male health practitioners (see Figure 72).

**Figure 72. Registered health practitioners by gender**



Note: Practitioners can also be registered as neither female nor male, though these numbers are too low to be represented in the figure.

## Register of practitioners

You can check our *Register of practitioners* to see if someone is registered and if there are any special requirements on their registration.

We have continued to improve the register to make it more accessible and easy to use. Changes include:

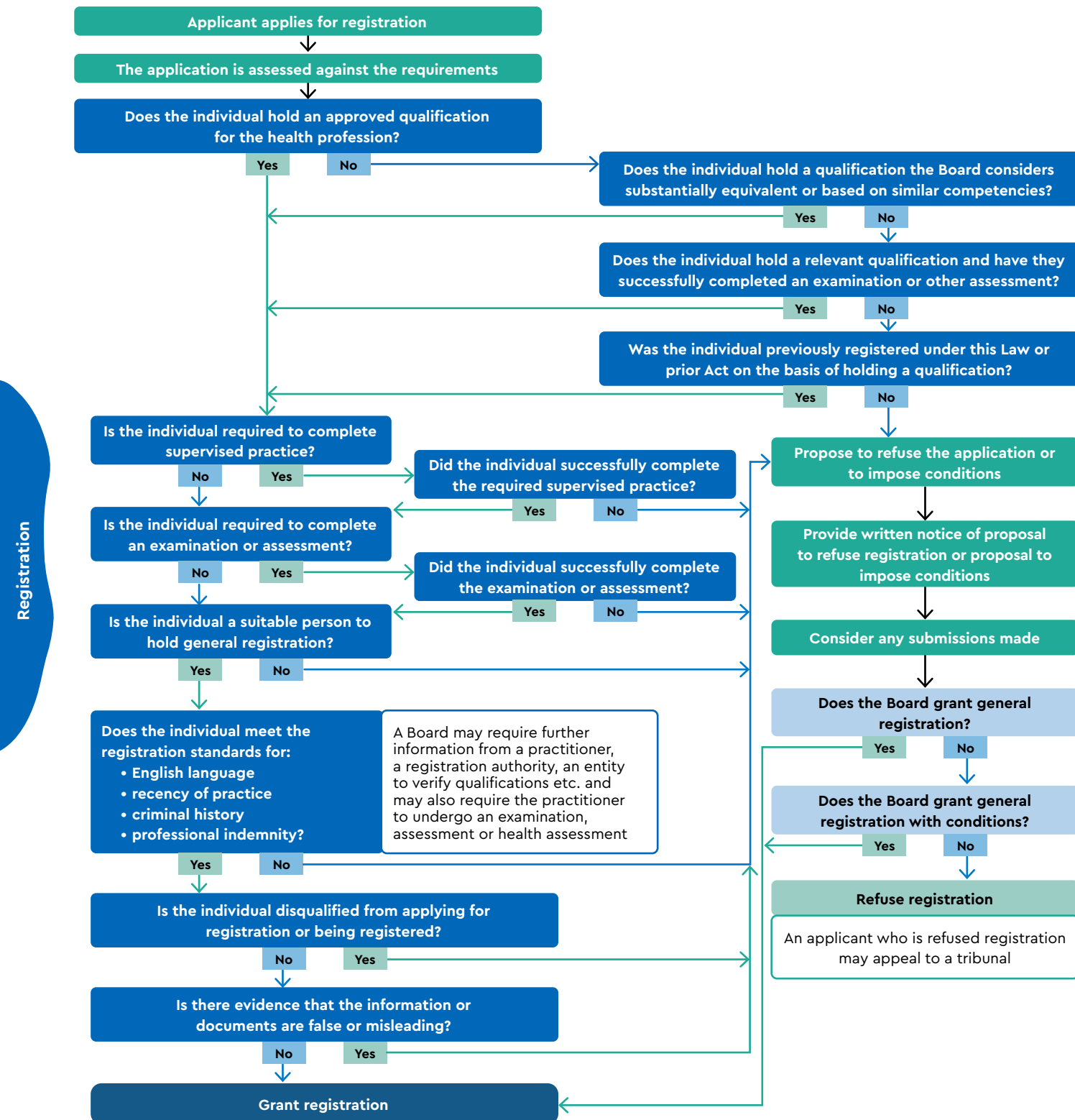
- increased prominence of the register on our redesigned website, with the 'Look up a practitioner' button visible on every page
- improved search functionality, with predictive text and refined filters (including being able to search by gender and language spoken)
- simplified language and pop-up boxes with links to definitions of unfamiliar terms.

# Who can be registered?

Only practitioners who are suitably trained and qualified to practise in a competent manner are registered. National Boards can place conditions on a practitioner's registration or refuse an application entirely.

Figure 73 shows how we decide an application for general registration.

**Figure 73.** The general registration process





**Table 7. Registered health practitioners, 30 June**

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP <sup>1</sup>	Total 2022/23	Total 2021/22 <sup>2</sup>	% change 2021/22– 2022/23
Aboriginal and Torres Strait Islander Health Practitioner		227	196	163	96	4	44	157		887	886	0.1%
Chinese medicine practitioner	61	1,920	13	890	206	46	1,308	265	114	4,823	4,839	-0.3%
Chiropractor	69	2,092	25	1,044	383	68	1,604	854	206	6,345	6,147	3.2%
Dental practitioner	488	7,818	172	5,473	2,155	424	6,437	3,044	681	26,692	26,038	2.5%
Medical practitioner	2,584	40,356	1,567	27,715	9,446	3,060	34,545	14,209	3,260	136,742	131,953	3.6%
Medical radiation practitioner	331	6,279	145	3,919	1,489	370	4,444	1,636	363	18,976	18,601	2.0%
Midwife	249	1,899	115	1,862	935	80	1,716	564	263	7,683	7,161	7.3%
Nurse	7,483	117,950	4,599	93,867	37,499	10,868	118,356	44,626	18,267	453,515	441,891	2.6%
Nurse and midwife <sup>3</sup>	441	7,149	450	5,457	1,615	622	7,749	2,810	262	26,555	28,095	-5.5%
Occupational therapist	497	7,978	241	6,088	2,363	429	7,620	4,049	477	29,742	27,666	7.5%
Optometrist	121	2,152	35	1,363	449	124	1,844	531	143	6,762	6,500	4.0%
Osteopath	45	659	4	333	47	54	2,058	75	50	3,325	3,147	5.7%
Paramedic	337	6,171	255	6,130	1,585	688	6,928	1,743	327	24,164	23,053	4.8%
Pharmacist	766	10,613	276	7,194	2,579	897	9,508	3,995	597	36,425	35,368	3.0%
Physiotherapist	863	12,046	259	8,303	3,311	680	10,192	4,831	1,613	42,098	40,018	5.2%
Podiatrist	83	1,716	36	1,059	573	124	1,830	549	68	6,038	5,992	0.8%
Psychologist	1,180	14,867	288	8,470	2,264	821	12,977	4,868	612	46,347	44,917	3.2%
<b>Total 2022/23</b>	<b>15,598</b>	<b>241,892</b>	<b>8,676</b>	<b>179,330</b>	<b>66,995</b>	<b>19,359</b>	<b>229,160</b>	<b>88,806</b>	<b>27,303</b>	<b>877,119</b>		
<b>Total 2021/22</b>	<b>15,349</b>	<b>238,369</b>	<b>8,842</b>	<b>175,067</b>	<b>65,804</b>	<b>19,225</b>	<b>222,264</b>	<b>85,888</b>	<b>21,464</b>		<b>852,272</b>	<b>2.9%</b>

- 1 No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
- 2 Includes practitioners registered on the temporary sub-register created in response to the COVID-19 pandemic. The pandemic sub-register was closed on 8 June 2023 and any practitioners who remained on it were transitioned to the main *Register of practitioners*.
- 3 Registrants who hold dual registration as both a nurse and a midwife.





## A service for employers to check registration

A total of 161 government departments, public and private hospitals, healthcare businesses, pharmaceutical companies, medical insurers, and nursing and aged care agencies subscribed to the Practitioner Information Exchange (PIE). The PIE is a secure web-based system that enables bulk checking of registration status, drawing on public information published on the *Register of practitioners*. This is an increase from 142 subscribers in 2021/22.

## Criminal history checks

We check every applicant's criminal history before they are registered.

- **79,759** results were received from domestic and international criminal history checks of practitioners and/or applicants (see Table 8). This is an increase on the 75,543 results received in 2021/22.

**Table 8. Criminal history checks and disclosable court outcomes**

State/ territory <sup>1</sup>	2022/23		2021/22	
	Criminal history checks <sup>2</sup>	Disclosable court outcomes	Criminal history checks <sup>2</sup>	Disclosable court outcomes
ACT	1,589	45	1,473	43
NSW	20,009	657	19,015	770
NT	771	35	759	39
QLD	13,994	430	14,510	561
SA	6,443	191	6,303	253
TAS <sup>3</sup>	1,551	290	1,590	296
VIC	19,886	394	18,715	491
WA	8,142	354	8,366	430
No PPP <sup>4</sup>	7,374	12	4,812	16
<b>Total 2022/23</b>	<b>79,759</b>	<b>2,408</b>		
<b>Total 2021/22</b>			<b>75,543</b>	<b>2,899</b>

- 1 Data are by principal place of practice.
- 2 Refers to both domestic and international criminal history checks submitted.
- 3 The National Law requires that all criminal history be released. In Tasmania, police include traffic offences such as speeding and seatbelt use in their definition of 'criminal history', while other states do not.
- 4 No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.

## The pandemic sub-register

The temporary pandemic response sub-register was established in April 2020 to enable a rapid return to the workforce of experienced and qualified health practitioners to assist in the COVID-19 pandemic. These practitioners were selected because they had previously held general or specialist registration and had become unregistered or moved to non-practising registration in the previous three years.

Since then, there have been various adjustments to the sub-register to optimise Australia's health workforce capacity. At its peak, there were more than 40,000 practitioners on the sub-register and around 1,000 have successfully applied to return to the main *Register of practitioners*.

The National Boards decided to close the sub-register in June 2023, and return the last 1,700 practitioners to the main register. These practitioners will be able to apply to renew their registration at the next scheduled renewal date for their profession.

After this transfer of the remaining practitioners, the sub-register was closed.

**The temporary pandemic response sub-register was established in April 2020 to enable a rapid return to the workforce of experienced and qualified health practitioners to assist in the COVID-19 pandemic**

# Applications for registration

We finalised **96,136** applications for registration (see Table 9), an increase of 14.3% from last year.

We received **96,879** applications for registration. The largest number were from new graduates, followed by practitioners transitioning from provisional to general registration, and practitioners transitioning from general to non-practising registration.

- **91.4%** (88,534 applicants) sought practising registration.
- **1.7%** resulted in conditions being placed or a refusal of registration.
- There was a slight reduction in the refusals of registration (111 this year compared to 137 last year).
- 3,805 applicants withdrew before a final decision was made on their application.

**Table 9. All applications finalised, by profession and outcome**

Profession	Register	Register with conditions	Refuse application <sup>1</sup>	Withdrawn <sup>2</sup>	Total 2022/23	Total 2021/22
Aboriginal and Torres Strait Islander Health Practitioner	137	3		30	170	190
Chinese medicine practitioner	559	28	12	102	701	702
Chiropractor	468	12	2	23	505	441
Dental practitioner	2,024	25	7	96	2,152	1,907
Medical practitioner	19,762	274	23	613	20,672	18,372
Medical radiation practitioner	1,446	20	6	95	1,567	1,439
Midwife	2,120	28	3	74	2,225	1,966
Nurse	42,845	752	38	1,990	45,625	37,806
Occupational therapist	3,107	184	2	74	3,367	2,825
Optometrist	490	3	1	10	504	429
Osteopath	338	3		8	349	341
Paramedic	2,347	58	3	96	2,504	2,772
Pharmacist	4,128	67	1	102	4,298	3,620
Physiotherapist	4,319	35	5	263	4,622	3,736
Podiatrist	381	13	1	18	413	370
Psychologist	6,201	43	7	211	6,462	7,225
<b>Total 2022/23</b>	<b>90,672</b>	<b>1,548</b>	<b>111</b>	<b>3,805</b>	<b>96,136</b>	
<b>Total 2021/22</b>	<b>78,936</b>	<b>1,452</b>	<b>137</b>	<b>3,616</b>		<b>84,141</b>

1 If an applicant cannot demonstrate that they meet the eligibility, suitability and/or qualification requirements of the relevant National Board, their application will be refused.

2 If an application for registration is withdrawn by the applicant before a final decision is made it is counted as withdrawn.

## New graduate applications

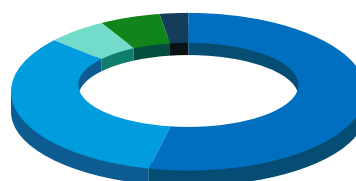
We received **42,565** applications from new graduates, including 24,084 nursing applications.

- This is a 3.5% decrease in new graduate applications from last year.
- **31,668** of these applications were received between mid-September and March, the peak registration period for new graduates. This is a 3.6% decrease from last year.
- Timeframes to assign, assess, make first contact and finalise when complete all improved on last year and contributed to our improved graduate survey results. The average time to assign and assess an application was down from 11 days to seven.

This year we invited 29,059 new graduates to participate in the survey and 2,817 responded (a 9.7% participation rate). Overall, most measures improved when compared to last year.

This year saw the best result to date in how well we managed graduate applications, with 86.2% of respondents satisfied overall (see Figure 74), compared to 83.1% last year.

**Figure 74. Graduate survey**



- **53.5%** Extremely satisfied
- **32.7%** Somewhat satisfied
- **5.6%** Neither satisfied nor dissatisfied
- **5.5%** Somewhat dissatisfied
- **2.6%** Extremely dissatisfied

## End-of-year graduate survey

The end-of-year graduate survey is a voluntary customer experience survey now in its fourth year. The results give us valuable insights about the graduate experience of joining the National Scheme as a qualified health practitioner.

## International applicants

This year, **19,288** overseas-qualified practitioners gained registration, a 92.5% increase from last year.

- We registered 4,211 international medical graduates (IMGs), a **41.1%** increase on last year.
- We registered 273 internationally qualified midwives and 11,188 internationally qualified nurses, an increase of **127.5%** and **148.1%**, respectively.
- We registered 3,616 overseas-qualified practitioners across the allied health professions, an increase of **50.3%** from last year.

## Mutual recognition for New Zealand practitioners

The *Trans-Tasman Mutual Recognition Act 1997* (TTMR Act) allows for many types of health practitioners registered in either Australia or New Zealand to apply for registration in the other country through a streamlined registration process. The objective is to remove regulatory barriers and drive workforce mobility for health practitioners who hold current practising registration in either jurisdiction.

Registration in Australia will only be granted in the same category as the practitioner's New Zealand registration. Any conditions, limitations or endorsements that apply in New Zealand may also apply to the practitioner's registration in Australia. For most TTMR matters, a final registration decision must be made within 30 days of receipt of the application.

There has been a significant increase in TTMR applications in the past 12 months. Ahpra approved 3,562 TTMR applications in 2021/22 and 9,129 in 2022/23 (Table 10). The increase is most notable for nurses, occupational therapists, medical radiation practitioners and physiotherapists.

## The Kruk review

In September, National Cabinet commissioned the *Independent review of overseas health practitioner regulatory settings* to examine the entry of overseas-trained health professionals who want to work in Australia. The review considered ways to help ease health workforce shortages while maintaining high standards in healthcare quality and patient safety. Ms Robyn Kruk AO was appointed to lead the review, which focused on five reform priorities:

- improve the experience of applicants seeking to come to Australia to work as registered health professionals
- expand 'fast track' registration pathways for those health professionals with comparable qualifications and skills to Australian requirements
- improve workforce planning for the Australian health system
- increase flexibility in regulation while supporting safety
- enhance regulator performance and stewardship.

**Table 10. New practitioners registered under the TTMR Act**

Profession <sup>2</sup>	2020/21		2021/22		2022/23	
	Number registered <sup>1</sup>	% change 2019/20–2020/21	Number registered <sup>1</sup>	% change 2020/21–2021/22	Number registered <sup>1</sup>	% change 2021/22–2022/23
Chiropractor	20	-9.1%	14	-30.0%	31	121.4%
Dental practitioner	79	17.9%	70	-11.4%	92	31.4%
Medical radiation practitioner	22	-50.0%	35	59.1%	85	142.9%
Midwife	15	-55.9%	54	260.0%	85	57.4%
Nurse	1,268	-23.5%	2,968	134.1%	7,848	164.4%
Occupational therapist	48	-37.7%	113	135.4%	243	115.0%
Optometrist	6	50.0%	6	0.0%	11	83.3%
Osteopath	4	-20.0%	3	-25.0%	4	33.3%
Paramedic <sup>3</sup>			19		60	215.8%
Pharmacist	17	-60.5%	41	141.2%	73	78.0%
Physiotherapist	107	-32.3%	186	73.8%	540	190.3%
Podiatrist	9	-25.0%	12	33.3%	21	75.0%
Psychologist	38	-32.1%	41	7.9%	36	-12.2%
<b>Total</b>	<b>1,633</b>	<b>-25.1%</b>	<b>3,562</b>	<b>118.1%</b>	<b>9,129</b>	<b>156.3%</b>

1 Includes applications finalised with an outcome of registered or registered with conditions.

2 Aboriginal and Torres Strait Islander Health Practitioners, Chinese medicine practitioners and medical practitioners are not subject to the TTMR Act.

3 Paramedicine entered the National Scheme on 1 December 2018. The first applications under the TTMR Act were finalised in 2021/22.

In April, Ms Kruk released an interim report containing 56 recommendations across these five reform priorities. Ahpra and the National Boards have a significant program of work to improve the recognition of qualifications and assessment of skills for overseas-qualified practitioners, including:

- developing our Business Transformation Program, which will create a better experience for applicants seeking registration in Australia
- increasing our staffing to improve the timeframe for assessment of applications
- working towards new fast-track pathways for comparable practitioners in priority professions
- significantly boosting examination capacity for internationally qualified nurses and midwives who need structured assessment of their knowledge and skills for registration.

Ms Kruk is expected to hand down her final report in late 2023.

## Comprehensive guide for international practitioners

Ahpra launched a new webpage to provide clear information to international applicants. A flyer was also developed which outlines what international practitioners must do before they can start practising in Australia. This includes advice on:

- visa applications
- certificates (good standing or registration status)
- assessment of qualifications
- applying for registration as a health practitioner
- how to get a provider or prescriber number.

## Accelerated assessments

We implemented a new approach to assessing applications, which involves an initial risk assessment and more senior staff assessing applications at their earliest stage to reduce delays. This immediately improved the time it takes to make first contact with an applicant and reduced the average timeframe to assess applications from 29 days to 10 days.

## Supporting employers

We continue to work with jurisdictions and provide advice on improving the complex registration processes for overseas-qualified practitioners, including IMG pathways to registration and the internationally qualified nurse and midwife (IQNM) qualification assessment process. This supports employers who are seeking overseas-qualified practitioners to ease pressure on stretched local health services.

Ahpra delivered five virtual education sessions to employers and stakeholders who work with international applicants in every state and territory. The objective of the sessions was to increase understanding of complex IMG and IQNM registration processes. These sessions received very positive feedback from employers and resulted in more complete and accurate applications being submitted. This in turn reduced the time taken to finalise applications and improved the overall experience for applicants and employers.

## Some applicants sit an exam

### Internationally qualified nurses and midwives

IQNMs who wish to apply for registration in Australia are required to complete an online assessment of their qualifications. Those who hold qualifications that are substantially equivalent or based on similar competencies to an Australian graduate (and who meet the mandatory registration standards) progress to an application for registration.

IQNMs who hold relevant but not equivalent qualifications must successfully complete an outcomes-based assessment before being eligible to apply. These IQNMs complete two exams:

- a multiple-choice question (MCQ) examination (knowledge test)
- an objective structured clinical examination (OSCE) (behavioural test).

The MCQ examinations are:

- Enrolled nurse – a paper-based exam coordinated by Ahpra and conducted at our offices around Australia. Two exams (including re-sits) were conducted this year.
- Registered nurse – the online National Council of State Boards of Nursing (NCSBN) National Council Licensure Examination – Registered Nurse (NCLEX-RN) conducted at Pearson VUE testing centres in more than 20 countries, including Australia. This year, 8,077 exams (including re-sits) were conducted, a large increase from 3,390 last year.
- Midwife – an online exam conducted at Aspeq-managed facilities in Australia, New Zealand and internationally. There were 31 exams (including re-sits) this year.

This year, 1,489 internationally qualified registered nurses participated in the registered nurse OSCE. The midwife OSCE was held three times throughout the year.

### Pharmacy, psychology, medical radiation practice and Chinese medicine exams

Ahpra coordinated the following exams:

- 1,945 pharmacy interns were assessed in the oral examination (practice) in October, February and June. All these exams used a hybrid online and face-to-face model.
- 89 oral exams were held for pharmacy practitioners holding limited or general registration with conditions on their registration that required the completion of an examination in practice, or in law and ethics. These exams were offered monthly.
- 1,569 candidates sat the quarterly national psychology examination. Candidates could choose to sit the exam in a test centre (where available) or by online supervision.
- 83 candidates sat the quarterly national medical radiation practice examination. These exams were also offered in a test centre or online.
- 26 candidates sat the scenario-based multiple-choice exam for Chinese medicine. Again, candidates could choose to sit the exam in a test centre (where available) or by online supervision. The OSCE for Chinese medicine was not held in 2022/23.

# Renewals

Ahpra renewed registration for **800,943** health practitioners. This is an increase of 4.7% from last year.

Each year when they renew, practitioners must confirm they continue to meet their National Board's mandatory registration standards. They must also let us know if there's been any change to their criminal history or any health impairment that may negatively affect their ability to safely practise. This year we revised communications to practitioners about what they need to tell us at renewal, which reduced the number of unnecessary disclosures.

This year, health practitioners across all professions were expected to fully meet their continuing professional development requirements – some expectations had been reduced or paused during the first years of the COVID-19 pandemic. Practitioners who hadn't met the requirements had to let us know.

We continued to transition all renewals to online, phasing out hard-copy forms. To accommodate practitioners who were unable to access the online platform for renewal, a verbal submission process was implemented. Only 11 health practitioners accessed this service, and all successfully finalised their application for renewal.



## Responding to extraordinary circumstance

From time to time, we are challenged to respond quickly and decisively to ensure positive health outcomes.

### Critical timing for specialist plastic surgery

We registered a specialist plastic surgeon under urgent circumstances this year, which resulted in positive health outcomes for his patients. A children's hospital called to advise that a specialist surgeon needed to be registered so he could treat 30 children who required his expertise. Eight of the children needed operations for craniofacial deformities that had to be precisely timed with their developmental requirements, so registering the surgeon in a timely manner was crucial.

Our team worked out of hours to ensure the right information reached the Medical Board of Australia delegate committee at short notice, liaised within Ahpra to ensure the importance of the situation was understood and the case given priority, and ensured the *Register of practitioners* was updated without delay.

The team's quick work meant the specialist plastic surgeon was registered in time to start reviewing cases and operating within a week, in time for the first scheduled surgery.

### Our part in Australia's first-ever uterine transplant operation

In late 2022 our international registration team was delighted to play a part in enabling Australia's first-ever uterine transplant operation.

The surgery was part of a research trial at the Royal Hospital for Women in Sydney.

After receiving several limited registration applications for the specialists from Sweden on 13 December, our team worked throughout the Christmas period to prepare papers and liaise with the MBA delegate committee, to finalise registration in time for the operation on 10 January.

The life-changing surgery was a success, and a thank you letter from hospital staff confirmed it could not have happened without the efforts of our dedicated regulatory officers.

It was an outstanding achievement for all involved and our team was proud to help this landmark surgery occur in Australia.



# Aboriginal and Torres Strait Islander Peoples in the workforce

Aboriginal and Torres Strait Islander Peoples are under-represented in our health workforce. Increasing participation in the registered health workforce is a goal of our Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy. For more about the work we are doing to improve participation, see page 99.

Ahpra and the National Boards ask about Aboriginal and/or Torres Strait Islander cultural identity in application and renewal processes. This enables us to understand workforce trends and the proportion of registered health practitioners who identify as Aboriginal and/or Torres Strait Islander.

At 30 June:

- Aboriginal and/or Torres Strait Islander Peoples' participation in the regulated health professions was **1.2%**.
- This is well short of the **3.8%** Aboriginal and Torres Strait Islander representation in the general population.
- **100%** of Aboriginal and Torres Strait Islander Health Practitioners are Aboriginal and/or Torres Strait Islander. It is a requirement for registration in that profession.
- Midwifery (including dual-registered midwives and nurses) had the second-highest representation with **2.3%** of their workforce identifying as Aboriginal and/or Torres Strait Islander.
- Paramedicine was next with **2.0%**, followed by nursing (including dual-registered) with **1.5%**.

- During the end-of-year new-graduate registration campaign, an additional **527** health practitioners who identified as Aboriginal and/or Torres Strait Islander joined the National Scheme (across all professions).

## Engagement and support

A new Aboriginal and Torres Strait Islander Engagement and Support team was established in July to better support Aboriginal and Torres Strait Islander applicants, registrants and stakeholders to engage with Ahpra's registration processes. Supporting Aboriginal and Torres Strait Islander health practitioners (across all professions) to join the health workforce and helping them have a positive and culturally safe experience is the Engagement and Support team's core purpose.

The team initially focused on supporting Aboriginal and/or Torres Strait Islander graduates with their registration applications (especially with any issues that arose or disclosures they needed to make), before expanding the support service to the nursing and midwifery renewal campaign. The team will continue to use feedback obtained from the new graduate survey, relevant stakeholders, and directly from the applicants and registrants they support, to improve the services provided by Ahpra to Aboriginal and/or Torres Strait Islander applicants and registrants.

**Table 11. Health practitioners who identified as Aboriginal and/or Torres Strait Islander**

Profession	2021/22 <sup>1</sup>		2022/23	
	Registrants	%	Registrants	%
Aboriginal and Torres Strait Islander Health Practitioner	886	100.0%	887	100.0%
Chinese medicine practitioner	24	0.5%	21	0.4%
Chiropractor	39	0.6%	38	0.6%
Dental practitioner	144	0.6%	151	0.6%
Medical practitioner	790	0.6%	845	0.6%
Medical radiation practitioner	118	0.6%	122	0.6%
Midwife	155	2.2%	180	2.3%
Nurse	6,317	1.4%	6,759	1.5%
Nurse and midwife <sup>2</sup>	357	1.3%	362	1.4%
Occupational therapist	167	0.6%	172	0.6%
Optometrist	14	0.2%	15	0.2%
Osteopath	24	0.8%	25	0.8%
Paramedic	454	2.0%	477	2.0%
Pharmacist	116	0.3%	118	0.3%
Physiotherapist	265	0.7%	292	0.7%
Podiatrist	41	0.7%	38	0.6%
Psychologist	298	0.7%	311	0.7%
<b>Total</b>	<b>10,209</b>	<b>1.2%</b>	<b>10,813</b>	<b>1.2%</b>

Note: In previous reports, this table drew on the National Health Workforce Data Set. This year, we are using our own data about practitioners who identified as Aboriginal and/or Torres Strait Islander on application for registration or renewal of registration. Data may vary between reports due to different methodology in the two datasets.

- 1 Includes practitioners registered on the temporary sub-register created in response to the COVID-19 pandemic. The pandemic sub-register was closed on 8 June 2023 and any practitioners who remained on it were transitioned to the main Register of practitioners.
- 2 Registrants who hold dual registration as both a nurse and a midwife.

# Registered students

Students are the health practitioners of the future.

- **183,900** students were studying to be health practitioners through an approved program of study or clinical training program (Table 12).

Education providers supply student information so students can be registered.

All National Boards except the Psychology Board register students. Psychology students receive provisional registration.

The student register is not open to the public.

**Table 12. Registered students**

Students by profession <sup>1</sup>	Approved program of study <sup>2</sup> students by expected completion date	Clinical training <sup>3</sup> students by expected completion date	Total 2022/23 <sup>4,5</sup>	Total 2021/22
Aboriginal and Torres Strait Islander Health Practice	334	14	348	322
Chinese medicine	923		923	1,574
Chiropractic	2,053	202	2,255	2,103
Dental	4,855		4,855	4,613
Medical	21,275	181	21,456	20,880
Medical radiation practice	5,125	475	5,600	5,042
Midwifery <sup>6</sup>	4,068		4,068	4,006
Nursing <sup>6</sup>	99,269	635	99,904	103,550
Occupational therapy	11,756		11,756	10,566
Optometry	1,891	194	2,085	2,364
Osteopathy	1,256		1,256	1,465
Paramedicine <sup>6</sup>	7,324	123	7,447	7,915
Pharmacy	9,573	7	9,580	7,722
Physiotherapy	11,026	244	11,270	11,107
Podiatry	1,097		1,097	1,124
<b>Total 2022/23</b>	<b>181,825</b>	<b>2,075</b>	<b>183,900</b>	
<b>Total 2021/22</b>	<b>182,844</b>	<b>1,509</b>		<b>184,353</b>

- 1 The number of students reported as undertaking an approved program of study/clinical training program (accurate at 30 June and does not account for fluctuations throughout the year). This may include ongoing students or students with a completion date falling within the period. These data reflect the information received from education providers, and as such have limitations if being used as a comprehensive, comparative or planning tool.
- 2 A course that has been approved by a National Board and that leads to a qualification for registration.
- 3 Clinical training is defined as any form of clinical experience that does not form part of an approved program of study.
- 4 Due to ongoing improvements in validation and reporting processes, these data should not be objectively compared to those of previous years.
- 5 These data have been adjusted to remove duplicate students who meet the 100% match criteria, based on full name, date of birth, education provider, email address and program of study name.
- 6 To avoid double-counting, 3,165 students undertaking an approved double degree involving more than one profession (nursing/midwifery and nursing/paramedicine) have only been assigned to a single profession (nursing [1,977]/midwifery [154] and nursing [1,034]/paramedicine [0]).

**Students are the health practitioners of the future – 183,900 students were studying to be health practitioners**

# Audits

We audit practitioners to check that they comply with registration standards. Our approach to audits is designed to be educative and ensure that practitioners understand and meet the requirements of their profession's registration standards.

Auditing provides additional assurance to the public, Boards and practitioners that practitioners are meeting required standards.

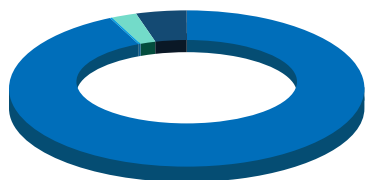
Since we began conducting audits, in 2012, the overwhelming majority of audited practitioners have been found to comply with registration standards.

In 2022/23, we did not complete as many audits as in previous years because we transferred resources to focus on assessing more applications for registration.

## Audit results

We completed **2,956** audits with a compliance rate of **95.8%** (Figure 75).

**Figure 75. Audit outcomes**



- **95.8%** compliant
- **0.1%** compliant through education
- **1.4%** non-compliant
- **2.7%** no audit action

Of the 81 (2.7%) matters with no audit action:

- 62 practitioners changed their registration type to non-practising or failed to renew their registration; usually these were practitioners residing overseas or those who were no longer practising but maintained registration
- 19 practitioners were referred to a co-regulatory jurisdiction to manage, to determine whether any further regulatory action was required.

Of the 40 (1.4%) practitioners found to be non-compliant:

- 10 matters resulted in no further regulatory action, after additional information was received that indicated there was no risk to the public
- 5 practitioners were cautioned
- 25 practitioners were referred for further investigation.

A further 928 audits were initiated but not completed. Due to the timing of these audits, we expect to complete these matters in parallel with the practitioners' next renewal application.

## How our audit process works

Audits ensure that a practitioner's disclosures at renewal are accurate. During an audit, a practitioner is required to provide evidence to support the declarations made in the previous year's renewal of registration.

The standards that may be audited are:

- continuing professional development
- recency of practice
- professional indemnity insurance arrangements
- criminal history.

When an audit finds that a practitioner has not complied with standards audited, Boards identify the risks that need to be considered. Practitioners who are found to have not quite met the registration standard but who are able to provide evidence of achieving full compliance during the audit period are managed through education to achieve full compliance. These practitioners are recorded as being 'compliant through education'.

All matters that involve issuing a caution or placing conditions on a registration are subject to a 'show cause' process. This process alerts the practitioner to the intended action and gives them an opportunity to respond before a decision is made.

**Our approach to audits is designed to be educative**

# Notifications



**Hearing from individuals or organisations with concerns about individual practitioners is an important way we monitor safety and professionalism among registered health professionals.**

The role for the National Boards, supported by Ahpra, is to decide whether, because of a single concern or a pattern of concerns, we need to restrict a practitioner's ability to practise.

When we make these decisions, we are guided by the National Boards' codes of conduct, community expectations and public safety.

## The year in summary

- We received **9,706** notifications about **7,970** health practitioners or students. This was 10.2% fewer notifications than we received last year.
- We closed **10,659** notifications. This was 3.0% more than last year.
- At 30 June, there were 5,006 open notifications, which was 16.1% fewer than last year. Of these, 585 notifications had been referred to a tribunal hearing, and 6 had been referred to a panel hearing.

## Explaining the data

In this report, we mostly report on notifications received and managed by Ahpra and the National Boards.

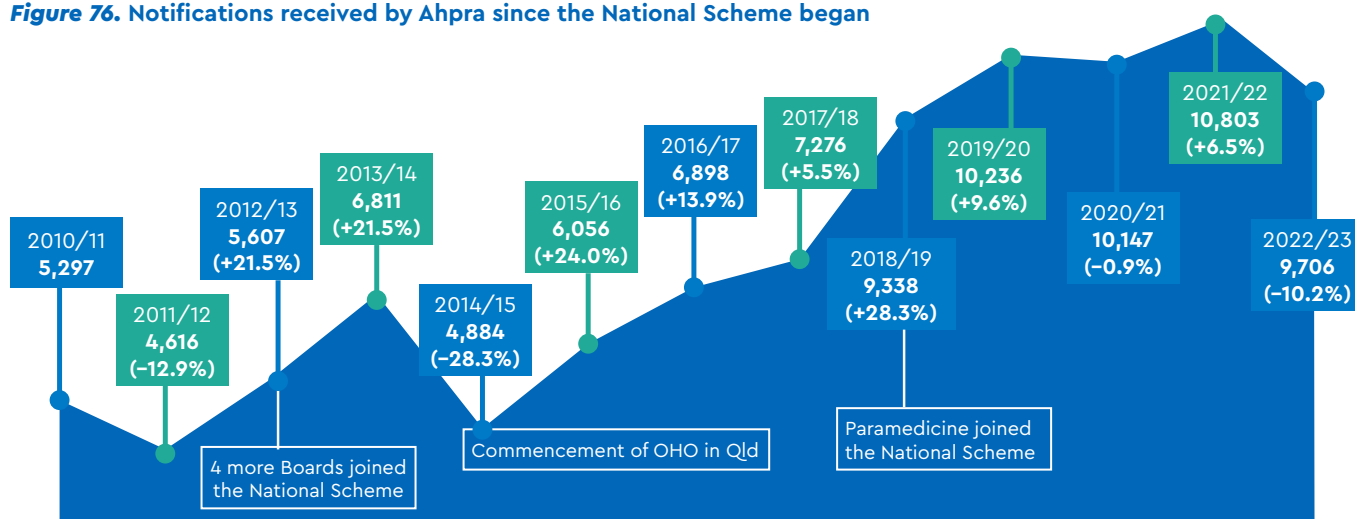
When we include data about matters received and managed by the HPCA in NSW and OHO in Queensland, they are either provided in separate columns or, if incorporated into Ahpra data, acknowledged in the table title.



**Just 1.5% of all registered health practitioners had a notification made about them**



**Figure 76. Notifications received by Ahpra since the National Scheme began**



**Table 13. Notifications received, by profession and state or territory**

Profession	Ahpra <sup>1</sup>									Ahpra subtotal	HPCA <sup>5</sup>	OHO <sup>6</sup>	Total 2022/23	Total 2021/22
	ACT	NSW <sup>2</sup>	NT	QLD <sup>3</sup>	SA	TAS	VIC	WA	No PPP <sup>4</sup>					
Aboriginal and Torres Strait Islander Health Practitioner				2				1		3	3		6	12
Chinese medicine practitioner	1			6	1		3	3		14	17	10	41	76
Chiropractor		1	1	11	14	2	28	9	1	67	45	11	123	214
Dental practitioner	11	4	10	108	73	9	269	116	10	610	355	109	1,074	1,249
Medical practitioner	171	51	68	1,236	715	189	2,235	861	89	5,615	3,078	1,245	9,938	10,873
Medical radiation practitioner		2		10	6	4	9	2	1	34	14	5	53	70
Midwife	2		7	24	8	5	23	29	1	99	49	20	168	147
Nurse	41	16	60	477	314	78	510	210	85	1,791	885	208	2,884	2,970
Occupational therapist	2	3	2	15	13		32	14	2	83	51	15	149	142
Optometrist	1			8			12	5	1	27	29	7	63	68
Osteopath	1			2	1	3	12	1		20	8	1	29	68
Paramedic	1		6	41	11	6	16	15	8	104	95	17	216	296
Pharmacist	15	1	4	77	33	14	146	46	43	379	401	50	830	1,048
Physiotherapist	7	2	1	41	19	4	44	18	4	140	61	23	224	227
Podiatrist		1		10	5	1	21	11		49	34	7	90	102
Psychologist	39	9	14	144	63	18	274	103	7	671	410	127	1,208	1,148
<b>Total 2022/23</b>	<b>292</b>	<b>90</b>	<b>173</b>	<b>2,212</b>	<b>1,276</b>	<b>333</b>	<b>3,634</b>	<b>1,444</b>	<b>252</b>	<b>9,706</b>	<b>5,535</b>	<b>1,855</b>	<b>17,096</b>	
<b>Total 2021/22</b>	<b>312</b>	<b>108</b>	<b>152</b>	<b>2,622</b>	<b>1,111</b>	<b>304</b>	<b>4,092</b>	<b>1,530</b>	<b>572</b>	<b>10,803</b>	<b>5,880</b>	<b>2,027</b>		<b>18,710</b>

- 1 Based on state or territory of the practitioner's principal place of practice (PPP).
- 2 Matters managed by Ahpra where the conduct occurred outside NSW.
- 3 Matters referred to Ahpra to manage, where the practitioner's PPP is in Queensland.
- 4 No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
- 5 Matters received and managed by the HPCA in NSW.
- 6 Matters received and managed by OHO in Queensland.
- 7 Includes matters managed by the HPCA and OHO.



**Table 14. Number of practitioners with notifications (including HPCA and OHO)**

Profession <sup>1</sup>	ACT	NSW <sup>2</sup>	NT	QLD <sup>3</sup>	SA	TAS	VIC	WA	No PPP <sup>4</sup>	Total 2022/23 <sup>5</sup>	Total 2021/22 <sup>5</sup>
Aboriginal and Torres Strait Islander Health Practitioner				2				1		3	10
Chinese medicine practitioner	1	12		13	1		3	3		33	63
Chiropractor	1	39	1	18	11	2	27	7		106	173
Dental practitioner	10	286	8	192	67	8	234	95	3	903	1,021
Medical practitioner	135	2,366	58	1,921	597	160	1,835	671	18	7,761	8,146
Medical radiation practitioner		13		14	3	3	8	2		43	57
Midwife <sup>6</sup>	2	31	7	42	6	4	19	21	3	135	131
Nurse <sup>7</sup>	44	657	49	594	276	72	471	188	14	2,365	2,357
Occupational therapist	2	41	2	30	12	1	31	13		132	117
Optometrist	1	26		12			12	5	1	57	61
Osteopath	1	8		3	1	3	12	1		29	51
Paramedic	1	68	3	53	12	5	15	15	3	175	213
Pharmacist	13	225	3	120	32	12	129	46	19	599	719
Physiotherapist	7	48	1	55	15	4	42	18	1	191	196
Podiatrist		26		13	5	1	21	5		71	89
Psychologist	31	336	9	215	49	16	231	92	2	981	909
<b>Total 2022/23</b>	<b>249</b>	<b>4,182</b>	<b>141</b>	<b>3,297</b>	<b>1,087</b>	<b>291</b>	<b>3,090</b>	<b>1,183</b>	<b>64</b>	<b>13,584</b>	
<b>Total 2021/22</b>	<b>237</b>	<b>4,460</b>	<b>131</b>	<b>3,641</b>	<b>963</b>	<b>260</b>	<b>3,239</b>	<b>1,254</b>	<b>128</b>		<b>14,313</b>

1 Data for each profession are for registrants whose profession has been identified.

2 Matters managed by the HPCA, and notifications managed by Ahpra about a practitioner with a principal place of practice (PPP) in NSW.

3 Matters managed by OHO, and matters referred to Ahpra to manage, where the practitioner's PPP is in Queensland.

4 No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.

5 Includes practitioners with notifications managed by the HPCA and OHO.

6 Registrants with midwifery registration or with dual nursing and midwifery registration.

7 Registrants with nursing registration or with dual nursing and midwifery registration.

**Table 15. Percentage of all registered health practitioners with notifications (including HPCA and OHO)**

Profession <sup>1</sup>	ACT	NSW <sup>2</sup>	NT	QLD <sup>3</sup>	SA	TAS	VIC	WA	No PPP <sup>4</sup>	Total 2022/23	Total 2021/22 <sup>5</sup>
Aboriginal and Torres Strait Islander Health Practitioner				1.2%				0.6%		0.3%	1.1%
Chinese medicine practitioner	1.6%	0.6%		1.5%	0.5%		0.2%	1.1%		0.7%	1.3%
Chiropractor	1.4%	1.9%	4.0%	1.7%	2.9%	2.9%	1.7%	0.8%		1.7%	2.8%
Dental practitioner	2.0%	3.7%	4.7%	3.5%	3.1%	1.9%	3.6%	3.1%	0.4%	3.4%	3.9%
Medical practitioner	5.2%	5.9%	3.7%	6.9%	6.3%	5.2%	5.3%	4.7%	0.6%	5.7%	6.2%
Medical radiation practitioner		0.2%		0.4%	0.2%	0.8%	0.2%	0.1%		0.2%	0.3%
Midwife <sup>6</sup>	0.3%	0.3%	1.2%	0.6%	0.2%	0.6%	0.2%	0.6%	0.6%	0.4%	0.4%
Nurse <sup>7</sup>	0.6%	0.5%	1.0%	0.6%	0.7%	0.6%	0.4%	0.4%	0.1%	0.5%	0.5%
Occupational therapist	0.4%	0.5%	0.8%	0.5%	0.5%	0.2%	0.4%	0.3%		0.4%	0.4%
Optometrist	0.8%	1.2%		0.9%			0.7%	0.9%	0.7%	0.8%	0.9%
Osteopath	2.2%	1.2%		0.9%	2.1%	5.6%	0.6%	1.3%		0.9%	1.6%
Paramedic	0.3%	1.1%	1.2%	0.9%	0.8%	0.7%	0.2%	0.9%	0.9%	0.7%	0.9%
Pharmacist	1.7%	2.1%	1.1%	1.7%	1.2%	1.3%	1.4%	1.2%	3.2%	1.6%	2.0%
Physiotherapist	0.8%	0.4%	0.4%	0.7%	0.5%	0.6%	0.4%	0.4%	0.1%	0.5%	0.5%
Podiatrist		1.5%		1.2%	0.9%	0.8%	1.1%	0.9%		1.2%	1.5%
Psychologist	2.6%	2.3%	3.1%	2.5%	2.2%	1.9%	1.8%	1.9%	0.3%	2.1%	2.0%
<b>Total 2022/23</b>	<b>1.6%</b>	<b>1.7%</b>	<b>1.6%</b>	<b>1.8%</b>	<b>1.6%</b>	<b>1.5%</b>	<b>1.3%</b>	<b>1.3%</b>	<b>0.2%</b>	<b>1.5%</b>	
<b>Total 2021/22</b>	<b>1.5%</b>	<b>1.9%</b>	<b>1.5%</b>	<b>2.1%</b>	<b>1.5%</b>	<b>1.4%</b>	<b>1.5%</b>	<b>1.5%</b>	<b>0.6%</b>		<b>1.7%</b>

1 Data for each profession are for registrants whose profession has been identified.

2 Matters managed by the HPCA, and notifications managed by Ahpra about a practitioner with a principal place of practice (PPP) in NSW.

3 Matters managed by OHO, and matters referred to Ahpra to manage, where the practitioner's PPP is in Queensland.

4 No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.

5 Includes registrants on the temporary sub-register created in response to the COVID-19 pandemic. The pandemic sub-register was closed on 8 June 2023 and any practitioners who remained on it were transitioned to the main Register of practitioners.

6 Registrants with midwifery registration or with dual nursing and midwifery registration.

7 Registrants with nursing registration or with dual nursing and midwifery registration.

## Who makes notifications?

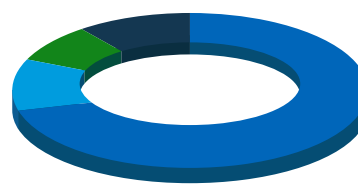
Figure 77 shows the sources of notifications.

We received most notifications (**71.0%**) from patients, their families and friends, and other members of the public; this is similar to last year (**71.1%**). We received some notifications (**18.5%**) from health practitioners and employers.

In previous reports, we have shown notifications referred to us from health complaints entities as a separate category. However, as these complaints are typically made by patients, we have revised the categories in this overview to remove health complaints entities as a source of notifications.

We received 1,808 confidential and anonymous notifications. Confidential notifications are when we know the identity of the notifier and are asked not to disclose it. Anonymous notifications are when we don't know the identity of the notifier.

**Figure 77. Who makes notifications?**



- Patient, relative or member of the public **71.0%**
- Other practitioner **10.7%**
- Employer **7.8%**
- Other **10.4%**

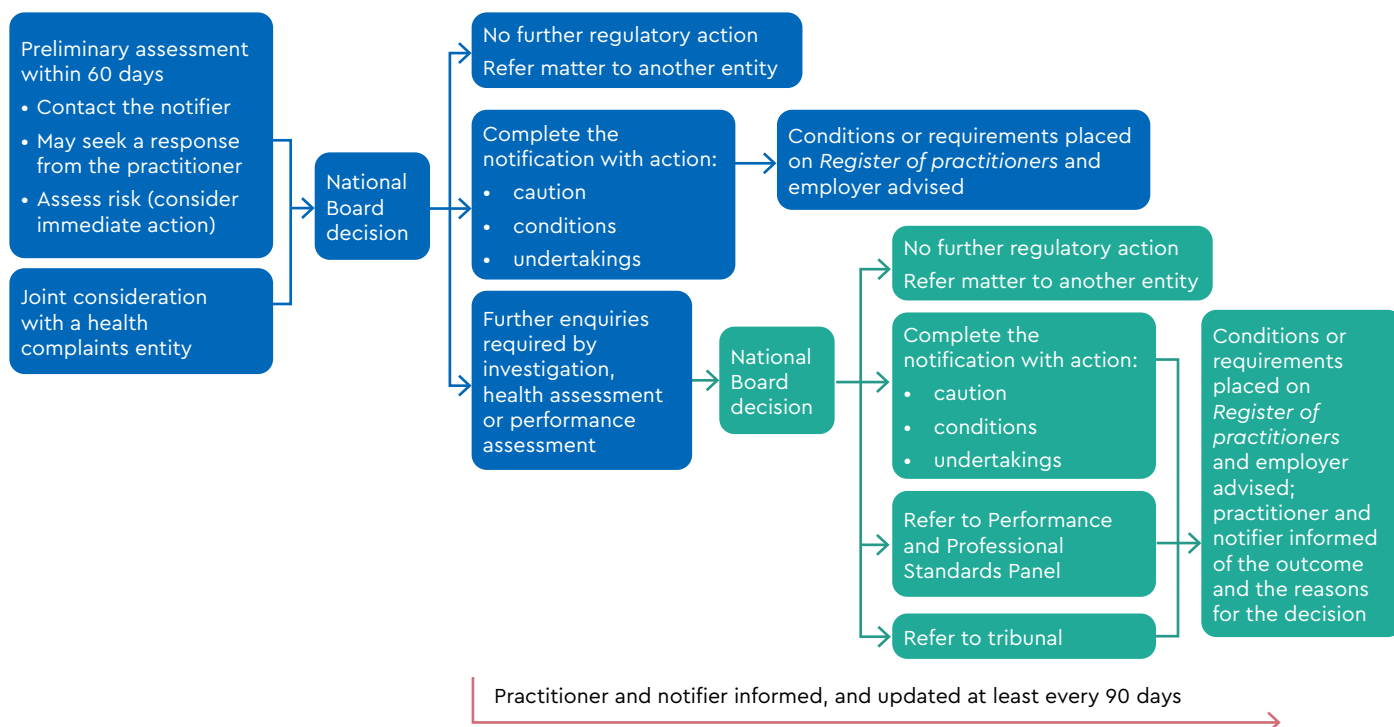
## Managing concerns received

A notification can be about more than one concern. During the year, **66.3%** of notifications we received were about a single concern, **24.1%** were about two concerns, and **9.6%** were about three or more concerns (see Table 16).

**Table 16. The number of concerns raised**

Number of concerns	Number of notifications
1	6,438
2	2,340
3-4	816
5-7	106
8-9	6

**Figure 78. The notifications process**



**Table 17. The five most common concerns raised**

Concern category (and specific issue) <sup>1</sup>	Number of times raised	% of all concerns raised
<b>Clinical care</b>	<b>5,419</b>	<b>37.8%</b>
Inadequate or inappropriate treatment	1,961	13.7%
Other clinical care issue	515	3.6%
Inadequate or inappropriate procedure	494	3.4%
Inadequate or inappropriate history or examination	433	3.0%
Missed, incorrect or delayed diagnosis	431	3.0%
Inadequate or inappropriate follow-up or review	323	2.3%
Refusal to assist or attend or admit	309	2.2%
Delayed or inadequate or inappropriate referral	218	1.5%
Inadequate or inappropriate testing or investigation	201	1.4%
Inadequate or inappropriate monitoring	161	1.1%
Inappropriate delay in care	105	0.7%
Inappropriate discharge or transfer	68	0.5%
Cosmetic surgery	64	0.4%
Unnecessary treatment/over-servicing	55	0.4%
Cosmetic procedure or treatment	52	0.4%
Failure to ensure physical privacy	20	0.1%
Inappropriate admission	9	0.1%
<b>Communication</b>	<b>1,812</b>	<b>12.6%</b>
<b>Pharmacy/medication</b>	<b>1,558</b>	<b>10.9%</b>
<b>Documentation</b>	<b>755</b>	<b>5.3%</b>
<b>Behaviour</b>	<b>740</b>	<b>5.2%</b>

1 Either as a single concern or one of multiple concerns received in a notification.

Clinical care was the most common type of concern received, specifically inadequate or inappropriate treatment (see Table 17).

The National Law sets out specific grounds on which a notification can be made. Notifications can be made where:

- a practitioner's behaviour is placing the public at risk
- a practitioner is practising their profession in an unsafe way
- a practitioner's ability to make safe judgements about their patients might be impaired because of their health.

Not all concerns raised with us are about individuals we register or about things that can be dealt with by a National Board. When concerns are raised with us that we can't help with, we direct the notifier to alternative sources of support where appropriate.

## Case study: Not a ground for a notification

A notifier reported that they were contracted by a company, the director of which was a psychologist.

The notifier claimed to be out of pocket for a tender that they provided to the company. The company did not accept the tender but instead accepted a cheaper proposal from another tenderer.

We considered that the issue was a commercial dispute between the notifier and the company. Although the notifier identified the psychologist as a director of the company, it was the corporate entity that the notifier had been dealing with.

We determined the complaint was not about a person registered in the scheme and was therefore not a ground for a notification.

We directed the notifier to a complaints resolution body that may be able to assist with their concern.

## A case-management approach

The way we manage concerns once we accept them continues to evolve. This year, we made some significant changes to improve our processes.

Instead of having one team assess each notification and hand it to another team to *investigate*, our revised approach is to allocate a single case manager to each notification for its whole life cycle.

To accomplish these changes, we looked closely at the sorts of notifications that we receive and how they could best be dealt with. We allocate notifications based on a combination of:

- risk assessment
- which powers or processes might be best suited to gathering the required information
- the likelihood that regulatory action might be needed.

## Early determination

An early determination team manages the notifications that we judge to be low risk to the public, based on the notification and on an overall risk assessment of the practitioner. Where appropriate, we consider making a decision to take no action in response to the notification.

For notifications that are raised by consumers, we consider whether it is appropriate to refer the notification to a health complaints entity (HCE). There are HCEs in every state and territory of Australia. They are vital partners in ensuring that consumer complaints about health services are resolved.

HCEs share every complaint they receive about a registered health practitioner with Ahpra. Ahpra shares any complaint that could also have an aspect that Ahpra can't address, such as helping the consumer get an apology or a refund. For every complaint that is shared, Ahpra and the HCE decide which is the most appropriate body to deal with the complaint.

A total of 2,395 concerns were retained by, or referred to, an HCE during the year. This represents 22.5% of all the notifications we completed. It is slightly fewer than were retained by or referred to an HCE in the previous year.

## Case study: Referral to an HCE

A patient had a filling placed by a dentist but a few weeks later the filling fell out. The patient paid to have the filling replaced by another dentist.

The patient complained to us that the original filling had failed, that they needed an appointment with another dentist, and that they were out of pocket.

The original dentist had been practising as a dentist for more than 20 years without being the subject of any previous notifications. They worked in a medium-size suburban dental practice with other dentists.

No concerns were raised by the second practitioner, or by our clinical advisor, that the work performed by the first dentist was inappropriate. There is an inherent risk of fillings falling out, fracturing, or failing in some other way. This risk may vary depending on the material used, where it is placed, the condition of the tooth beforehand or several other factors that may not relate to the knowledge, skill or competency of the practitioner.

The patient had been invited by the original dentist to return to the practice if there were any issues with the filling, which they decided not to do. We referred the complaint to the health complaints entity in the state where the care was provided. They secured a refund and an explanation for the patient.

## Case study: No further regulatory action needed

A patient attended an appointment with a physiotherapist after suffering a fall and experiencing significant pain and swelling of their ankle.

At the initial examination, the physiotherapist recommended that the patient have their ankle X-rayed to rule out a bone fracture before undertaking any manual therapy. The physiotherapist suggested the patient return for treatment once a fracture was ruled out.

The patient made a notification after the X-ray confirmed no fracture, because they believe that the failure to provide treatment prolonged their pain.

The physiotherapist works at a group physiotherapy practice and had been registered for eight years without any previous notifications.

Our clinical advisors confirmed that it was reasonable for the physiotherapist to want to rule out a fracture before providing manual treatment, despite this prolonging the patient's pain.

The Physiotherapy Board of Australia decided no regulatory action was required in response to the concerns.

## Strengthening practice

A strengthening practice team manages notifications where we consider there to be some risk to the public based on the notification and following an overall risk assessment of the practitioner. Around half of the notifications we accepted were referred to the strengthening practice team.

This team focuses on outcomes that result in a practitioner improving their practice. It ensures there are sufficient individual, organisational or regulatory risk controls in place to be confident the practitioner is acting safely and professionally.

When our assessment is that the risk is lower, we rely more heavily on protective factors that are implemented by a practitioner or their workplace.

As the risk level increases, the amount and type of information that we seek also increases, to ensure the right safeguards are in place for us to be confident that the practitioner is practising safely and professionally (see Figure 79).

**Figure 79. Assessing and controlling levels of risk**



### Case discussions

Our approach to strengthening practice champions non-adversarial, personal engagement between notification staff, our clinical advisors and the practitioners who are the subject of a notification. We use case discussions with greater frequency to prevent drawn-out written processes, which practitioners have reported were overly bureaucratic.

Case discussions give us, the practitioner and the practitioner's advisors or supporters a chance to discuss the concerns in a reflective and open way. They are an opportunity to consider safety issues that arise from the concerns, and understand how they are being, or could be, addressed.

### Case study: Strengthening practice approaches for moderate-risk concerns

A nurse unit manager of a busy emergency department made a mandatory notification about the performance of a registered nurse. The nurse unit manager reported that the nurse had failed to follow hospital protocol when triaging a patient. The patient's health had deteriorated while they were waiting for care and should have been assessed as a more urgent case.

The nurse was a relatively junior member of the nursing team and had only worked at the hospital for a month before the incident.

The nurse had participated in a review of the case with the hospital, had undertaken further education about the hospital's triage, assessment and escalation processes, and had accepted a warning from the owner of the hospital.

The nurse shared the information provided by the workplace along with details of continuing professional development they had undertaken to ensure safer practice in future. They also participated in a case discussion where they shared their reflections of the incident, and the impact it had had on their ongoing practice.

The Nursing and Midwifery Board of Australia was satisfied that the individual and workplace risk controls that had been implemented ensured the nurse's practice would be stronger in future, and so they decided to take no further regulatory action.



**We use case discussions with greater frequency to prevent drawn-out written processes, which practitioners have reported were overly bureaucratic**





## Case study: Strengthening practice approaches for more serious concerns

We received a notification about a practitioner's prescribing of opiates and benzodiazepines. The notifier, another regulator, identified multiple instances of prescribing that raised concerns about:

- managing requests for drugs of dependence from drug-dependent or dependence-developing patients
- maintaining appropriate boundaries and expectations when dealing with requests for drugs of dependence
- the adequacy of clinical records.

The medical practitioner had been the subject of three prior notifications made by relatives of patients concerned about prescribing.

Several patients had suffered harm from the prescribing and the Medical Board of Australia imposed immediate conditions on the practitioner's registration preventing them from prescribing certain medication while further information was sought.

We sought information from relevant drug and poison regulators, the practitioner's workplace, and the records for the patients identified in the notification.

We met with the medical practitioner for a case discussion.

During the case discussion, the medical practitioner acknowledged facing several problems in their work environment. They discussed steps taken, including:

- moving to a group practice, with greater administrative and collegial support
- completing education to improve their understanding of prescription monitoring, pain management and opioid dependency
- attending multidisciplinary meetings at a tertiary hospital where opportunities to discuss cases with colleagues were provided
- documenting referral pathways for patients with special needs to be jointly cared for by addiction medicine specialists.

Because of the seriousness and repetitive nature of the unsafe prescribing that was observed, the Board accepted an undertaking from the practitioner for ongoing mentoring, peer support and education. It also imposed a condition requiring quarterly auditing of prescribing practices over a 12-month period to ensure ongoing safety.

With an undertaking and condition in place, the Board then removed the restrictions on prescribing.

## Health management

If a practitioner has a health issue that does not adversely affect their ability to practise their profession, then a concern raised about their health can be closed quickly, with no need for action.

When the health issue could adversely affect a practitioner's ability to practise safely, we have a role. A health management team manages these concerns.

We adopt the following principles when we respond to concerns about a health impairment:

- We provide continuity of case management in a timely and efficient manner, and we keep the practitioner experience at the centre of our case management.
- Where possible we individualise our case management to the circumstances of the practitioner.
- We endeavour to keep the practitioner engaged in practice, at the level they choose, as long as it is safe to do so.
- We ensure that regulatory action recommendations are proportionate to the risk posed, aligned with the regulatory principles that underpin the work of the National Boards, and provide consistency in decision-making.

We publish information about the changes we have made when dealing with impaired practitioners on our website.

We continued to implement changes consistent with recommendations made by the Expert Advisory Group (EAG) on minimising practitioner distress for practitioners involved in our regulatory processes. For more information about the EAG, see page 96.

Practitioners with impairments can be some of the most vulnerable individuals we engage with. A lengthy investigation is generally not required where an impaired practitioner has shown good insight into their impairment. Where there is evidence of an impairment, and it is well managed by a practitioner and their treating team, National Boards generally do not need to act.

We reviewed the use of immediate action powers in response to impairment. Instead, we prioritise actions like greater use of undertakings and supportive conditions on registration. Undertakings and conditions are actively monitored.

The improvements we are making have had a significant impact on timeframes for health cases. For example, during the year, 50% of high-risk health concerns were completed within three months, compared to 11% before the introduction of our dedicated health team. For more information about this team, see page 97.

## Case study: Managing a practitioner with a health concern

A doctor working in an acute mental health facility made a notification advising that they were caring for a medical radiation practitioner. The medical radiation practitioner had a health condition, severe anxiety and depression, requiring hospital admission as a voluntary patient, and a sustained period of treatment, including electroconvulsive therapy.

When we spoke with the medical radiation practitioner, they acknowledged a treatment-resistant, long-standing depression.

The medical radiation practitioner advised they were on a period of extended leave from work and that their employer was aware of their admission to hospital. They gave consent for Ahpra to speak with the treating practitioners and their employers.

All treating practitioners reported that the practitioner displayed a strong willingness to seek help when their health deteriorated. They agreed there was no suggestion that the practitioner had practised with impaired judgement.

The practitioner's employer provided reassurance that they were satisfied with the practitioner's performance before this period of leave. They were supportive of a graduated return to practice. They also advised that the practitioner worked within a group-practice setting, where there were considerable opportunities for health and wellbeing checks, as well as case reviews and sharing of patients.

The Medical Radiation Practice Board of Australia was satisfied that individual and organisational risk controls were sufficient to manage any future deterioration in the practitioner's mental health.

The case was closed without any regulatory action by the Board.

## Professional standards

When the behaviour of a practitioner may be substantially below the standard expected by the public or their peers, either because of a one-off incident or a pattern of incidents, National Boards investigate and refer the behaviour to *responsible tribunals* across the country. The professional standards team manages these notifications.

A National Board *must* refer a practitioner to a tribunal if they form a reasonable belief the practitioner has behaved in a way that constitutes *professional misconduct*.

Professional misconduct includes conduct that is substantially below the standard reasonably expected of the practitioner's peers, and conduct that is inconsistent with the practitioner being a fit and proper person to hold registration.

This year, there was a 7.9% increase in the number of practitioners referred to a tribunal by a National Board.

The changes we made to improve our approaches to notification management include a significant focus on cases that may involve professional misconduct by a practitioner. Changes that make the notification process less onerous for most notification types have enabled us to ensure:

- greater investment in managing the most serious concerns we receive
- lower caseloads for investigators managing potential misconduct
- better support for victims and witnesses of professional misconduct.

Over time, these commitments are intended to speed up investigation timeframes to ensure more timely referral of misconduct to tribunals as part of improved regulatory responsiveness to serious concerns.

## Case study: Investigations into serious conduct concerns

A pharmacist raised concerns that a nurse had presented handwritten prescriptions for significant quantities of Schedule 8 medication. The pharmacist was worried that the prescriptions had not been written by the medical practitioner whose prescriber number was used.

We investigated and determined that the nurse had misappropriated prescriptions belonging to a medical practitioner at their place of work. They had presented several of the stolen scripts at pharmacies to obtain medication unlawfully.

In collaboration with the workplace, the police and medicine regulators in the state, we established that the nurse had been obtaining drugs of addiction for unlawful sale to others. They were subsequently charged by the police and medicines regulator with a range of offences.

The Nursing and Midwifery Board of Australia suspended the nurse and referred their behaviour to a tribunal, where it will allege their behaviour constitutes professional misconduct.

## Improved sexual misconduct processes

In February, we launched a blueprint to strengthen public safety in healthcare, with a strong focus on improving our handling of sexual misconduct matters. This work aims to raise the bar for patient safety and increase transparency and support for victim/survivors.

The blueprint is in part a response to the growth in complaints about sexual misconduct and other boundary violations by health practitioners.

Table 18 shows that we received 841 complaints about boundary violations (relating to 728 registered health practitioners), which is almost twice as many as we received three years ago. The types of complaints include inappropriate or sexualised remarks, intimate touching of a patient without consent, personal relationships where there is an imbalance of power, and aggressive sexual offending, including criminal behaviour.

Highlights of our work on the blueprint included:

- starting a public review of the criminal history registration standard that applies to all health practitioners, particularly to examine how the standard is applied to sexual misconduct offences
- adding another 10 full-time staff to our specialist investigation team
- progressing our work to implement a culturally safe notifications program for Aboriginal and Torres Strait Islander Peoples
- making our social-worker-led Notifier Support Service permanent and increasing its staffing
- working towards a clear statement of commitments for those people who have been harmed by practitioners
- examining options to increase the voice of the community in decision-making about practitioner misconduct.

Importantly, we also asked health ministers to consider changes to the National Law on two matters of patient safety. The first would allow Ahpra and the National Boards to publish more information on the *Register of practitioners* about practitioners with a history of professional misconduct in sexual boundary cases. The second would require tribunals to decide (in an open hearing) if practitioners who have had their registration cancelled can apply for re-registration. These changes are under active consideration by health ministers.

## Special Issues Committee

The Medical Board's National Special Issues Committee (Sexual boundaries and family violence) is made up of practitioner and community members and chaired by community member Ms Christine Gee AM. The committee has been making decisions about sexual boundary cases since 2017, a period in which Ms Gee has seen changes in the way sexual misconduct is viewed.

'It is so encouraging to see more patients reaching out each year to tell us about their experiences, as difficult as it is for them to share their stories. The committee has zero tolerance for sexual misconduct, and we will recommend immediate action to place strict conditions or temporarily suspend a practitioner if we're concerned about risk to the public while we investigate.'

**Table 18. Notifications received about boundary violations**

Profession	ACT	NSW <sup>1</sup>	NT	QLD <sup>2</sup>	SA	TAS	VIC	WA	No PPP <sup>3</sup>	Total 2022/23	Total 2021/22
Aboriginal and Torres Strait Islander Health Practitioner								1		1	0
Chinese medicine practitioner	1			1			1			3	6
Chiropractor				1	6		6	3		16	16
Dental practitioner		1			4		10	10		25	47
Medical practitioner	8	11	5	60	49	20	142	62	4	361	397
Medical radiation practitioner		1				2	1	1		5	6
Midwife				1				2	1	4	3
Nurse	3	1	7	36	33	5	76	44	10	215	237
Occupational therapist				1	2		3	1		7	9
Optometrist										0	1
Osteopath					1	1	3			5	9
Paramedicine				8	1	2	2	5	1	19	20
Pharmacist	1			2	2	1	10	2	2	20	27
Physiotherapist	1			1	13		15	3		33	23
Podiatrist				2	1		2	1		6	5
Psychologist	4	3	5	30	12	1	52	13	1	121	119
<b>Total 2022/23</b>	<b>18</b>	<b>17</b>	<b>17</b>	<b>143</b>	<b>124</b>	<b>32</b>	<b>323</b>	<b>148</b>	<b>19</b>	<b>841</b>	
<b>Total 2021/22</b>	<b>31</b>	<b>6</b>	<b>23</b>	<b>164</b>	<b>93</b>	<b>43</b>	<b>358</b>	<b>158</b>	<b>49</b>		<b>925</b>

1 Matters managed by Ahpra where the conduct occurred outside NSW.

2 Matters managed by OHO, and matters referred to Ahpra to manage, where the practitioner's principal place of practice is in Queensland.

3 No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.

## Case study: Managing sexual boundary concerns

We received concerns that a medical practitioner carried out inappropriate clinical examinations of patients. Specifically, examinations were undertaken on female anatomical regions not connected with the health issues patients were consulting the practitioner for. The practitioner was suspended under immediate action powers.

We worked closely to support the patients to ensure the Medical Board of Australia and state police could obtain evidence of the examinations.

We obtained expert advice that indicated there was no reasonable clinical justification for the examinations.

Although the police formed the opinion that there was insufficient evidence to prosecute the practitioner to a criminal standard, the Board referred the practitioner to a tribunal, where it will allege the practitioner's behaviour constitutes professional misconduct.

trauma-informed approach, our social workers work in partnership with our regulatory and legal advisors to help respond to the emotional impact experienced by notifiers.

The service received 129 referrals. The majority (72%) of victim/survivors who were referred accepted the offer of support. We increased the support for notifiers, including attendance at tribunal hearings when they are giving evidence. Evaluation of the service is progressing, and feedback received from participants continues to show that the support offered is appreciated.

## Mandatory notifications

In certain circumstances, practitioners and employers must tell us if they think another practitioner's conduct, performance or health places their patients at risk.

Data about mandatory notifications are presented in Table 19. Mandatory notifications made up 10.4% of notifications received.

We received 1,011 mandatory notifications, 2.1% fewer than last year.

- 50.6% (512) were about nurses.
- 30.2% (305) were about medical practitioners.

Most mandatory notifications related to impairment (46.8%), followed by departure from professional standards (34.9%), sexual misconduct (10.6%) and intoxication (7.7%).

## Notifier Support Service

Now in its second year, the Notifier Support Service works to support those who have experienced sexual misconduct by registered health practitioners to navigate the notifications process. Using a

**Table 19. Mandatory notifications received**

Profession	Ahpra <sup>1</sup>									Ahpra subtotal	HPCA <sup>5</sup>	OHO <sup>6</sup>	Total 2022/23	Total 2021/22 <sup>7</sup>
	ACT	NSW <sup>2</sup>	NT	QLD <sup>3</sup>	SA	TAS	VIC	WA	No PPP <sup>4</sup>					
Aboriginal and Torres Strait Islander Health Practitioner										0	1		1	1
Chinese medicine practitioner				1						1	3	1	5	4
Chiropractor					1		3	1		5	3	2	10	19
Dental practitioner		1		1	3		8	2		15	6	2	23	36
Medical practitioner	8	5	7	24	67	28	110	54	2	305	117	25	447	489
Medical radiation practitioner					4	3				7	2	1	10	10
Midwife				1	5		6	12		24	13	6	43	22
Nurse	13	6	20	65	111	30	187	75	5	512	234	44	790	634
Occupational therapist	1			1	1		3	2		8	3	1	12	12
Optometrist							2			2			2	2
Osteopath							1			1	2		3	8
Paramedic			5	3	4	1	4	2		19	23	3	45	94
Pharmacist	4		1		1	1	15	7	4	33	16	5	54	46
Physiotherapist			1		2	1	7	2	2	15	4	3	22	28
Podiatrist					1		3			4	2	1	7	8
Psychologist	4	1	4	7	4	1	30	8	1	60	50	9	119	102
<b>Total 2022/23</b>	<b>30</b>	<b>13</b>	<b>38</b>	<b>103</b>	<b>204</b>	<b>65</b>	<b>379</b>	<b>165</b>	<b>14</b>	<b>1,011</b>	<b>479</b>	<b>103</b>	<b>1,593</b>	
<b>Total 2021/22</b>	<b>29</b>	<b>13</b>	<b>42</b>	<b>158</b>	<b>140</b>	<b>58</b>	<b>371</b>	<b>194</b>	<b>28</b>	<b>1,033</b>	<b>410</b>	<b>72</b>		<b>1,515</b>

1 Based on state and territory of the practitioner's principal place of practice (PPP).

2 Matters managed by Ahpra where the conduct occurred outside NSW.

3 Matters referred to Ahpra to manage, where the practitioner's PPP is in Queensland.

4 No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.

5 Matters received and managed by the HPCA in NSW.

6 Matters received and managed by OHO in Queensland.

7 Includes matters managed by the HPCA and OHO.

## Immediate action

When we are worried that there is a serious risk to public safety, or it is otherwise in the public interest, we can take immediate action while we make further enquiries.

Table 20 shows that immediate action was taken 335 times, down 51.1% from last year. This reduction is primarily due to the changes we have made when dealing with health matters, where closer and more collaborative engagement with practitioners, their employers and their treating teams has allowed us to determine more quickly whether a practitioner is safe to practise. This often avoids the need for immediate action.

Being the subject of an immediate action by a Board can be extremely daunting. We only use our immediate action powers when:

- there is a serious risk to the public
- we believe a practitioner's registration has been improperly obtained, because they have provided misleading information when applying for registration
- the practitioner holds registration outside Australia, and that registration has been suspended or cancelled by another regulator
- there is a clear and compelling reason to suspend the practitioner's registration based on public interest reasons (including, for example, that a practitioner has been charged with or convicted of serious criminal behaviour).

**Table 20. Immediate action cases**

Profession	No immediate action taken			Action taken¹												Decision pending²			Total 2022/23			Total 2021/22		
				Suspend registration			Accept surrender of registration			Impose conditions			Accept undertaking											
	Ahpra	HPCA³	OHO⁴	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO
Aboriginal and Torres Strait Islander Health Practitioner		1	1																0	1	1	1	0	0
Chinese medicine practitioner	3			1	2														4	2	0	13	5	1
Chiropractor	11	2		1							4		1			1			14	6	0	27	4	1
Dental practitioner	4	8	1		6	1	2			1	9					2			9	23	2	34	18	0
Medical practitioner	200	25	24	61	7	3	4	11		61	57	14	22			37		6	385	100	47	677	154	26
Medical radiation practitioner	2		1	2						1									5	0	1	8	3	0
Midwife	4	6		6			2	2		2	6								14	14	0	11	6	1
Nurse	97	26	23	67	19	8	2	6		30	146	8	12			11	7		219	197	46	390	149	28
Occupational therapist											2						1		0	2	1	2	2	0
Optometrist		2																	0	2	0	2	0	0
Osteopath	3		1								1								3	1	1	6	3	1
Paramedic	5	4	2	2	2	1				1	13								8	19	3	37	21	2
Pharmacist	10	7	2	9	7	2	1			4	30		2			1	1		27	44	5	45	71	5
Physiotherapist	8	3	5	3	1	2	1			4	1		1			3			20	5	7	20	5	4
Podiatrist	3									1	2								4	2	0	6	3	0
Psychologist	17		1	6	7	1				17	25	4	5			9	1		54	32	7	81	17	8
Total 2022/23	367	84	61	158	51	18	12	19		122	296	26	43	0		64	0	16	766	450	121			
Total 2021/22	621	94	15	314	81	16	4	23		236	263	36	131	0		54	0	10				1,360	461	77

1 Cases where immediate action has been initiated under Part 8, Division 7 of the National Law.

2 Cases where immediate action was initiated towards the close of the reporting year, and an outcome decision has not been finalised.

3 HPCA columns in this table show matters managed by the HPCA in NSW. HPCA data exclude matters that were considered for immediate action but did not proceed to a hearing, other than matters where the case did not proceed because the practitioner surrendered registration.

4 OHO columns in this table show matters received and managed by OHO in Queensland.



## Students

We look into concerns raised about students who are studying to become registered health practitioners.

There are limited grounds for making notifications about students compared to registered health practitioners. A notification can be made about a student's criminal history, impairment or if they have not complied with a restriction on their registration.

There is only one ground for a mandatory notification – an education provider needs to tell us when they have formed a reasonable belief that a student has an impairment that may place a patient at substantial risk of harm when the student is doing clinical training.

- 16 notifications were made to Ahpra about students; this is down from 35 last year.
- 4 notifications resulted in conditions or undertakings affecting a student's registration, compared to 2 last year.

## Case study: A notification about a student

A member of the public raised a concern with us that a nursing student had cheated on a recent assessment by having a family member write an assignment.

We can only accept notifications about students if:

- they have an impairment, which would mean they posed a risk to the public during a period of clinical placement, or
- they have been charged with a serious criminal offence.

Although we don't condone any form of academic misconduct, this is not a ground for a notification about a student. We advised the notifier that the educational institution may be better equipped to address their concern.

# Notifications performance

## Timeframes

The changes we are making to the ways we manage concerns are enabling us to close more notifications sooner.

We reduced the number of open notifications, and closed substantially more notifications within three months of them being received (see Figure 80 and Table 21). The number of notifications open for more than 12 months fell by 12.8% across the year, excluding those being managed through a panel or tribunal process.

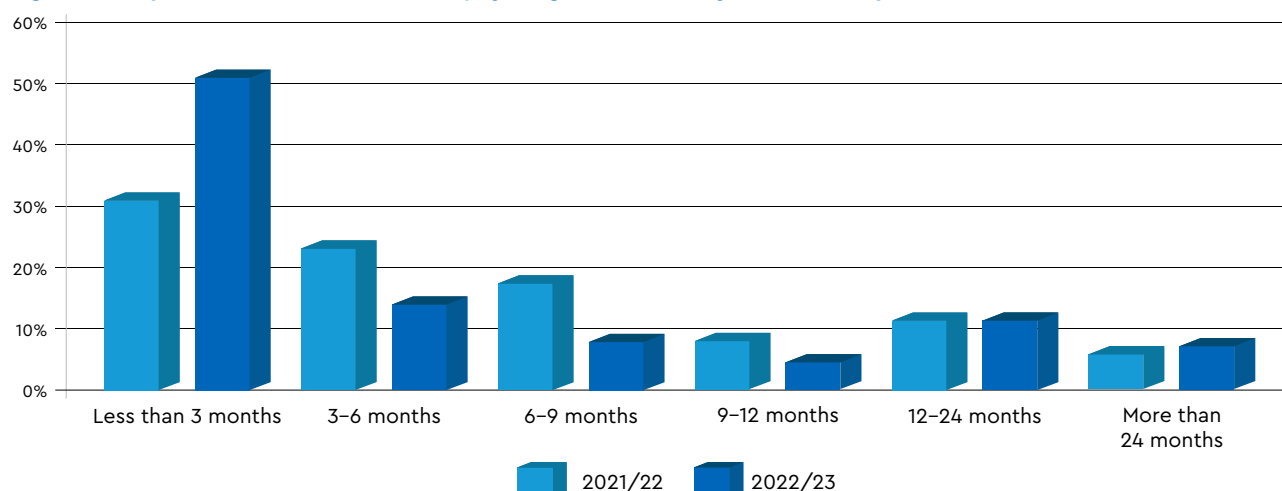
While only 235 of the notifications closed during the year were referred to a tribunal or panel (this is 2.2% of all closed notifications), these matters were generally open for an extended time. The notifications that were referred to a tribunal or panel often involved complex and long-running investigations or were

on hold for a considerable period due to an external investigation taking place (for example, a police investigation or coronial inquiry). Of all notifications that were closed in 2022/23, 2.4% had spent time on hold. The average time they spent on hold was 192 days.

Once a matter has been referred to a panel or tribunal, we rely in part on the timeliness of external parties, such as the tribunal itself or the practitioner's representatives. This year we continued to see the effects of the COVID-19 pandemic on tribunals' capacity to hear matters in a timely way. Once a matter was referred to a tribunal, it took on average 660 days for it to be finalised by the tribunal.

We are committed to continuing to improve timeliness.

**Figure 80. Open notifications at 30 June, by length of time they have been open**



**Table 21. Open notifications at 30 June, by length of time at each stage**

Current stage of open notification	Less than 3 months	3–6 months	6–9 months	9–12 months	12–24 months	More than 24 months <sup>1</sup>	Total 2022/23	Total 2021/22
Assessment	1,898	429	127	39	13	1	2,507	2,634
Health or performance assessment	7	6	7	5	26	14	65	239
Investigation	369	205	212	168	537	352	1,843	2,581
<b>Subtotal 2022/23</b>	<b>2,274</b>	<b>640</b>	<b>346</b>	<b>212</b>	<b>576</b>	<b>367</b>	<b>4,415</b>	
<b>Subtotal 2021/22</b>	<b>1,722</b>	<b>1,324</b>	<b>909</b>	<b>415</b>	<b>717</b>	<b>371</b>		<b>5,454</b>
Panel hearing	5	1					6	4
Tribunal hearing <sup>2</sup>	78	102	58	41	207	99	585	510
<b>Total 2022/23</b>	<b>2,357</b>	<b>743</b>	<b>404</b>	<b>253</b>	<b>783</b>	<b>466</b>	<b>5,006</b>	
<b>Total 2021/22</b>	<b>1,800</b>	<b>1,402</b>	<b>988</b>	<b>490</b>	<b>805</b>	<b>483</b>		<b>5,968</b>

- 1 The majority of these notifications involve liaison with external agencies (including police, coroners and employers) as well as multiple witnesses, which prolongs the investigation process.
- 2 Tribunal proceedings are conducted in accordance with timetables set by the tribunal in each jurisdiction.

## Outcomes

There are several possible outcomes for notifications (see Tables 22, 23 and 26).

The National Law requires that restrictions on the practice of a health practitioner are to be imposed only if it is necessary to ensure health services are

provided safely and are of an appropriate quality. Actions taken by practitioners, workplaces and other regulators or entities can contribute to an outcome of 'no further regulatory action'.

**Table 22. Notifications closed, by outcome, Ahpra**

Profession	No further regulatory action Refer all or part of the notification to another body	HCE to retain <sup>1</sup>	Accept undertaking	Caution or reprimand	Fine registrant	Impose conditions	Accept surrender of registration	Suspend registration	Cancel registration	Disqualify from applying for registration	Total 2022/23 <sup>2</sup>	Total 2021/22
Aboriginal and Torres Strait Islander Health Practitioner				3							3	11
Chinese medicine practitioner	23	1		2		6					32	36
Chiropractor	59	3	7	15		15		3			103	128
Dental practitioner	380	72	201	27		60		2		1	750	749
Medical practitioner	3,702	525	1,173	238	3	345		16	15	13	6,087	5,874
Medical radiation practitioner	25	1	2	3		4					35	34
Midwife	84	3	3	5		7					103	125
Nurse	1,351	49	123	122		202		18	21	11	1,919	1,896
Occupational therapist	40	8	5	4		8					66	84
Optometrist	9	3	7	5		7					31	33
Osteopath	18	1	2	5		3					29	32
Paramedic	103	1	3	11		17			2		140	132
Pharmacist	303	45	34	38		19	1	2	4	1	449	451
Physiotherapist	80	5	13	18		12				3	135	133
Podiatrist	27	3	6	7		12		1			56	56
Psychologist	474	41	55	51		89		3	1	1	721	576
<b>Total 2022/23</b>	<b>6,678</b>	<b>761</b>	<b>1,634</b>	<b>554</b>	<b>3</b>	<b>806</b>	<b>1</b>	<b>45</b>	<b>43</b>	<b>30</b>	<b>10,659</b>	
<b>Total 2021/22</b>	<b>6,320</b>	<b>1,053</b>	<b>1,591</b>	<b>498</b>	<b>0</b>	<b>698</b>	<b>1</b>	<b>40</b>	<b>69</b>	<b>0</b>		<b>10,350</b>

- 1 Health complaints entity.
- 2 A matter may result in more than one outcome. Only the most serious outcome from each closed notification has been included.

**Table 23. Notifications closed, by outcome, HPCA**

Outcome	Aboriginal and Torres Strait Islander Health Practitioner	Chinese medicine practitioner	Chiropractor	Dental practitioner	Medical practitioner	Medical radiation practitioner	Midwife	Nurse	Occupational therapist	Optometrist	Osteopath	Paramedic	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Total 2022/23	Total 2021/22
No further action <sup>1</sup>	2	3	9	109	277	5	6	211	9	6	5	30	87	15	5	57	836	1,097
No jurisdiction <sup>2</sup>		8	1	4	80	1	2	26	2		1	10	8	3	1	21	168	170
Discontinued	1	3	9	203	2,402	4	19	387	37	19	3	32	269	19	18	229	3,654	3,618
Withdrawn				7	107	1		22	1	2		1	14		2	12	169	166
Make a new complaint																	0	0
Refer all or part of the notification to another body			6	11	159	2	1	38	2	1		1	9	6	6	19	261	263
Caution				5				1				2	5				13	13
Reprimand				6	6			10			3		5				30	29
Orders – no conditions																	0	1
Finding – no orders								2									2	0
Counselling/ interview		1	11	7	74		1	43			3	3	83	17	5	4	252	277
Resolution/ conciliation by HCCC																	0	2
Fine																	0	0
Refund/ payment/ withhold fee/ re-treat				2													2	0
Conditions by consent		2		4	59			17			1		14	1	3		101	102
Order – impose conditions; would be conditions if registered			1	12	77	1	2	54	1		3	21	15	2	2	10	201	153
Accept surrender				1	19			8					2				30	46
Accept registration type change to non-practising					7			4								1	12	18
Suspend					16			6				14		1			37	24
Cancelled registration/ disqualified from registering			2	4	40			23	2			2	18			2	93	91
<b>Total 2022/23</b>	<b>3</b>	<b>17</b>	<b>39</b>	<b>375</b>	<b>3,323</b>	<b>14</b>	<b>31</b>	<b>852</b>	<b>54</b>	<b>28</b>	<b>19</b>	<b>116</b>	<b>529</b>	<b>64</b>	<b>42</b>	<b>355</b>	<b>5,861</b>	
<b>Total 2021/22</b>	<b>2</b>	<b>22</b>	<b>58</b>	<b>431</b>	<b>3,335</b>	<b>21</b>	<b>39</b>	<b>869</b>	<b>49</b>	<b>21</b>	<b>10</b>	<b>84</b>	<b>695</b>	<b>68</b>	<b>21</b>	<b>345</b>		<b>6,070</b>

This table was updated post-publication with corrected data supplied by the HPCA.

Source: HPCA. NSW legislation provides for a range of outcomes for complaints in NSW. Some of these map to outcomes available under the National Law; others are specific to the NSW jurisdiction. Each notification may have more than one outcome; all outcomes have been included.

1 Includes: Resolved before assessment, Apology, Advice, Council letter, Comments by Health Care Complaints Commission (HCCC), Deceased, Interview.

2 Includes practitioners who failed to renew.

**Table 24. Notifications closed, by stage at closure**

Profession	Assessment		Investigation		Health or performance assessment		Panel hearing		Tribunal hearing		Subtotal		Total 2022/23	Total 2021/22
	Ahpra	HPCA <sup>1</sup>	Ahpra	HPCA	Ahpra	HPCA	Ahpra <sup>2</sup>	HPCA	Ahpra <sup>3</sup>	HPCA <sup>4</sup>	Ahpra	HPCA		
Aboriginal and Torres Strait Islander Health Practitioner		2	3	1							3	3	6	13
Chinese medicine practitioner	17	9	14			4		4	1		32	17	49	58
Chiropractor	67	36	27		2			1	7	2	103	39	142	186
Dental practitioner	618	331	109	1	7	13		18	16	4	750	367	1,117	1,167
Medical practitioner	4,948	2,949	970	13	71	161	3	116	95	62	6,087	3,301	9,388	9,179
Medical radiation practitioner	25	12	9		1	1		1			35	14	49	55
Midwife	66	27	35	1	1	1		2	1		103	31	134	164
Nurse	1,360	667	432	18	58	45	3	66	66	37	1,919	833	2,752	2,755
Occupational therapist	56	49	9		1	2				2	66	53	119	133
Optometrist	27	28	4								31	28	59	54
Osteopath	17	13	10					3	2		29	16	45	42
Paramedic	73	66	62	2	3	8		7	2	16	140	99	239	215
Pharmacist	365	423	70	1	3	52		28	11	19	449	523	972	1,139
Physiotherapist	97	57	33			3		1	5	1	135	62	197	201
Podiatrist	32	37	23			2		3	1		56	42	98	77
Psychologist	541	328	146	1	12	14	4	10	18	2	721	355	1,076	920
<b>Total 2022/23</b>	<b>8,309</b>	<b>5,034</b>	<b>1,956</b>	<b>38</b>	<b>159</b>	<b>306</b>	<b>10</b>	<b>260</b>	<b>225</b>	<b>145</b>	<b>10,659</b>	<b>5,783</b>	<b>16,442</b>	
<b>Total 2021/22</b>	<b>7,749</b>	<b>5,295</b>	<b>2,212</b>	<b>68</b>	<b>197</b>	<b>276</b>	<b>1</b>	<b>250</b>	<b>191</b>	<b>119</b>	<b>10,350</b>	<b>6,008</b>		<b>16,358</b>

1 HPCA columns in this table show matters managed by the HPCA in NSW.

2 Excludes three matters that proceeded from compliance monitoring.

3 Includes 25 matters that did not progress to a tribunal: 23 were withdrawn and two were data entry errors.

4 Excludes appeals.

**Table 25. Open notifications by profession and state or territory, 30 June**

Profession	Ahpra <sup>1</sup>									Ahpra subtotal	HPCA <sup>3</sup>	Total 2022/23	Total 2021/22
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP <sup>2</sup>				
Aboriginal and Torres Strait Islander Health Practitioner				2				1		3		3	4
Chinese medicine practitioner	1			1	3		6	3		14	24	38	58
Chiropractor				16	7	3	35	9	2	72	29	101	128
Dental practitioner	6	3	1	68	20	4	72	34	1	209	252	461	623
Medical practitioner	64	31	41	711	260	94	1,052	394	19	2,666	1,186	3,852	4,600
Medical radiation practitioner		1		15		2	13	2		33	8	41	43
Midwife	1		4	9	4	2	15	11	1	47	28	75	53
Nurse	22	20	25	277	165	46	352	135	30	1,072	445	1,517	1,573
Occupational therapist	1			12	7		17	12		49	21	70	57
Optometrist				3	1		6	1		11	8	19	22
Osteopath	2			1	2		14			19	14	33	47
Paramedic		1		38	10	7	17	9	3	85	73	158	199
Pharmacist	5	3	2	57	15	10	61	22	4	179	161	340	532
Physiotherapist	4	1	1	25	11	6	40	17	1	106	30	136	137
Podiatrist				12	2		8	4		26	12	38	54
Psychologist	21	8	5	93	35	8	178	65	2	415	237	652	634
Total 2022/23	127	68	79	1,340	542	182	1,886	719	63	5,006	2,528	7,534	
Total 2021/22	138	70	77	1,911	580	171	2,095	805	121	5,968	2,796		8,764

1 Based on state or territory of the practitioner's principal place of practice.

2 No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.

3 Matters managed by the HPCA in NSW.

**Table 26. Closed notification outcomes**

Outcome	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
No further regulatory action	72.0%	69.5%	69.5%	71.1%	61.1%	62.7%
Refer to health complaints entity or other entity	3.4%	12.9%	16.5%	14.7%	25.5%	22.5%
Impose conditions	9.7%	8.0%	7.3%	7.2%	6.7%	7.6%
Caution or reprimand	11.5%	7.4%	4.6%	5.0%	4.8%	5.2%
Registration surrendered, suspended, disqualified or cancelled	1.0%	0.9%	0.9%	0.7%	1.1%	1.1%
Accept undertaking	2.2%	1.2%	1.1%	1.3%	0.8%	1.0%
Registrant fined	0.2%	0.1%	0.1%	< 0.1%	0.0%	0.0%

## Joint consideration in Queensland

The Office of the Health Ombudsman (OHO) receives notifications about registered and unregistered practitioners in Queensland.

This year was the first full year of joint consideration between Ahpra and OHO, with our two organisations working together to manage Queensland notifications. Together we responded to 3,690 notifications, and just under half were referred to Ahpra and the National Boards to manage (Table 27).

OHO closed 1,299 notifications about registered health practitioners following joint consideration, after agreeing with Ahpra that the concerns raised did not

require regulatory action. A further 573 notifications were retained by OHO for further action; for example, investigation or other complaints-resolution processes.

The average time from OHO receiving the notification to the completion of the joint consideration process was 7.4 days, down from 12 days last year. For matters that were retained by OHO to close, notifiers and practitioners were advised of the outcome in a significantly more timely way than was possible before joint consideration.

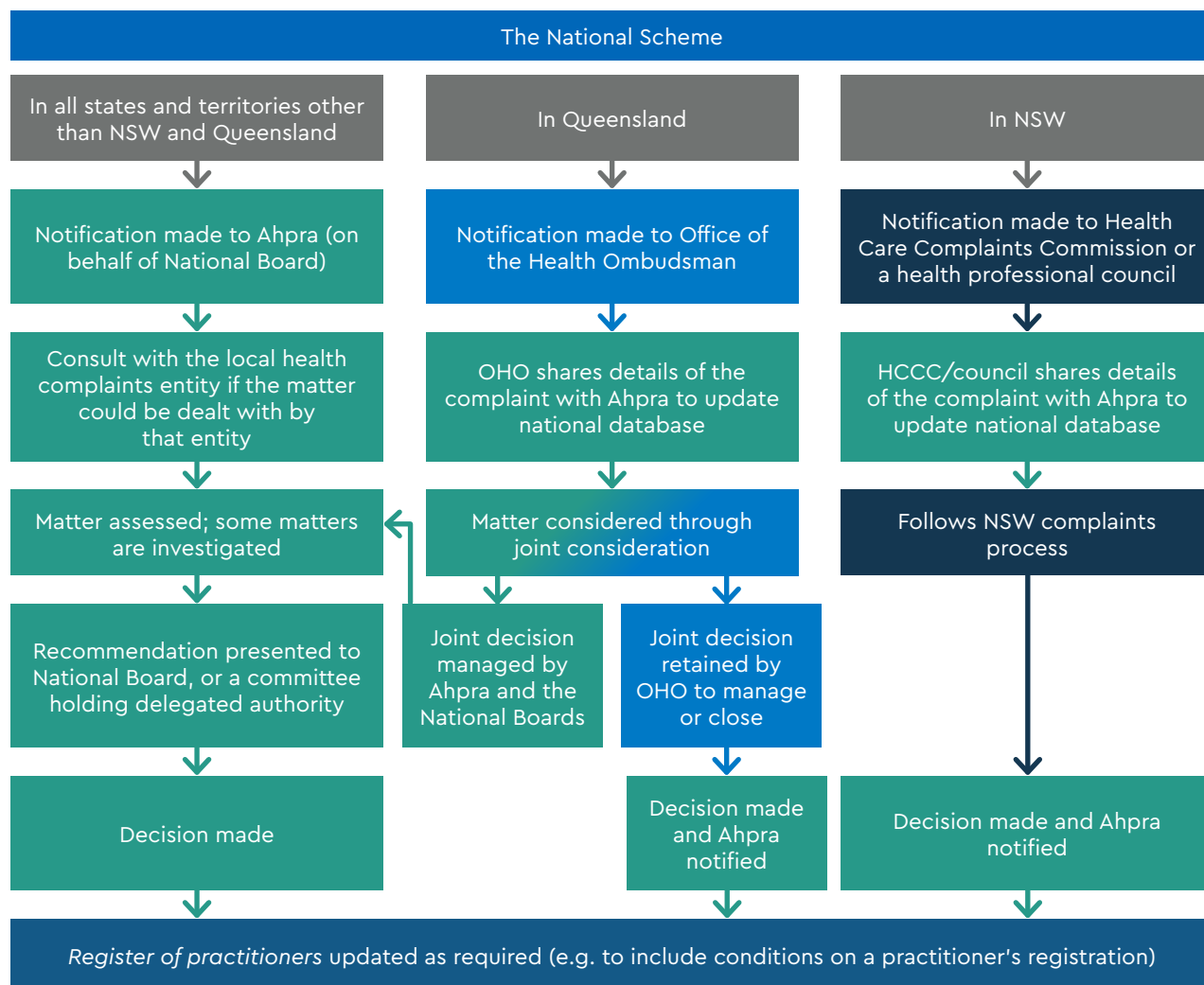
The notification process for NSW, Queensland and the other states and territories is outlined in Figure 81.

**Table 27. Initial joint consideration with the Office of the Health Ombudsman**

Profession	Outcome of completed initial joint consideration			Total 2022/23
	Retained by OHO for further assessment	Accepted by Ahpra for further assessment	Retained by OHO, unlikely to require further regulatory action	
Aboriginal and Torres Strait Islander Health Practitioner		1		1
Chinese medicine practitioner	1	6	5	12
Chiropractor	5	7	2	14
Dental practitioner	40	104	63	207
Medical practitioner	313	1,125	931	2,369
Medical radiation practitioner	3	9	2	14
Midwife	11	16	7	34
Nurse	108	276	128	512
Occupational therapist	11	14	5	30
Optometrist	3	7	2	12
Osteopath		2	1	3
Paramedicine	13	22	15	50
Pharmacist	12	60	30	102
Physiotherapist	14	33	13	60
Podiatrist	2	6	5	13
Psychologist	37	130	90	257
<b>Total 2022/23</b>	<b>573</b>	<b>1,818</b>	<b>1,299</b>	<b>3,690</b>



**Figure 81. Notification process in each state and territory**



**Under joint consideration, the average time from receiving a notification to the completion of the process was 7.4 days, down from 12 days last year**



# Compliance



**Placing restrictions on a practitioner's registration allows them to start or continue providing healthcare while keeping the public safe.**

We monitor any restrictions that are placed on a practitioner's registration and ensure they comply with advertising requirements.

## The year in summary

- **4,759** cases involving **4,750** practitioners were being actively monitored by Ahpra at 30 June.
- When combined with the **1,235** cases being monitored by the HPCA in NSW and OHO in Queensland, this is **less than 1%** of all registered health practitioners.

There was a 0.4% increase in cases being monitored from 2021/22. The number of monitored cases tends to broadly follow the trend in registration numbers.

Of the 4,759 cases at 30 June (see Tables 28 and 29):

- **3,022 cases (63.5%)** were about suitability/eligibility for registration
- **1,342 cases (28.2%)** were about conduct, health or performance
  - **411** for performance
  - **505** for health
  - **426** for conduct
- **395 cases (8.3%)** related to prohibited practitioners/students.

## Monitoring enables safe practice

We monitor five streams:

- conduct
- health
- performance
- prohibited practitioner/student
- suitability/eligibility.

When someone applies for registration but doesn't quite meet the standards, Boards consider whether there are additional things that practitioner can do, or if there are additional checks and balances that can be put in place so that they can practise safely.

The most common example is when a practitioner returns from an extended period away from the profession. Each profession has a recency of practice standard; for example, doctors must have practised for four weeks in the past year or 12 weeks in the past three years. An experienced doctor who has not practised for more than three years will need to provide a re-entry to practice plan and have an approved supervisor. This approach allows the practitioner to get back into practice while ensuring that patients receive safe and appropriate treatment. We review information from the practitioner and their supervisor to confirm that the arrangements continue to be appropriate and we remove the restrictions when they are no longer required.

**Table 28. Active monitoring cases at 30 June, by profession and stream**

Profession	Conduct			Health			Performance			Prohibited practitioner /student	Suitability /eligibility <sup>1</sup>	Total 2022/23			Total 2021/22		
	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	Ahpra	Ahpra <sup>2</sup>	HPCA	OHO <sup>3</sup>	Ahpra <sup>2</sup>	HPCA	OHO <sup>3</sup>
Aboriginal and Torres Strait Islander Health Practitioner				2							5	7	0	0	6	0	0
Chinese medicine practitioner	6	8	4	1	1		1	3		3	723	734	12	4	763	17	5
Chiropractor	14	8	1	2	2		7	1		9	10	42	11	1	39	10	1
Dental practitioner	13	13	1	9	20		57	27		6	22	107	60	1	149	58	2
Medical practitioner	158	144	31	180	122		220	209	1	124	560	1,242	475	32	1,303	478	33
Medical radiation practitioner	3	2	1	9	1		2			5	34	53	3	1	53	3	0
Midwife	1	4		3	2		9	2		3	35	51	8	0	42	9	0
Nurse	124	105	41	243	177		56	68	1	177	1,022	1,622	350	42	1,567	337	22
Occupational therapist	9	1		2	3		3			2	195	211	4	0	100	4	0
Optometrist	1	1					6			2	19	28	1	0	10	2	0
Osteopath	3	4	1				1			1	4	9	4	1	15	6	1
Paramedic	8	14	3	13	13		6			10	178	215	27	3	252	34	2
Pharmacist	16	43	8	20	24		7	20		24	71	138	87	8	151	128	5
Physiotherapist	12	9	8	5	3		5	3		7	50	79	15	8	47	9	5
Podiatrist	1	1		3	6		7	4			14	25	11	0	22	10	0
Psychologist	57	23	13	13	20		24	10		22	80	196	53	13	221	49	7
<b>Total 2022/23</b>	<b>426</b>	<b>380</b>	<b>112</b>	<b>505</b>	<b>394</b>	<b>0</b>	<b>411</b>	<b>347</b>	<b>2</b>	<b>395</b>	<b>3,022</b>	<b>4,759</b>	<b>1,121</b>	<b>114</b>			
<b>Total 2021/22</b>	<b>394</b>	<b>444</b>	<b>73</b>	<b>514</b>	<b>374</b>	<b>0</b>	<b>541</b>	<b>336</b>	<b>10</b>	<b>477</b>	<b>2,814</b>				<b>4,740</b>	<b>1,154</b>	<b>83</b>

- 1 Ahpra monitors compliance cases in the 'suitability/eligibility' stream in NSW.
- 2 Ahpra reports by monitoring cases established rather than by registrants being monitored. This is because a registrant may have a set of restrictions (conditions or undertakings) in more than one profession, division or stream. The 4,759 Ahpra monitoring cases relate to 4,750 registrants. The data provided by the HPCA report the number of registrants being monitored.
- 3 In Queensland, Ahpra monitors all cases except where the restrictions are imposed by OHO as immediate registration actions. OHO counts each of these actions separately, and not by practitioner under monitoring. In a small number of circumstances, one practitioner may be monitored in relation to more than one immediate registration action. A single immediate registration action may relate to more than one stream. These cases have been categorised according to the stream that comprises the bulk of the immediate registration action. Interim prohibition orders about registered practitioners who are currently being monitored are excluded.

The same is true when we receive notifications about a practitioner. Only a small number of notifications are so serious that the practitioner is not permitted to practise. Where a Board needs additional assurance, it may impose restrictions on the practitioner's registration. For example, a practitioner who has demonstrated poor record keeping may be required to attend additional education regarding record keeping and may then have their records audited to ensure that the education was successful. During the period of these restrictions, the practitioner is still permitted to practise while the education and audit ensure their practice is improving. Our role is to confirm that the practitioner nominates an appropriate education course, and to review the course completion and audit reports.

Where a Board imposes the requirements, we use the term *conditions*. In other cases, a practitioner is aware of what they need to do and provides an enforceable *undertaking* that they will meet additional requirements. We use the term *restrictions* to include both conditions and undertakings.

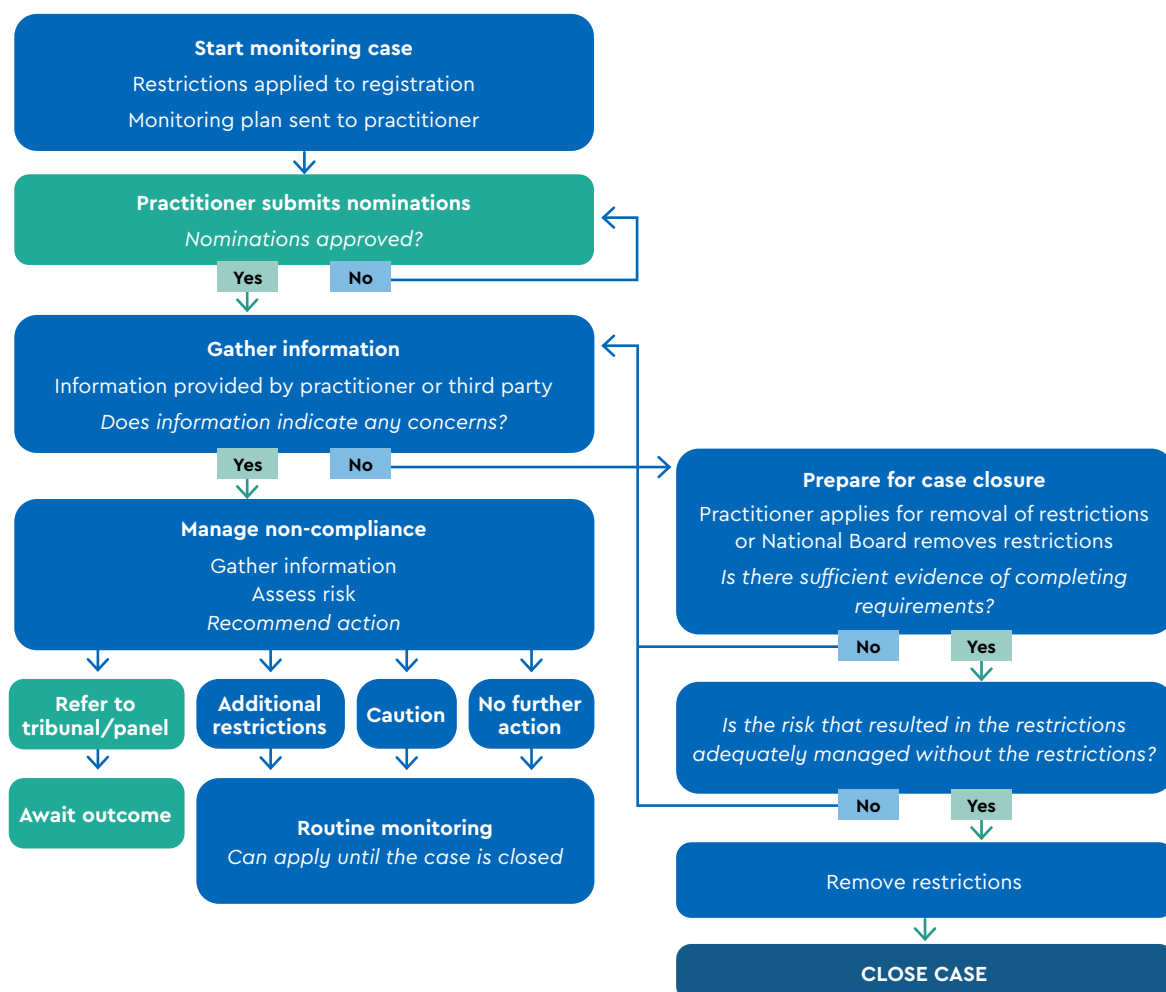
We recognise that having to comply with restrictions can be confusing and stressful for practitioners. We publish additional guidance to help practitioners understand our processes.

**Table 29. Active monitoring cases at 30 June, by state or territory**

Stream	Ahpra									Ahpra subtotal <sup>1</sup>	HPCA <sup>4</sup>	OHO <sup>5</sup>	Total 2022/23	Total 2021/22
	ACT	NSW <sup>6</sup>	NT	QLD	SA	TAS	VIC	WA	No PPP <sup>2</sup>					
Conduct	9	6	8	93	67	17	147	74	5	426	380	112	918	911
Health	11	5	9	189	64	16	139	66	6	505	394		899	888
Performance	6	9	6	143	48	10	130	58	1	411	347	2	760	887
Prohibited practitioner/student	10	2	9	77	54	14	162	56	11	395			395	477
Suitability/eligibility <sup>6</sup>	55	1,068	14	521	187	60	636	320	161	3,022			3,022	2,814
<b>Total 2022/23</b>	<b>91</b>	<b>1,090</b>	<b>46</b>	<b>1,023</b>	<b>420</b>	<b>117</b>	<b>1,214</b>	<b>574</b>	<b>184</b>	<b>4,759</b>	<b>1,121</b>	<b>114</b>	<b>5,994</b>	
<b>Total 2021/22</b>	<b>109</b>	<b>1,047</b>	<b>50</b>	<b>1,048</b>	<b>450</b>	<b>125</b>	<b>1,239</b>	<b>546</b>	<b>126</b>	<b>4,740</b>	<b>1,154</b>	<b>83</b>		<b>5,977</b>

- 1 Includes cases to be transitioned from Ahpra to HPCA for conduct, health and performance streams.
- 2 No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
- 3 Ahpra reports by monitoring cases established rather than by registrants being monitored. This is because a registrant may have a set of restrictions (conditions or undertakings) in more than one profession, division or stream. The 4,759 Ahpra monitoring cases relate to 4,750 registrants.
- 4 The data provided by the HPCA report the number of registrants being monitored. The HPCA monitors practitioners about health, performance and conduct in NSW.
- 5 OHO counts by immediate registration action, and not by practitioner being monitored. In a small number of circumstances, one practitioner may be monitored in relation to more than one immediate registration action. A single immediate registration action may relate to more than one stream. These cases have been categorised according to the stream that comprises the bulk of the immediate registration action. Interim prohibition orders about registered practitioners who are currently being monitored are excluded.
- 6 Ahpra monitors compliance cases in the 'suitability/eligibility' stream in NSW.

**Figure 82. How monitoring works**





## How we monitor

We gather information to monitor health practitioners and students with restrictions on their registration or whose registration has been suspended or cancelled. Monitoring plans guide our monitoring and compliance activities, and help practitioners understand what is required of them (see Figure 82).

We have a National Restrictions Library ([www.ahpra.gov.au/Registration/Monitoring-and-compliance/National-Restrictions-Library](http://www.ahpra.gov.au/Registration/Monitoring-and-compliance/National-Restrictions-Library)) and we use the same wording about restrictions for similar cases. This ensures that the restrictions are achieving the desired outcome, are understood by practitioners and that we develop consistent monitoring plans.

Where a practitioner does not do what the restrictions require, we first seek an explanation from them. The Board that placed the restrictions may choose to take additional action, such as a caution or further restrictions, to ensure the public remains protected.

## Prohibited practitioners

We also monitor practitioners who are not permitted to practise because they have had their registration cancelled or suspended, have surrendered their registration or are restricted from practising.

- Tribunals have the power to **cancel** a practitioner's registration – these practitioners must reapply for registration after an imposed minimum period of time.
- Tribunals and panels can **suspend** a practitioner's registration – these practitioners have their registration reinstated at the completion of the period of suspension.
- Boards are able to suspend a practitioner through an **immediate action** while awaiting completion of an investigation or an assessment.
- Boards can impose conditions or accept undertakings that **restrict the practitioner from practising** until some other requirement is met.
- Some practitioners who are subject to a notification may **surrender** their registration or request a non-practising form of registration.

## Most common restrictions

Each restriction on a practitioner's registration is assigned a restriction category. Where a practitioner is subject to multiple restrictions they will have multiple restriction categories – this results in a greater total number of restrictions on practitioners than total cases being monitored.

The top 10 restriction categories by volume being monitored by Ahpra at 30 June contained 5,840 restrictions (see Table 30).

- **69.4%** (4,051) of restrictions in the top 10 restriction categories were imposed following assessment of an application for registration or renewal of registration.
- **30.6%** (1,789) of the restrictions in the top 10 restriction categories were imposed because of a finding made by a National Board, panel or tribunal about a practitioner's health, performance or conduct.

**Table 30. Top 10 restriction categories, 30 June**

Category	Total at 30 June
Requirement for supervision <sup>1</sup>	1,621
Restriction on practice <sup>1</sup>	1,409
Undertake education <sup>2</sup>	465
Attend treating practitioner due to health condition <sup>2</sup>	465
Restriction on scope of practice <sup>1</sup>	433
Prohibition on practice <sup>2</sup>	326
Undertake assessment <sup>1</sup>	325
Workplace practice limitation <sup>2</sup>	295
Undertake continuous professional development <sup>1</sup>	263
Requirement to have a mentor <sup>2</sup>	238
<b>Total</b>	<b>5,840</b>

1 Imposed following assessment of an application for registration or renewal of registration.

2 Imposed because of a finding made by a National Board, panel or tribunal.

## Outcomes from monitoring cases

When a practitioner has completed the requirements, they can apply to the Board to remove the restrictions. The case is closed when the Board agrees that restrictions are no longer needed.

When we close the case, we retain important information to ensure that we consider the practitioner's regulatory history for any subsequent applications.

During the year, we created **2,208** new monitoring cases and closed **2,170**, leading to an increase in overall cases. Of the cases we closed:

- **1,429** cases were closed because the restrictions were removed
- **702** were closed because the practitioner was no longer registered
- **39** were closed for other reasons, such as transferring NSW practitioners to the HPCA for monitoring.





# Investigating advertising complaints

We assessed **380** complaints about advertising. Of these:

- **96** were complaints about corporate entities or unregistered persons, or assessed as serious-risk complaints
- **284** were lower-risk complaints about registered health practitioners and assessed under the *Advertising compliance and enforcement strategy*:
  - **187** were assessed as lower-risk potential breaches
  - **97** cases had no breach identified.

When we identify that advertising by registered health practitioners is not compliant with the *Guidelines for advertising a regulated health service*, we initially provide practitioners with an opportunity to correct their advertising and only take further regulatory action when this is unsuccessful.

Sometimes practitioners do not realise what they are not allowed to claim when they advertise. We provide information to help them. Where practitioners fail to correct their advertising, Boards may impose a caution or conditions on the practitioner's registration. Ahpra may also prosecute advertisers for breaching the National Law (see page 89).

## Proactive advertising audit

We completed a two-year-long advertising audit of a random sample of 1,242 practitioners across 13 health professions. We reviewed all online advertising by each of these practitioners, including on social media, and assessed a sample of this content against our advertising guidelines. Of the audited practitioners, we identified 529 (42.6%) who were advertising and 213 (17.1%) who had non-compliant advertising. Two of these cases were assessed as high risk and resolved using our normal advertising complaints procedures. The most common theme across professions was inappropriate use of terminology related to specialist registration.

This audit supplements our complaints-based approach to advertising breaches and helps us understand the rates of advertising in each profession along with the frequency of issues identified and any common themes. We are using this information to improve our guidelines for practitioners and the information on our website, as well as publishing articles in each Board's newsletter to encourage improved compliance.

**We found 65 cases of non-compliant cosmetic surgery advertising**

## Cosmetic surgery audit

We also conducted a targeted audit of advertising about cosmetic surgery. We searched for common terminology related to cosmetic surgery and identified practitioners and practices with the highest search results or the most followers on social media. This represents the advertising most likely to be viewed by consumers. We reviewed a sample of content on 69 practitioner or practice websites and social media to identify non-compliance and found 65 cases (94.2%) of non-compliant advertising. Practitioners were provided with details and an opportunity to address our concerns. The majority addressed the concerns without the need for further regulatory action. Where the concerns were not addressed, or the practitioner had been subject to prior advertising concerns, the Medical Board of Australia considered regulatory action and imposed five cautions and two conditions.

The most common concerns identified were:

- practitioners reposting patient social media imagery with no comparative 'before' photos
- trivialising the risk and recovery associated with cosmetic surgery procedures
- inappropriate use of terminology related to specialist registration
- use of testimonials
- content that was potentially misleading or may cause unreasonable expectations of benefits.

## Case study: Cosmetic surgery advertising

We reviewed a doctor's cosmetic surgery advertising on their website, YouTube, Instagram and Facebook. We identified issues such as:

- claims of permanent results (misleading)
- claims to improve self-confidence and self-esteem (misleading)
- videos of patients talking about their experiences (testimonial)
- engaging with patient comments on social media regarding their outcomes (testimonial)
- stock imagery rather than genuine 'before' and 'after' photos (unreasonable expectation)
- limited information about risks and recovery (unreasonable expectation).

The doctor addressed some of the concerns; however, subsequent audits identified further breaches. After several attempts to work with the practitioner to resolve remaining issues, the Medical Board of Australia imposed conditions requiring education about the advertising guidelines and restricted the practitioner's advertising. When the practitioner provided evidence of completing the education and a reflective report identifying what they had learned, the Board removed the conditions.

# Cosmetic surgery

In response to concerning reports of dangerous conduct by some medical practitioners in the cosmetics sector, the final report of the *Independent review of the regulation of medical practitioners who perform cosmetic surgery* was released on 1 September. Ahpra and the Medical Board accepted all recommendations in the report. For more information, see the Medical Board's report on page 20. An independent Cosmetic Surgery Oversight Group chaired by Ms Delia Rickard, former Deputy Commissioner of the Australian Competition and Consumer Commission (ACCC), was established to provide assurance to the Ahpra Board that the recommendations are being implemented.

## Enforcement unit

We established a Cosmetic Surgery Enforcement Unit with experienced investigators to manage all cosmetic surgery complaints, and we established a dedicated cosmetic surgery hotline available to members of the public and practitioners. Callers can make confidential or anonymous notifications.

From 5 September to 30 June, the hotline received 315 calls. Over the same period, Ahpra received 157 notifications related to cosmetic practice from all sources. At 30 June, Ahpra was managing 268 cosmetic practice notifications related to 90 health practitioners. More than half of these notifications (177) related to only 15 practitioners. These practitioners are no longer practising or are subject to restrictions on their registration while our investigations are being completed.

We began a targeted audit of advertising, with results reported on page 84. We are working closely with social media experts to monitor emerging trends on platforms such as Instagram. A new cosmetic surgery hub was developed on our website. The hotline and hub were supported by proactive communications and promoted with paid advertising.

## Targeted intervention

The Medical Board's National Special Issues Committee dealt with cosmetic practice matters and worked closely with the Cosmetic Surgery Enforcement Unit. This provides a consistent group of decision makers dealing with notifications and advertising breaches related to cosmetic practice.

The Medical Board consulted and released updated guidelines for medical practitioners who perform cosmetic surgery and procedures, and guidelines for medical practitioners who advertise cosmetic surgery. These guidelines were supported by FAQs and visual examples on our website. They took effect on 1 July 2023 and will inform future advertising audits and the assessment of future cosmetic surgery notifications.

## Working with others

We worked with other agencies to enhance cooperation and reduce potential gaps. We established regular meetings to examine cosmetic surgery risks and issues with state and territory health facility licensing units, the Therapeutic Goods Administration, the Office of the Health Ombudsman, the Health Care Complaints Commission and the Medical Council of NSW.

We provided input into an Australian Government public education campaign that is jointly funded by federal, state and territory governments.

The Australian Commission on Safety and Quality in Health Care drafted and consulted on safety, quality and licensing standards for cosmetic surgery. Ahpra and the Medical Board have representatives on the Project Advisory Committee and Executive Steering Committee for these projects.

“  
**The cosmetic surgery hotline received 315 calls**  
”

## Case studies: cosmetic surgery notifications

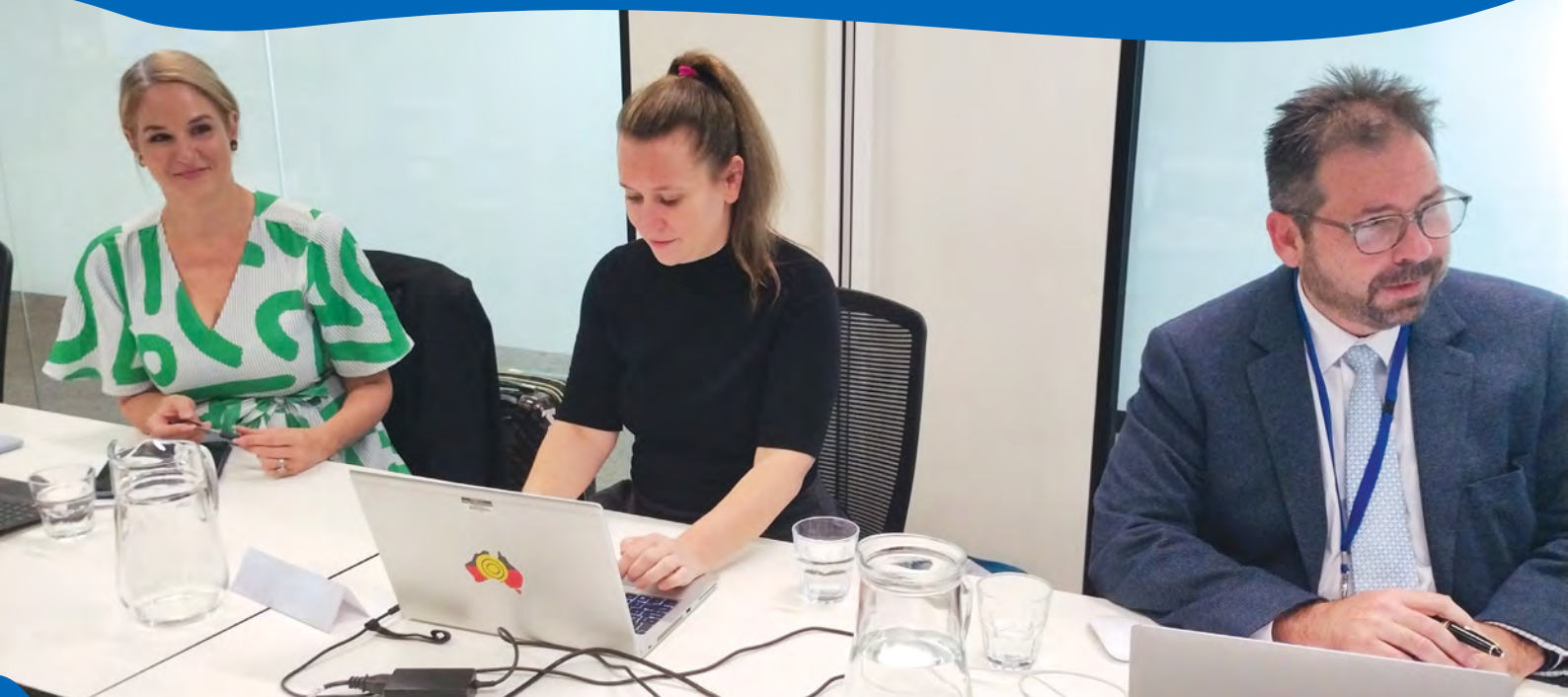
### Immediate action required

We received multiple concerns about liposuction performed by a medical practitioner with general registration. The concerns were raised by patients and through a mandatory notification from another practitioner who performed revision surgery. Concerns included inadequate consent practices for interstate patients, removing amounts of fat that were inconsistent with patient expectations and potentially in breach of state licensing requirements, use of sedation that was inconsistent with the extent of the surgery, and inadequate post-operative care. While investigations were underway, the Medical Board of Australia decided to take immediate action to protect public health and safety by imposing conditions requiring the practitioner to be supervised by another practitioner for liposuction procedures.

### No regulatory action required

We received concerns about a specialist plastic surgeon who performed breast reduction surgery. The patient reported that the surgery resulted in their breasts being uneven, misaligned and scarred. Ahpra's investigation identified that the practitioner provided appropriate information to the patient regarding risks and potential outcomes of the surgery, including asymmetry and scarring. The patient's outcomes were reviewed by another specialist plastic surgeon who concluded that they represented a reasonable outcome. The practitioner provided the patient with a partial refund in response to their dissatisfaction. The Board decided that no regulatory action was required.

# Legal action



**Legal action by or against the National Boards or Ahpra is conducted by Ahpra's National Legal Practice.**

The Legal Practice comprises:

- Professional Misconduct Unit, which handles tribunal referrals for alleged professional misconduct
- Panels, Appeals and Advice Unit, which handles appeals against National Board decisions and referrals to panels, and provides general legal advice
- Criminal Offences Unit, which investigates and prosecutes allegations of criminal offences under the National Law
- National Information Release Unit, which handles freedom of information requests and other releases of information in accordance with summons, subpoenas etc
- Corporate Legal, which handles all of Ahpra's governance and compliance responsibilities as well as advising on all contracts Ahpra enters into
- Legal Support Service, which provides para-legal and other support to all legal units.

## Tribunals

National Boards refer allegations of professional misconduct to tribunals in each state and territory. Only a tribunal can cancel a practitioner's registration, disqualify a person from applying for registration for a time, prohibit a person from using a specified title or prohibit them from providing a specified health service.

The data provided in this section include both the number of individual notifications and the number of affected practitioners or tribunal matters. These are often not the same because one tribunal matter can include multiple notifications. Most commonly, this occurs where there are multiple complaints about the same or similar misconduct of a particular practitioner. A practitioner may also have more than one tribunal referral open at a time.

There were **369** practitioners with open referral matters in tribunals at 30 June, compared with 286 practitioners last year. National Boards referred more practitioners to a tribunal, with **231** practitioners referred this year compared to 214 last year.

During the year, matters regarding **136** practitioners (relating to 223 notifications) were finalised at a tribunal.

- Matters about **129** practitioners (about 200 notifications) were decided by a tribunal.
  - 98.0% of those practitioners received disciplinary action (see Figure 83).

Of those that did not proceed, 7 matters (about 23 notifications) were withdrawn or did not proceed to a tribunal.

- 3 matters did not proceed because the practitioner was deceased.
- The remaining 4 did not proceed because:
  - the practitioner was chronically ill to the extent they were unable to participate in proceedings
  - the Board's referral relied entirely on a conviction made by a district court, and the conviction was set aside by the court after the referral was made
  - the Board became aware of evidentiary issues that were not apparent at the time they decided to refer
  - it was not in the public interest to proceed, noting the practitioner was no longer registered and already had a separate, objectively more serious, tribunal matter ongoing.

National Boards continue to appropriately identify the thresholds for referring a matter to a tribunal to protect the public.

**Figure 83. Matters decided by tribunals**



- **98.0%** disciplinary action
- **2.0%** no further regulatory action

## Tribunal decisions

Matters included findings of professional misconduct involving:

- family violence offending and other serious criminal offending
- sexual boundary breaches and other general boundary breaches, such as inappropriate relationships with patients
- failing to comply with public health directions relating to COVID-19
- misappropriating or prescribing of 'peptides' or other drugs that are at risk of misuse/abuse, for non-therapeutic purposes
- inappropriate commentary on social media
- inadequate clinical management and/or medical mismanagement
- issuing vaccination exemptions not in accordance with legislation.

Significant periods of disqualification were imposed in some matters, including in matters involving:

- sexual misconduct against a number of vulnerable female patients (25 years)
- multiple sexual assaults and acts of incest (conviction) (16 years)
- cause of serious harm by dangerous driving (conviction), breach of bail conditions, false statements to Ahpra (8 years)
- failures in conduct and performance while undertaking a clinical governance role (10 years).

We include links to published adverse tribunal (disciplinary) decisions and court outcomes for a practitioner in the *Register of practitioners*, unless the name of the practitioner has been suppressed by the court or tribunal.

When a court or tribunal cancels a practitioner's registration or disqualifies them from applying for registration, using a specified title, or providing a specified health service, this is recorded in the *Register of cancelled practitioners*.

When a tribunal reprimands, suspends or places conditions on the registration of a practitioner, this is recorded in the *Register of practitioners*.

## Published summaries

We published **61** summaries about publicly available court or tribunal decisions. Some decisions are not published for privacy reasons or due to suppression orders applied by the court or tribunal. Other decisions may not be published until the next reporting year, once a tribunal's full decision and orders have been publicly released.

## Panels

Ten matters (about 13 notifications) were decided by panels, all of which resulted in regulatory action. Panels are established by the Boards and include members from the community and relevant health profession. Health panels must include a medical practitioner.

## Appeals

There were **121** appeals lodged about decisions made by National Boards (see Table 31).

- This was higher than in 2021/22, when there were **103** lodged.
- The majority were from professions that have a higher number of regulatory decisions, such as medical practitioners (**85**) and nurses (**20**).
- **140** were finalised (see Table 32).
- **71** were not yet decided at 30 June.

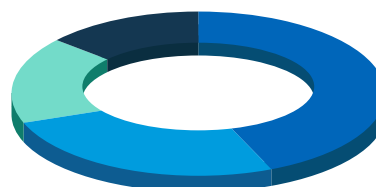


Figure 84. Nature of decision appealed



- **29.3%** decision to suspend a person's registration
- **26.4%** decision to impose or change a condition on a person's registration or endorsement
- **16.4%** decision to refuse registration, refuse renewal of registration, or refuse an endorsement on registration
- **7.9%** decision to refuse to change or remove a condition imposed on a person's registration, or an undertaking given by the practitioner, or the endorsement of a person's registration
- **20.0%** appeals against other decisions

Figure 85. Outcome of appeals finalised



- **43.6%** withdrawn by the appellant and did not proceed, meaning the original decision remained in place
- **25.7%** dismissed on administrative grounds
- **17.1%** original decision substituted with a new decision or the original decision amended
- **13.6%** original decision confirmed

Table 31. Appeals lodged, by profession and jurisdiction

Profession	Ahpra <sup>1</sup>								Ahpra subtotal	HPCA <sup>2</sup>	Total 2022/23	Total 2021/22
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA				
Aboriginal and Torres Strait Islander Health Practitioner									0		0	0
Chinese medicine practitioner									0		0	0
Chiropractor									0		0	1
Dental practitioner			2						2	2	4	2
Medical practitioner	2	5	3	18	7	4	29	17	85	12	97	86
Medical radiation practitioner									0	1	1	0
Midwife									0	1	1	0
Nurse		5	1	5	1	1	7		20	3	23	19
Nurse and midwife <sup>3</sup>									0		0	0
Occupational therapist									0		0	0
Optometrist									0		0	0
Osteopath									0		0	1
Paramedic							1		1		1	3
Pharmacist						1	2	1	4	3	7	11
Physiotherapist							1		1	1	2	2
Podiatrist		1							1		1	0
Psychologist		1		1	2		3		7	2	9	11
<b>Total 2022/23</b>	<b>2</b>	<b>12</b>	<b>6</b>	<b>24</b>	<b>10</b>	<b>6</b>	<b>43</b>	<b>18</b>	<b>121</b>	<b>25</b>	<b>146</b>	
<b>Total 2021/22</b>	<b>3</b>	<b>7</b>	<b>2</b>	<b>21</b>	<b>10</b>	<b>5</b>	<b>37</b>	<b>18</b>	<b>103</b>	<b>33</b>		<b>136</b>

1 Based on state and territory of the practitioner's principal place of practice.

2 Matters managed by the HPCA in NSW.

3 Registrants who hold dual registration as both a nurse and a midwife.

**In May, Ahpra completed its 100th prosecution since the National Scheme began – this marked a significant milestone in the protection of the public**



**Table 32. Nature of decision appealed where the appeal was finalised through consent order or contested hearing or was withdrawn**

Nature of decision appealed	Original decision confirmed		Original decision amended		Original decision substituted for a new decision		Withdrawn		Dismissed – administrative		Total 2022/23		Total 2021/22	
	Ahpra <sup>1</sup>	HPCA <sup>2</sup>	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA
Appeal against a tribunal decision	4		2		1				3		10	0	7	4
Decision to impose conditions on a person's registration under section 178	4		3		6		14		5		32	0	26	0
Decision to impose or change a condition on a person's registration or the endorsement of the person's registration	1	2		1			3	6	1	2	5	11	4	16
Decision to refuse to change or remove a condition imposed on the person's registration or the endorsement of the person's registration	1						5		4		10	0	9	2
Decision to refuse to revoke an undertaking							1				1	0	1	0
Decision to refuse to endorse a person's registration							2				2	0	2	0
Decision to refuse to register a person	8	3					8	1	3		19	4	12	1
Decision to refuse to renew a person's registration or endorsement							2				2	0	1	1
Decision to reprimand a person											0	0	0	0
Decision to suspend a person's registration		1			10		24	4	7	3	41	8	27	9
Other			1						10		11	0	5	1
Not an appellable decision											0	0	1	0
Judicial review	1				1		2		3		7	0	1	1
<b>Total 2022/23</b>	<b>19</b>	<b>6</b>	<b>6</b>	<b>1</b>	<b>18</b>	<b>0</b>	<b>61</b>	<b>11</b>	<b>36</b>	<b>5</b>	<b>140</b>	<b>23</b>		
<b>Total 2021/22</b>	<b>11</b>	<b>6</b>	<b>1</b>	<b>2</b>	<b>21</b>	<b>5</b>	<b>46</b>	<b>20</b>	<b>17</b>	<b>2</b>			<b>96</b>	<b>35</b>

1 Ahpra manages appeals of registration decisions in NSW, as shown in Ahpra columns.

2 HPCA columns show notification matters managed by the HPCA in NSW.

## Criminal offences

One way we ensure access to safe, professional healthcare is to investigate and, where appropriate, prosecute people alleged to have committed criminal offences under the National Law.

These offences include:

- unlawful use of protected titles
- unlawful claims that a person is registered
- performing a restricted act
- unlawful advertising.

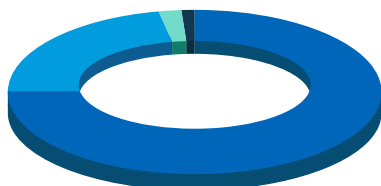
Only registered practitioners can use protected titles for their profession. It is also an offence to falsely claim to be qualified to practise in a health profession or hold yourself, or someone else, out as a registered health practitioner. Penalties of up to three years' imprisonment and/or a \$60,000 fine can be imposed on individuals who commit these offences, and fines of up to \$120,000 for companies.

During the year:

- **442** criminal offence complaints were received (see Table 33).
  - **75.1%** related to alleged unlawful use of title and unlawful claims to registration.
- **485** criminal offence complaints were considered and closed.
- **180** open criminal offence complaints were still under review at 30 June.
- **96** new complaints about advertising were considered and managed if advertising was assessed as unlawful – most related to the advertising of corporate entities or unregistered persons.
  - **107** advertising complaints were closed.

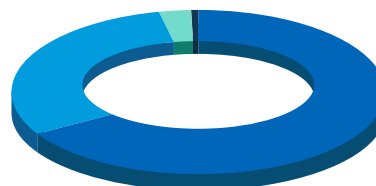
See page 84 for information about compliance checks of advertising.

Figure 86. Offence complaints received



- **75.1%** title protection offences
- **21.7%** advertising offences by corporate entities or unregistered persons
- **2.0%** practice protection offences
- **1.1%** other offences

Figure 87. Offence complaints open, 30 June



- **66.7%** title protection offences
- **30.0%** advertising offences by corporate entities or unregistered persons
- **2.8%** practice protection offences
- **0.6%** failing to cooperate with investigators and inspectors

Table 33. Criminal offence complaints received and closed, by type of offence and profession

Profession	Title protections (ss.113–120)		Practice protections (ss.121–123)		Advertising breach (s.133)		Directing or inciting unprofessional conduct/professional misconduct (s.136)		Other offence		Total 2022/23 <sup>1</sup>		Total 2021/22 <sup>1</sup>	
	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed
Aboriginal and Torres Strait Islander Health Practitioner											0	0	1	1
Chinese medicine practitioner	14	15			2	2				1	16	18	11	11
Chiropractor	13	10	2	5		1					15	16	20	16
Dental practitioner	6	6	3	6	4	14					13	26	24	24
Medical practitioner	79	85	1	1	45	51	2	1		4	127	142	130	119
Medical radiation practitioner	3	2			2	1					5	3	0	0
Midwife	3	1	1	1							4	2	4	5
Nurse	58	66	2	1	19	11					79	78	53	62
Occupational therapist	15	13			1						16	13	13	12
Optometrist											0	0	4	4
Osteopath	1	2		1							1	3	6	4
Paramedic	12	15			1						13	15	16	17
Pharmacist	4	9			3	5	1	1	2		10	15	19	16
Physiotherapist	25	23			5	5					30	28	15	13
Podiatrist	5	1			2	4					7	5	5	4
Psychologist	94	108			12	13					106	121	90	95
Unknown <sup>2</sup>											0	0	7	7
<b>Total 2022/23</b>	<b>332</b>	<b>356</b>	<b>9</b>	<b>15</b>	<b>96</b>	<b>107</b>	<b>3</b>	<b>2</b>	<b>2</b>	<b>5</b>	<b>442</b>	<b>485</b>		
<b>Total 2021/22</b>	<b>317</b>	<b>325</b>	<b>28</b>	<b>20</b>	<b>70</b>	<b>60</b>	<b>0</b>	<b>1</b>	<b>3</b>	<b>4</b>			<b>418</b>	<b>410</b>

<sup>1</sup> All National Law offences, not only offences about advertising, title and practice protection.

<sup>2</sup> Ahpra also received offence complaints about unregistered people.

## Criminal prosecutions

In May, Ahpra completed its 100th prosecution since the National Scheme began. This marked a significant milestone in the protection of the public.

Ahpra successfully prosecuted a number of people found to have committed criminal offences, including:

- 'fake' practitioners with no relevant formal qualifications, who held themselves out to patients and employers as registered practitioners
- practitioners who continued to practise after their registration was suspended by tribunals or a National Board
- practitioners who continued to practise after surrendering their registration
- practitioners who continued to practise after they failed to renew their registration, even after they realised they were not registered.

Significant prosecutions demonstrate the importance of criminal offence provisions for the protection of the public.

Outcomes show that Ahpra continues to identify appropriate thresholds for referring offence complaints for prosecution (see Table 34).

- 8 proceedings were completed in the courts for offences.
  - 6 prosecutions resulted in a finding of guilt against the defendant.
  - In 1 case the defendant left Australia before entering a plea and, while they are not expected to return, a warrant for their arrest has been issued by the court.
  - 1 case was formally dismissed under the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW).
- 12 prosecutions were ongoing at 30 June.

**Table 34. Completed prosecutions**

Date of decision	Jurisdiction	Relevant Board	Type of offence	Outcome
19 September 2022	Victoria	Nursing and Midwifery	Holding out as a registered nurse after surrendering registration in response to proposed suspension	Defendant found guilty after a trial; convicted and sentenced to an adjourned undertaking, \$1,000 payment into the court fund and \$500 costs. Ahpra requested appeal against sentence. Sentence set aside; defendant fined \$16,000 and ordered to pay Ahpra's legal costs, to be agreed or assessed failing agreement.
16 October 2022	Queensland	Paramedicine	Holding out as a paramedic while suspended	Defendant pleaded guilty and was sentenced to a fine of \$5,000 and ordered to pay \$2,357 of Ahpra's legal costs. No conviction recorded.
7 December 2022	Victoria	Nursing and Midwifery	Holding out as a registered nurse while registration was suspended by the Victorian Civil and Administrative Tribunal	Defendant pleaded guilty and was convicted. Sentenced to a fine of \$10,000 and ordered to pay \$3,132 in legal and court costs.
22 February 2023	Victoria	Occupational Therapy	Two charges of holding out as a registered occupational therapist	Defendant pleaded guilty and was convicted. Sentenced to a fine of \$4,000 and ordered to pay \$5,500 in costs.
14 April 2023	Victoria	Nursing and Midwifery	Holding out as registered nurse after surrendering registration	Defendant returned to their home country and told the court that they are never returning. Bench warrant for arrest issued.
14 April 2023	New South Wales	Nursing and Midwifery	Two charges of holding out and one charge of using a title (nurse practitioner)	Defendant's application under section 14 of the <i>Mental Health and Cognitive Impairment Forensic Provisions Act 2020</i> was heard and granted on 14 April. Charges dismissed.
24 May 2023	South Australia	Pharmacy	Holding out as a pharmacist with general registration after failing to renew provisional registration	Defendant pleaded guilty and was convicted. Sentenced to a fine of \$1,200, placed on a community service order requiring 42 hours' community service within 18 months, and ordered to pay \$1,276 of Ahpra's legal costs.
21 June 2023	Queensland	Occupational Therapy	Holding out as an occupational therapist while unregistered	Defendant failed to appear and was convicted in their absence. Sentenced to \$4,000 fine and ordered to pay \$1,750 in costs.

# Improving health practice



## Using research to identify emerging risks

The health sector is ever-changing, with technological, social and economic influences shaking up traditional modes of care. To be effective as a regulator and achieve our paramount objective of public protection, Ahpra must stay abreast of emerging issues. By integrating research, advanced analytics, human insights and regulatory experience, we can identify and respond to regulatory issues early, enabling us to focus on prevention.

Research is the foundation – studying and analysing trends, policies and frameworks in regulation, practice and healthcare to gain a comprehensive understanding of the regulatory landscape. Ahpra can use its own and external data to identify potential risks and emerging issues. Having an evidence-based approach provides a solid basis for informed decision-making and proactive management of risks.

Advanced analytics allows us to use technology to augment and assist in data gathering, and helps to recognise trends and highlight key risks early. Advanced analytics tools can efficiently gather vast amounts of data from sources including regulatory publications, news articles and social media platforms. These tools will help us to analyse large datasets, identify patterns and detect early warning signs of regulatory changes or emerging risks. They can process and categorise information, providing valuable information that assists human decision-making and risk assessment.

Of course, advanced analytics tools cannot replace human insight and expertise. Human input and oversight are essential in interpreting the data generated by advanced analytics tools – to sense-check, provide contextual understanding and identify nuances that automated systems may miss. Regulatory experts with deep industry knowledge and experience can offer valuable insights, guide the interpretation of research findings and help prioritise regulatory risks.

Our regulatory experience brings a practical dimension to these insights. Regulation professionals who have hands-on experience with registration, notifications, compliance and accreditation can offer valuable perspectives on regulatory risk and potential regulatory interventions. By combining regulatory experience and regulatory intelligence, we can develop targeted and practical solutions to any such risks.

A multidisciplinary team of researchers, data analysts and regulatory experts work together to develop a comprehensive understanding of the regulatory landscape, regulatory risks and potential regulatory interventions. This collaborative effort allows cross-pollination of ideas, combines diverse perspectives, and is designed to develop targeted and effective regulatory responses.

## Research and data Projects

Our research and evaluation work improves our regulatory effectiveness and helps us become an evidence-informed regulator. We developed a research and evaluation policy and supporting processes for Ahpra and the National Boards, including an internal advisory committee to provide advice about when an ethics review is required.

Research and evaluation projects were focused on:

- analysing trends in health practitioner workforce and publication of workforce demographic snapshots
- evaluating the Notifier Support Service
- gaining insights into medical training in Australia – results from the Medical Training Survey (MTS)
- establishing an evidence-based approach to reputational research
- exploring positive experiences of the notification process
- reviewing the response to the pandemic sub-register
- reviewing the literature and conducting rapid evidence reviews on:
  - health practitioners in the World Health Organization South-East Asia region: research protocol, global evidence and expert review
  - minimum levels of clinical experience, comparable health settings, and prediction of clinical outcomes based on clinical experience.

## Publications

We contributed four publications to peer-reviewed health journals, to share knowledge:

- Anderson S, Saar E, Evans J, Rasmussen M, Bayyavarapu SB, Main PAE, Stark S & Townley H (2023). 'Demographic changes in Australia's regulated health professions: 6-year trends', *Australian Health Review*, 47. [doi: 10.1071/AH23004](https://doi.org/10.1071/AH23004)
- Mahat A, Dhillon IS, Benton DC, Fletcher M & Wafula F (2023). 'Health practitioner regulation and national health goals', *Bulletin of the World Health Organization*, June. Available at [https://cdn.who.int/media/docs/default-source/bulletin/online-first/blt.21.287728.pdf?sfvrsn=5078c3b0\\_3](https://cdn.who.int/media/docs/default-source/bulletin/online-first/blt.21.287728.pdf?sfvrsn=5078c3b0_3)
- Main PAE & Anderson S (2023). 'Evidence for continuing professional development standards for regulated health practitioners in Australia: a systematic review', *Human Resources for Health*, 21(23). <https://doi.org/10.1186/s12960-023-00803-x>
- Main PAE & Anderson S (2023). 'Evidence for recency of practice standards for regulated health practitioners in Australia: a systematic review', *Human Resources for Health*, 21(14). <https://doi.org/10.1186/s12960-023-00794-9>

## Research and evaluation ethics

We used the ethics pathway established with the Metro North Health Human Research Ethics Committees in Brisbane, in line with best-practice research and evaluation, and the National Health and Medical Research Council's ethical requirements. Ethics approval was granted for the following new and ongoing projects.

Ongoing projects:

- Workforce trends of regulated professions
- Exploring positive experiences of the notification process
- Notifier Support Service evaluation
- Examination of notifications involving people of Aboriginal and/or Torres Strait Islander origin
- Coronial inquest analysis
- Identifying and minimising the risk of distress in practitioners subject to regulatory action: a quality improvement project
- Post-implementation review of the professional capabilities for medical radiation practice
- Pandemic response 2020 and 2021 sub-registers: data analysis, surveys, interviews and notifications about practitioners on the sub-register
- Operation Reset evaluation
- Identifying and improving stakeholder access and use of the Medical Training Survey (MTS): an impact assessment plan.

New projects:

- Project REACH, a plan for research on trust and confidence in the National Scheme
- Review into the approach of re-entry into practice for nursing and midwifery
- Nursing and Midwifery Board of Australia Student Survey
- Exploring factors associated with workforce retention and attrition of physiotherapists in Australia
- Exploring notifier and practitioner experiences with Ahpra regulatory processes over time.

## Data strategy consultation

From 10 November to 31 January, Ahpra held public consultation on a draft data strategy and future directions for the data we hold. There were three areas of focus: the *Register of practitioners*, data sharing and advanced analytics. In January, we held webinars for members of the public and practitioners to learn more about the draft data strategy. We received 109 submissions from registered health practitioners, members of the public, employers and our health system partners. A consultation report was published in March, summarising what we heard, and the data strategy was published in July.



**Table 35. Requests for access to data for research**

Type of data access request	Number of requests	Information able to be provided	Approved for release
Copies or extracts of the <i>Register of practitioners</i>	36	36	36
Quantitative statistics (regulatory data)	35	13	10
Graduate student tracking	8	8	8
Request to contact or survey practitioners	7	1	1
Research data <sup>1</sup>	4		
Other (general information)	15		
<b>Total</b>	<b>105</b>	<b>58</b>	<b>55</b>

<sup>1</sup> Two research requests are in progress; Ahpra was unable to provide the information for one request; one request was not approved.

## Access to data for research

The comprehensive national regulation data that Ahpra collects have registration, workforce planning, demographic, commercial and research value, recognising that the National Law and the *Privacy Act 1988* (Cth) impose strict limits on their use. Our data access and research policy focuses on helping researchers and other parties to better understand the process for considering requests for data and research.

A summary of the requests we received is shown in Table 35. Ahpra's website outlines the data already available and how to access them, the processes for accessing data not publicly available, and the policies and legislation that govern what can and cannot be released.

## Tracking graduate outcomes

Ahpra provides a data-matching service to Australian universities wishing to track graduate outcomes. Ahpra can match a graduate's student number to their registration number so the university does not have to manually search the *Register of practitioners*. This enables universities to determine whether they are meeting their funding requirements and the intended outcomes of their rural training programs by determining how many of their health students are working in regional and rural locations. Some universities also use it to assess graduate outcomes more broadly in metropolitan and rural areas. We received and fulfilled eight requests for student data matching in 2022/23 (Table 35).

## Medical students

Each year Ahpra provides an extract of medical practitioner data from the *Register of practitioners* to Medical Deans, who combine it with their own data from surveys of final-year medical students. Including Ahpra's data with their own allows Medical Deans to display information about medical practitioners that is broken down by a range of demographic factors, such as gender, rurality, specialty, and graduates' preferred versus their actual work locations.

## Collaborating on shared policy issues

The National Boards and Ahpra regularly collaborate on shared policy issues that affect professions similarly. This collaboration facilitates effective and collaborative care, supports good interprofessional practice, and helps to simplify regulation.

It makes it easier for the public, practitioners and employers to know what to expect of registered health practitioners.

We have continued to explore and expand how our work as a health practitioner regulator can support registered health practitioners to provide safe and effective care in their professional practice.

## Supporting professional practice

We published new resources on the Ahpra website ([www.ahpra.gov.au/Resources](http://www.ahpra.gov.au/Resources)) to support practitioners' professional practice and help the public make safer health choices. These included:

- a summary of the guidance about record management and a self-reflective tool to help practitioners assess the adequacy of their record keeping and management
- an Easy English summary of the revised shared *Code of conduct*, which applies to practitioners in 12 professions – the revised code supports good patient care and the delivery of services within an ethical framework.

## Patient safety partnership

We continued our work with the Australian Commission on Safety and Quality in Health Care (the commission) in exploring opportunities to improve the consumer experience of making a health complaint in Australia.

In 2021, Ahpra and the commission established a reference group to guide this joint work, which brings together voices from the consumer and health profession perspectives. It included representation from health consumer organisations, Ahpra's Community Advisory Council and Aboriginal and Torres Strait Islander Health Strategy Group, professional associations and National Boards. Recognising that Ahpra is one of many bodies responding to consumer health complaints, there has also been engagement with other health complaints bodies.

The project has focused on ensuring that the consumer experience is better understood. To do this, there was wide-ranging consultation, including with consumers with a lived experience of making a health complaint and key professional groups.

There are many areas that Ahpra and the commission are exploring to improve the experience of consumers, including consistent messaging across both organisations' websites and resources. We are also examining ways to provide education and guidance to strengthen the complaints culture and complaints-handling processes at the local level (directly with the health service or practitioner). Ahpra and the commission are working on resources to support both consumers and practitioners, to be published in late 2023.

## Policy consultations

Together the National Boards and Ahpra provided input to the following external policy consultations and reviews.

- Australian Government Department of Health and Aged Care consultations on:
  - Designing Australia's Centre for Disease Control
  - Intellectual Disability Health Core Capabilities
  - Healthcare Identifiers Framework Project
- Victorian Department of Health consultations on:
  - Proposed Secretary Directions: COVID-19 vaccination requirements for healthcare workers
  - Renewal of Secretary Approvals – Nurse Immuniser & Pharmacist
- Australian Commission on Safety and Quality in Health Care consultations on:
  - Review of the Diagnostic Imaging Accreditation Scheme
  - Draft National Safety and Quality Primary and Community Healthcare Standards Guide for Healthcare Services
  - Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard

- Department of Education consultation on the Australian Universities Accord Panel Discussion Paper
- National Mental Health Commission consultation on the National Stigma and Discrimination Reduction Strategy
- National Skills Commission Skills Priority List Stakeholder Survey
- Australian Bureau of Statistics Review of the Australian and New Zealand Standard Classification of Occupations
- Jobs and Skills Australia review of draft Australian Skills Classification occupation profiles

## Other work

So that the National Boards' regulatory requirements remain contemporary and relevant, we:

- continued work for 14 professions on a joint review of the English language skills registration standards (ELS standards), completing public consultation on revised draft ELS standards in late 2022
- helped practitioners understand when to report unsafe practice or patient harm in the cosmetic surgery sector through publication of case studies.

## Regulatory insights for practitioners

Through our data, we gain insights into challenges and opportunities for registered health practitioners. We want to use this knowledge to protect the public by supporting practitioners to practise professionally and avoid being the subject of a notification. We continue to see similar issues raised. These are:

- lapsed professional indemnity insurance
- poor complaints handling
- lack of informed consent
- inappropriate social media use
- providing care to family and friends.

Guidance to help practitioners practise professionally and protect their patients is available in codes of conduct, guidelines and registration standards published to the Ahpra and National Boards websites. The Boards and Ahpra periodically publish additional resources to support professional practice, including website resources and newsletter articles. Other helpful information on these topics can be found through many professional associations and organisational websites, such as that of the Australian Commission on Safety and Quality in Health Care.

# Working with communities, governments and the professions

## Improving experience and awareness

We aim to build trust and confidence in our work through building awareness and understanding, developing relationships and partnerships, and improving people's experiences with us.

Many people who are studying to be health professionals have limited knowledge of the regulatory system in Australia and what it means for them now and once they complete their training. One of the ways we have sought to **build awareness and understanding** is by developing and releasing four online modules for final year medical students on regulation and professionalism. The modules cover the purpose of regulation, replacing fear with facts about notifications, what matters to patients, and navigating professional challenges. They address specific issues such as the importance of doctors seeking help early for their own health issues, managing social media, mandatory notifications and important professional boundaries. The modules have been developed with input from students and MDANZ (Medical Deans Australia and New Zealand). They can be downloaded from the MBA website.

With patient safety our primary focus, we are consistently looking for ways to **develop relationships and partnerships** with the public and particularly those who represent diverse and underserved communities. One of the ways we are doing this is by including the voices of consumers with lived experience in our work to ensure that their unique knowledge and insights are considered. For example, we recruited consumers with recent experience of cosmetic surgery to be involved in our work to make cosmetic surgery safer. We have also been working on establishing a working group of community members to help us improve public safety in our management of practitioner sexual misconduct.

We are committed to **improving people's experiences** with us across all of our work. A major focus is the experience of navigating our regulatory processes. This year we completed a significant project that was aimed at understanding and minimising the distress

experienced by practitioners who are subject to a notification and those who have restrictions placed on their registration.

To do this, we commissioned an Expert Advisory Group (EAG) to advise us. We felt it was important to hear the firsthand experiences of these practitioners so we conducted a series of interviews. We also wanted to better understand the circumstances in which some practitioners involved in our processes had attempted or died by suicide to learn whether there are things we can do, either alone or in partnership with others, to prevent this devastating outcome. We looked at past cases over a four-year period of serious incidents involving practitioner suicide or attempted suicide.

**We are including the voices of consumers with lived experience in our work to ensure that their unique knowledge and insights are considered**

Practitioners we interviewed told us about the stigma associated with receiving a notification and the fear of the worst-case-scenario outcome. Overseas-trained practitioners said that they felt particularly alone and isolated: 'I have no family here ... no one to guide me where to go'.

Most practitioners involved in the serious incidents had pre-existing mental health issues or a history of substance use disorders or both. Some had serious criminal or misconduct allegations.

The results highlighted specific areas of our processes that could be improved. Ultimately, the EAG made 15 recommendations covering 33 specific actions. They

include improving how we manage health-related notifications, increasing our transparency and communication, increasing support for practitioners (and working to improve uptake of it) and making a commitment to learn from serious incidents and improve how we respond to them. Ahpra has accepted all recommendations and actions and is currently working to implement them.

As a regulator, our primary focus is protection of the public. We believe we can and should hold a concurrent concern for the wellbeing of practitioners. A more humane and compassionate approach to regulation will ultimately benefit patients and families as well as practitioners.

## Compassionate management of health concerns

The health management team (HMT) was established on 4 July. It is made up of staff who have an interest in working with practitioners who have concerns raised about their health. This dedicated team's case management model was developed around a mission to identify and carefully support practitioners who have an impairment.

Compassion, communication and respect are at the centre of the way this team operates.

The HMT recognises and values the services that practitioners provide to our community, and acknowledges, without judgement, that health concerns are universal. It is well known that being the subject of a notification is a stressful experience for a practitioner, and even more so if the issue is about one's health.

Clear and regular communication through a continuity of case management approach helps the development of rapport and allows for the timely assessment of a practitioner's capacity to manage their health effectively. We consider whether practitioners are engaged in treatment and what measures their workplace is taking in terms of support and oversight.

Trust is a crucial factor in the development of productive relationships with our wider stakeholders such as treating practitioners, medical indemnifiers, unions and employers. We recognise that we all have an interest in the practitioner being able to practise their chosen profession safely and therefore we aim to work together to enable this where possible.

In our first 12 months of operation, we have seen:

- a significant reduction in the time taken to close a notification
- a significant reduction in the use of investigative and immediate action powers to manage a notification
- a significant increase in the offering and acceptance of undertakings to manage health concerns
- a significant increase in positive feedback from practitioners and their legal representatives about their experience.

For more information about how we manage health concerns, see page 69.



**We all have an interest in practitioners being able to practise their chosen profession safely**



## Strengthening consumer voices

The **Community Advisory Council (CAC)** continued to be the primary source representing the community voice. The CAC provided a consumer and community perspective on Ahpra and National Board strategies, standards, codes, guidelines, policies and publications; how and where other consumer and community voices are required; and how best to consult with specific consumers and communities.

CAC members participated on reference and working groups and collectively engaged on the following issues and activities: desired community member attributes for decision-making committees; the review of regulation of medical practitioners who provide cosmetic medical and surgical procedures; the blueprint to better protect patients from sexual misconduct in healthcare; the *Independent review of overseas health practitioner regulatory settings*; the review of the National Scheme and engagement strategies; and a range of broader reforms to keep patients safe.

The CAC has a particular focus on underserved consumers and communities whose health and wellbeing is affected by limited access to healthcare, and equity and inclusion barriers. The CAC also provided general feedback about the need to use clear and unambiguous language, with less use of technical and difficult terms.

The CAC met seven times and was chaired by Ms Patricia Hall. Communiqués of its meetings are published on our website.

## Consulting the professions

The **Professions Reference Group (PRG)** met eight times. It was chaired by Mr Nello Marino from the Australian Podiatry Association from July to December, and by Ms Julianne Bryce from the Australian Nursing and Midwifery Association from January. The PRG brings together professional associations for each of the regulated health professions. It provided feedback on the *Independent review of overseas health practitioner regulatory settings*, our reforms to improve the safety of cosmetic surgery and procedures, the development of practitioner resources to support professional practice, and the refresh of the Ahpra and National Board websites.

Ahpra updated PRG members on the work of the Expert Advisory Group on identifying and minimising distress for practitioners involved in a notifications process, our blueprint to improve public safety, Ahpra's Business Transformation Program, our graduate registration and practitioner renewal campaigns, the implementation of legislative amendments to the National Law and updates on our accreditation work.



## National Law amendments

Our attention turned to implementing the more than 30 reforms in the *Health Practitioner Regulation National Law and Other Legislation Amendment Act 2022*, passed in the Queensland Parliament (as host jurisdiction for the National Scheme) in October. The reforms keep our law fit for purpose and include a stronger focus on protections for the public.

Highlights include:

- a new paramount principle that public protection and public confidence in the safety of services provided by registered health practitioners is of primary importance to our work
- enshrining cultural safety for Aboriginal and Torres Strait Islander Peoples as a new objective and guiding principle
- a new power for Ahpra and the National Boards to issue public statements to warn the public about a serious risk from an individual.

The Health Practitioner Regulation National Law (Surgeons) Amendment Bill 2023 was introduced into Queensland Parliament on 22 May. The Bill proposes to protect the title 'surgeon' when used by medical practitioners, and is an important element of cosmetic surgery reforms agreed to by all Australian health ministers.

## Other government relations work

Ahpra maintains a strong working relationship with the Australian, state and territory health departments, including through its Jurisdictional Advisory Committee.

- We appeared for the first time at Senate budget estimates hearings in November, and again in February and June. This was an opportunity for us to provide senators with information about the work and performance of the National Scheme, and address any queries and concerns.
- Ahpra and the National Boards have contributed to the work of the *Independent review of overseas health practitioner regulatory settings*. On 28 April, we welcomed the release of the report's interim review. The report complements work already underway to improve assessment processes for overseas-trained practitioners.

## Contributing internationally

As a World Health Organization (WHO) Collaborating Centre for Health Workforce Regulation, Ahpra works in partnership to strengthen the capacity and skills of regulators in the Western Pacific Region of WHO. As part of this work, we lead the Western Pacific Regional Network of Health Workforce Regulators, with members from approximately 20 countries. We held four regional network webinars on important health workforce regulation topics.





# Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025



We made significant progress in the third year of implementing the Health and Cultural Safety Strategy.

## Culturally safe notification process

The creation of a culturally safe notification process, led by Aboriginal and Torres Strait Islander Peoples, is a major milestone in the implementation of the strategy.

Committees comprising a majority of Aboriginal and Torres Strait Islander practitioners from each of the professions, along with community members, make decisions about notifications concerning Aboriginal and Torres Strait Islander Peoples, culturally safe healthcare and racism. In the most serious matters, this includes decisions about whether to refer a practitioner to an independent tribunal.

## Increased participation

Aboriginal and Torres Strait Islander workforce participation has increased, with the appointment of nine people to Identified and non-Identified roles at Ahpra in 2022/23, taking our total number of Aboriginal or Torres Strait Islander staff to 15. Targeted recruitment campaigns also resulted in the appointment of eight new Aboriginal and Torres Strait Islander Board and committee members, bringing the current total to 33.

Delivery of the Moong-moong-gak cultural safety training program concluded in September. A total of 1,596 participants have attended the training since it began in 2021. An evaluation of the program was delivered, which will inform future delivery of the training to new employees, Board and committee members.

## Cultural safety in the National Law

In October, an amendment bill was passed in the Queensland Parliament, which saw cultural safety for Aboriginal and Torres Strait Islander Peoples enshrined as a new objective and guiding principle of the National Law. This change acknowledges the National Scheme's role in ensuring the development of a culturally safe and respectful health workforce that is responsive to Aboriginal and Torres Strait Islander Peoples and their health, and that contributes to the elimination of racism in the provision of health services.

## Registration engagement and support team

As part of the commitment to increasing participation in the registered health workforce, in July we established a new Aboriginal and Torres Strait Islander Engagement and Support team within Registration. The team provides culturally safe services to Aboriginal and Torres Strait Islander students, graduates and health practitioners across all professions.

## Reconciliation Action Plan

In April, Ahpra appointed an Aboriginal race scholar, Professor Yin Paradies, to develop an Anti-Racism Policy for Aboriginal and Torres Strait Islander Peoples working in or accessing the National Scheme. This was the final remaining commitment to be delivered from our 2021–2023 Innovate Reconciliation Action Plan (RAP).

The National RAP Group was re-formed to include senior leaders from every area of Ahpra, to ensure that RAP work is core business. National Boards enthusiastically agreed to partner with Ahpra on the development of a National Scheme RAP.

## Workforce event series

In August and September, Ahpra held a series of Aboriginal and Torres Strait Islander health workforce events. The series was an opportunity for key stakeholders to meet and discuss important factors affecting the Aboriginal and Torres Strait Islander health workforce and identify actions needed to best support Aboriginal and Torres Strait Islander practitioners. Through listening to experiences of Indigenous practitioners and critically reflecting on our own practices, we identified opportunities to increase the Aboriginal and Torres Strait Islander health workforce and improve the support structures around them. Three national webinars were held, which identified clear calls to action.

# Strategy

Arranging our strategy into themes helps to communicate how we will achieve our vision.

## Regulatory effectiveness

We are responsive to the rapidly evolving nature and scope of health practice and develop management approaches that are sustainable in the long term.

### Initiatives

- Building contemporary and user-friendly technological systems for our regulatory operations
- National Law amendments
- Cosmetic surgery response
- Blueprint to improve public safety in regulation

### Benefits

- Improved experience for practitioners, applicants and the community
- Improved efficiency and quality of our core regulatory functions
- Improved risk assessments

## Trust and confidence

We are focused on strengthening the trust and confidence that the public, health practitioners, organisational partners and other stakeholders have in the National Scheme.

### Initiatives

- Continuing to provide Moong-moong-gak cultural safety training as part of our commitment to improve Aboriginal and Torres Strait Islander Peoples' health and equity
- Ahpra website project

### Benefits

- Improved experience for Aboriginal and Torres Strait Islander stakeholders
- Improved access to information and experience for the public, practitioners and employers

## Evidence and innovation

We use our data to develop insights that help us better manage critical issues in health practitioner regulation and the healthcare environment. We make sure that our standards, codes and guidelines continue to be supported by strong evidence. We develop and improve our systems and processes to identify risk and make sure we have a strong, reliable and consistent framework for data analysis, evaluation and reporting. We proactively share our data and insights with key stakeholders.

### Initiatives

- Building a modern data platform
- Enhancements to the *Register of practitioners*

### Benefits

- Improved digital capability
- Improved data quality and transparency

## Capability and culture

We strive to create a workplace that is psychologically and physically safe for all, that enhances capability, learning and development, and that motivates our people to actively participate and achieve positive outcomes.

### Initiatives

- Supporting our people through our flexible working policy
- Actions from the Ahpra Aboriginal and Torres Strait Islander Employment Strategy 2020-2025
- Delivering a wellbeing and support program

### Benefits

- Improved quality and safety of our people
- A culturally safe work environment to increase Aboriginal and Torres Strait Islander participation and representation

## Health Workforce Program

The ongoing impact of COVID-19 led to an urgent and concentrated focus on addressing system pressures on the Australian health workforce. Increased hospitalisations and staff absences in the sector, as well as the ongoing impact of stress, burnout and resignation of frontline health workers, poses real and significant risks to patient safety.

Aligned to our 'regulatory effectiveness' and 'trust and confidence' strategic themes, we created a National Scheme Health Workforce Program to respond to these workforce and safety issues. The program included these activities:

- streamlining and accelerating skills and qualification recognition while maintaining appropriate levels of safety and quality
- contributing to the National Health Workforce Taskforce
- strengthening, and improving access to, sustainable healthcare
- agreeing to items from the interim report of the *Independent review of overseas health practitioner regulatory settings*. The interim report made 56 recommendations and 32 of those will either be led by Ahpra and the National Boards or require their significant involvement.

Outcomes of the program to date include increased staffing capacity in registration and assessment, improved systems and communications through a consolidated webpage and a dedicated liaison team, increased access to existing assessment facilities and planning for additional facilities. Planning was also accelerated to deliver online registration forms through our Business Transformation Program.

# Organisation



Ahpra's National Legal Practice won an Excellence Award at the 2023 Australasian Law Awards.

## Communicating

**The Ahpra website was viewed more than 29 million times.** The most frequently visited section was 'Registration' with more than 15 million unique page views. The *Register of practitioners* was the most popular individual page with more than 6 million unique views.

**The website's home pages were redesigned to be more engaging and easier to use.** The new design went live in February.

**We published nine new episodes of our *Taking Care* podcast, and they were downloaded 11,532 times.** There were 21,633 downloads across all episodes. The most popular episodes this year were about the challenges for our overseas workforce, rural and remote healthcare, and the link between climate change and healthcare.

**Our social media posts were seen 2.63 million times and received 93,800 interactions** (likes, shares and comments). Overall, we increased our audience by 20%, with 133,544 LinkedIn followers, 38,900 Facebook followers, 11,900 Twitter followers and 4,240 Instagram followers.

**We published 51 National Board newsletters,** with an average open rate of 63.1%.

**We published 508 news items,** including 43 media releases.

**We responded to 461 media enquiries.**

**Our national Customer Service team handled an average of 675 telephone calls and closed 350 web enquiries each business day.** Compared with 2021/22, call volumes were down by 4.6% and web enquiries were up by 25.3%, continuing the trend over the past few years of fewer calls and more web enquiries. On average, 35% of callers opted to use the call-back service, meaning they were able to retain their place in the queue without waiting on hold.

**The *Register of practitioners* was the most popular individual webpage, with more than 6 million unique views**

# Leading, directing and managing

## Ahpra Board

Ahpra's governing body meets up to 11 times per year. The board publishes a communiqué of meetings that summarises issues discussed and decisions made. It has established four committees.

The **Accreditation Committee** provides advice on accreditation governance, reform, accountability and transparency issues, and a whole-of-scheme perspective on accreditation performance.

The **Finance, Audit and Risk Management Committee** oversees risk and advises on the effectiveness of the corporate assurance framework, risk management, financial strategy, sustainability and internal audits. It also oversees the external audit process.

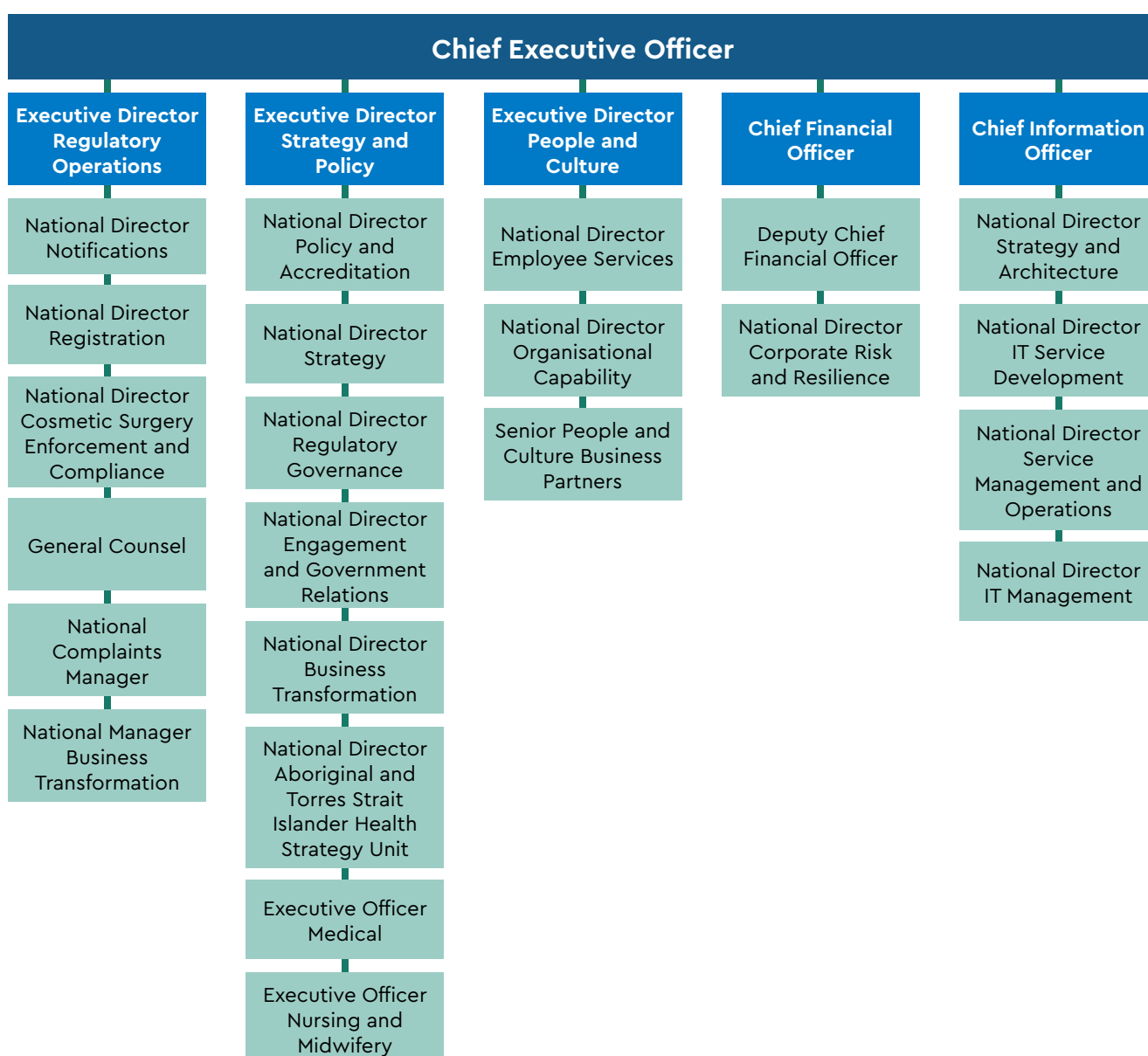
The **Regulatory Performance Committee** provides advice, oversight and scrutiny of regulatory performance measures and data.

The **People and Remuneration Committee** provides governance oversight of strategy and performance in relation to people, capability and culture.

## National Executive

The National Executive is Ahpra's national leadership group.

- Mr Martin Fletcher: Chief Executive Officer
- Ms Kym Ayscough: Executive Director, Regulatory Operations
- Ms Liz Davenport: Chief Financial Officer, Finance and Risk
- Mr Mark Edwards: Executive Director, People and Culture
- Mr Chris Robertson: Executive Director, Strategy and Policy
- Mr Clarence Yap: Chief Information Officer, Information Technology





## Directorates

**Regulatory Operations** carries out Ahpra's core functions of registration, notifications and compliance, and includes the national legal practice. It also includes the Cosmetic Surgery Enforcement Unit, which was established in September. The directorate applies risk-based approaches to regulatory matters, so we can focus our regulatory efforts on matters of high risk and high complexity and, wherever possible, resolve other matters more quickly.

**Strategy and Policy**'s purpose is effective and responsive strategy and policy in partnership with National Boards and in collaboration with our key partners. Our goal is that our partners and stakeholders have trust and confidence in our work.

**Information Technology** partners with internal and external stakeholders to provide the technology and services required to support health practitioner regulation in Australia.

**People and Culture** is accountable for whole-of-organisation initiatives that drive employee engagement and include services such as learning and organisational capability, health, safety and wellbeing, recruitment, payroll, property and facilities.

**Finance and Risk** is responsible for efficient and effective financial strategy and management, procurement, risk management and assurance, and audit programs.

## State and territory managers

Our state and territory managers are our senior leaders in each jurisdiction, and are based at each of our offices.

- Australian Capital Territory: Mr Anthony McEachran
- New South Wales: Mr Timothy Bowen
- Northern Territory: Ms Claudia Manu-Preston
- Queensland: Ms Heather Edwards
- South Australia: Mr Patrick Maher
- Tasmania: Mr David Clements
- Victoria: Ms Joe Goddard-Williams
- Western Australia: Ms Jodie Holbrook

Mr Daniel Hillary was acting state manager in South Australia for part of the year.

**The Business Transformation Program is implementing a new regulatory operating system to modernise our practices**

**Table 36. Staff, 30 June**

Directorate	Full-time equivalent staff
Regulatory Operations	847
Strategy and Policy	205
Information Technology	95
People and Culture	55
Finance and Risk	49
Office of the CEO	2
<b>Total</b>	<b>1,253</b>

**Figure 88. Gender of staff, 30 June**

- **72.2%** Female
- **27.7%** Male
- **0.1%** Non-binary



## Transformation Program

A structured multiyear program of work, the Business Transformation Program is implementing a new regulatory operating system to modernise our practices.

There are several planned releases for the program, with the first focusing on improving practitioners' experiences when engaging with Ahpra. To achieve this, we're introducing practitioner portals – one-stop shops for engaging and communicating with Ahpra. The portals will include digital smart forms for all applications, replacing paper forms; a more secure, single sign-on process to increase the security of individuals' information; and integrated biometric ID verification, which will remove the need for manual, face-to-face approaches.

We're also planning to introduce integrated student register data for improved workforce and operational planning, adapting to the changing needs of Australia's healthcare workforce.





# Financial management

Ahpra and the National Boards work in partnership to ensure the National Scheme operates efficiently, effectively and economically. The financial statements section of the annual report describes the scheme's position and performance in more detail, including the equity position for each National Board.

## Financial overview

Key financial information for the past five years is summarised in Table 37. Income and expenses have steadily increased since 2018/19. Accounting for other economic flows, the comprehensive result for 2022/23 of -\$6.6 million is a decrease from \$14.9 million in 2021/22.

The changes to the comprehensive result each period largely reflect the growing number of registered practitioners, fee income, costs to regulate and the investment being made to support public safety objectives.

**Table 37. Financial summary, 2019–23**

Five-year financial summary	2023 (million)	2022 (million)	2021 (million)	2020 (million)	2019 (million)
Revenue from government grants	\$1.4	\$2.6	\$4.6	\$1.7	
Income from operating activities	\$273.3	\$247.1	\$230.6	\$218.8	\$203.2
<b>Total income from transactions</b>	<b>\$274.7</b>	<b>\$249.7</b>	<b>\$235.2</b>	<b>\$220.4</b>	<b>\$203.2</b>
<b>Total expenses from transactions</b>	<b>\$285.0</b>	<b>\$232.0</b>	<b>\$217.8</b>	<b>\$213.8</b>	<b>\$209.0</b>
Other economic flows included in net result	\$3.7	(\$2.8)	(\$0.9)		
<b>Comprehensive result for the year</b>	<b>(\$6.6)</b>	<b>\$14.9</b>	<b>\$17.3</b>	<b>\$6.7</b>	<b>(\$5.8)</b>
Net cash flow from operating activities	\$10.8	\$37.4	\$37.7	\$24.4	\$20.0
Collections on behalf of government agencies	\$45.5	\$41.1	\$39.3	\$37.1	\$34.3
<b>Total assets</b>	<b>\$307.6</b>	<b>\$303.5</b>	<b>\$284.8</b>	<b>\$266.4</b>	<b>\$208.1</b>
<b>Total liabilities</b>	<b>\$212.5</b>	<b>\$201.8</b>	<b>\$197.9</b>	<b>\$196.9</b>	<b>\$145.3</b>

## Financial performance

A deficit comprehensive result was planned as we invest in the Business Transformation Program. Income growth was offset by increased expenses, investment in technology, and responses to regulatory and health workforce priorities.

The income for the financial year was \$274.7 million, an increase of \$25 million from 2021/22 due to application and associated fee income jumping as international borders reopened. The economic recovery provided improved interest income and return on investments reflected in other economic flows.

The fees for each National Board for 2023/24 were set to recover the full costs of regulation for each profession. In some cases, these fees were indexed up to 3%, with one Board required to raise the fee by 18.4% to meet an increased share of regulation costs. For professions with very strong equity balances, fees were not increased.

Total expenses from transactions were \$285.0 million, an increase of \$53 million from 2021/22. Significant cost increases were due to wage inflation and workforce growth, additional costs of business operations, and it being a pivotal year in delivering the transformation program.

The investment in the transformation program, totalling \$21.9 million, includes employee and contractor costs of design, delivery and associated overheads, and was made to accelerate some of the work to meet Australia's health workforce objectives. The program costs are recognised in the audited financial statements: operating expenses of \$10.4 million, intangible capital work in progress of \$7.9 million and prepayment assets of \$3.7 million.

Actions in response to the recommendations of the *Independent review of the regulation of medical practitioners who perform cosmetic surgery* (see page 85) had an estimated cost of \$4.5 million. These costs were incurred in 2022/23 for enforcement action, standards setting and compliance monitoring.

Significant resources and expertise were also invested to meet emerging priorities including a national health workforce program and a comprehensive review of overseas health practitioner regulatory settings.

There was an increase in the expenditure on consultants and contractors for specialist skills, services and advice that cannot be provided through internal workforce capacity or capability. This includes specialist resources engaged for technology skills, and consultancy contracts in place for expert advice, services and independent reviews. Ahpra employs staff and engages consultants and contractors in accordance with policies and administrative authorisations.

## Financial position

The financial statements disclose income and expenditure, and the equity balances held as compared to target equity for each National Board. Target equity is the amount of equity that should ideally be held and covers both Board and Ahpra risks, as well as the amount of funds that should be collected to date for funding future projects.

## Equity

Equity has fallen to \$95.1 million with the \$6.6 million operating deficit for the year. Equity is held by each Board in accordance with an agreed framework. During the year, the equity framework was reviewed, through stakeholder consultation, actuarial engagement and international benchmarking. Recommendations of the review to improve the quantification of risk and management of the investment pool were adopted.

Equity serves several important purposes, including:

- mitigating against unexpected loss not covered by our comprehensive insurance
- funding capital and strategic projects that support the effective and efficient operation of Boards and the scheme – including the transformation program
- offsetting the impact to the financial position due to variance in the operating result.

The equity balance also includes funding for planned projects that we have committed to, to support effective and efficient operations.

## Assets

The financial assets of \$248.1 million includes \$124.3 million registration fees paid in advance.

Non-financial assets include IT intangible assets that increased to \$22.7 million from \$17.0 million in 2021/22, and property lease assets that have been consumed, reducing to \$36.8 million in 2022/23 as scheduled.

Intangible asset investment includes \$7.9 million in completed technology projects and data platform assets. The \$12.5 million in capital work in progress includes investment in integration and data platforms, along with other system-readiness work for the launch of the transformation program, in addition to other technology initiatives.

Ahpra recognised \$3.7 million as prepayments of the costs of configuration and customisation related to the implementation of software-as-a-service (SaaS) arrangements within the transformation program. Once the system goes live, the configuration and customisation expenditure will start, and be consumed over a period of up to five years.

## Liabilities

The increase in liabilities relates to higher registration fees held in advance for all professions, higher contract payables for supplies as timing of the transformation program speeds up, and higher employee benefits. It is offset by lower lease liability in line with lease terms.

## The year ahead

The expected financial performance in 2023/24 is for another operating deficit to occur, as the investment in the transformation program remains funded from equity reserves. In the forward years, break-even results are forecast, consistent with our five-year financial plan that aims to adequately fund the required workforce and technology, support and systems from continued increases to regulatory income.

# Risk and assurance management

Risk exposure is managed in accordance with the Australian and New Zealand Standard (AS/NZS ISO 31000:2018). Ahpra's *Risk management framework* aims to provide sufficient, continuous and reliable assurance on the management of major risks to continuously improve regulatory services. We seek to manage risks in ways that allow us to meet the objectives of the National Scheme's strategy. During 2022/23, the scheme managed its risks within the following themes:

- regulatory effectiveness and partnerships
- business transformation outcomes
- financial sustainability
- actions to eliminate racism for Aboriginal and Torres Strait Islander Peoples within healthcare
- removal of barriers to access for identified communities
- public confidence/trust
- engagement with technology
- people and culture
- health practitioner workforce sustainability.

The corporate-assurance and risk-management processes are integrated with the strategic and business-planning processes and come from many sources within the organisation.

Insurable risk is managed through the ongoing maintenance of Ahpra's insurance portfolio, which includes policies to adequately mitigate the risk of financial losses arising from an (insured) event.

**Our five-year financial plan considers the regulatory income needed for our critical services. For this, we are looking at existing and alternative income streams**

## Corporate assurance

Assurance is provided through internal audit, which provides independent objective assurance and advice regarding risk management to the Finance Audit and Risk Management Committee and the Ahpra Board. In addition, quality assurance activities are undertaken to provide assurance to stakeholders of the efficacy of Ahpra's operational activities. These activities help identify and mitigate risks, determine whether processes assist Ahpra to achieve its objectives, produce required outputs and outcomes, and identify good practices and opportunities for improvement.

## Corporate compliance management

Enhancements were made to improve the way that Ahpra identifies, assesses and manages compliance obligations. Development of a corporate compliance framework in alignment with the AS ISO 37301:2023 *Compliance management systems – Requirements with guidance for use*, is underway. As part of this, compliance obligations are identified and assigned to various business units for ongoing management.

## Corporate legal compliance

To ensure corporate compliance, we have:

- Implemented an Ahpra-wide legislative compliance program, which enabled us to report to the Ahpra Board that Ahpra was compliant with its various legislative obligations.
- Updated Ahpra's *Intellectual property (IP) policy* and *IT security monitoring policy* and ensured Ahpra employees are aware of:
  - their obligations regarding their use of IP material
  - how Ahpra may monitor their access through IT infrastructure.

- Reviewed the new or amended powers contained in the *Health Practitioner Regulation National Law and Other Legislation Amendment Act 2022* and ensured they have been appropriately delegated by either the Ahpra Board or National Boards to reduce any legal risk arising from the exercise of those powers.
- Evaluated the Multi-Profession Registration and Notifications Committee (MPRNC), which deals with matters involving a broad conflict of interest to ensure they are handled in a fair, robust, consistent and transparent way without undermining the capacity of the relevant National Board. The evaluation found that the MPRNC is operating as intended and is addressing a continued need.
- Reviewed our contract precedents and associated documents to ensure they are consistent, fair and robust to protect Ahpra's and the National Boards' position.
- Improved the arrangements for the appropriate release of information through the Practitioner Information Exchange and our research work.

## Modern slavery

Our modern slavery procedure addresses the risks of modern slavery in supply chains. The procedure requires procurement officers to consider the risk profile of the procurement or the supplier relating to modern slavery compliance before they engage a supplier or renew an existing contract. The modern slavery procedure is an important part of our commitment to responsible sourcing and helps to ensure that we do not contribute to modern slavery in our supply chains.

Additionally, Ahpra published its first *Modern slavery statement* in the modern slavery register. The statement outlines our approach to modern slavery, including our risk assessment, due diligence and training programs. The statement also includes information about Ahpra's whistleblowing policy and how people can report suspected modern slavery. The statement provides transparency and accountability for Ahpra's efforts to address this issue.



# Administrative complaints

When people raise concerns about Ahpra and the National Boards, we aim to listen, to respond promptly, empathetically and fairly, and to learn from the issues raised.

Administrative complaints relate to concerns about the service delivery, policies, procedures and decisions of Ahpra, the National Boards, the Ahpra Board and committees. There are three types:

- **Stage 1** (straightforward) complaints are handled by the area of Ahpra that receives them.
- **Stage 2** (complex) complaints are managed by a National Complaints team.
- **Stage 3** complaints are investigated or reviewed externally by the National Health Practitioner Ombudsman (NHPO).

This year we received fewer complaints than the previous year (731, down from 853). Table 38 outlines who raised complaints.

The most significant decrease in complaints were those about a public campaign – this year we received 57, well down from 160 in 2021/22. A public campaign complaint is made about our regulatory role by individuals who are not a party to a regulatory action and do not have a personal relationship with the subject of a regulatory action. Often this involves submitting a complaint after being made aware of a regulatory matter, usually through traditional or social media.

Other areas where we saw fewer complaints were from health practitioners who were the subject of a notification (60, down from 76 in 2021/22), health practitioners who had made an application for registration (307, down from 348) and members of the public (28, down from 34). We saw small increases in complaints from people who had made a notification about a practitioner (189, up from 165) and employers (16, up from 9).

The 731 complaints we received were about 1,163 issues. A complaint may include more than one issue. Table 39 includes all issues raised. In Table 40, more detail is shown about the main issues raised for each profession.

**Table 38. Source of administrative complaints**

Who made the complaint?	2021/22	2022/23
Health practitioner (applicant)	348	307
Notifier	165	189
Public campaign	160	57
Health practitioner (notification)	76	60
Health practitioner (other)	52	71
Member of the public	34	28
Employer	9	16
Government department		1
Education provider	2	1
Member of Parliament	1	1
Non-government organisation	6	
<b>Total</b>	<b>853</b>	<b>731</b>

## Issues raised

**Table 39. Administrative complaints by issue**

Issues raised	2021/22	2022/23
Dissatisfied with regulatory outcome	249	305
Communication	227	273
Process/policy	254	204
Delay	172	164
Related to COVID-19	160	51
Fees	45	45
Privacy breach	11	20
Other	121	101
<b>Total</b>	<b>1,239</b>	<b>1,163</b>

### Registration issues

In the 339 complaints received about registration, processes and policies were raised 127 times, communication was raised 122 times, a perceived delay in our management of applications was raised 96 times, and dissatisfaction with a regulatory outcome was raised 54 times.

In complaints received from practitioners about our management of their application for registration, there was a reduction in concerns raised about communication during the application process (mentioned 122 times, down from 151 in 2021/22) and time taken to assess an application (mentioned 93 times, down from 100 in 2021/22). This reflects changes we made that aim to improve communication with applicants and speed up the assessment of applications.

### Notifications issues

In the 350 complaints received about notifications, dissatisfaction with the outcome was raised 228 times, making this the most common issue raised. Communication was raised 99 times, policies or processes 57 times, and the time taken to finalise a notification 46 times.

In complaints received from practitioners regarding our management of a notification made about them, there was a reduction in concerns raised about the notifications process (mentioned 25 times, compared to 41 times in 2021/22), communication during the notifications process (mentioned 24 times, compared to 32 in 2021/22) and time to finalise a notification (mentioned 17 times, compared to 27 in 2021/22).

## Engaging with the NHPO

The NHPO receives complaints from people who think they have been treated unfairly in our administrative processes. We collaborate with the NHPO to resolve complaints, and we value its contribution. Under our early resolution transfer process with the NHPO, 143 complaints were handed to us to resolve directly. We responded to 81 enquiries received from the NHPO seeking preliminary information. We also provided documents and other information in response to 15 notices of investigation.

**Table 40. Administrative complaints by profession and area of main issue raised**

Board	Stage 1 complaints	Stage 2 complaints	Total complaints received	Area of issue <sup>1</sup>						
				Registration	Notifications	Customer service interactions	Compliance	Legal	IT/website issues	Other
Aboriginal and Torres Strait Islander Health Practice			0							
Chinese Medicine	2	5	7	5	1				1	1
Chiropractic	1	2	3	1	1			1		
Dental	6	22	28	8	26		1			1
Medical	146	186	332	84	249	15	13	8	2	21
Medical Radiation Practice	4	2	6	4	2					
Nursing and Midwifery	124	56	180	135	20	9	13	2	6	6
Occupational Therapy	11	4	15	11	4		1		1	
Optometry	1	1	2	1	1					
Osteopathy		1	1	1						
Paramedicine	4	7	11	5	4		1	2	1	
Pharmacy	7	3	10	7	2	1				
Physiotherapy	6	14	20	17	3	1			1	1
Podiatry	3		3	3						
Psychology	36	46	82	44	34	4	2	1	2	3
Unknown	26	5	31	13	3	4	1		1	9
<b>Total</b>	<b>377</b>	<b>354</b>	<b>731</b>	<b>339</b>	<b>350</b>	<b>34</b>	<b>32</b>	<b>14</b>	<b>15</b>	<b>42</b>

1 The number of issues often outnumbers the number of complaints received, as a complaint may include more than one issue.

## Resolving complaints

We responded to 721 complaints. We look carefully at the information provided and at how people would like their complaint resolved. We then review the information we hold and endeavour to respond in a way that meaningfully addresses the concerns.

Table 41 outlines the actions we took to resolve complaints. We may take more than one action to address a complaint.

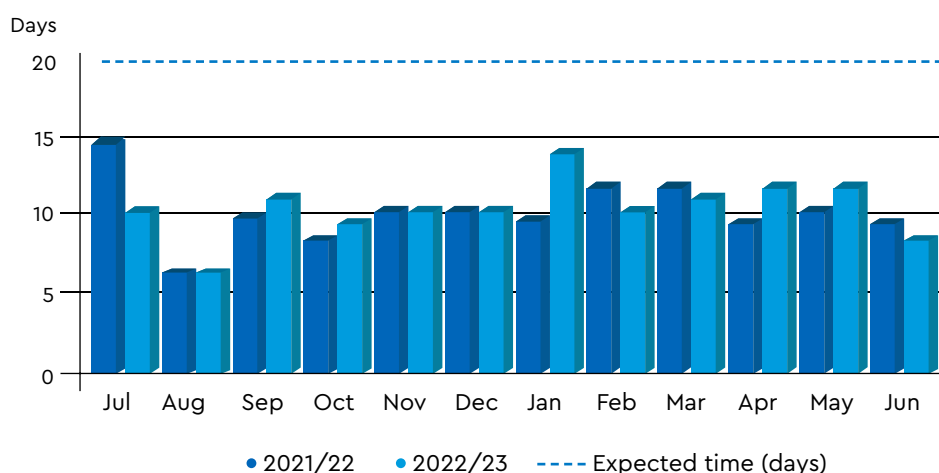
**Table 41. Action taken**

Action taken to resolve issues	Number
Provided further explanation	504
Offered apology	220
Advised will consider feedback for improvement	91
Provided update	84
Arranged for a matter to be reconsidered	15
Corrected an error	10
Other	142

## Performance

We aim to respond to complaints within 20 business days. Figure 89 shows that our average time to respond was consistently within the expected timeframes.

**Figure 89. Time taken to finalise complaints**





# Freedom of information requests

Ahpra received:

- **248** valid applications for access to documents under the *Freedom of Information Act 1982* (FOI Act)
- **15** applications for internal review of an FOI decision.

The National Health Practitioner Privacy Commissioner (NHPPC) notified Ahpra that:

- **6** applications for external review of an Ahpra FOI decision had been undertaken
- **12** external review applications had been closed.

The NHPPC provided notice that Ahpra's FOI decision had been affirmed in two matters and varied in one matter. Ahpra was advised that one applicant had withdrawn their application for external review and a further eight matters were discontinued by the NHPPC.

One application was made to a tribunal for a review of an FOI decision.

During the year, 240 FOI applications were finalised. Outcomes are shown in Table 42. At 30 June, 40 FOI matters were open and had not been finalised.

## Evidentiary certificates

Ahpra issued 135 evidentiary certificates, most in response to requests from our co-regulatory partners, health complaints entities and police, to help them perform their functions in the community.

## Production of documents

We responded to 131 subpoenas and orders to produce documents issued by courts, tribunals and law enforcement bodies about proceedings in which neither Ahpra nor a National Board was a party.

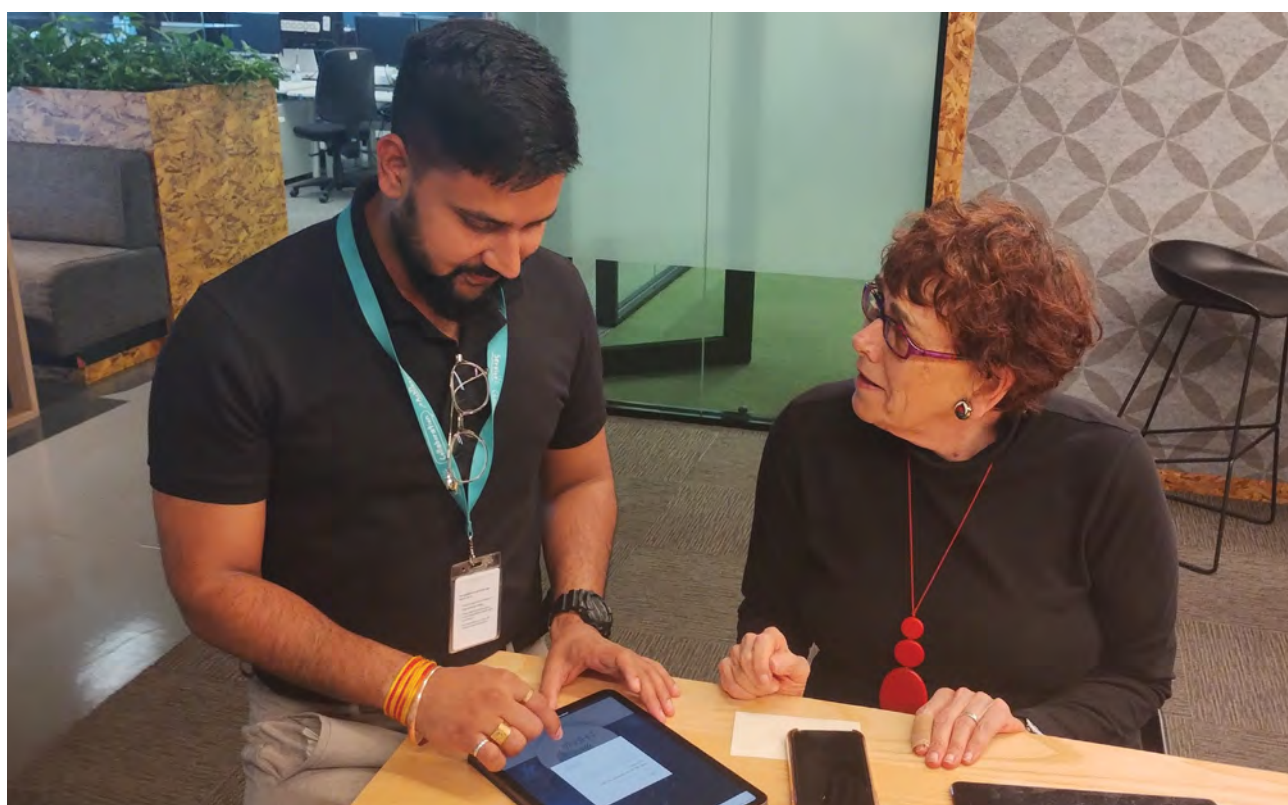
**Table 42. Finalised FOI applications**

Application outcome	Number
Granted in full	46
Granted in part	121
Access refused	63
Withdrawn	10
<b>Total</b>	<b>240</b>
Internal review	14
External review (NHPPC)	12
External review (tribunal)	1

Table 43 describes the nature of the documents sought by FOI applicants.

**Table 43. Documents sought by FOI applicants**

Document type	Number of applications
Notifications/complaints	189
Registration applications and decisions	20
Statistics and general data	13
Policy procedure, guidelines	5
Monitoring and compliance of registration restrictions	2
Criminal offences	1
Other	10
<b>Total</b>	<b>240</b>



# Financial statements for the year ended 30 June 2023

Australian Health Practitioner Regulation Agency

## Declaration by Chair of the Ahpra Board, Chief Executive Officer and Chief Financial Officer

The attached financial statements for the Australian Health Practitioner Regulation Agency have been prepared in accordance with Part 3 of Schedule 3 to the Health Practitioner Regulation National Law Act 2009 (the National Law), as in force in each state and territory, Australian Accounting Standards and Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the *Statement of comprehensive income*, *Statement of financial position*, *Statement of changes in equity*, *Statement of cash flow*, and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2023 and financial position of the Australian Health Practitioner Regulation Agency as at 30 June 2023.

At the time of signing, we are not aware of any circumstance that would render any particulars included in the financial statements to be misleading or inaccurate.

We are authorised by the Ahpra Board to issue the attached financial statements on this day.

**Gill Callister PSM**  
Chair, Ahpra Board  
24 August 2023

**Martin Fletcher**  
Chief Executive Officer  
24 August 2023

**Elizabeth Davenport FCPA**  
Chief Financial Officer  
24 August 2023

## Independent Auditor's Report

### To the Board of the Australian Health Practitioner Regulation Agency

<b>Opinion</b>	<p>I have audited the financial report of the Australian Health Practitioner Regulation Agency (the agency) which comprises the:</p> <ul style="list-style-type: none"> <li>• statement of financial position as at 30 June 2023</li> <li>• statement of comprehensive income for the year then ended</li> <li>• statement of changes in equity for the year then ended</li> <li>• statement of cash flows for the year then ended</li> <li>• notes to the financial statements, including significant accounting policies</li> <li>• declaration by chair of the Board of the agency, chief executive officer and chief financial officer.</li> </ul> <p>In my opinion the financial report presents fairly, in all material respects, the financial position of the agency as at 30 June 2023 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 3 of Schedule 3 to the <i>Health Practitioner Regulation National Law Act 2009</i> and applicable Australian Accounting Standards.</p>
<b>Basis for Opinion</b>	<p>I have conducted my audit in accordance with the <i>Audit Act 1994</i> which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the <i>Auditor's Responsibilities for the Audit of the Financial Report</i> section of my report.</p> <p>My independence is established by the <i>Constitution Act 1975</i>. My staff and I are independent of the agency in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 <i>Code of Ethics for Professional Accountants</i> (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.</p> <p>I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.</p>
<b>Board's responsibilities for the financial report</b>	<p>The Board of the agency is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the <i>Health Practitioner Regulation National Law Act 2009</i>, and for such internal control as the Board of the agency determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error.</p> <p>In preparing the financial report, the Board of the agency is responsible for assessing the agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.</p>

**Auditor's responsibilities for the audit of the financial report**

As required by the *Audit Act 1994*, my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the agency's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board of the agency
- conclude on the appropriateness of the Board of the agency's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the agency's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the agency to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Board of the agency regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

MELBOURNE  
30 August 2023



Sanchu Chummar

*as delegate for the Auditor-General of Victoria*



# Statement of comprehensive income for the year ended 30 June 2023

	Note	2023 \$'000	2022 \$'000
<b>Continuing operations</b>			
<b>Revenue and income from transactions</b>			
Registration and application fee	A1.1	254,375	235,607
Investment income	A2	7,371	4,065
Grant revenue	A3	1,425	2,591
Other income and revenue	A4	11,560	7,422
<b>Total revenue and income from transactions</b>		<b>274,731</b>	<b>249,685</b>
<b>Expenses from transactions</b>			
Employee costs	B1.1	176,079	151,081
Board and committee sitting fees		5,778	5,734
Legal and notification costs		14,763	12,945
Accreditation expenses		10,178	9,592
Other operating expenses	B2	64,728	39,869
Depreciation and amortisation	C4.1	12,785	12,071
Finance costs – leases	E1.2	716	736
<b>Total expenses from transactions</b>		<b>285,027</b>	<b>232,028</b>
<b>Net result from transactions</b>		<b>(10,296)</b>	<b>17,657</b>
<b>Other economic flows included in net result</b>			
Net (loss) on non-financial assets	C4.2	0	(78)
Net gain/(loss) on financial instruments at fair value	B3	3,429	(4,277)
Other gain from other economic flows	B3	270	1,572
<b>Total other economic flows included in net result</b>		<b>3,699</b>	<b>(2,783)</b>
<b>Net result for the year</b>		<b>(6,597)</b>	<b>14,874</b>
Other comprehensive income		0	0
<b>Comprehensive result for the year</b>		<b>(6,597)</b>	<b>14,874</b>

# Statement of financial position as at 30 June 2023

	Note	2023 \$'000	2022 \$'000
<b>Assets</b>			
<b>Financial assets</b>			
Cash and cash equivalents	E2	16,596	5,683
Receivables	D1	4,732	5,016
Prepayments	D3	11,557	3,728
Investments and other financial assets	C1	215,242	227,818
<b>Total financial assets</b>		<b>248,127</b>	<b>242,245</b>
<b>Non-financial assets</b>			
Property, plant and equipment	C2	36,791	44,247
Intangible assets	C3	22,733	17,025
<b>Total non-financial assets</b>		<b>59,524</b>	<b>61,272</b>
<b>Total assets</b>		<b>307,651</b>	<b>303,517</b>
<b>Liabilities</b>			
Payables and accruals	D2	17,805	10,931
Contract liabilities	A1.2	124,282	117,295
Employee benefits	B1.2	32,442	29,511
Lease liability	E1	37,194	43,293
Other provisions	D4	792	754
<b>Total liabilities</b>		<b>212,515</b>	<b>201,784</b>
<b>Net assets</b>		<b>95,136</b>	<b>101,733</b>
<b>Equity</b>			
Contributed capital	G7	43,895	43,895
Accumulated surplus	G7	51,241	57,838
<b>Total equity</b>		<b>95,136</b>	<b>101,733</b>

Commitments

E3

Contingent assets and liabilities

F3

These statements should be read in conjunction with the accompanying notes.



## Statement of changes in equity for the year ended 30 June 2023

	Note	Contributed capital \$'000	Accumulated surplus \$'000	Total equity \$'000
Balance at 1 July 2021		43,895	42,964	86,859
Net result for the year		0	14,874	14,874
Balance at 30 June 2022		43,895	57,838	101,733
Net result for the year		0	(6,597)	(6,597)
Balance at 30 June 2023	G7	43,895	51,241	95,136

This statement should be read in conjunction with the accompanying notes.

## Statement of cash flows for the year ended 30 June 2023

	Note	2023 \$'000	2022 \$'000
<b>Cash flows from operating activities</b>			
<b>Receipts</b>			
Receipts relating to regulatory fees		261,362	242,434
Receipts from government grant	A3	495	3,521
Goods and Services Tax (GST) recovered from the Australian Taxation Office (ATO)		10,602	7,509
Other receipts		14,496	6,255
Interest received		4,485	3,069
<b>Total receipts</b>		<b>291,440</b>	<b>262,788</b>
<b>Payments</b>			
Payments to suppliers, employees and others		(279,924)	(224,686)
Interest paid		(716)	(736)
<b>Total payments</b>		<b>(280,640)</b>	<b>(225,422)</b>
<b>Net cash flows from operating activities</b>	E2	<b>10,800</b>	<b>37,366</b>
<b>Cash flows from investing activities</b>			
Payments for plant and equipment, intangibles and work in progress		(10,946)	(12,289)
Purchase of investments and other financial assets		(117,000)	(243,000)
Proceeds of investments		136,000	220,500
<b>Net cash flows used in investing activities</b>		<b>8,054</b>	<b>(34,789)</b>
<b>Cash flows from financing activities</b>			
Repayment of principal portion of lease liabilities		(7,941)	(7,554)
<b>Net cash flows used in financing activities</b>		<b>(7,941)</b>	<b>(7,554)</b>
<b>Net increase in cash and cash equivalents</b>		<b>10,913</b>	<b>(4,977)</b>
Cash and cash equivalents at the beginning of the year		5,683	10,661
<b>Total cash and cash equivalents at end of the year</b>	E2	<b>16,596</b>	<b>5,683</b>

All amounts are inclusive of GST.

This statement should be read in conjunction with the accompanying notes.

## About this report

### Reporting entity

The Australian Health Practitioner Regulation Agency (Ahpra) is a statutory body governed by the Health Practitioner Regulation National Law (the National Law), which came into effect in most states and territories on 1 July 2010 and in Western Australia on 18 October 2010. This law means that registered health professions are regulated by nationally consistent legislation.

Ahpra supports the National Boards in the administration of the National Registration and Accreditation Scheme (the National Scheme) across Australia. National Boards are responsible for regulating their respective health professions. The primary role of the National Boards is to protect the public and set standards and policies that all registered health practitioners must meet.

The Ahpra Board oversees the work of Ahpra. The Chair of the Ahpra Board is Ms Gill Callister PSM. The Chief Executive Officer is Mr Martin Fletcher.

The financial statements include activities of Ahpra and National Boards.

Ahpra's corporate address is 111 Bourke Street, Melbourne, Victoria, 3000.

### Basis of accounting preparation and measurement

The financial statements have been prepared on a going-concern basis.

These financial statements are in Australian dollars and the historical cost convention is used unless a different measurement basis is specifically disclosed in the note associated with the item measured on a different basis.

The accrual basis of accounting has been applied in preparing these financial statements, except for the cash flow information, whereby assets, liabilities, equity, income or expenses are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The estimates and underlying assumptions used in preparing these financial statements are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised and in future periods that are affected by the revision. Judgements and assumptions made by management in the application of Australian Accounting Standards (AAS) that have significant effects on the financial statements and estimates relate to:

- assessing whether there is an enforceable contract with sufficiently specific performance obligations to recognise revenue or income (refer to Note A1 and A3)

- assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note B1)
- the intangible assets initial recognition and impairment (refer to Note C3)
- the fair value measurement of financial assets and liabilities (refer to Note F1)
- the determination, in accordance with AASB 16 *Leases*, of the lease term, the estimation of the discount rate when not implicit in the lease and whether an arrangement is in substance short term or low value (refer to Note E1)
- the impairment assessment of Ahpra's contractual receivables, applying AASB 9 *Financial Instruments*, based on the assumptions about risk of default and expected loss rates. Ahpra has grouped contractual receivables on shared credit risk characteristics and days past due, and selected the expected credit loss rate based on Ahpra's history, existing market conditions, as well as forward-looking estimates at the end of the financial year (refer to Note F1.2)
- the determination of configuration and customisation services received during the implementation of Software-as-a-Service (SaaS) arrangements, primarily in response to the International Financial Reporting Standards Interpretations Committee (IFRIC) agenda decision, which provides clarity on how existing accounting standards are applicable to such arrangements (refer to Note G5).

All amounts in the financial statements have been rounded to the nearest thousand dollars unless otherwise stated.

Regulatory fees do not constitute a supply and are therefore exempt from GST. Revenue, expenses and assets are recognised net of GST except where the amount of GST incurred is not recoverable, in which case it is recognised as part of the cost of acquisition of an asset or part of an item of expense or revenue. GST receivable from or payable to the Australian Taxation Office (ATO) is included in the *Statement of financial position*. The GST component of a receipt or payment is recognised on a gross basis in the *Statement of cash flows* in accordance with AASB 107 *Statement of Cash Flows*.

Income tax effect accounting has not been applied as Ahpra is exempt from income tax under section 50–25 of the *Income Tax Assessment Act 1997*.

### Statement of compliance

These financial statements are referred to as general purpose financial statements which have been prepared in accordance with Australian Accounting Standards and Interpretations and other mandatory requirements.

The financial statements have also been prepared in accordance with the relevant requirements of the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory.

For the purpose of preparing the financial statements, Ahpra is a not-for-profit entity.

Accounting policies selected and applied in preparing the financial statements for the year ended 30 June 2023 ensure that the resulting financial information satisfies the concepts of relevance and reliability,

thereby ensuring that the substance of the underlying transactions or other events is appropriately reported. Change in accounting policy interpretation in relation to accounting for SaaS (refer to Note G5) has been applied in preparing the financial statements.

These financial statements were authorised to be issued by the Ahpra Board on 24 August 2023.

## Note A: Funding the delivery of our services

### A1. Registration and application fees

### A2. Investment income

### A3. Grant revenue

### A4. Other income and revenue

## Introduction

Ahpra supports the National Boards in the administration of the National Scheme across Australia. National Boards are responsible for regulating their respective health professions. The primary role of the National Boards is to protect the public and set standards and policies that all registered health practitioners must meet.

Ahpra is predominantly funded by regulatory fees to deliver services in partnership with the National Boards.

## Judgement required

Ahpra has made judgement assessing whether there is an enforceable contract with specific performance obligations to recognise revenue or income.

Revenue and income are recognised to the extent that it is probable that the economic benefits will flow to Ahpra and it can be reliably measured. Revenue and income over which Ahpra does not have control is disclosed as administered revenue and income (see Note G8).

## Note A1: Registration and application fees

Ahpra collects registration fees and in return provides eligible registrants rights to practise and provide suitable healthcare to the public. Ahpra has determined it has an enforceable contract with sufficiently specific performance obligations to recognise registration fees in accordance with AASB 15 *Revenue from Contracts with Customers*.

AASB 15 recognition exemption permits accounting for short-term licences or low-value licences with two options:

- recognise the revenue associated with those licences at the point in time the licence is issued, or
- on a straight-line basis over the licence term or another systematic basis.

When a person pays a registration fee, the fee is recognised over the term of the registration.

When a person pays an application fee, the fee is recognised at the point in time the fee is received.

Registration fees are payable periodically in advance. Only the portion of registration fees that is attributable to the current financial year is recognised as revenue. Consideration received in advance of recognising the associated revenue from registrants is recorded as a contract liability.

### A1.1: Registration and application fee revenue

	2023 \$'000	2022 \$'000
Registration fees	232,155	218,343
Application fees	22,220	17,264
<b>Total registration and application fee revenue</b>	<b>254,375</b>	<b>235,607</b>

### A1.2 Contract liabilities

Contract liabilities	Note	2023 \$'000	2022 \$'000
<b>Registration fees received in advance</b>			
Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA)		55	50
Chinese Medicine Board of Australia (CMBA)		845	713
Chiropractic Board of Australia (ChiroBA)		932	1,083
Dental Board of Australia (DBA)		5,554	5,365
Medical Board of Australia (MBA)		24,236	21,782
Medical Radiation Practice Board of Australia (MRPBA)		1,464	1,236
Nursing and Midwifery Board of Australia (NMBA)		70,609	66,602
Occupational Therapy Board of Australia (OTBA)		1,379	1,202
Optometry Board of Australia (OptomBA)		849	769
Osteopathy Board of Australia (OsteoBA)		488	458
Paramedicine Board of Australia (ParaBA)		2,092	2,257
Pharmacy Board of Australia (PharmBA)		5,246	4,943
Physiotherapy Board of Australia (PhysioBA)		2,738	2,031
Podiatry Board of Australia (PodBA)		819	802
Psychology Board of Australia (PsyBA)		6,976	7,072
<b>Total registration fees received in advance</b>		<b>124,282</b>	<b>116,365</b>
<b>Other contract liabilities</b>			
Government grant received in advance	A3	0	930
<b>Total contract liabilities</b>		<b>124,282</b>	<b>117,295</b>
<i>Represented by</i>			
Current liabilities		124,282	117,295
		<b>124,282</b>	<b>117,295</b>

Registration fees received in advance	2023 \$'000	2022 \$'000
<b>Opening balance</b>	<b>116,365</b>	<b>109,538</b>
Add: Registration fees received during the year	240,072	225,170
Less: Revenue recognised from performance obligations satisfied	(232,155)	(218,343)
<b>Total payments received for performance obligations yet to be completed</b>	<b>124,282</b>	<b>116,365</b>

## Note A2: Investment income

Interest income is accrued by reference to the principal of a financial asset at the effective interest rate when earned.

Distribution from investment in managed funds is recognised as income when the right to receive payment is established. It represents the income arising from Ahpra's investments in managed funds consistent with Ahpra's investment policy.

Net unrealised gains and losses on the revaluation of investments do not form part of income from transactions, but are reported as other economic flows in the net result.

	2023 \$'000	2022 \$'000
Interest on term deposits	5,545	2,009
Distribution from investments in managed fund	1,826	2,056
<b>Total investment income</b>	<b>7,371</b>	<b>4,065</b>

## Note A3: Grant revenue

Revenue from grants that are enforceable and with sufficiently specific performance obligations are accounted for under AASB 15 *Revenue from Contracts with Customers*, with revenue recognised as these performance obligations are met.

During 2022/23, the Commonwealth Government provided a grant of \$0.495 million to support the delivery of 'Area of Practice' endorsement. This endorsement outlines the minimum qualifications and skills required for performing complex cosmetic surgery procedures.

The grant encompasses activities with measurable performance obligations.

Grant revenue is recognised when the relevant services are provided, and performance obligations are met. In 2022/23, Ahpra recognised a \$1.425 million grant received as revenue, including \$930K from 2021/22 recognised as contract liabilities and \$495K received from 2022/23.

Other contract liabilities – government grant received in advance	2023 \$'000	2022 \$'000
<b>Opening balance</b>	<b>930</b>	<b>0</b>
Add: Grant consideration for sufficiently specific performance obligations received during the year	495	3,521
Less: Revenue recognised from performance obligations satisfied	(1,425)	(2,591)
<b>Total payments received for performance obligations yet to be completed</b>	<b>0</b>	<b>930</b>
<i>Represented by</i>		
Current liabilities	0	930
	<b>0</b>	<b>930</b>

## Note A4: Other income and revenue

Other income and revenue include legal fee recoveries, fees received for examinations and revenue from providing the practitioner information service to external parties.

Legal fee recoveries and fines are recognised when an invoice is issued, which establishes the entitlement to payment.

Practitioner Information Exchange and examinations are recognised when invoices are issued and services are received by customers. Examination income includes the internationally qualified nurse and midwives (IQNM) exam and the objective structured clinical examination (OSCE). These exams cleared a backlog created by COVID-19 lockdowns in previous years, which prevented exam sittings.

	2023 \$'000	2022 \$'000
Accreditation	657	654
Certificate of registration status	305	254
Legal fee recoveries and fines	933	1,182
Examinations	7,844	3,443
Practitioner Information Exchange (PIE)	1,291	1,323
Application for registrar program	303	281
Other	227	285
<b>Total other income and revenue</b>	<b>11,560</b>	<b>7,422</b>

## Note B: The cost of delivering services

### B1. Employee benefits

### B2. Other operating expenses

### B3. Other economic flows

## Introduction

This section provides an account of the expenses incurred by Ahpra in delivering services.

## Judgement required

Judgements have been applied in the calculations of employee benefits provisions such as likely tenure of staff, historical patterns of leave claims, the future salary movements and discount rates.

Expenses from transactions are recognised in the *Statement of comprehensive income* when they are incurred.

Expenses from transactions	Note	2023 \$'000	2022 \$'000
Employee costs	B1.1	176,079	151,081
Board and committee sitting fees		5,778	5,734
Legal and notification costs		14,763	12,945
Accreditation expenses		10,178	9,592
Other operating expenses	B2	64,728	39,869

## Board and committee sitting fees

Board and committee sitting fees include costs related to meetings held by the Ahpra Board as well as those national, state and territory board meetings held by the National Boards and their committees.

## Legal and notification costs

Legal costs include external costs relating to managing the notification (complaint) process by Ahpra. These costs include legal fees paid to external firms and costs of civil tribunals. They do not include the costs associated with Ahpra staff in the assessment and investigation of notifications, or the cost of legal staff employed by Ahpra.

## Accreditation expenses

Accreditation expenses relate to payments to external accreditation bodies to exercise accreditation functions, as defined in section 42 of the National Law. Staff costs and committee sitting fees when these functions are carried out by accreditation committees are not included.

Five boards have assigned accreditation functions under section 42 of the National Law to accreditation committees administered by Ahpra.

Accrediting activities relating to registration of health practitioners under section 52 of the National Law are disclosed separately as funding for intern training accreditation authorities under other operating expenses.

## Note B1: Employee benefits

Employee costs relate to all Ahpra employment costs, including wages and salaries, fringe benefits tax, leave entitlements and on-costs, termination payments, WorkCover premiums, superannuation and contractors' costs.

### B1.1 Employee costs

	Note	2023 \$'000	2022 \$'000
Salaries and related on-costs		137,996	118,407
Leave entitlements		13,848	13,789
Superannuation expenses	B1.3	15,251	12,823
Termination benefits		103	487
Contractors		7,796	4,841
Staff development and amenities		1,085	734
<b>Total employee costs</b>		<b>176,079</b>	<b>151,081</b>

Ahpra's expenditure on contractor resources has increased in 2022/23, as budgeted to address IT improvements and cybersecurity and transformation program needs, new opportunities such as cosmetic surgery response and National Cabinet health workforce expectations, and resumption of strategic projects deferred or delayed by COVID-19 restrictions.

### B1.2 Employee benefits in the Statement of financial position

Provision is made for benefits accruing to employees in respect of annual leave and long service leave for services rendered to the reporting date and recorded as an expense during the period the entitlements are consumed.

Current employee benefits provisions	2023 \$'000	2022 \$'000
<b>Annual leave</b>		
Unconditional and expected to be settled within 12 months	9,147	9,088
Unconditional and expected to be settled after 12 months	3,001	2,546
<b>Long service leave</b>		
Unconditional and expected to be settled within 12 months	2,110	1,776
Unconditional and expected to be settled after 12 months	9,314	8,552
<b>Provision for on-costs</b>		
Unconditional and expected to be settled within 12 months	1,881	1,747
Unconditional and expected to be settled after 12 months	2,083	1,782
<b>Total current provisions for employee benefits and on-costs</b>	<b>27,536</b>	<b>25,491</b>
<b>Non-current employee benefits provisions</b>		
Conditional long service leave entitlements expected to be settled after 12 months	3,750	3,113
On-costs	1,156	907
<b>Total non-current provisions for employee benefits and on-costs</b>	<b>4,906</b>	<b>4,020</b>
<b>Total provisions for employee benefits and on-costs</b>	<b>32,442</b>	<b>29,511</b>

### Reconciliation of movement in provisions and on-costs

	Annual leave \$'000	Long service leave \$'000	On-costs \$'000	Total \$'000
<b>Carrying amount at 30 June 2022</b>	<b>11,634</b>	<b>13,441</b>	<b>4,436</b>	<b>29,511</b>
Additional provisions recognised	9,701	4,311	2,558	16,570
Reductions arising from payments	(9,070)	(1,585)	(1,776)	(12,431)
Reductions resulting from settlement without cost	0	(574)	(98)	(672)
Effect of changes in the discount rate	(117)	(419)	0	(536)
<b>Carrying amount at 30 June 2023</b>	<b>12,148</b>	<b>15,174</b>	<b>5,120</b>	<b>32,442</b>
Current	12,148	11,424	3,964	27,536
Non-current	0	3,750	1,156	4,906
<b>Total</b>	<b>12,148</b>	<b>15,174</b>	<b>5,120</b>	<b>32,442</b>

#### (a) Annual leave

Liabilities for annual leave are recognised in the provision for employee benefits as current liabilities, because Ahpra does not have an unconditional right to defer settlements of these liabilities.

The liabilities for salaries are recognised in the *Statement of financial position* at remuneration rates which are current at the reporting date.



When the annual leave is expected to wholly settle within 12 months of the reporting date, it is measured at its nominal value. Those liabilities not expected to be wholly settled within 12 months of the reporting date are measured at the present value of the amounts expected to be paid when the liabilities are settled using remuneration rates expected to apply at the time of settlement.

#### (b) Sick leave

No provision has been made for sick leave as all sick leave is non-vesting. An expense is recognised in the *Statement of comprehensive income* as it is taken.

#### (c) Long service leave

The long service leave entitlement is recognised from an employee's start date and becomes payable according to the employment arrangements in place. Long service leave is classified as a current liability for those employees who have met the conditions of service to take long service leave, while the classification for those employees still to meet the conditions of service is recognised as a non-current liability.

Part of the current liability is measured at nominal value when it is expected to wholly settle within 12 months of the reporting date. When liabilities are not expected to wholly settle within 12 months of the reporting date, it is measured at the present value of the expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given to expected future wage and salary levels, experience of employee departures, and periods of service. Expected future payments are discounted using Reserve Bank of Australia's 10-year rate for semi-annual coupon bonds, which is 4.063% as of 30 June 2023 (3.693% as of 30 June 2022).

#### (d) Employee benefits on-costs

Employee benefits on-costs such as payroll tax, WorkCover insurance premium and superannuation entitlements are not employee benefits. They are recognised as liabilities when the employee benefits to which they relate are recognised.

#### (e) Termination benefits

Termination benefits are payable when employment is terminated before the normal retirement date or when an employee accepts voluntary redundancy in exchange for these benefits. Ahpra recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy.

#### B1.3 Superannuation contributions

The amount expensed in respect of superannuation represents Ahpra contributions for members of both defined benefit and defined contribution superannuation plans that are paid or payable during the reporting period.

Ahpra employees and statutory appointees are entitled to receive superannuation benefits and Ahpra contributes to both defined benefit and defined contribution plans. The defined benefit plans provide benefits based on years of service and final average salary.

Contributions to defined contribution and defined benefits superannuation plans are expensed when incurred.

Superannuation contributions paid or payable for the reporting period are included as part of staffing costs in Ahpra's *Statement of comprehensive income*.

The reported contributions reflect gross superannuation payments to each of the funds, inclusive of superannuation guarantee contributions.

The name, details and amounts expensed in relation to the major employee and statutory appointees' superannuation funds and contributions made by Ahpra are as follows:

Fund	Paid contribution for the year		Contribution outstanding at year end	
	2023 \$'000	2022 \$'000	2023 \$'000	2022 \$'000
<b>Defined benefit plans:</b>				
Southern State Superannuation Scheme	225	215	0	1
QSuper	98	107	0	0
Other (5 funds)	96	98	0	1
<b>Defined contribution plans:</b>				
Australian Super	5,747	4,811	0	0
First State accumulation <sup>1</sup>	406	575	0	0
HESTA	576	509	0	0
Hostplus	650	472	0	0
Vic Super <sup>1</sup>	410	421	0	0
QSuper accumulation	737	578	0	0
Rest Super	567	417	0	0
Sunsuper	567	510	0	0
UniSuper	705	548	0	0
Other (2023: 225 funds; 2022: 223 funds)	4,416	3,509	51	51
<b>Total</b>	<b>15,200</b>	<b>12,770</b>	<b>51</b>	<b>53</b>

1 Both First State accumulation and Vic Super become Aware Super in 2022/23.

## Note B2: Other operating expenses

	Note	2023 \$'000	2022 \$'000
Bank charges and merchant fees		1,568	1,289
Consultant costs		6,048	2,991
Criminal history checks		1,337	1,318
External contract services		7,115	2,327
Funding for intern training accreditation authorities		966	936
Health programs		4,298	3,044
Insurance		1,292	1,128
Internal audit fees		323	282
National Health Practitioner Ombudsman and Privacy Commissioner Office		2,890	2,640
Office of the Health Ombudsman (OHO, in Queensland)	G8	7,324	4,451
Printing, postage and publications		725	917
Property expenses		2,589	2,695
Systems and communications		18,408	11,719
Travel and accommodation		7,379	1,603
Other		2,466	2,529
<b>Total other operating expenses</b>		<b>64,728</b>	<b>39,869</b>

### External contract services

External contract services spend covers a range of services contracted with external organisations. The rise in expenses is attributed to additional spend on the cosmetic surgery review and the newly formed Cosmetic Surgery Enforcement Unit, as well as Ahpra's technology enhancement project.

### Health programs

Health programs are national schemes financially supported by Boards and operated at arm's length. A health program provides telephone and online services offering health support to practitioners, contributing to better health and wellbeing for practitioners, and safer care for the public.

### National Health Practitioner Ombudsman and Privacy Commissioner Office

The National Health Practitioner Ombudsman (NHPO) investigates complaints, facilitates resolutions and makes recommendations to improve the regulation of Australia's registered health practitioners. The NHPO is funded by registration fees paid by health practitioners. The Health Chief Executives Forum (HCEF) approves the budget request from the NHPO each year and directs Ahpra to pay the approved funds.

### Property expenses

Property expenses include maintenance of leased properties, variable lease payments such as rates and outgoings, and offsite storage costs.

In accordance with the AASB 16 *Leases*, lease payments for office rental are accounted as depreciation of right-of-use assets and interest on leases (Note E1.2). Variable lease payments, such as rates and outgoings, which do not depend on an index or a rate and which are not in substance fixed, are recognised in the period they occur as property expenses.

## Consultant costs

Strategic and project consultants are engaged for tasks requiring specialist skill sets when the skills and capacity do not normally reside in house. A significant number of consultants were engaged this year for expert advice and services, and independent reviews. These expenses are assessed as not meeting the definition of an asset under AASB 138 *Intangible Assets*.

## Systems and communications

Systems and communications costs relate to the technology systems of Ahpra. The rise in expenses is attributed to the increased demands within technology enhancement underway and the supporting cybersecurity protection needed.

## Travel and accommodation

Travel and accommodation costs relate to flights, taxis and hotel costs incurred by Ahpra, National Boards and their committees for travel costs to attend scheduled board and committee meetings. Prior year expenditure was affected by the COVID-19 lockdowns and precautionary measures. This year has returned to pre-COVID activity as face-to-face meetings resumed.

## Others

Expenses to administer exams, advertisements, external audit fees, membership and affiliations, recruitment costs and venue hire are reported as other expenses.

## Note B3: Other economic flows

Other economic flows are changes in the value of an asset or liability that do not result from transactions.

Net gain/(loss) on financial instruments at fair value includes:

- realised and unrealised gains and losses from revaluations of financial instruments at fair value
- disposals of financial assets
- bad and doubtful debts impairments and reversals of impairment.

	2023 \$'000	2022 \$'000
<b>Net gain/(loss) on financial instruments at fair value</b>		
Net gain/(loss) arising from revaluation of financial assets at fair value through profit and loss	3,470	(4,318)
Doubtful debts recoveries/write-off	(41)	41
<b>Total net gain/(loss) on financial instruments at fair value</b>	<b>3,429</b>	<b>(4,277)</b>
<b>Other gain/(loss) from other economic flows</b>		
Net gain arising from revaluation of leave liability	270	1,572
<b>Total other gain from other economic flows</b>	<b>270</b>	<b>1,572</b>
<b>Total gain/(loss) from other economic flows</b>	<b>3,699</b>	<b>(2,705)</b>

## Note C: Key assets available to support delivery of services

### C1. Investments and other financial assets

### C2. Property, plant and equipment (PPE)

### C3. Intangible assets

### C4. Depreciation, amortisation and impairment

## Introduction

Ahpra controls property, plant and equipment that are used in fulfilling our objectives and conducting our activities. Along with financial assets, they represent a key resource we used in the delivery of services.

## Judgement required

Financial assets such as units held in the managed investment scheme are measured at fair value. Non-financial assets such as property, plant and equipment and intangible assets are carried at cost less accumulated depreciation and impairment. Judgement has been applied in assessing the useful lives of plant and equipment.

## Note C1: Investments and other financial assets

Ahpra manages its investments and other financial assets in accordance with the investment policy approved by the Ahpra Board.

Investments include both term deposits that Ahpra has the positive intent and ability to hold to maturity at fixed or repricing interest rates and managed funds.

Investments are recognised when Ahpra enters a contract to purchase the investment. They are measured at fair value through net result.

Term deposits are classified as current assets with maturing dates of three to 12 months, while term deposits with maturing dates in excess of 12 months are classified as non-current. Investments in managed investment schemes (funds) are classified between current and non-current based on Ahpra's intention at balance date with respect to the timing of disposal of each asset.

	2023 \$'000	2022 \$'000
<b>Current</b>		
Bank term deposits maturing less than 90 days	20,000	28,000
Bank term deposits maturing more than 90 days but less than 1 year	58,000	63,000
<b>Total current investments</b>	<b>78,000</b>	<b>91,000</b>
<b>Non-current</b>		
Bank term deposits maturing greater than 1 year	50,000	56,000
Managed investment schemes	87,242	80,818
<b>Total non-current investments</b>	<b>137,242</b>	<b>136,818</b>
<b>Total investments and other financial assets</b>	<b>215,242</b>	<b>227,818</b>

## Note C2: Property, plant and equipment (PPE)

Items of plant, equipment and leasehold improvements are measured at cost less accumulated depreciation and impairment.

	Right-of-use property \$'000	Leasehold improvements \$'000	Furniture and fittings \$'000	Computer equipment \$'000	Office equipment \$'000	Total property, plant and equipment \$'000
<b>At cost</b>						
Balance at 30 June 2021	56,861	15,051	1,543	8,695	601	<b>82,751</b>
Additions	2,635	1,433	33	1,007	19	<b>5,127</b>
Disposals/write-offs	(1,385)	(186)	(108)	(464)	(233)	<b>(2,376)</b>
<b>Balance at 30 June 2022</b>	<b>58,111</b>	<b>16,298</b>	<b>1,468</b>	<b>9,238</b>	<b>387</b>	<b>85,502</b>
Additions	98	516 <sup>1</sup>	371	1,784	14	<b>2,783</b>
Disposals/write-offs	0	0	0	(1,547)	0	<b>(1,547)</b>
<b>Balance at 30 June 2023</b>	<b>58,209</b>	<b>16,814</b>	<b>1,839</b>	<b>9,475</b>	<b>401</b>	<b>86,738</b>
<b>Accumulated depreciation</b>						
Balance at 30 June 2021	(15,240)	(9,457)	(822)	(7,547)	(338)	<b>(33,404)</b>
Depreciation charge during the year	(7,577)	(1,176)	(176)	(971)	(61)	<b>(9,961)</b>
Disposals/write-offs	1,216	166	101	464	163	<b>2,110</b>
<b>Balance at 30 June 2022</b>	<b>(21,601)</b>	<b>(10,467)</b>	<b>(897)</b>	<b>(8,054)</b>	<b>(236)</b>	<b>(41,255)</b>
Depreciation charge during the year	(7,503)	(1,355)	(179)	(1,163)	(40)	<b>(10,240)</b>
Disposals/write-offs	0	0	0	1,547	0	<b>1,547</b>
<b>Balance at 30 June 2023</b>	<b>(29,104)</b>	<b>(11,822)</b>	<b>(1,076)</b>	<b>(7,670)</b>	<b>(276)</b>	<b>(49,948)</b>
<b>Net book value</b>						
<b>At 30 June 2022</b>	<b>36,510</b>	<b>5,831</b>	<b>571</b>	<b>1,184</b>	<b>151</b>	<b>44,247</b>
<b>At 30 June 2023</b>	<b>29,105</b>	<b>4,992</b>	<b>763</b>	<b>1,805</b>	<b>125</b>	<b>36,791</b>

<sup>1</sup> This includes \$9K completed projects transferred in from work in progress.

## C2.1: Right-of-use assets

For any contracts entered into or changed, Ahpra considers whether a contract is, or contains, a lease. A contract is, or contains, a lease if the contract conveys the right to control the use of an identified asset for a period of time in exchange for consideration. To apply this definition, Ahpra assesses whether the contract meets three key criteria:

- the contract involves the use of an identified asset
- Ahpra has the right to obtain substantially all of the economic benefits from use of the asset throughout the period of use, and
- Ahpra has the right to direct the use of the asset.

As a lessee, Ahpra recognises a right-of-use asset and a lease liability at the lease commencement date. The right-of-use asset is initially measured at cost, which comprises the initial amount of the lease liability adjusted for:

- less any lease payments made at or before the commencement date
- plus any initial direct costs incurred
- plus any estimate of costs to dismantle and remove the underlying assets or to restore the underlying asset or the site the asset is located on
- less any lease incentive received.

The right-of-use asset is subsequently measured at cost less accumulated depreciation and impairment. It is depreciated using the straight-line method from the commencement date to the earlier of the end of the useful life of the right-of-use asset or the end of the lease term, ranging from two to 12 years. The estimated useful lives of right-of-use assets are determined on the same basis as those of property, plant and equipment. In addition, the right-of-use asset is periodically reduced by impairment losses, if any, and adjusted for certain remeasurements of the lease liability.

During 2022/23, all existing office leases remained active. Ahpra signed up to a new one-year lease for a fleet of photocopiers. A right-of-use asset was added accordingly.

## Note C3: Intangible assets

Purchased intangible assets are initially recognised at cost. When the recognition criteria in AASB 138 *Intangible Assets* are met, internally generated intangible assets are recognised and measured at cost less accumulated amortisation and accumulated impairment.

An internally generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

1. the technical feasibility of completing the intangible asset so that it will be available for use or sale
2. an intention to complete the intangible asset and use it
3. the ability to use the intangible asset
4. the intangible asset will generate probable future economic benefits

5. the availability of adequate technical, financial and other resources to complete the development and to use the intangible asset
6. the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Expenditure on research activities is recognised as an expense in the period in which it is incurred.

Intangible assets not yet available for use are tested annually for impairment and whenever there is an indication that the asset may be impaired.

## Capitalisation of configuration and customisation costs in SaaS arrangements

In implementing SaaS arrangements, Ahpra has developed software code that either enhances, modifies or creates additional capability to the existing owned software that is used to integrate with the SaaS cloud-based applications. Judgement has been applied in determining whether the change to the owned software meets the definition of, and recognition criteria for, an intangible asset in accordance with AASB 138 *Intangible Assets*.

During the 2022/23 financial year, Ahpra recognised \$10.263 million as work in progress in respect of customisation and configuration costs incurred in implementing SaaS arrangements.

	Computer software \$'000	Work in progress \$'000	Total \$'000
<b>At cost</b>			
Balance at 30 June 2021	22,383	3,083	<b>25,466</b>
Additions	0	11,148	<b>11,148</b>
Disposals/write-offs	(1,482)	(42)	<b>(1,524)</b>
Transfer to additions	614	(1,981)	<b>(1,367)</b>
<b>Balance at 30 June 2022</b>	<b>21,515</b>	<b>12,208</b>	<b>33,723</b>
Additions	0	11,598	<b>11,598</b>
Disposals/write-offs	0	(3,336)	<b>(3,336)</b>
Completed projects	7,932	(7,941)	<b>(9)<sup>1</sup></b>
<b>Balance at 30 June 2023</b>	<b>29,447</b>	<b>12,529</b>	<b>41,976</b>
<b>Accumulated amortisation</b>			
Balance at 30 June 2021	(16,070)	0	<b>(16,070)</b>
Amortisation charge during the year	(2,110)	0	<b>(2,110)</b>
Disposals/write-offs	1,482	0	<b>1,482</b>
<b>Balance at 30 June 2022</b>	<b>(16,698)</b>	<b>0</b>	<b>(16,698)</b>
Amortisation charge during the year	(2,545)	0	<b>(2,545)</b>
Disposals/write-offs	0	0	<b>0</b>
<b>Balance at 30 June 2023</b>	<b>(19,243)</b>	<b>0</b>	<b>(19,243)</b>
<b>Net book value</b>			
<b>At 30 June 2022</b>	<b>4,817</b>	<b>12,208</b>	<b>17,025</b>
<b>At 30 June 2023</b>	<b>10,204</b>	<b>12,529</b>	<b>22,733</b>

1 This includes \$9K completed projects transferred out to leasehold improvement assets.

## Note C4: Depreciation, amortisation and impairment

Plant and equipment are measured at cost less accumulated depreciation and impairment. These assets are depreciated at rates based on their expected useful lives, using the straight-line method, which is reviewed annually.

Leasehold improvements are depreciated over the shorter of the remaining term of the lease or their estimated useful lives.

Work in progress is not depreciated until it reaches service delivery capacity.

The annual depreciation rates and estimated assets' useful lives used for major assets in each class for current and prior years are included in the table below:

	2023		2022	
Furniture and fittings	13%	7 years	13%	7 years
Computer equipment	20-40%	2.5-5 years	20-40%	2.5-5 years
Office equipment	15%	7 years	15%	7 years
Intangibles	20-40%	5 years	20-40%	5 years

### C4.1: Depreciation and amortisation charged for the reporting period

	2023 \$'000	2022 \$'000
<b>Depreciation</b>		
Leasehold improvements	1,355	1,176
Furniture and fittings	179	176
Computer equipment	1,163	971
Office equipment	40	61
Right-of-use assets	7,503	7,577
<b>Amortisation</b>		
Computer software	2,545	2,110
<b>Total depreciation and amortisation</b>	<b>12,785</b>	<b>12,071</b>

### C4.2: Impairment

All non-financial assets are assessed annually for indications of impairment. If there is an indication of impairment, the asset concerned is tested as to whether its carrying amount exceeds its possible recoverable amount. Any difference is written off as an expense (other operating expenses – other).

The net gain or loss arising from the sale of non-financial assets is included as revenue (other income and revenue) or expenses (other operating expenses – other) at the date control passes to the buyer, usually when an unconditional contract of sale is signed.

The net gain or loss on disposal is calculated as the difference between the carrying amount of the asset at the time of the disposal and the net proceeds on disposal.

Written-down value of non-financial assets written off	2023 \$'000	2022 \$'000
Right-of-use assets	0	169
Leasehold improvement	0	20
<b>Total written-down value of non-financial assets written off</b>	<b>0</b>	<b>189</b>
Net gain/(loss) on disposal of non-financial assets	2023 \$'000	2022 \$'000
<b>Proceeds from disposal of non-financial assets</b>		
Office equipment	0	0
Furniture and fittings	0	0
Leasehold improvement	0	0
<b>Total proceeds from disposal</b>	<b>0</b>	<b>0</b>
<b>Less: Written down value of assets disposed</b>		
Right-of-use assets	0	0
Computer equipment	0	0
Office equipment	0	(70)
Furniture and fittings	0	(8)
Leasehold improvement	0	0
<b>Net gain/(loss) on disposal</b>	<b>0</b>	<b>(78)</b>

## Note D: Other assets and liabilities

### D1: Receivables

### D2: Payables and accruals

### D3: Prepayments

### D4: Other provisions

## Introduction

This section sets out other financial and non-financial assets arising from Ahpra's operations. It also includes information on Ahpra's financial liability towards external suppliers.

## Judgement required

Judgement is exercised in estimating provision and prepayments.

Judgement is provided on the provision for expected credit losses, and to determine the present value of Ahpra's obligation to restore leased assets to their original condition at the end of a lease term.

Judgement is provided on determining prepayment of configuration and customisation services, which is significant and distinct from SaaS access. Further detail is provided in Note G5.

## Note D1: Receivables

	Note	2023 \$'000	2022 \$'000
<b>Contractual</b>			
Trade receivables		2,982	3,454
Credit loss allowance	F2	(1,775)	(1,813)
Accrued investment income		2,380	2,449
<b>Statutory</b>			
GST receivable		1,145	926
<b>Total receivables</b>		<b>4,732</b>	<b>5,016</b>
<i>Represented by:</i>			
Current receivables		4,732	5,016
		<b>4,732</b>	<b>5,016</b>



Movement in the credit loss allowance for contractual receivables	2023 \$'000	2022 \$'000
Balance at beginning of year	1,813	1,854
Increase in allowance recognised in net result for the year	329	342
Reversal of provision of receivables written off during the year	(282)	(383)
Decrease in amounts written off as uncollectable	(85)	0
<b>Balance at end of year</b>	<b>1,775</b>	<b>1,813</b>

**Contractual receivables** are classified as financial instruments and categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. Ahpra holds the contractual receivables with the objective to collect the contractual cash flows and are thereafter subsequently measured at amortised cost using the effective interest method, less any impairment.

**Statutory receivables** do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. Ahpra applies AASB 9 *Financial Instruments* for initial measurement of the statutory receivables and, as a result, statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

Details about Ahpra's impairment policies, its exposure to credit risk and the calculation of the credit loss allowance are set out in Note F1.2.

## Note D2: Payables and accruals

	2023 \$'000	2022 \$'000
<b>Contractual</b>		
Trade creditors	5,958	2,951
Accrued expenses	11,363	7,335
<b>Statutory</b>		
Payroll tax and other payables	484	645
<b>Total payables and accruals</b>	<b>17,805</b>	<b>10,931</b>
<i>Represented by:</i>		
Current payables	17,643	10,769
Non-current payables	162	162
	<b>17,805</b>	<b>10,931</b>

**Contractual payables** are classified as financial instruments and measured at amortised cost. Accounts payable represent liabilities for goods and services provided to Ahpra prior to the end of the financial year that are unpaid.

**Statutory payables** are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost because they do not arise from contracts.

Payables for suppliers and services have an average credit period of 30 days. No interest is charged on the trade creditors.

Terms and conditions of amounts payable to the government and agencies vary according to the particular agreements.

## Note D3: Prepayments

Prepayments represent payments made in advance of receipt of goods or services or expenditure made in one accounting period that covers a term extending beyond that period. It is then recognised as expenditure in the period to which the service relates.

Note G5 describes Ahpra's accounting policy in respect of configuration and customisation costs incurred in implementing SaaS arrangements. In applying the accounting policy, Ahpra management made the following key judgements that may have the most significant effect on the amounts recognised in financial statements.

### Determination whether configuration and customisation services are distinct from the SaaS access

Implementation costs including costs to configure or customise the cloud provider's application software are recognised as operating expenses when the services are received. Where the SaaS arrangement supplier provides both configuration and customisation services, judgement has been applied to determine whether each of these services is distinct or not from the underlying use of the SaaS application software. Distinct configuration and customisation costs are expensed as incurred as the software is configured or customised (i.e. upfront). Non-distinct configuration and customisation costs are expensed over the SaaS contract term.

As the configuration and customisation activities significantly modify or customise the cloud software, Ahpra assessed these activities as not distinct from the access to the SaaS platform over the contract term. Judgement has been applied and determined that the degree of customisation and modification is significant.

During the financial year, Ahpra recognised \$3.672 million as prepayments in respect of configuration and customisation activities undertaken in implementing SaaS arrangements which are considered not to be distinct from the access to the SaaS application software over the contract term. Ahpra also recognised \$4.148 million prepayments for SaaS-related licence fees paid in advance.

	2023 \$'000	2022 \$'000
<b>Current other assets</b>		
Prepayments	8,127	3,291
<b>Total current prepayments</b>	<b>8,127</b>	<b>3,291</b>
<b>Non-current other assets</b>		
Prepayments	3,430	437
<b>Total non-current prepayments</b>	<b>3,430</b>	<b>437</b>
<b>Total prepayments</b>	<b>11,557</b>	<b>3,728</b>

## Note D4: Other provisions

	2023 \$'000	2022 \$'000
<b>Current provisions</b>		
Other contractual provisions	0	0
Make-good provisions	340	0
<b>Total current provisions</b>	<b>340</b>	<b>0</b>
<b>Non-current provisions</b>		
Make-good provisions	452	754
<b>Total non-current provisions</b>	<b>452</b>	<b>754</b>
<b>Total other provisions</b>	<b>792</b>	<b>754</b>

Provisions are recognised when Ahpra has a present obligation, the future sacrifice of economic benefits is probable and the amount of the provision can be measured reliably. The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at the reporting date, taking into account the risks and uncertainties surrounding the obligation.

Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.

Make-good provisions are recognised when Ahpra has contractual obligations to remove leasehold improvements from leased properties and restore the leased premises to their original condition at the end of the lease term. During the calculation of make-good provisions, assumptions and estimations have been applied to work out the average make-good cost per square metre when ongoing maintenance and updating is committed to, and/or the local market conditions in re-negotiating an incentive at lease expiration for each office.

The make-good provision is recognised in accordance with the lease agreement over the offices' leases.

#### Reconciliation of movements in provisions

	Make-good \$'000	Total \$'000
<b>Opening balance at 30 June 2022</b>	<b>754</b>	<b>754</b>
Additional provisions recognised	38	38
Reductions arising from payments	0	0
Reductions due to reversal of provision not required	0	0
<b>Closing balance at 30 June 2023</b>	<b>792</b>	<b>792</b>
Current	340	340
Non-current	452	452
<b>Total</b>	<b>792</b>	<b>792</b>

## Note E: Financing our operations

### E1. Leases

### E2. Cash flow information and balances

### E3. Commitments

#### Introduction

This section provides information on the sources of finance utilised by Ahpra during its operations and other information related to financing activities of Ahpra.

#### Judgement required

Ahpra applies judgement to determine if a contract is or contains a lease and whether the lease meets the short-term or low-value asset lease exemption. Ahpra estimates the discount rate applied to future lease payments and assesses the lease term when there is an option to extend or terminate leases.

## Note E1: Leases

A lease is defined as a contract, or part of a contract, that conveys the right for Ahpra to use an asset for a period of time in exchange for payment.

To apply this definition, Ahpra ensures the contract meets the following criteria:

- The contract contains an identified asset, which is either explicitly identified in the contract or implicitly specified by being identified at the time the asset is made available to Ahpra and for which the supplier does not have substantive substitution rights.
- Ahpra has the right to obtain substantially all of the economic benefits from use of the identified asset throughout the period of use, considering its rights within the defined scope of the contract, and Ahpra has the right to direct the use of the identified asset throughout the period of use.
- Ahpra has the right to take decisions in respect of 'how and for what purpose' the asset is used throughout the period of use.

Ahpra's lease arrangements consist of various properties for office operations in each state and territory. The lease contracts are typically made for fixed periods of three to 10 years, with an option to renew the lease after that date.

All leases are recognised on the balance sheet, with the exception of low-value leases (less than \$10,000) and short-term leases of less than 12 months. The payments in relation to these are recognised as an expense on a straight-line basis over the lease term.

#### E1.1 Right-of-use assets

Right-of-use assets are presented in Note C2.1.

#### E1.2 Other presentation of leases in financial statements

The following amounts are recognised in the *Statement of comprehensive income* relating to leases:

	2023 \$'000	2022 \$'000
Interest expense on lease liabilities	716	736
Variable lease payments, not included in the measurement of lease liabilities	1,582	1,576
<b>Total amount recognised in the Statement of comprehensive income</b>	<b>2,298</b>	<b>2,312</b>

The following amounts are recognised in the *Statement of cash flows* relating to leases:

	2023 \$'000	2022 \$'000
Interest paid	716	736
Repayment of principal portion of lease liabilities	7,941	7,554
<b>Total cash outflow for leases</b>	<b>8,657</b>	<b>8,290</b>

The following amounts are recognised as lease liabilities in the *Statement of financial position* at 30 June:

Lease liabilities	2023 \$'000	2022 \$'000
Current	8,318	7,681
Non-current	28,876	35,612
<b>Total lease liabilities recognised in the Statement of financial position<sup>1</sup></b>	<b>37,194</b>	<b>43,293</b>

<sup>1</sup> Lease liabilities reported include lease liabilities of \$4.177 million from lease fit-out incentives and \$33.017 million from lease accounting implementation, both to be amortised over lease terms.

### E1.3 Recognition and measurement of leases as a lessee

The lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using Ahpra's incremental borrowing rate.

Lease payments included in the measurement of the lease liabilities comprise fixed payments less any lease incentive receivable, plus payments arising from lease extension options reasonably certain to be exercised. Variable lease payments are not included in the measurement of the lease liability or the carrying amount of right-of-use asset.

In determining the lease term, management considers all facts and circumstances that create an economic incentive to exercise an extension option. South Australia and Tasmania office leases contain five-year extension options which have been included in the lease term and lease liability because the lease is reasonably certain to be extended.

The assessment is reviewed if a significant event or a significant change in circumstances occurs that affects this assessment and that is within the control of the lessee.

Subsequent to initial measurement, the liability will be reduced for payments made and increased for interest. It is remeasured to reflect any reassessment or modification, or if there are changes to in-substance fixed payments. When the lease liability is remeasured, a corresponding adjustment is made to the carrying amount of the right-of-use asset, or is recorded in profit or loss if the carrying amount of the right-of-use asset is already reduced to zero.

Minimum future lease payments (undiscounted)		
Repayments in relation to leases are payable as follows:	2023 \$'000	2022 \$'000
Less than one year	8,919	8,401
One to five years	25,220	30,203
More than five years	5,308	7,653
<b>Total undiscounted lease liabilities as at 30 June</b>	<b>39,447</b>	<b>46,257</b>

### Note E2: Cash flow information and balances

Cash and cash equivalents include cash on hand and cash at bank, deposits held at call, and other short-term liquid deposits with an original maturity of three months or less, which are readily convertible to known amounts of cash with an insignificant risk of changes in value.

	2023 \$'000	2022 \$'000
Cash and cash equivalents, at bank	16,596	5,683
<b>Total cash and cash equivalents</b>	<b>16,596</b>	<b>5,683</b>

### Reconciliation of net result for the period to cash flow from operating activities

	2023 \$'000	2022 \$'000
<b>Net result for the year</b>	<b>(6,597)</b>	<b>14,874</b>
<b>Non-cash movements</b>		
Depreciation and amortisation	12,785	12,071
Loss on disposal of non-financial assets	0	78
(Gain)/loss on revaluation of financial assets	(3,470)	4,318
Distribution income from managed funds reinvested	(1,826)	(2,057)
Write-off work in progress/assets	0	42
Recognition of lease incentives	1,789	0
Credit loss allowance	(367)	(384)
<b>Movements in assets and liabilities</b>		
Decrease in receivables	1,131	277
(Increase) in prepayments	(7,829)	(857)
Increase in contract liabilities	6,987	7,757
Increase in payables and accruals	5,267	123
Increase in employee benefits	2,930	1,129
(Decrease) in other provisions	0	(5)
<b>Net cash flows from operating activities</b>	<b>10,800</b>	<b>37,366</b>

### Note E3: Commitments

Commitments for future expenditure include operating commitments arising from non-cancellable contractual or statutory obligations. Ahpra's contractual obligations are with Information Technology (IT) and Enterprise Resource Planning (ERP) platform providers. These commitments are recorded below at their nominal value and are inclusive of GST. The future expenditures cease to be disclosed as commitments once the related liabilities are recognised in the *Statement of financial position*.

Ahpra does not have capital commitments as at 30 June 2023.

Nominal amounts	Not later than 1 year \$'000	1-5 years \$'000	5+ years \$'000	Total \$'000
<i>Non-cancellable:</i>				
<b>2023</b>				
<b>Other commitments payable (inclusive of GST)</b>	4,173	11,011	0	<b>15,184</b>
<b>Less: GST recoverable</b>	(379)	(1,001)	0	<b>(1,380)</b>
<b>Total commitments (exclusive of GST)</b>	<b>3,794</b>	<b>10,010</b>	<b>0</b>	<b>13,804</b>
<b>2022</b>				
<b>Other commitments payable (inclusive of GST)</b>	3,014	3,835	0	<b>6,849</b>
<b>Less: GST recoverable</b>	(274)	(349)	0	<b>(623)</b>
<b>Total commitments (exclusive of GST)</b>	<b>2,740</b>	<b>3,486</b>	<b>0</b>	<b>6,226</b>

## Note F: Risks, contingencies and valuation

### F1. Financial instruments

### F2. Financial risk management

### F3. Contingent assets and liabilities

#### Introduction

Ahpra is exposed to risk from its activities and outside factors. In addition, it is often necessary to make judgements and estimates associated with recognition and measurement of items in the financial statements. This section sets out financial-instrument-specific information, including exposures to financial risks, as well as those items that are contingent in nature or require a higher level of judgement to be applied, which for Ahpra related mainly to fair value determination.

#### Note F1: Financial instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Certain financial assets and financial liabilities arise under statute rather than contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation*.

#### F1.1: Categories of contractual financial instruments

Categories of contractual financial instruments under AASB 9 include:

##### Financial assets at amortised cost

Financial assets in this category are held by Ahpra to collect the contractual cash flows, and the assets' contractual terms give rise to cash flows that are solely payments of principal and interest. These assets are initially recognised at fair value plus any directly attributable transaction costs and are subsequently measured at amortised costs using the effective interest method less any impairment.

Ahpra recognises the following financial assets at amortised cost:

- cash and cash equivalents
- term deposit investments
- contractual receivables
- accrued interest income on term deposit investment.

##### Financial assets at fair value through profit and loss

Financial assets in this category are held by Ahpra to achieve its objective by collecting both:

- the distributions based on the earnings from the fund's assets over the period and may include income from share dividends, distribution income from units held in fund investment, rent from property or interest from cash investments less any costs, and
- capital growth from the revaluation of the units held in managed fund investment.

Ahpra recognises the following financial asset at fair value through profit and loss:

- managed fund investment.

##### Financial liabilities at amortised cost

Financial instrument liabilities are recognised on the date they originate. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, these liabilities are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in the *Statement of comprehensive income* over the period of the interest-bearing liability, using the effective interest rate method.

The effective interest method is a method of calculating the amortised cost of a debt instrument and of allocating interest expense in net result over the relevant period. The effective interest is the internal rate of return of the financial asset or liability. That is, it is the rate that exactly discounts the estimated future cash flows through the expected life of the instrument to the net carrying amount at initial recognition.

A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

Ahpra recognises the following as financial liabilities at amortised cost:

- contractual payables
- lease liabilities.

#### F1.2: Impairment of financial assets

Ahpra records the allowance for expected credit loss for the relevant financial instruments applying AASB 9's *Expected Credit Loss* (ECL) approach. Subject to AASB 9, impairment assessment includes Ahpra's contractual receivables. Cash and cash equivalents are also subject to the impairment requirements of AASB 9, but the identified impairment loss was immaterial.

Credit loss allowance is classified as other economic flows in the net result. Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

Ahpra applies the AASB 9 simplified approach for contractual receivables to measure expected credit losses using a lifetime expected loss allowance based on the assumptions about risk of default and expected loss rates. The loss allowance is measured in the same period as an asset is recognised. Ahpra has grouped contractual receivables on shared credit risk characteristics and days past due and selected the expected credit loss rate based on the agency's history, existing market conditions, as well as forward-looking estimates at the end of the financial year.

## Note F2: Financial risk management

The main purpose in holding financial instruments is to prudentially manage Ahpra's financial risks within the financial risk management policy parameters. Ahpra's main financial risks include credit risk, liquidity risk and interest rate risk. Ahpra's exposure to foreign exchange rate risk and equity price risk is through managed investment schemes.

### (a) Credit risk exposure

Credit risk is the risk that a party will fail to fulfil its obligations to Ahpra, resulting in financial loss. The maximum exposure to credit risk, excluding the value of any collateral or other security at balance date, is the carrying amount, net of any provisions for impairment of those assets, as disclosed in the *Statement of financial position* and notes to the financial statements. Credit risk associated with Ahpra's contractual financial assets is minimal because Ahpra mainly obtains contractual financial assets that are term deposits and cash at bank.

Ahpra is exposed to credit risk in relation to units held in managed investment schemes (managed fund) that is designated at fair value through the operating statement. The maximum exposure at the end of the reporting period is the carrying amount of the investments.

Ahpra's term deposit investments are in line with the investment policy and maintained with banks with credit ratings of AA- or above. Ahpra does not have more than 40% of term deposits with one individual bank.

Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents Ahpra's maximum exposure to credit risk.

### Credit quality of contractual financial assets<sup>1</sup>

	Financial institutions (AA- credit rating) <sup>2</sup>	Other	Total
2023	\$'000	\$'000	\$'000
<b>Financial assets with loss allowance measured at 12-month expected credit loss:</b>			
Cash and cash equivalents	16,596	0	<b>16,596</b>
Term deposit investments	128,000	0	<b>128,000</b>
Accrued interest and investment income	1,588	792	<b>2,380</b>
Statutory receivables (with no impairment loss recognised)	0	1,145	<b>1,145</b>
<b>Financial assets with loss allowance measured at lifetime expected credit loss:</b>			
Contractual receivables applying the simplified approach for impairment	0	1,207	<b>1,207</b>
<b>Total financial assets</b>	<b>146,184</b>	<b>3,144</b>	<b>149,328</b>

	Financial institutions (AA- credit rating) <sup>2</sup>	Other	Total
2022	\$'000	\$'000	\$'000
<b>Financial assets with loss allowance measured at 12-month expected credit loss:</b>			
Cash and cash equivalents	5,683	0	<b>5,683</b>
Term deposit investments	147,000	0	<b>147,000</b>
Accrued interest and investment income	528	1921	<b>2,449</b>
Statutory receivables (with no impairment loss recognised)	926	0	<b>926</b>
<b>Financial assets with loss allowance measured at lifetime expected credit loss:</b>			
Contractual receivables applying the simplified approach for impairment	0	1,641	<b>1,641</b>
<b>Total financial assets</b>	<b>154,137</b>	<b>3,562</b>	<b>157,699</b>

1 The total amount disclosed here excludes statutory amounts (e.g. GST input tax credit recoverable).

2 Standard & Poor's rate AA-. Moody's Investors Service rates Aa3. Fitch rates A+.



Ahpra determines the loss allowance at end of the financial year as follows:

30 June 2023	Current \$'000	Less than 1 month \$'000	1-3 months \$'000	3-12 months \$'000	More than 1 year \$'000	Total \$'000
Expected loss rate						
Fines and legal fee recoveries	0%	15%	20-50%	60%	94%	
Others	0%	0-10%	1-15%	11-20%	17-30%	
Contractual receivables		848	123	314	1,697	<b>2,982</b>
<b>Loss allowance</b>		<b>(16)</b>	<b>(27)</b>	<b>(185)</b>	<b>(1,547)</b>	<b>(1,775)</b>

30 June 2022	Current \$'000	Less than 1 month \$'000	1-3 months \$'000	3-12 months \$'000	More than 1 year \$'000	Total \$'000
Expected loss rate						
Fines and legal fee recoveries	0%	15%	20-50%	60%	94%	
Others	0%	0-10%	1-30%	11-40%	17-50%	
Contractual receivables	36	1,134	225	305	1,754	<b>3,454</b>
<b>Loss allowance</b>	<b>0</b>	<b>(15)</b>	<b>(43)</b>	<b>(155)</b>	<b>(1,600)</b>	<b>(1,813)</b>

Reconciliation of the movement in the loss allowance for contractual receivables can be found in Note D1.

Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

Ahpra's statutory receivable relates to GST input tax receivables. No loss allowance was recognised at 30 June 2023 under AASB 9 *Financial instruments*.

### (b) Liquidity risk exposure

Liquidity risk is the risk that an entity will encounter difficulty in meeting obligations associated with financial liabilities as they fall due. Ahpra manages liquidity risk by monitoring cash flows' forecast and ensuring that adequate liquid funds are available to meet current obligations.

Ahpra's exposure to liquidity risk is deemed insignificant based on prior period's data and current assessment of risk. Cash for unexpected events is generally sourced from liquidation of available-to-recall term deposits.

This table discloses the maturity analysis of Ahpra's financial liabilities:

	Carrying amount \$'000	Maturity dates				
		Less than 1 month \$'000	1–3 months \$'000	3 months– 1 year \$'000	1–5 years \$'000	More than 5 years \$'000
2023						
Payables¹						
Trade creditors	5,958	5,958	0	0	0	0
Accrued expenses	11,363	11,363	0	0	0	0
Lease liabilities²	35,270	0	0	7,918	19,778	7,574
Total	52,591	17,321	0	7,918	19,778	7,574
2022						
Payables¹						
Trade creditors	2,951	2,723	16	50	0	162
Accrued expenses	7,335	7,335	0	0	0	0
Lease liabilities²	42,867	0	0	7,603	27,699	7,565
Total	53,153	10,058	16	7,653	27,699	7,727

1 The total amount disclosed here excludes statutory amounts (e.g. payroll tax payable).

2 Contractual amounts disclosed in the maturity analysis are the contractual undiscounted cash flows. For lease liabilities, it is gross lease obligation before deducting finance charge.

The maximum exposure to liquidity risk is the total carrying amount of the financial liabilities as shown above.

### (c) Performance risk exposure

Investing in managed funds provides access to different asset classes and industry sectors; however there is always a risk that the managed fund investments may underperform or decline in value. Ahpra is exposed to the fluctuations in the performance of the underlying financial assets held within managed funds in which Ahpra holds units.

Ahpra monitors the managed funds investment strategy and asset allocation against Ahpra's own investment policy risk tolerances.

### Interest rate risk

Exposure to interest rate risk is limited to assets bearing variable interest rates. Ahpra has a combination of deposits with floating and fixed interest rates. Exposure to variable interest rate risk is with financial institutions with AA- credit rating.<sup>3</sup>

3 Standard & Poor's rate AA-. Moody's Investors Service rates Aa3. Fitch rates A+.

## Interest rate exposure of financial instruments

2023	Weighted average interest rate	Non-interest bearing \$'000	Floating interest rate \$'000	Fixed interest rate \$'000	Total \$'000
<b>Financial assets</b>					
Cash and cash equivalents	4.05%	0	16,596	0	16,596
Investments in term deposits	4.11%	0	0	128,000	128,000
Investments in managed fund	0.00%	88,090	0	0	88,090
Receivables	0.00%	2,982	0	0	2,982
Accrued income	0.00%	2,380	0	0	2,380
<b>Total financial assets</b>		<b>93,452</b>	<b>16,596</b>	<b>128,000</b>	<b>238,048</b>
<b>Financial liabilities</b>					
Payables <sup>1</sup>	0.00%	5,958	0	0	5,958
Accrued expenses	0.00%	11,363	0	0	11,363
Lease liabilities <sup>2</sup>	0.00%	0	0	33,017	33,017
<b>Total financial liabilities</b>		<b>17,321</b>	<b>0</b>	<b>33,017</b>	<b>50,338</b>

2022	Weighted average interest rate	Non-interest bearing \$'000	Floating interest rate \$'000	Fixed interest rate \$'000	Total \$'000
<b>Financial assets</b>					
Cash and cash equivalents	0.79%	0	5,683	0	5,683
Investments in term deposits	1.28%	0	11,000	136,000	147,000
Investments in managed fund	0.00%	85,136	0	0	85,136
Receivables	0.00%	3,454	0	0	3,454
Accrued income	0.00%	2,449	0	0	2,449
<b>Total financial assets</b>		<b>91,039</b>	<b>16,683</b>	<b>136,000</b>	<b>243,722</b>
<b>Financial liabilities</b>					
Payables <sup>1</sup>	0.00%	2,951	0	0	2,951
Accrued expenses	0.00%	7,335	0	0	7,335
Lease liabilities <sup>2</sup>	1.28–4.05%	0	0	39,904	39,904
<b>Total financial liabilities</b>		<b>10,286</b>	<b>0</b>	<b>39,904</b>	<b>50,190</b>

1 The total amount disclosed here excludes statutory amounts (e.g. payroll tax payable).

2 Lease liabilities subject to interest rate risk excludes lease fit-out incentive of \$4,177K.

### Sensitivity analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, Ahpra cannot predict market rates and the below is for illustrative purposes only:

A parallel shift of +0.50% and –0.50% (2022: +2.00% and –0.05%) in market interest rates (AUD) from year-end rates of 4.11% and 4.05% due to multiple rate hikes throughout the year and Reserve Bank's intention to manage inflation within its target of between 2% and 3%.

The following table discloses the impact on net operating result and equity for each category of financial instrument held by Ahpra at year end. Investments that have fixed rates of return over the next 12 months are assessed as not subject to the market interest rates shift. Investments that will mature during the next 12 months or are invested in floating rates of return are assessed accordingly for the impacts on net operation result and equity.

Financial assets	Carrying amount \$'000	At +0.50% \$'000 Surplus	At +0.50% \$'000 Equity	At –0.50% \$'000 Surplus	At –0.50% \$'000 Equity
<b>2023</b>					
Cash and cash equivalents	16,596	83	83	(83)	(83)
Investments	128,000	258	258	(258)	(258)
<b>Total</b>		<b>341</b>	<b>341</b>	<b>(341)</b>	<b>(341)</b>
<b>2022</b>					
Cash and cash equivalents	5,683	114	114	(3)	(3)
Investments	147,000	1,056	1,056	(26)	(26)
<b>Total</b>		<b>1,170</b>	<b>1,170</b>	<b>(29)</b>	<b>(29)</b>

## F2.1: Fair value determination

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

In determining fair values, a number of inputs are used. To increase consistency and comparability in the financial statements, these inputs are categorised into three levels, known as the fair value hierarchy. The levels are as follows:

- Level 1 – the fair value of financial instruments with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices.
- Level 2 – the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly.
- Level 3 – the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

Ahpra's managed fund investments are facilitated by the Victorian Funds Management Corporation (VFMC) in its Capital Stable Fund using Level 2 valuation. It has quoted market and redemption price. The daily net asset value (NAV) is directly observed and is the net value of the fund's assets less its liabilities, divided by the number of units on issue. The NAV of these funds is considered a reasonable input used to measure their fair value.

Ahpra considers the carrying amount of financial instrument assets and liabilities recorded in the financial statements to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be settled in full.

The following table shows that the fair values of the contractual financial assets and liabilities are the same as the carrying amounts.

### Comparison between carrying amount and fair value

	Note	Carrying amount 2023 \$'000	Fair value 2023 \$'000	Carrying amount 2022 \$'000	Fair value 2022 \$'000
<b>Contractual financial assets</b>					
Cash and cash equivalents		16,596	16,596	5,683	5,683
Investments – bank term deposits		128,000	128,000	147,000	147,000
Investments – managed fund		87,242	87,242	80,818	80,818
Receivables	D1	1,207	1,207	1,641	1,641
Accrued income		2,380	2,380	2,449	2,449
<b>Total contractual financial assets</b>		<b>235,425</b>	<b>235,425</b>	<b>237,591</b>	<b>237,591</b>
<b>Contractual financial liabilities</b>					
Payables	D2	5,958	5,958	2,951	2,951
Accrued expenses		11,363	11,363	7,335	7,335
Lease liabilities		33,017	33,017	39,904	39,904
<b>Total contractual financial liabilities</b>		<b>50,338</b>	<b>50,338</b>	<b>50,190</b>	<b>50,190</b>

## Note F3: Contingent assets and liabilities

	2023 \$'000	2022 \$'000
<b>Contingent assets</b>		
Legal proceedings and disputes	0	0

No claim for damages was lodged during the year.

	2023 \$'000	2022 \$'000
<b>Contingent liabilities</b>		
Legal proceedings and disputes	0	0

Contingent assets and contingent liabilities are not recognised in the *Statement of financial position*, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

Contingent assets and liabilities are possible assets and obligations that arise from past events, whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of Ahpra.

Contingent liabilities could also be present obligations arising from past events, but are not recognised when it is not probable that an outflow of resource embodying economic benefits will be required to settle the obligations, or the amount of the obligations cannot be measured with sufficient reliability.

Claims for damages were lodged during the year. Liabilities have been disclaimed and the actions have been defended. Insurers are involved in defending these matters. The extent to which an outflow of funds is required in excess of insurance is dependent on the case outcomes being less favourable than currently expected.

## Note G: Other disclosures

### G1. Related party disclosures

### G2. Remuneration of executives

### G3. Remuneration of external auditor for the audit of the financial statements

### G4. Australian Accounting Standards issued that are not yet effective

### G5. Changes in interpretation of accounting policies

### G6. Events occurring after the balance sheet date

### G7. Equity by Board

### G8. Co-regulatory jurisdictions

#### (a) Ministerial Council

The Ministerial Council comprises Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health. The following Ministers were members of the Ministerial Council (formally known as the Australian Health Workforce Ministerial Council) during the year 1 July 2022 to 30 June 2023, unless otherwise noted.

Name	Portfolio	Jurisdiction
Ms Rachel Stephen-Smith MLA	Minister for Health Minister for Children, Youth and Families Minister for Aboriginal and Torres Strait Islander Affairs	Australian Capital Territory
The Hon Mark Butler MP	Minister for Health and Aged Care	Commonwealth
The Hon Bradley Hazzard MP (to March 2023)	Minister for Health	New South Wales
The Hon Ryan Park MP (from March 2023)	Minister for Health Minister for Regional Health	New South Wales
The Hon Natasha Fyles MLA	Chief Minister Minister for Health Minister for Alcohol Policy Minister for Defence Minister for Major Projects	Northern Territory
The Hon Yvette D'Ath MP (to May 2023)	Minister for Health and Ambulance Services	Queensland
The Hon Shannon Fentiman MP (from May 2023)	Minister for Health, Mental Health and Ambulance Services Minister for Women	Queensland
The Hon Chris Picton MP	Minister for Health and Wellbeing	South Australia
The Hon Jeremy Rockliff MP	Premier Minister for Health Minister for Mental Health and Wellbeing Minister for Tourism Minister for Trade	Tasmania
The Hon Mary-Anne Thomas MP	Minister for Health	Victoria
The Hon Amber-Jade Sanderson MLA	Minister for Health; Mental Health	Western Australia

Amounts relating to responsible ministers' remuneration are reported in the financial statements of the relevant minister's jurisdiction.

#### (b) Ahpra Board members

	Period
Ms Gill Callister PSM, Chair	1/07/2022–30/6/2023
Ms Jenny Taing OAM	1/07/2022–30/6/2023
Ms Barbara Yeoh AM	1/07/2022–30/6/2023
Dr Susan Young	1/07/2022–30/6/2023
Emeritus Professor Arie Freiberg AM, FASSA, FAAL	1/07/2022–30/6/2023
Mr Lynton Norris	1/07/2022–30/6/2023
Mr Jeffrey Moffet	1/07/2022–30/6/2023
Hon Associate Professor Carmen Parter	15/07/2022–30/6/2023

## Introduction

This section includes additional material disclosures required by accounting standards or otherwise, for the understanding of this financial report.

### Note G1: Related party disclosures

Key management personnel (KMP) of Ahpra include the responsible minister in each jurisdiction that forms part of the Ministerial Council under the National Law, members of the Ahpra Board, the Chief Executive Officer and members of the National Executive team.

#### (c) Chief Executive Officer and National Executive team

- Chief Executive Officer, Mr Martin Fletcher
- Executive Director, Regulatory Operations, Ms Kym Ayscough
- Executive Director, Strategy and Policy, Mr Chris Robertson
- Executive Director, People and Culture, Mr Mark Edwards
- Chief Financial Officer, Ms Elizabeth Davenport
- Chief Information Officer, Mr Clarence Yap

#### (d) Remuneration of KMP

Other than the responsible ministers, the remuneration for KMP is disclosed as follows.

	2023 \$	2022 \$
Short-term employee benefits	2,213,794	2,126,833
Long-term employee benefits	51,392	23,818
Post-employment benefits	180,201	162,060
<b>Total</b>	<b>2,445,387</b>	<b>2,312,711</b>

Outside of normal-citizen-type transactions with Ahpra, there were no related party transactions that involved KMP, their close family members and their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

There were no transactions involving the Ministerial Council during 2022/23 (2021/22: Nil).

#### Note G2: Remuneration of executives

##### Remuneration of Chief Executive Officer and Executive Directors

The Chief Executive Officer (CEO) is Mr Martin Fletcher who held the position throughout the period 1 July 2022 to 30 June 2023.

The aggregate compensation made to the CEO and National Executive team is set out below:

	2023 \$	2022 \$
Short-term employee benefits	2,116,230	2,041,853
Long-term employee benefits	51,392	23,818
Post-employment benefits	169,957	153,562
<b>Total</b>	<b>2,337,579</b>	<b>2,219,233</b>
Total number of executives	6	6
Total annualised employee equivalents	6	6

#### Note G3: Remuneration of external auditor for the audit of the financial statements

	2023 \$'000	2022 \$'000
Victorian Auditor-General's Office	168	164
<b>Total</b>	<b>168</b>	<b>164</b>

#### Note G4: Australian Accounting Standards issued that are not yet effective

The following table outlines the accounting pronouncements that have been issued but are not effective for 2022/23, which may result in potential impacts for future reporting periods. AASB 108 requires disclosure of the impact on Ahpra's financial statements of these changes. These are set out below.

Standard/ interpretation	Summary	Applicable for annual reporting periods beginning on or after	Impact on Ahpra financial statements
2022-10 Amendments to Australian Accounting Standards – <i>Fair Value Measurement of Non-Financial Assets of Not- for-Profit Public Sector Entities</i>	<p>This standard amends AASB 13 <i>Fair Value Measurement</i> by adding authoritative implementation guidance and illustrative examples for fair value measurements of non-financial assets of not-for-profit public sector entities not held primarily for their ability to generate net cash inflows.</p> <p>The standard:</p> <ul style="list-style-type: none"> <li>• specifies that an entity needs to consider whether an asset's highest and best use differs from its current use only when it is held for sale or held for distribution to owners under AASB 5 <i>Non-current Assets Held for Sale and Discontinued Operations</i> or if it is highly probable that it will be used for an alternative purpose</li> <li>• clarifies that an asset's use is 'financially feasible' if market participants would be willing to invest in the asset's service capacity, considering both the capacity to provide needed goods or services and the resulting costs of those goods and services</li> <li>• specifies that if both market selling price and some market participant data required to fair value the asset are not observable, an entity needs to start with its own assumptions and adjust them to the extent that reasonably available information indicates that other market participants would use different data, and</li> <li>• provides guidance on the application of the cost approach to fair value, including the nature of costs to be included in a reference asset and identification of economic obsolescence.</li> </ul>	1 January 2024	Ahpra will assess the impacts accordingly.
AASB 2022-5 Amendments to Australian Accounting Standards – <i>Lease Liability in a Sale and Leaseback</i>	<p>AASB 2022-5 amends AASB 16 <i>Leases</i> to add subsequent measurement requirements for sale and leaseback transactions that satisfy the requirements for sale in AASB 15 <i>Revenue from Contracts with Customers</i>.</p> <p>The amendments ensure that a seller-lessee subsequently remeasures lease liabilities arising from a leaseback in a way that does not recognise any amount of gain or loss that related to the right of use it retains.</p>	1 January 2024	Ahpra does not expect this accounting standard amendment to have impacts.



## Note G5: Changes in interpretation of accounting policies

### Software-as-a-Service (SaaS) arrangements

The International Financial Reporting Standards Interpretations Committee (IFRIC) has issued two final agenda decisions which impact SaaS arrangements:

- Customer's right to receive access to the supplier's software hosted on the cloud (March 2019). This decision considers whether a customer receives a software asset at the contract commencement date or a service over the contract term.
- Configuration or customisation costs in a cloud computing arrangement (April 2021). This decision discusses whether configuration or customisation expenditure relating to SaaS arrangements can be recognised as an intangible asset and, if not, over what time period the expenditure is expensed.

Ahpra's accounting policy has historically been to capitalise SaaS arrangements' implementation costs as intangible assets in the *Statement of financial position*. The clarification of the above agenda decisions has resulted in accounting of these costs as either a prepaid asset (see Note D3) in the *Statement of financial position* and/or recognition as an expense in the *Statement of comprehensive income* (see Note B2), impacting the current periods presented.

## Note G6: Events occurring after the balance sheet date

Assets, liabilities, income or expenses arise from past transactions or other past events.

Where the transactions result from an agreement between Ahpra and other parties, the transactions are only recognised when the agreement is irrevocable at or before the end of the reporting period.

For events that occur between the end of the reporting period and the date when the financial statements are authorised for issue, where those events provide information about conditions that existed at the reporting date, adjustments are made to amounts recognised in the financial statements.

Note disclosure is made about events between the end of the reporting period and the date the financial statements are authorised for issue where the events relate to conditions that arose after the end of the reporting period, and which are considered to be of material interest.

While the COVID-19 pandemic has created unprecedented economic uncertainty, it is not expected that economic events and conditions will be materially different from those observed by Ahpra at the reporting date.

No subsequent events are identified for disclosure in this report.

## Note G7: Equity by Board

### G7.1: Summary of revenue, income and expenses by Board

The Ahpra annual financial statements are a report of the Agency Fund under the National Law and include transactions of all 15 National Boards administered by Ahpra.

Under the National Law, the National Boards are unable to enter into transactions themselves, with Ahpra administering all revenue and expense transactions on behalf of each National Board, as set out in each Health Profession Agreement.

The total amount transacted is reflected in the *Statement of comprehensive income* and accompanying notes. The aggregated total revenue and income and total expenses transacted and attributed to each National Board are shown in the table below.

National Board	2023					2022			
			Net result from transactions	Other comprehensive gain	Net result			Other comprehensive loss	Net result
	Revenue \$'000	Expenses \$'000	\$'000	\$'000	\$'000	Revenue \$'000	Expenses \$'000	\$'000	\$'000
ATSIHPBA	1,070	(1,071)	(1)	1	0	623	(627)	4	0
ChiroBA	2,768	(3,119)	(351)	99	(252)	2,828	(1,920)	(143)	765
CMBA	2,199	(2,335)	(136)	91	(45)	2,004	(1,631)	(137)	236
DBA	14,239	(13,468)	771	182	953	13,399	(12,679)	(132)	588
MBA	97,559	(110,889)	(13,330)	830	(12,500)	87,392	(85,408)	(258)	1,726
MRPBA	3,883	(3,982)	(99)	62	(37)	3,517	(3,879)	(58)	(420)
NMBA	94,549	(88,892)	5,657	1,529	7,186	83,674	(75,397)	(1,173)	7,104
OptomBA	2,143	(2,235)	(92)	40	(52)	1,942	(1,866)	(42)	34
OsteoBA	1,303	(1,583)	(280)	30	(250)	1,179	(876)	(37)	266
OTBA	3,727	(4,947)	(1,220)	81	(1,139)	3,266	(3,545)	(85)	(364)
ParaBA	6,327	(4,919)	1,408	137	1,545	6,331	(4,299)	(189)	1,843
PharmBA	14,203	(14,694)	(491)	175	(316)	13,362	(12,291)	(122)	949
PhysioBA	6,656	(7,783)	(1,127)	91	(1,036)	5,294	(5,177)	(72)	45
PodBA	2,275	(2,553)	(278)	60	(218)	2,141	(1,847)	(78)	216
PsyBA	19,543	(20,269)	(726)	290	(436)	19,023	(16,876)	(261)	1,886
Other	2,287	(2,287)	0	0	0	3,710	(3,710)	0	0
Total	274,731	(285,026)	(10,295)	3,698	(6,597)	249,685	(232,028)	(2,783)	14,874

## G7.2: Summary of equity by Board

Consistent with the requirements of AASB 1004 *Contributions*, contributions by owners (that is, contributed capital) are treated as equity transactions and, therefore, do not form part of the revenue, income and expenses of Ahpra.

Additions to net assets designated as contributions by all former boards at transition to Ahpra are recognised as contributed capital.

### Summary of contributed capital, equity and accumulated surplus/(deficit) by Board

National Board	Contributed capital \$'000	2022/23 net result \$'000	2022/23 net result funded from equity \$'000	Accumulated surplus/(deficit) to 30 June 2023 \$'000	Equity at 30 June 2023 \$'000	Accumulated surplus/(deficit) to 30 June 2022 \$'000	Equity at 30 June 2022 \$'000
ATSIHPBA	276	0	0	(276)	0	(276)	0
ChiroBA	1,164	0	(252)	5,699	6,863	5,951	7,115
CMBA	1,293	0	(46)	5,718	7,011	5,764	7,057
DBA	3,120	954	0	2,974	6,094	2,020	5,140
MBA	12,257	0	(12,500)	(8,207)	4,050	4,293	16,550
MRPBA	2,218	0	(37)	596	2,814	633	2,851
NMBA	12,816	7,186	0	16,652	29,468	9,466	22,282
OptomBA	1,061	0	(52)	827	1,888	879	1,940
OsteoBA	996	0	(250)	568	1,564	818	1,814
OTBA	3,574	0	(1,139)	(415)	3,159	724	4,298
ParaBA	0	1,545	0	10,592	10,592	9,047	9,047
PharmBA	2,716	0	(316)	1,823	4,539	2,139	4,855
PhysioBA	2,728	0	(1,036)	(534)	2,194	502	3,230
PodBA	420	0	(218)	3,243	3,663	3,461	3,881
PsyBA	2,194	0	(436)	9,043	11,237	9,479	11,673
Other	(2,938)	0	0	2,938	0	2,938	0
<b>Total</b>	<b>43,895</b>	<b>9,685</b>	<b>(16,282)</b>	<b>51,241</b>	<b>95,136</b>	<b>57,838</b>	<b>101,733</b>

## Note G8: Co-regulatory jurisdictions

The *Health Practitioner Regulation National Law (NSW) No. 86a* and the *Queensland Health Ombudsman Act 2013* allow for co-regulation of registered health practitioners at the discretion of the respective member jurisdictions. Both New South Wales (NSW) and Queensland (Qld) have determined that co-regulation applies.

### NSW Health Professional Councils Authority (HPCA)

Transactions relating to the HPCA are reported as administered (non-controlled) items in the following table.

In NSW, the Health Minister informs Ahpra and the National Boards of the amount to be collected per registrant on behalf of the HPCA, for the purpose of handling notifications related to NSW-based practitioners. Ahpra collects these amounts and passes them on to the various Health Profession Councils via the HPCA. As this amount is set per registrant and collected by Ahpra and remitted to the HPCA within seven days after the end of the month, it is treated as an administered item in these financial statements. These amounts are not recorded within the *Statement of comprehensive income* or *Statement of cash flows*.

### Summary of HPCA fees collected and payable

National Board	2023 \$'000	2022 \$'000
ATSIHPBA	11	9
ChiroBA	411	470
CMBA	0	361
DBA	4,212	4,285
MBA	21,838	17,475
MRPBA	224	218
NMBA	11,254	10,831
OptomBA	185	260
OsteoBA	174	177
OTBA	264	276
ParaBA	930	735
PharmBA	3,512	3,343
PhysioBA	505	543
PodBA	289	282
PsyBA	1,695	1,848
<b>Total</b>	<b>45,504</b>	<b>41,113</b>

### Office of the Health Ombudsman (OHO) Queensland

OHO is funded for each activity it undertakes in relation to notifications about registered health practitioners at a unit rate agreed between Ahpra and OHO. The Queensland Health Minister informs Ahpra and the National Boards of the amount to be paid to OHO. This payment is included in the *Statement of comprehensive income* as an expense.

In 2022/23, a tripartite Funding Review Committee was established to review and report on a sustainable funding model for OHO. It was established that additional activities were required to be included in the funding model and that the cost of activities required updating.

In 2022/23, Ahpra was required to pay \$7.41 million (2021/22: \$4.20 million) to OHO under these arrangements.

The breakdown of the payment and adjustment is shown in this table.

National Board	2023 \$'000	2022 \$'000
ATSIHPBA	(1)	1
ChiroBA	230	76
CMBA	19	46
DBA	140	208
MBA	3,070	1,762
MRPBA	231	(8)
NMBA	1,881	1,272
OptomBA	6	1
OsteoBA	96	54
OTBA	18	5
ParaBA	51	255
PharmBA	531	340
PhysioBA	322	3
PodBA	12	(4)
PsyBA	718	440
<b>Total</b>	<b>7,324</b>	<b>4,451</b>

# Common abbreviations

## National Boards

### **ATSIHPBA**

Aboriginal and Torres Strait Islander Health Practice Board of Australia

### **ChiroBA**

Chiropractic Board of Australia

### **CMBA**

Chinese Medicine Board of Australia

### **DBA**

Dental Board of Australia

### **MBA**

Medical Board of Australia

### **MRPBA**

Medical Radiation Practice Board of Australia

### **NMBA**

Nursing and Midwifery Board of Australia

### **OptomBA**

Optometry Board of Australia

### **OsteoBA**

Osteopathy Board of Australia

### **OTBA**

Occupational Therapy Board of Australia

### **ParaBA**

Paramedicine Board of Australia

### **PharmBA**

Pharmacy Board of Australia

### **PhysioBA**

Physiotherapy Board of Australia

### **PodBA**

Podiatry Board of Australia

### **PsyBA**

Psychology Board of Australia

## Other organisations

### **Ahpra**

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

### **HCCC**

Health Care Complaints Commission (NSW)  
[www.hccc.nsw.gov.au](http://www.hccc.nsw.gov.au)

### **HCE**

Health complaints entity  
[www.ahpra.gov.au/notifications/further-information/health-complaints-organisations](http://www.ahpra.gov.au/notifications/further-information/health-complaints-organisations)

### **HCEF**

Health Chief Executives Forum  
[www.health.gov.au/committees-and-groups/health-chief-executives-forum-hcef](http://www.health.gov.au/committees-and-groups/health-chief-executives-forum-hcef)

### **HPCA**

Health Professional Councils Authority (NSW)  
[www.hPCA.nsw.gov.au](http://www.hPCA.nsw.gov.au)

### **NHPO**

National Health Practitioner Ombudsman  
[www.nhpo.gov.au](http://www.nhpo.gov.au)

### **OHO**

Office of the Health Ombudsman (Qld)  
[www.oho.qld.gov.au](http://www.oho.qld.gov.au)

# Glossary

More definitions are available at [www.ahpra.gov.au/support/glossary](http://www.ahpra.gov.au/support/glossary).

## accreditation

Accreditation ensures that the education and training leading to registration as a health practitioner meets approved standards and prepares graduates to practise a health profession safely and competently. The accreditation authority may be a committee established by a National Board, or a separate organisation.

## adjudication body

A health panel, a performance and professional standards panel, a responsible tribunal, a court or an entity in a co-regulatory jurisdiction that is declared to be an adjudication body.

## appeal

A person may appeal to a tribunal against a decision by a National Board, a health panel or a performance and professional standards panel. Decisions may also be judicially reviewed if there is a perceived flaw in the administrative decision-making process, as opposed to a concern about the merits of the individual decision itself.

## breach of non-offence provision under the National Law

Ahpra receives notifications alleging that a practitioner has breached a registration standard or endorsement, breached a condition on registration or an undertaking accepted by a National Board, or provided care beyond scope of practice. In these matters, the Board has the option to take regulatory action. They are not offences under the National Law.

## caution

A formal caution may be issued by a National Board or an adjudication body. A caution is intended to act as a deterrent so that the practitioner does not repeat the conduct. A caution is not usually recorded on the *Register of practitioners*; however, a National Board can require a caution to be recorded on the *Register of practitioners*.

## condition

A National Board or an adjudication body can impose a condition on the registration of a practitioner or student, or on an endorsement of registration. A condition aims to restrict practice in some way, to protect the public.

Current conditions are published on the *Register of practitioners*. When a National Board or adjudication body decides the conditions are no longer required to ensure safe practice, they are removed and no longer published.

Examples of conditions include requiring a practitioner to:

- complete specified further education or training within a specified period
- complete a specified period of supervised practice

- do, or refrain from doing, something in connection with the practitioner's practice
- manage their practice in a specified way
- report to a specified person at specified times about the practitioner's practice, or
- not employ, engage or recommend a specified person, or class of persons.

There may also be conditions related to a practitioner's health, such as psychiatric care or drug screening.

The details of health conditions are not usually published on the *Register of practitioners*. Also see the definition of *undertaking*.

## criminal offence

Criminal offences under the National Law by a person (including registered health practitioners and unregistered individuals) and/or corporate entity predominantly relate to breaching prohibition orders, inappropriate use of protected titles, unlawful claims about registration, performing restricted acts, and advertising of regulated health services.

Ahpra also receives notifications about practitioners who have been charged or convicted of an offence contained in a law other than the National Law, such as a criminal law. A Board may take action if the nature of the offence may affect the practitioner's suitability to practise the profession.

## disciplinary action

Regulatory action taken by a performance and professional standards panel or a tribunal after it decides that:

- a practitioner has engaged in unprofessional conduct, unsatisfactory professional performance or professional misconduct
- a practitioner's registration was improperly obtained.

## division

Part of a health profession. A practitioner can be registered in more than one division within a profession. Not all professions have divisions.

For more information, refer to the list published at [www.ahpra.gov.au/registration/registers-of-practitioners/professions-and-divisions](http://www.ahpra.gov.au/registration/registers-of-practitioners/professions-and-divisions).

## education provider

A university, tertiary education institution, specialist medical or other health-profession college that provides a program of study.



## endorsement

An endorsement of registration recognises that a person has an extended scope of practice in a particular area because they have an additional qualification that is approved by the National Board.

There are many types of endorsement available, including:

- scheduled medicines
- nurse practitioner
- acupuncture
- approved area of practice.

In psychology, these are divided into 'subtypes' that describe additional qualifications and expertise. An endorsement can include more than one subtype.

## health complaints entity (HCE)

National Boards are provided with copies of all concerns about registered health practitioners that are made to an HCE.

A National Board may talk to the HCE about the complaint and refer it to the HCE if they are the appropriate entity to deal with it.

HCE decisions, made on receipt of concerns, are not defined as regulatory action and are counted and reported on separately in the report.

The HCEs in each state and territory are listed on page 8.

## health impairment

Physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects, or is likely to detrimentally affect, a registered health practitioner's capacity to safely practise the profession or a student's capacity to do clinical training.

## immediate action

Also referred to as interim action. This can be taken as an interim step to restrict a practitioner's registration while a complaint is investigated. Immediate actions include:

- the suspension of, or imposition of a condition on, a registered health practitioner's or student's registration
- accepting an undertaking from a registered health practitioner or student
- accepting the surrender of a registered health practitioner's or student's registration.

## mandatory notification

It is mandatory that colleagues, treating practitioners, employers or education providers of a registered practitioner or student submit a notification about them if they have behaved in a way that constitutes notifiable conduct. Refer to each Board's website for *Guidelines for mandatory notifications*.

## Ministerial Council

Defined in the National Law as 'the COAG [Council of Australian Governments] Health Council or a successor of the Council by whatever name called, constituted by Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health'.

## National Board

Appointed by the Ministerial Council to regulate a profession in the public interest and meet the responsibilities set down in the National Law. Comprising practitioner members and community members, National Boards and/or state boards and/or committees are delegated the functions/powers of the National Board.

## National Law

The Act adopted in each state and territory setting out the provisions of the Health Practitioner Regulation National Law. The National Law is generally consistent in all states and territories. NSW did not adopt Part 8 of the National Law.

## National Registration and Accreditation Scheme (National Scheme)

The National Registration and Accreditation Scheme for registered health practitioners was established by the Council of Australian Governments (COAG) under the National Law. The scheme began on 1 July 2010 (or 18 October 2010 in WA). In 2010, 10 professions became nationally regulated by a corresponding National Board. In 2012, four additional professions joined the National Scheme. In 2017, the Paramedicine Board of Australia was established and the regulation of paramedics began in late 2018.

## National Restrictions Library (NRL)

Lists common restrictions (conditions or undertakings) used across the regulatory functions of the National Boards to support:

- consistency in recommendations from Ahpra to the National Boards and delegates
- consistency in the restrictions appearing on the *Register of practitioners*
- a best practice approach to monitoring compliance with restrictions.

The NRL is available at [www.ahpra.gov.au/registration/monitoring-and-compliance/national-restrictions-library](http://www.ahpra.gov.au/registration/monitoring-and-compliance/national-restrictions-library).

## no conviction recorded

An outcome that is available to a court after a plea or finding of guilt. This is a common outcome for first offenders for 'low level' offences, which reflects the willingness of the legislature and the community to give first offenders, in certain circumstances, a second chance to maintain a reputation of good character.

## no further action

No further action is taken when, based on the available information, the Board determines there is no risk to the public that requires regulatory action.

## notation

Records a limitation on the practice of a registrant. Used by National Boards to describe and explain the scope of a practitioner's practice by noting the limitations on that practice. The notation does not change the practitioner's scope of practice but may reflect the requirements of a registration standard.

### **notifiable conduct**

When a registered health practitioner has:

- practised their profession while intoxicated by alcohol or drugs
- engaged in sexual misconduct in connection with the practice of their profession
- placed the public at risk of substantial harm in the practice of their profession because they have an impairment, or
- placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

### **notification**

Any person or organisation can raise a concern about a registered health practitioner's behaviour or health with Ahpra on behalf of a National Board.

A notification is a concern about a practitioner or student relating to a matter that is a ground for a notification under the National Law.

National Boards gather information contained in notifications to help identify risks in the way an individual practitioner is practising a health profession.

Concerns can be raised by contacting Ahpra on 1300 419 495 (within Australia), +61 3 9125 3010 (outside Australia) or at [www.ahpra.gov.au/notifications](http://www.ahpra.gov.au/notifications).

In response to a notification, a Board may:

- store the information provided in a notification, and take no further action on that occasion, or
- make further enquiries in relation to a practitioner, by investigating the practitioner or requiring the practitioner to attend a health or performance assessment.

After making necessary enquiries in response to a notification and considering the information, a National Board or independent adjudication body may decide to take regulatory action.

### **notifier**

A person or entity who makes a notification to Ahpra.

### **practice**

The definition of *practice* used in a number of National Board registration standards means any role, whether remunerated or not, in which an individual uses their skills and knowledge as a practitioner in their regulated health profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of health services in the health profession.

Some National Boards have also issued guidance about when practitioners need to be registered.

### **principal place of practice**

The location declared by a practitioner as the address at which they mostly practise their profession. If the practitioner is not practising, or not practising mostly at one address, then the practitioner's principal place of residence is used.

If the location of the principal place of practice is in Australia, the following information is displayed on the *Register of practitioners*:

- suburb
- state
- postcode.

If the location is outside Australia, the following information is displayed on the *Register of practitioners*:

- international state/province
- international postcode
- country.

In rare cases, when a practitioner has demonstrated that their health and safety may be at risk from the publication of information about their principal place of practice, a National Board may choose to not publish this information.

### **prohibited practitioner/student**

A person who is being monitored because they are subject to a cancellation order, suspension or a restriction not to practise. Alternatively, as an outcome of a notification they may have surrendered their registration or changed to non-practising registration.

### **qualification**

Professional qualifications that a practitioner must have to meet the requirements for registration. Undergraduate and postgraduate Australian qualifications recognised by National Boards are published on their websites. Individual practitioners' approved qualifications are published on the *Register of practitioners*.

### **Register of practitioners**

A publicly accessible database of all health practitioners currently registered in Australia. Ahpra also maintains a list of cancelled practitioners and a list of practitioners who have given an undertaking not to practise. You can search these databases at [www.ahpra.gov.au/registration/registers-of-practitioners](http://www.ahpra.gov.au/registration/registers-of-practitioners).

### **registered health practitioner**

An individual who is registered under the National Law to practise a health profession, other than as a student, or who holds a non-practising registration in a health profession.

### **registration expiry date**

The date when a practitioner's current registration expires. Practitioners must apply to renew their registration annually. If the practitioner's name appears on the *Register of practitioners*, they are registered and can practise within the scope of their registration, consistent with any conditions or undertakings that apply.

During the renewal period, practitioners remain registered for one month after their registration

expiry date where they fail to lodge an application for renewal. Registrants who apply to renew can continue to practise while their application is being assessed.

### registration number

Since March 2012, practitioners have been allocated a unique registration number for each profession in which they are registered. This number stays with the practitioner for life, even if they have periods when they are not registered.

### registration status

The status of a registration can be:

- **Registered:** The practitioner is registered. The practitioner's name is published on the *Register of practitioners*.
- **Suspended:** The practitioner is not permitted to practise while suspended. The practitioner's name is published on the *Register of practitioners*.
- **Cancelled:** The registration has been cancelled and the practitioner is not permitted to practise. The practitioner's name is not published on the *Register of practitioners* but is published on the list of cancelled practitioners.

### registration type

A National Board can grant various types of registration to an eligible practitioner. Examples include:

- general registration
- limited registration
- non-practising registration
- provisional registration
- specialist registration.

### regulatory action

Action taken by a National Board that affects a practitioner's registration. It can be taken if a Board reasonably believes that a practitioner:

- has practised in a way that is or may be below the standard reasonably expected
- has behaved in a way that is or may be below the standard reasonably expected of the practitioner by the public or the practitioner's peers
- has or may have an impairment that could detrimentally affect a practitioner's ability to practise safely.

The regulatory actions that can be taken by a National Board are:

- cautioning a practitioner
- accepting an undertaking
- imposing a condition.

Regulatory action can also be taken by a health panel, a performance and professional standards panel (PPSP) or a tribunal after it decides that:

- a practitioner has an impairment
- a practitioner has engaged in unprofessional conduct or unsatisfactory professional performance
- a practitioner has engaged in professional misconduct (tribunal only)
- a practitioner's registration was improperly obtained (tribunal only).

The regulatory actions that can be taken by a health panel, PPSP or a tribunal are:

- imposing a condition
- cautioning a practitioner (PPSP or tribunal)
- reprimanding a practitioner for practising or behaving in a certain way (PPSP or tribunal)
- requiring a practitioner to pay a fine (tribunal only)
- suspending a practitioner's registration for a period of time (health panel or tribunal)
- cancelling a practitioner's registration, either temporarily or permanently (tribunal only)
- disqualifying a person from applying for registration for a specified time (tribunal only)
- prohibiting the person from providing a health service or using a title (tribunal only).

### reprimand

A chastisement for conduct; a formal rebuke.

Reprimands issued since the start of the National Scheme are published on the *Register of practitioners*.

### specialty

There are currently three professions with specialist registration: dental, medical and podiatry. The Ministerial Council is responsible for approving a list of specialties for each profession and for approving one or more specialist titles for each specialty. The National Boards decide the requirements for specialist registration in their profession.

### spent conviction order

A court order that a criminal conviction is spent immediately. This means that the conviction does not need to be disclosed in many circumstances and the conviction will never appear on a standard National Police Clearance. However, the conviction still needs to be disclosed in some circumstances; for example, Working with Children Checks and when applying for registration as a health practitioner.

### standard

Registration standards define the requirements that applicants, registrants or students need to meet to be registered as a health practitioner.

### student

A person whose name is entered in a student register as being currently registered as a student practitioner under the National Law.

### suspension

If a practitioner's registration is suspended, they are not eligible to practise. A tribunal has the power to suspend a practitioner's registration as a result of a hearing. A National Board also has the power to suspend a practitioner's registration pending other assessment or action, if it believes:

- there is serious risk to the health and safety of the public from the practitioner's continued practice of the profession, and that suspension is necessary to protect the public from that risk, or
- there are public interest grounds for suspending a practitioner's registration; for example, when the practitioner has been charged with serious criminal conduct.

A health panel can suspend a practitioner's registration if the panel finds that the practitioner (or student) has an impairment and it is necessary to suspend the practitioner's registration to protect the public.

#### **undertaking**

National Boards can accept an undertaking from a practitioner to limit their practice in some way if this is necessary to protect the public. The undertaking means the practitioner agrees to do, or to not do, something in relation to their practice of the profession.

Current undertakings that restrict a practitioner's practice of the profession are published on the *Register of practitioners*. Current undertakings that relate to a practitioner's health are mentioned on the register but details are not provided. When a National Board or adjudication body decides the undertakings are no longer required to ensure safe practice, they are revoked and are no longer published.

An undertaking is voluntary (but enforceable), whereas a condition is imposed on a practitioner's registration.

#### **unprofessional conduct**

Conduct that is of a lesser standard than that which might reasonably be expected of a health practitioner by the public or the practitioner's professional peers. A more extensive definition is available under section 5 of the National Law.

Each profession has a set of standards and guidelines that clarify the acceptable standard of professional conduct.

#### **unsatisfactory professional performance**

This is when the knowledge, skill or judgement possessed, or care exercised, by a practitioner in the practice of the health profession in which they are registered is below the standard reasonably expected for a health practitioner with an equivalent level of training or experience.

#### **voluntary notification**

A notification made on a voluntary basis. The grounds for a voluntary notification are set out in section 144 of the National Law.

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