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# Cost-effectiveness and efficiency review of the Australian National Registration and Accreditation Scheme for health professionals

Final report  
October 2014

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Centre for  
Health Service Economics  
& Organisation







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# 1. Introduction

1.1 In June 2014, the Professional Standards Authority, working in collaboration with the Centre for Health Service Economics and Organisation, was contracted to review the cost-effectiveness and efficiency of the National Registration and Accreditation Scheme for health practitioners (NRAS) in Australia. The review was scheduled to take place between July and October 2014.

1.2 This review was one element of the broader review of the NRAS, commissioned by the Australian Health Workforce Ministerial Council (AHWMC), in accordance with the Intergovernmental Agreement (IGA) for a National Registration and Accreditation Scheme for the Health Professions that was signed by the Council of Australian Governments (COAG) in March 2008. The IGA provided for an independent review of the NRAS to be initiated by the AHWMC following three years of the scheme's operation; it has been in operation since July 2010. It was anticipated that the findings from the cost- effectiveness and efficiency review would be critical to the provision of advice and options for reform to improve the operations and governance arrangements to ensure the sustainability of the NRAS.

## The Professional Standards Authority

1.3 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament. We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance annually and audit and scrutinise their decisions about whether people on their registers are fit to practise. We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

1.4 To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation<sup>1</sup>. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake international commissions in which we review the performance of a profession regulatory organisation, advise on regulatory arrangements, and make recommendations for regulatory improvement and development. More information on the Authority's work can be found at [www.professionalstandards.org.uk](http://www.professionalstandards.org.uk)

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<sup>1</sup> *Right-touch regulation*, Council for Healthcare Regulatory Excellence, August 2010. <http://www.professionalstandards.org.uk/library/document-detail?id=a3ea5638-fadf-400e-8635-47bf4b028a1f>

## The Centre for Health Service Economics and Organisation

- 1.5 The Centre for Health Service Economics and Organisation is a research unit with economists, statisticians and operational researchers, focused on whole-system analysis of healthcare and local health economies. Embedded in the Departments of Primary Care Health Services and Economics at the University of Oxford, the Centre has carried out projects commissioned by the Department of Health, the NIHR (NHS research-funding body) and various other public bodies (eg NHS London, the Health Foundation, CHRE (now the Professional Standards Authority), and Homeless Link. More information on the Centre's work can be found at [www.chseo.org.uk](http://www.chseo.org.uk)
- 1.6 In undertaking the review we have applied a methodology developed specifically for assessing the cost-effectiveness and efficiency of professional regulatory arrangements. This was developed when the Authority, working with the CHSEO, was commissioned by the Department of Health in 2011 to conduct a cost-effectiveness and efficiency review of the nine UK health and care regulators<sup>2</sup>. This work involved collection and cleaning of financial data, its integration with performance data, the development of economic modelling and the publication in 2012 of an analytical report and recommendations. The methodology which was developed in that exercise has been applied to the data on operating costs for the regulatory functions in Australia that has been provided to us. We are not aware of any alternative methodologies having been developed elsewhere for a cost-effectiveness and efficiency assessment of professional regulatory arrangements and we consider this collaboration with colleagues in Australia shows the value of the model but also enables us to refine it further. We hope that this report will be of value to governmental and regulatory bodies in Australia and ultimately, through the analysis of cost and comparative data between Australia and the UK which it provides, to regulatory bodies worldwide as they consider their own cost-effectiveness and efficiency.
- 1.7 We are grateful to colleagues in Australia for the constructive and helpful way in which they have worked with us during this review.

## 2. Executive summary

- 2.1 In this report we have calculated an annual operating cost of the National Registration and Accreditation Scheme of \$214,117,803. This equates to \$346 per registered health professional.
- 2.2 We have shown how this total operating cost has been calculated, looking at three areas of expenditure: the Australian Health Practitioner Regulation Agency, the accreditation authorities, and the notifications arrangements in New South Wales.

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<sup>2</sup> Final report available at <http://www.professionalstandards.org.uk/library/document-detail?id=5c7ffe06-95cf-4284-8a56-f3c6a4d300e6>

- 2.3 We have calculated the operating costs for each of the national boards, showing how much they spend on each function and how they compare to each other, including an analysis of per-registrant unit costs. We show that while the average unit cost is \$346 per registrant, when analysed by profession this varies between \$162 and \$1,792.
- 2.4 We have then analysed the data in terms of the complexity of regulating different professions, and we show how effects of scale differ across the regulatory functions. We identify the aspects of the different regulatory functions which increase complexity and therefore, potentially, cost.
- 2.5 We compare the cost of the regulatory functions in Australia with the UK. While we find that the unit cost per registrant in the UK (which we estimate at \$301.50) is slightly lower than in Australia, there are a number of factors which prevent a direct comparison of relative efficiency. We find that as a proportion of total spending the accreditation function in Australia is markedly more expensive than the quality assurance of higher education function in the UK, and we provide analysis of the possible reasons for this.
- 2.6 We have identified a number of potential areas for cost savings. These include two options for merging boards where we calculate hypothetical annual savings of between \$11.9m and \$58m. We also make a number of specific recommendations in different functional areas (registration, notifications and accreditation) where we identify potential areas where costs may be saved or more effectively controlled.
- 2.7 We offer a number of conclusions and recommendations, including for further areas of review and analysis.

### 3. Provisions for health professional regulation: Australia and the UK

- 3.1 In this section we outline the main provisions for the regulation of health professionals in Australia and in the UK, given the importance of comparison to this review and in order to give context to the economic interpretations that follow.
- 3.2 New legislation in Australia in 2010, the Health Practitioner National Law Act, established nationally consistent legislation for the regulation of ten health professions, with national boards for each of these professions. This replaced the previous state-based structures, with 85 boards and 66 acts of Parliament. The Australian Health Practitioner Regulation Agency (AHPRA) was established to support the boards in operating the National Registration and Accreditation Scheme (NRAS). From July 2012, four further groups were brought into the scheme. All 14 professional groups in the scheme are listed below, together with the relevant boards.
- 3.3 Registration of regulated health professionals is undertaken by AHPRA, which has established a single national register for all professions. The national boards set out standards of conduct. AHPRA and the boards work together to investigate and adjudicate where an allegation ('notification') is

made that standards have not been met. There are different arrangements in New South Wales for notifications, where this function is undertaken by the New South Wales Health Care Complaints Commission and professional councils. Also, an Ombudsman role has been established from July 2014 in Queensland<sup>3</sup>. Quality assurance of higher education is the responsibility of national councils for 11 of the 14 professions, and of a committee of the national board for the remaining three.

<b>Health professional regulatory boards in Australia</b>	<b>Profession(s)</b>	<b>Number on register</b>
Aboriginal and Torres Strait Islander Health Practice Board of Australia	Aboriginal and Torres Strait islander health practitioners	330
Chinese Medicine Board of Australia	Chinese medicine practitioners	4,259
Chiropractic Board of Australia	Chiropractors	4,843
Dental Board of Australia	Dentists, dental specialists, dental therapists, dental hygienists, oral health therapists and dental prosthetists	20,692
Medical Board of Australia	Medical practitioners	99,209
Medical Radiation Practice Board of Australia	Medical radiation practitioners	14,360
Nursing and Midwifery Board of Australia	Nurses and midwives	362,008
Occupational Therapy Board of Australia	Occupational therapists	16,174
Optometry Board of Australia	Optometrists	4,790
Osteopathy Board of Australia	Osteopaths	1,864
Pharmacy Board of Australia	Pharmacists	28,252
Physiotherapy Board of Australia	Physiotherapists	26,076
Podiatry Board of Australia	Podiatrists	4,125
Psychology Board of Australia	Psychologists	31,649
	<b>Total</b>	<b>618,631</b>

<sup>3</sup> The costs of these new arrangements in Queensland are beyond the scope of this exercise.

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- 3.4 In the United Kingdom, the regulation of health professionals is the responsibility of nine separate statutory regulatory bodies. These are listed below. The organisations have been set up over many years under different Acts of Parliament. Their performance is overseen by the Professional Standards Authority. They are mostly UK-wide bodies with the exception of the General Pharmaceutical Council (England, Wales and Scotland) and the Pharmaceutical Society of Northern Ireland.
- 3.5 In addition to a wide range of health professions, the Health and Care Professions Council also regulates social workers in England only. There are separate regulators of social workers in Wales, Scotland and Northern Ireland and these are not overseen by the Professional Standards Authority.
- 3.6 Each of the nine bodies however has a common set of core functions. They all set and promote the standards that professionals must meet before and after they are admitted to the register; maintain the register of those professionals who meet the standards; take action where a registered professional's fitness to practise has been called into question; and quality assure the courses of higher education that lead to registration. The arrangements are set out in summary below.



<b>Regulatory bodies of health professionals in the UK and social workers in England</b>	<b>Profession(s)</b>	<b>Number on register</b>
General Chiropractic Council	Chiropractors	2,959
General Dental Council	Dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians, orthodontic therapists	103,765
General Medical Council	Doctors	259,826
General Optical Council	Optometrists, dispensing opticians, student opticians (optical businesses)	24,421
General Osteopathic Council	Osteopaths	4,810
General Pharmaceutical Council	Pharmacists, pharmacy technicians (England, Scotland, Wales)	71,221
Health and Care Professions Council	Arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists and orthotists, radiographers, speech and language therapists, social workers (England only)	322,037
Nursing and Midwifery Council	Nurses and midwives	680,858
Pharmaceutical Society of Northern Ireland	Pharmacists (Northern Ireland only)	2,155
	<b>Total</b>	<b>1,472,052</b>

## 4. Aggregate operating costs in Australia

- 4.1 We calculate that the annual operating cost of the National Registration and Accreditation scheme is \$214,117,803<sup>4</sup>. This equates to \$346 per registrant in the scheme, and \$9.14 per head of the Australian population. This compares to our estimate of the current operating cost of the regulatory arrangements in the UK of \$392,000,000, or \$301.50 per registrant, or \$6.23 per head of population in the UK.
- 4.2 While the majority of this cost is incurred directly by AHPRA, the total also includes a calculation of the cost of the notifications process in New South Wales, and the cost of the arrangements for the accreditation of the higher education courses that lead to registration. In this chapter we take each of these elements separately below, and set out the basis for our calculations.
- 4.3 Table 1 gives a breakdown of the total costs, for each function giving the total cost at national level for all professions, and the percentage of total spending by function by AHPRA.

### AHPRA expenditure

- 4.4 AHPRA has provided 2013/14 data for each of the boards, broken down by regulatory function. Six basic regulatory functions have been identified: notifications, registration, compliance, accreditation, professional standards and governance. There are also 'other costs' that cannot be directly allocated to one of these functions. These seven cost categories can be found in Table 1. AHPRA spend approximately \$152m regulating health professionals in Australia. About half of expense concerns notifications (\$40m) and registration (\$35m).
- 4.5 Table 1 also provides a helpful calculation by AHPRA which distributes 'other costs', a further \$45m in the data that was provided to us, across specific functions. AHPRA have done this on an FTE basis, with costs shared across functions according to the number of staff employed in each function. AHPRA have also carried out an ad-hoc adjustment to make these figures fit with their experience of their operations, slightly increasing the size of notification expenditure and decreasing the size of spending on registration<sup>5</sup>.
- 4.6 When the allocations and adjustments to 'other costs' have been performed, registration becomes the biggest area of expense (\$54.9m or 36.5% of total spending), marginally above notifications (\$54.5m, 36.2%). The four other areas each account for between 5.3% (\$8.1m) and 8.0% (\$12.1m) of AHPRA's expenditure.

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<sup>4</sup> The figures that we have used to compile this estimate have been drawn from the most recently available financial data. For most of this expenditure (ie AHPRA) this has been for the financial year 2013/14 however in other cases the data has been for 2012/13.

<sup>5</sup> We have assessed this methodology and have concluded it is a valid way to distribute costs across functions.

## Cost of New South Wales notifications arrangements

- 4.7 In addition to spending incurred centrally by AHPRA, our calculations also provide for the additional cost of investigating notifications in New South Wales (NSW). NSW operates its own notification system. This is funded in part by the NSW Government (the Health Care Commissioner and his office) and in part by AHPRA (the professional councils). These figures are not included in the figures discussed above. Due to this different notification system, NSW health professionals can pay different fees to AHPRA from those paid by health professionals in other states or territories.
- 4.8 Table 2 shows the work carried out by the Health Care Complaints Commissioner (HCCC) in 2012/13. Using figures they provided on the average cost of each stage of the notifications process, we have calculated an estimate of the total cost of this element of the notifications arrangements in Australia. The Commissioner's remit goes beyond just complaints against individual professionals, and includes complaints about health services more generally. Therefore we have not allocated the Commissioner's total expenditure of \$11.7m to our estimated total operating cost. The HCCC told us that of that \$11.7m, \$9.9m was spent on cases involving individual professionals; the figure we have used differs slightly from this value. With assessments, resolutions and investigations, the figures relate to cases that were concluded during 2012/13, but we did not have information about the professions of those cases which went to legal resolution. As such it was decided to use those 'referred to Director of Proceedings' (of which we do know the profession) as a proxy for this measure, as this enables us to analyse expenditure by profession. There were 85 of these in 2012-13 as opposed to 88 that were resolved and this difference explains the difference between our figures and theirs.
- 4.9 The third element of the total costs of notifications in Australia is the costs incurred by the NSW professional councils in pursuing less serious cases. We estimate this to be an additional \$20,273,096. Therefore, we calculate the total cost of notifications in NSW to be \$30,029,821. Notifications cost on average \$166 per registrant in NSW and \$125 per registrant in the rest of Australia.
- 4.10 Table 3 amalgamates this with the costs incurred centrally by AHPRA to show the total cost of the notifications function in Australia. First, a per-registrant notification cost was calculated for each profession in the rest of Australia, excluding NSW (column 6). Column 4 provides the difference in registration fee for each profession. Given that AHPRA carry out all other regulatory functions (excluding accreditation), this was assumed to be the difference per registrant in the cost of notifications in the rest of Australia. Therefore, adding this figure to column 6 gives the cost per registrant for notifications in NSW (column 8). Multiplying column 8 by the number of registrants in NSW gives an estimated total cost for the work of the professional councils funded by AHPRA (column 7). The addition of this to the total cost of notifications in the rest of Australia (column 5) and the total cost of relevant HCCC activities (reproduced as column 9) gives the total cost of notifications in Australia, which we calculate to be \$84,958,309.

4.11 We are not able to comment on the qualitative differences between the co-regulatory arrangements for notifications in NSW as opposed to those in place in the rest of Australia. Nevertheless, given the marked difference in unit cost set out at paragraph 4.9, we think that the relative costs and benefits of these different arrangements should be the subject of further analysis. We are aware that the notification arrangements are currently the subject of detailed analysis and research which when complete will contribute to understanding of the costs and benefits of the NSW model. We make some further observations and recommendations regarding notifications at paragraphs 8.17-8.19.

### Cost of accreditation

4.12 Accreditation of higher education courses in Australia is carried out by an accreditation council for 11 of the 14 professions in the NRAS. The councils are separate organisations, external to AHPRA and the national boards, with their own governance, staffing, premises and websites. The councils, which are listed below, are under contract to provide accreditation of the higher education courses that can lead to registration.

Accreditation councils in Australia	Websites
Australian and New Zealand Osteopathic Council	<a href="http://www.osteopathiccouncil.org.au/">http://www.osteopathiccouncil.org.au/</a>
Australian and New Zealand Podiatry Accreditation Council	<a href="http://www.anzpac.org.au/">http://www.anzpac.org.au/</a>
Australian Dental Council	<a href="http://www.adc.org.au/">http://www.adc.org.au/</a>
Australian Pharmacy Council	<a href="http://pharmacycouncil.org.au/content/">http://pharmacycouncil.org.au/content/</a>
Australian Physiotherapy Council	<a href="http://www.physiocouncil.com.au/">http://www.physiocouncil.com.au/</a>
Australian Psychology Accreditation Council	<a href="https://www.psychologycouncil.org.au/">https://www.psychologycouncil.org.au/</a>
Council on Chiropractic Education Australasia	<a href="http://www.ccea.com.au/">http://www.ccea.com.au/</a>
Australian Medical Council	<a href="http://www.amc.org.au/">http://www.amc.org.au/</a>
Australian Nursing and Midwifery Accreditation Council	<a href="http://www.anmac.org.au/">http://www.anmac.org.au/</a>
Occupational Therapy Council (Australia and New Zealand)	<a href="http://otcouncil.com.au/">http://otcouncil.com.au/</a>
Optometry Council of Australia and New Zealand	<a href="http://www.ocanz.org/">http://www.ocanz.org/</a>

For the three remaining professions in the Scheme the responsibility for accreditation is vested in a committee of the national board: Aboriginal and Torres Strait islander health practice, Chinese medicine, and medical radiation practice.

4.13 The accreditation councils have three sources of income: contribution from the relevant national board, fees charged to education providers, and income from fees charged to overseas applicants for assessment of their

- qualification<sup>6</sup>. The board for each profession approves the standards against which the council is under contract to accredit. There is a group which brings together the accreditation council chief executives, the boards and AHPRA which agrees a cross-professions quality framework.
- 4.14 For the three professions which have not contracted with an accreditation council, AHPRA has recently established a unit to deliver this function. The unit has established accreditation standards, has put in place operational arrangements, has appointed assessors, and has established an application process for education providers. There are 16 programmes identified for review across the three professions. The unit provides the opportunity to explore innovative approaches including, for example, joint assessments and inspections. This activity is funded from two sources; funding from AHPRA through the registration fee, and fees charged to the institution under assessment.
- 4.15 At Table 4 we have set out the fees charged to education institutions, where available, for the past five years by councils.
- 4.16 The Australian approach contrasts markedly with UK arrangements, where the quality assurance of higher education courses is undertaken by the regulator and is funded from the registration fee like other regulatory functions. There is no direct charge to the institution whose course is being quality assured in the UK. There are of course compliance costs for course providers, in both approaches.
- 4.17 We have collated data on annual expenditure by the accreditation councils and have reached an estimated figure representing annual expenditure on accreditation within the scheme of \$41,534,341. The method by which we have reached this figure is set out in Table 5 which attempts to capture the full direct cost of accreditation in Australia. Column (a) shows expenditure by national boards, as taken from AHPRA accounts. Column (b) shows expenditure by the accreditation councils. Column (c) shows transfers from national boards to accreditation councils to pay for their activity. To avoid double counting, this figure is removed from the total expenditure by councils and boards for each profession. Following discussion with the accreditation councils, it was decided not to try controlling for activity in New Zealand. However, three councils have provided amounts received as grants from New Zealand, so these figures have been removed from the councils' expenses so that as far as possible we are comparing like with like. The final column combines this information to provide an estimate of the total spend on accrediting courses in each profession. We note that due to accreditation cycles within Australia, and the undertaking of different projects by the councils, these figures may not necessarily represent an accurate representation of accreditation spending beyond the year under investigation. However, this data provides a general guide to the annual cost of accreditation and demonstrates the proportion of accreditation expenditure under the NRAS, since we have not seen any evidence which would suggest that cumulatively the 11 councils have had exceptional costs in this year.

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<sup>6</sup> This process would be considered part of the registration function within a UK regulator

- 4.18 The total expenditure on accreditation that we have calculated now represents 19.4% of the total expenditure on the NRAS of \$214,117,803. This compares to the UK arrangements where the quality assurance of higher education accounts for 6% of total regulatory expenditure. While we acknowledge that there may be differences of focus and approach between the UK and Australia, the reasons for such a marked difference in the proportion of expenditure on this function are not clear to us. We recommend that the reasons for this difference warrant further investigation. We discuss this further at paragraphs 8.20-8.34.

## 5. Operating costs by board

- 5.1 There are 14 health profession boards in the NRAS, ranging in size from ATSIHPBA with 330 registrants up to NMBA which had 362,008 registrants in May 2014. Table 6 shows each board's aggregate spending by function, using the data provided by AHPRA, adjusted to account for the additional cost of the NSW notifications process and the spending of the accreditation councils. Given the wide variation in size of the boards it is no surprise that their budgets vary significantly too, with ATSIHPBA spending \$591,449 while MBA and NMBA have budgets in excess of \$88m and \$58m respectively. MBA spend twice as much on notifications than anyone else, and nearly 50% of the total spent on notifications nationally. Registration spending generally increases with the size of the profession, so ATSIHPBA spends the least and NMBA spends the most. ATSIHPBA spends less on every function than any other boards. MBA and NMBA are more expensive than the other boards for compliance, accreditation, professional standards and governance.
- 5.2 Table 7 shows how the proportion of a board's spending on the various functions differs across the professions. ATSIHPBA spend a much larger proportion than the national average on professional standards. The lowest proportion spent on this function is the MBA at 3.7%; the result of this is that most boards spend more than the mean of 5.6% on professional standards. CMBA, OsteoBA, ChiroBA and MBA spend more than would be expected on notifications; DBA, PhysioBA and OptomBA incur large costs on accreditation; NMBA, ATSIHPBA and PsyBA spend a large proportion on registration; the proportion spent on governance varies from 3.5% in OsteoBA to 7.2% in NMBA, and the proportion spent on compliance costs is relatively standard across the boards<sup>7</sup>.
- 5.3 It is interesting to compare regulators of similar size. Leaving aside ATSIHPBA and OsteoBA which are significantly smaller than the third smallest regulator, and the two largest boards NMBA and MBA, the other eleven can be collected into three groups of similar size.

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<sup>7</sup> We note that fluctuations in year on year workload may affect these figures disproportionately for the smaller professions.

#### **4,000-5,000 registrants: CMBA, ChiroBA, OptomBA and PodBA**

- 5.4 Of these four boards, PodBA is much the lowest cost, costing just more than half of the expense incurred by ChiroBA. They spend just \$725,987 on notifications compared to \$1.56m in ChiroBA, and their spend on registration, compliance and governance are all significantly lower than that of ChiroBA. The PodBA accreditation spend is comparable to that of ChiroBA, but OptomBA spend twice as much as ChiroBA on accreditation while CMBA have low accreditation costs.

#### **14,000-16,000 registrants: MRPBA and OTBA**

- 5.5 These two regulators are similar in most functions as well as in overall scale. The biggest difference is that OTBA spend a much larger proportion on accreditation – 11% of their total spend compared to 5.2% in MRPBA.

#### **20,000-32,000 registrants: DBA, PharmBA, PhysioBA and PsyBA**

- 5.6 PhysioBA is the lowest cost of these boards at \$5.6m, with PsyBA and PharmBA costing approximately \$13m each and DBA nearly \$17m. PhysioBA are also lowest cost for all functions except accreditation, on which they spend twice as much as PsyBA. DBA, the smallest of these four regulators, are relatively expensive as a consequence of their high notification and accreditation spending.
- 5.7 A second way to aid comparison across different sized boards is to look at the unit cost, or cost per registrant, for each function at board level, that is, the total amount spent by each board on the individual functions of registration divided by the number of registrants in each profession. The rest of the analysis presented here concentrates on measures of this nature. Table 8 presents this information for the 14 boards, as well as an average for all registered professionals, in aggregate and for each of the 6 individual functions.
- 5.8 On average, regulating a health professional in Australia cost \$346 in 2013/14. There is wide variation across the different boards, with ATSIHPBA costing \$1,792 per registrant while an NMBA registrant cost about \$162. ATSIHPBA is the most expensive board for five of the six functions as well as on an aggregate level. The one exception is accreditation, on which DBA spend most per registrant. This unit cost analysis suggests that the size of the board has some role in explaining the relative expense of regulation, with larger boards appearing less costly, so Figures 1-8 in the next section of the report investigate this subject further.

## **6. Scale and complexity**

- 6.1 Figure 1 explores the relationship between the scale of each board and its unit cost. The relationship is expressed in logarithms because it appears

reasonable to expect a 'percentage relationship'<sup>8</sup> between the two variables; namely, a one percent increase in scale is associated with an x-percent decrease in unit cost. Figure 1 gives the natural log of total unit cost on the y-axis against the natural log of the number of registrants on the x-axis. The fitted line shows the percentage increase (or decrease) if the number of registrants was 1% higher (or lower). In Figure 1, the slope of -0.24 implies that regulators that are 10% larger in size are 2.4% lower in the unit cost of regulation. Across the regulatory functions, an increase in size of 10% results in a unit cost reduction of between 2 and 3%. It is important to recognise that although a significant correlation exists between scale and cost this does not in itself demonstrate a causal link.

- 6.2 Figure 2 looks at the relationship between size and notifications, using the same methods as adopted in Figure 1. As we discovered a significant relationship between overall unit cost and size, it is not surprising that a similar relationship is discovered in the function responsible for the largest proportion of spending. The coefficient on scale in this graph, -0.25, shows that boards with a 10% higher number of registrants have a 2.5% lower unit cost of notifications. Spend on notifications may be a function of the number of complaints received rather than the number of registrants regulated by the board. Therefore, it is important to consider the possibility that the larger boards appear more efficient because they receive fewer complaints per registrant rather than are more efficient at dealing with them. However Figure 3 plots the number of registrants against the number of complaints per registrant for the fourteen boards, and shows no evidence to support this hypothesis. Therefore, it is likely that the scale effect is due to larger boards being more efficient at dealing with notifications and not because they simply receive a smaller number per registrant.
- 6.3 The coefficient on scale in Figure 4, -0.22, shows that if the size of the board is 10% larger, the unit cost of registration is 2.2% lower. The coefficient on scale in Figure 5, -0.20, shows that if the size of a board is 10% larger, the unit cost of compliance is 2% lower. The coefficient on scale in Figure 6, -0.09, shows that if the size of a board is 10% larger, the unit cost of accreditation is 0.9% lower. Given that accreditation is more closely attached to the number of courses it should not be a surprise that the sensitivity of accreditation costs to registrant numbers is somewhat lower.
- 6.4 The coefficient on scale in Figure 7, -0.46, shows that if the size of a board is 10% larger, the unit cost of professional standards is 4.6% lower. This is the largest coefficient in all the functions. One explanation is that setting professional standards is a task not much affected by the size of the professional group, hence increasing the size of the profession means the same total cost is being distributed across a larger pool of registrants.

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<sup>8</sup> A commonly used alternative relationship is that an absolute increase in scale would be associated with an absolute change in another variable. In some contexts, a 'percentage relationship' is more plausible than an absolute relationship. In the scale relationships here, a unit change of scale at high scale levels is unlikely to have the same influence as at low scale levels. The 'percentage relationship' fits the scale relationships here acceptably well.



- 6.5 The coefficient on scale in Figure 8, -0.20, shows that if the size of a board is 10% larger, the unit cost of governance is 2% lower.
- 6.6 Figure 9 and Table 9 provides a measure of efficiency that shows how the boards are performing relative to the costs that could be predicted by their size, for each function and in aggregate. In this Figure, a value of 1 implies that they are performing as expected given their size; a value greater than 1 that their performance is more costly relative to the levels that could be expected for an organisation of their size, and a value less than 1 shows that their performance is less costly than size would suggest.
- 6.7 Distance from the line analysis suggests that ATSIHPBA, DBA, MBA and PsyBA are more costly than would have been predicted purely on scale. MRPBA, OTBA, PhysioBA and PodBA generally operate at costs lower than would have been expected. The Figures are not conclusive and do not generate explanations for deviation from the line. However, they do provide an indication of areas of interest for further analysis and investigation.

#### **Analysis of regulatory complexity by comparing ratios with UK regulators**

- 6.8 Work to this point supposes that the only variable that would affect cost is the size of the regulated profession. This is unlikely to be the case, as professions differ in terms of complexity and therefore the regulatory force required and these factors will impact on the cost of regulation. There is no direct way of capturing complexity or its relationship to regulatory force required. However, a variety of data can be used to give an indication of the relative risk and complexity across professions and the work that follows presents data that can provide an indication of that. We suggest caution in interpreting these correlations but they may be indicative of the links between risk, complexity, regulatory force and cost.

#### **Australia/UK comparison**

- 6.9 We begin by looking at costs in Australia and the UK, the assumption being that each profession will face a similar risk and complexity profile in the two countries. Any systemic differences in the regulation of healthcare in the two jurisdictions should impact on all professions in a similar way; therefore, variation from this overall ratio can be interpreted as differences in the cost efficiency of regulators in the two countries.
- 6.10 In Table 10 it appears that chiropractors and osteopaths in Australia are regulated quite cost effectively compared to the UK system. The professions covered by HCPC in the UK appear particularly expensive in Australia. This is perhaps further evidence supporting the existence of scale effects. The HCPC regulates 16 professions in the UK and has a register of 322,037. Therefore it is significantly larger than the individual Australian boards and is able to extract efficiencies that arise from having a large number of registrants, and similar methods of undertaking each function across all professions. The annual performance reviews conducted by the Professional Standards Authority have found that the HCPC is an effective and efficient

regulator, which meets all of the Authority's *Standards of Good Regulation*<sup>9</sup>. The HCPC recognises the generic component of the delivery of regulatory functions across all of the professions it regulates, securing professional input into regulatory processes and policy development only when required, and maintaining wider engagement with the professions through partners' councils.

- 6.11 Comparing regulators in this way assumes that regulators of the same profession face similar challenges in both countries. This may not always be the case, for reasons of policy, legislation or structure. As such, further analysis is now provided using more subjective measures of complexity and regulatory force required.

### **Risk – using notifications to measure prevalence and severity**

- 6.12 The notifications system is organised in a way that produces data that can measure two different features of risk – the prevalence of risk and the severity of risk when it occurs. As either of these figures increase, the role of the regulator will become greater and potentially more expensive as it is required to exert more regulatory force in mitigation of those risks, and in order to prevent harm to patients. Data is presented in Table 11 for the overall number of notifications and the rate by profession. These are measures of prevalence. The final column is the rate of mandatory notifications. Mandatory notifications<sup>10</sup> have been used as these are more likely to be matters which call into question a registrant's fitness to practise and result in a regulatory sanction. We recognise that other measures could be used, however we think this is a reasonable proxy for identifiable risk using available data. In Figure 10, we illustrate the combined effects of prevalence and severity of risk; the further towards the top right of Figure 10 a profession appears, the greater the regulatory force (and therefore cost) that is likely to be required to regulate it.

- 6.13 In other words, the boards that are near to the origin in Figure 10 are relatively low risk or 'safe' and likely to require less regulatory force than those further out, which need increasing regulatory force as prevalence and severity grow. There is some coincidence between the location of professions on Figure 10, and the identified five professions which account for 94%<sup>11</sup> of all notifications: medicine, nursing and midwifery, dentistry, pharmacy and psychology.

- 6.14 Additional features of the boards that may explain their costs relative to each other are published annually and some of these are presented below, beginning with features of registration.

### **Features of registration**

- 6.15 Issues beyond scale that may affect cost in registration are presented in Table 12. The first column presents raw data on the number of registrants

<sup>9</sup> Performance Review Report 2013/14, Professional Standards Authority, June 2014.

<sup>10</sup> Mandatory notifications are those made by registered health practitioners, employers and education providers under mandatory obligations imposed by the National Law.

<sup>11</sup> Source: AHPRA.

and this data has been used to produce the rate of criminal history checks conducted per 10,000. Boards which perform more checks will be incurring greater expense. ATSIHBA, CMBA, MBA and OsteoBA all carry out more than 1500 checks per 10,000 registrants per year. A larger student register is also likely to incur cost, and student registrants are not included in the full registrant numbers. MBA and NMBA have much the largest student register, with PsyBA the only board which does not have one at all. The final three columns are additional characteristics of registrants of which only some boards keep a record. MBA, DBA and PodBA record specialties, five boards approve additional qualifications which are called endorsements, and four split their professions into smaller categories or divisions. Keeping this extra information is likely to increase the cost of regulation. Every additional feature of the registration function is likely to increase cost as it will require, for example, additional staff time and more complex information management systems.

#### **Features of accreditation**

- 6.16 The number of accredited courses is likely to have an impact on the overall cost of accreditation; it would be no surprise if it was actually a more important determinant of cost in this function than the number of registrants. We have set out at Table 13 the total number of accredited courses in Australia, drawing on information available from the councils' websites. NMBA and PsyBA accredit in the region of eight times more courses than any other board.
- 6.17 A second factor to consider in accreditation is the rate of international assessments performed. Professions that experience a large flow of international applicants for registration are likely to spend proportionately more on this function<sup>12</sup>.

#### **Features of notifications (in addition to those discussed above)**

- 6.18 The final function for which there is significant data to explain cost differences is notifications. The amount of notifications per registrant, the complexity of cases and the potential danger caused by offenders could all lead to increased cost within this function, set out at Table 14. DBA and MBA receive a large amount of notifications per 10,000 registrants relative to the other boards. ChiroBA and DBA have a disproportionate number of notifications that progress to a panel or tribunal hearing; i.e. the latter stages at which notifications can be resolved. Finally, immediate action cases are those in which the public have been placed at greatest danger and in which the professional needs to be immediately prevented from practising. These cases are most likely to occur in DBA, MBA or PharmBA.

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<sup>12</sup> We were unable to obtain a complete data set on the number of international applicants from publicly available sources.

## 7. A comparison of the cost of Australian boards and UK councils

- 7.1 This research has paralleled a similar review carried out by the Professional Standards Authority (then the Council for Healthcare Regulatory Excellence) which examined cost-effectiveness and efficiency of the regulatory bodies that the Authority supervises in the UK. As such, it is possible and indeed worthwhile to see how Australian boards compare with their counterparts in the different regulatory framework that exists in the UK. There are fewer regulators in the UK (nine) than there are boards in Australia (14), and they cover a slightly different mix of professions. While in the UK the regulators are all overseen by the Professional Standards Authority, they operate independently of each other and were formed under different acts of Parliament over the course of many years. Therefore, they do not necessarily act consistently because they have different legal standing and may interpret the relevant laws in different ways.
- 7.2 Looking first at aggregate unit costs, it seems that the unit cost of regulation is quite similar in the two jurisdictions, at \$346 per registrant in Australia and \$301.50 in the UK. There are however caveats to this comparison. Firstly, the number of UK health professionals is much larger than that in Australia – approximately 1.3m<sup>13</sup> at the time the UK review was undertaken, compared to 618,631 in Australia. This larger total population of regulated health professionals in the UK would be likely to result in positive scale effects on cost, compared to Australia, all else being equal. However, spreading the regulated population across a larger number of regulators in Australia – 14 as opposed to nine in the UK - makes it harder for regulators in Australia to reach levels at which scale effects can provide benefits to the system, as on average the number of Australian health professionals covered by each board is smaller. As shown above, there is evidence regarding scale showing that the unit cost of regulation falls as the size of the registers increase, so the UK system could be expected to be proportionately cheaper than the Australian system. Secondly, the aggregate similarities disguise significant difference across the functions. Governance appears to cost regulators roughly the same per registrant in the two countries, but notifications (complaints) are much more costly in the UK and account for more than 60% of the total cost. Registration and accreditation appear to be more expensive in Australia compared to the UK, as is compliance but this last is the least costly function of regulation. In the paragraphs that follow we explore some of the comparisons in more detail.
- 7.3 There are six professions regulated by a board in Australia and a council in the UK which can be directly compared. Pharmacists have two independent regulators in the UK, one for Northern Ireland and one for the rest of the UK. There are five Australian boards covering professions which are among the

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<sup>13</sup> The figure given at page 6 is the current figure of 1,472,052. The total number of registrants now includes social workers in England, which did not apply at the time of the UK cost-effectiveness and efficiency review.

16 regulated by the HCPC in the UK. Chinese medicine and Aboriginal and Torres Strait islander health practice medicine are not regulated in the UK. This means that we have eight groups that can be compared, in addition to the aggregate unit cost of regulation in the two countries. This information is presented in Table 15 and Figures 11-28.

### **Nurses and midwives**

- 7.4 Regulating each nurse and midwife costs about \$162 in Australia and \$136 in the UK. Notifications account for more than 60% of this cost in the UK and only 33% in Australia. Registration though, is almost three times more expensive in Australia. The other three functions account for less than 30% of the total cost in both jurisdictions.

### **Medical practitioners**

- 7.5 Medical practitioners cost more to regulate in Australia, at \$889 compared to \$741 in the UK. This is due to accreditation being about \$180 per registrant more expensive in Australia. Similarly registration for nurses and midwives, is more expensive in Australia in terms of actual costs but the proportion of total regulator spend is similar.

### **Dentists**

- 7.6 The cost of dentists follows a similar pattern to that of medical practitioners – more expensive in Australia, in aggregate, for registration and accreditation, but notifications cost more in the UK.

### **Chiropractors**

- 7.7 Chiropractors are one of the few examples where UK regulation appears much more expensive than Australia. Despite having zero accreditation costs, regulating UK chiropractors costs more than twice as much as regulating those in Australia. It is notable that ChiroBA spends 25% of its aggregate spend on registration compared to 14% in the UK. The unit costs for notifications are \$322 in Australia and \$825 in the UK, representing 48% and 57% of total expenditure respectively.

### **Osteopaths**

- 7.8 UK osteopaths are also significantly more costly per registrant than those in Australia. Apart from accreditation which is more expensive in Australia, every other function costs more per registrant in the UK, although the scale of this varies from just 19% in accreditation to more than 600% in governance.

### **Optometrists/Opticians**

- 7.9 Regulating optometrists is more expensive in Australia than regulating optometrists and dispensing opticians in the UK. Costs for the individual functions vary quite significantly, with Australia spending a bigger proportion on accreditation and professional standards, while the UK spending on governance, compliance, and notifications is much greater.

## Professions covered by the HCPC in the UK

- 7.10 The cost of these five professions (physiotherapy, podiatry, radiography, psychology, occupational therapy) vary between \$202 and \$436 per registrant. Proportion of spending by function is quite similar, with the exception of accreditation on which physiotherapy spend 31% whereas medical radiation and psychology are around 5%-6%<sup>14</sup>. They are all more expensive than the HCPC (\$152), but HCPC spend on compliance is minimal, while it also has low costs of professional standards. This comparison is less straightforward than the other professions though, as the HCPC also covers several other professions not regulated in Australia, and given its size, is also able to exploit scale efficiencies unobtainable by their Australian counterparts.

## Pharmacists

- 7.11 In the UK the General Pharmaceutical Council registers premises as well as individual professionals. However, data about monitoring premises was omitted from the UK review so pharmaceutical regulators can be compared directly. The Australian board's expenditure is between that of the GPhC and the PSNI, but registration costs are higher in Australia. PharmBA also spends a large proportion on accreditation relative to the UK regulators, while PSNI is notably more expensive on compliance.

# 8. Potential areas for cost savings

- 8.1 In this section, we set out some ideas on where there is potential for cost savings within the NRAS, and have set out some hypothetical scenarios which could indicate the degree of savings that might be possible in future.

## Board mergers

- 8.2 The existence of potential scale effects raises the possibility of realising savings by merging boards into fewer organisations. One possible option would be to create a board covering several of the lower-risk professions. A precedent for multi-professional regulation exists in the UK, where as we have discussed the HCPC runs the register for 16 different professional groups, including several which have their own boards in Australia.
- 8.3 In order to estimate the potential savings, we use the equations showing the relationship between scale and unit cost presented in the previous section. By inputting the number of registrants for each board, we get a measure of expected cost for the individual boards which is then summed to show the aggregate expected cost of the individual boards. We then repeat the calculation using the total number of registrants if those boards were merged into one organisation. The hypothetical potential savings are the difference between the two values.

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<sup>14</sup> These figures could be affected by accreditation cycles resulting in fluctuating activity year on year.

- 8.4 Calculations have been performed using both the aggregate unit cost equation from Figure 1, and the function specific equations in Figures 2, 4, 5, 6, 7 and 8.
- 8.5 Table 16 presents two calculations. Firstly, merging nine of the lower-risk boards into one. In this situation, a new board containing 76,821 registrants would be created. Depending on whether the aggregate equation is used or a sum of the function specific equations, the individual boards should hypothetically cost \$36.1m (function specific equations \$33.9m); the proposed board containing all 76,821 registrants should cost \$22.9 (\$22.1m) and this may realise annual savings of \$13.2m (\$11.8m).
- 8.6 We have also calculated the hypothetical costs were all of the boards to be merged into one, and of full centralisation of the regulatory functions individually. This could theoretically result in significant annual savings; for example, combining the registration function into one unit could save \$14.2m per annum, while a central accrediting body could be hoped to save about \$3.8m per annum.
- 8.7 It is important to stress that these are purely hypothetical calculations. There may be aspects of the system or special circumstances within the boards that prevent the full realisation of these savings, plus other issues that these calculations are unable to account for. In particular, the data used throughout this analysis does not take into account the extra spending that occurs in accreditation at institutions not funded through AHPRA. In addition, altering the structure of NRAS will incur significant transition costs and this will undermine the benefits, at least in the short term.
- 8.8 An accurate projection of cost savings from the amalgamation of boards would be extremely complex to construct. For example, many of the board committees are in fact carrying out executive functions – making decisions which are core to the delivery of the scheme’s regulatory purposes. Committees are not an efficient mechanism for operational decision-making and tend to generate administrative cost rather than reduce it. Further exploration of the possibility of reducing the number of boards may present opportunities to consider more cost-effective working arrangements, which might include staff making regulatory and operational decisions currently made by board committees.
- 8.9 It is also important to stress that we recognise that to some extent merger already occurs in the way that regulatory functions are delivered, for example in the registration function staff already work across a number of professions. In the area of standards opportunities for standards that apply to all health professional are being pursued, such as guidance on blood borne viruses.
- 8.10 It may therefore be the case that the main savings through any amalgamation of smaller boards would be through the altered governance arrangements and the need to manage and serve a smaller number of boards, rather than through economies of scale achieved in the delivery of regulatory functions in a more multi-professional way. Even without merging boards, there are already obvious ways for achieving cost savings, for example through the use of video and teleconference rather than meeting in

person, which we understand is already being adopted or at least piloted by some boards.

- 8.11 Irrespective of whether boards are merged or not, a review of the remit and effectiveness of the 62 committees of the national boards would be timely. For example, it may be the case that it is no longer adding value for each of the national boards to have its own finance committee, given that AHPRA is now well established and financially secure, with established reserves and risk management processes.
- 8.12 Given that to some extent the delivery of functions is already merged across professions, particularly in registration, it is perhaps surprising that there remains the degree of variation in unit costs that our calculations have demonstrated. To address this, we recommend the development of more transparent cost benchmarking across the boards, supported by consistent financial management data and key performance indicators. This will enable areas of concern to be easily identified.
- 8.13 On the basis of the hypothetical calculations that we have set out, there is the scope for substantial savings from the merger of boards and regulatory functions. We recommend that our calculations are taken into account in the ongoing discussions of options for merger in the review.

### Registration

- 8.14 One of the key achievements of the NRAS is the establishment of a single national register for regulated health professionals.
- 8.15 We understand that at present the registration function involves staff in AHPRA offices working across professions, and that in most AHPRA offices there are three teams – those processing applications from medical practitioners, those processing applications from nurses and those processing applications from other professions. In some areas of specialised registration there are national registration teams. Therefore, AHPRA staff are already working flexibly in delivering the registration function across different professions; economies of scale are probably already being realised.
- 8.16 Nevertheless it seems likely that costs are being accrued in managing the relationship between state/territory registration staff, and the registration committees, be they at national or state/territory level. An application for registration or renewal is first made through the AHPRA website. The application is forwarded to the relevant registration team in the state/territory from which it originated. If the application is complete and satisfactory, the staff in the state/territory office can either register or renew it on the national register. If however the application is complex or contentious it is referred either (i) to the state/territory committee for the profession where such exists, or (ii) to the national registration committee where that profession does not have state/territory boards.
- 8.17 AHPRA has provided us with estimated figures on the number of registration decisions (both registration and renewal) which have been decided by committee. For renewal decisions, perhaps unsurprisingly, the figure is very



low, between 0.12% and 3.51% of applications, with 11 of the 14 professions below 0.5%. For initial registration decisions, the figure is higher, with 13 of the 14 professions between 6.8% and 22.4%, and Aboriginal and Torres Strait islander health practitioners an outlier at 40%. We understand that until this year the board had not delegated decision making to AHPRA in relation to criminal history, no matter how minor, and the percentage may also have been increased by grandparenting arrangements for access to this profession in which decisions could only be taken at board level.

- 8.18 In Table 17 we have set out some hypothetical cost savings that might be achievable through the creation of a single registrations function, if it were possible to achieve reduction of costs in different scenarios. We acknowledge that we have not attempted to assess the costs of transition to a different structure, but hope that these calculations will contribute to further discussion and planning of future options.
- 8.19 We recommend that the hypothetical cost savings are taken into account in further discussion and planning for future options for the delivery of the registration functions. A particular area for further consideration whatever structure is adopted would be to review the delegation arrangements that are in place with a view to reducing where possible the number of decisions that need to be taken by a committee, rather than by AHPRA staff.

### **Notifications**

- 8.20 Unlike in the UK, when a complaint is received (other than in NSW) , the board must confer with the local health complaints entity to decide on what is the correct course of action for any particular complaint at the outset, including whether the complaint is a regulatory matter for the relevant board or not. If it is referred to the board, there is an initial risk assessment which can result in immediate action if necessary. There is then a preliminary assessment after which the case will go to the notifications committee of the national board or the state/territory notifications committee for those professions which have state/territory boards. The committee can decide that no further action is required, or can instigate an investigation. We understand that investigations can be lengthy, possibly due to the scope not being well articulated at the outset, and that the prevalence of 'no further action' decisions after investigation, in matters which could have been closed without one, is already a matter of concern. Clearly reducing the number of unnecessary investigations could save costs. This could be supported by reviewing the effectiveness of the assessment of complaints at an early stage.
- 8.21 In the Australian system, the committee can either refer a case to another entity, caution the practitioner, seek an undertaking or impose conditions; or it may refer the case to a panel for unsatisfactory professional conduct. The panel can determine all the same actions as the committee; the only additional sanction that can be imposed is a reprimand. Any further action can only be achieved by the referral of the matter to a tribunal, which is broadly comparable to a first tier tribunal in the UK. It is external to the board, and cases can take a long time to be resolved and at considerable cost. We understand that the cost to AHPRA of a panel hearing is estimated

as being in the region of \$10,000, and that a tribunal could be from \$20,000-\$30,000, or up to \$300,000 in extreme cases. We think that an area for further work as part of this review could be to review these arrangements and explore the costs and benefits of vesting in the regulator the power to remove registrants from the register.

- 8.22 Another area for further consideration could be the relative costs and benefits of the different notification arrangements in NSW and Queensland<sup>15</sup>. At Table 3 we showed that notifications cost on average \$125 per registrant outside NSW and \$166 per registrant inside NSW. The aggregate cost of notifications within NSW is \$30,029,821, and the aggregate cost of notifications in the rest of Australia is \$54,931,584. We are not able to comment on the qualitative differences between the different arrangements. However we are aware that these processes are currently the subject of detailed analysis and research, and recommend that the data that we have provided is taken into account in future discussion about the direction of policy in this area.

### Accreditation

- 8.23 In paragraphs 4.10-4.16 we set out how we had compiled an estimate of annual expenditure on the delivery of the accreditation function across all professions. We described how accreditation of higher education courses in Australia is carried out by an accreditation council for 11 of the 14 professions in the NRAS. The councils are separate organisations, external to AHPRA and the national boards, with their own governance arrangements, staffing, premises, websites and so forth. For three of the professions, the responsibility for accreditation is vested in a committee of the National Board: Aboriginal and Torres Strait islander health practitioners, Chinese medicine and medical radiation practitioners. The councils have a number of different sources of income.
- 8.24 These arrangements differ markedly from the arrangements for the quality assurance of higher education courses in the UK. The UK regulators quality assure relevant higher education courses themselves, and the activity is funded from the income from registrant fees in the same way as the regulators' other activities are funded. There is no direct charge to the institution whose course is being quality assured, although there are of course compliance costs.
- 8.25 We understand that in Australia the board for each profession approves the accreditation standards, which the accreditation council is then under contract to accredit courses against; and that there is a group which brings together the accreditation council chief executives, the boards and AHPRA which agrees a cross-professions quality framework. This takes place within the statutory framework of the National Law and its guiding principles.
- 8.26 The percentage of regulatory expenditure on this function in the two systems also differs markedly, with 19.4% being spent in Australia and 6% being spent in the UK system on the quality assurance of higher education courses.

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<sup>15</sup> The costs of arrangements in Queensland introduced in 2014 were beyond the scope of this exercise.

- 8.27 On the face of it, the existence of 11 separate councils looks an inherently more expensive arrangement for the delivery of this function, because of the cost of the items listed above: staff costs, the cost of servicing the councils and holding meetings, the cost of premises and so forth. The fact that this activity is organised in a disaggregated way suggests that there might be the potential for savings were mergers possible in some form. The integration of accreditation in the UK into the core functions of the regulators, in particular standard setting, has clear benefits in terms of organisational simplicity, appropriate balancing of resources across regulatory functions, and avoidance of duplication of costs.
- 8.28 One consequence of a system where just one body is allowed to provide accreditation for specific education courses is that monopoly power might be exploited to extract surplus from university establishments or students. All professional regulators are by definition statutory monopolies and therefore not subject to normal external market pressures on cost. This is not unique to the Australian system – it could equally exist in the UK framework – but it provides good reason to consider the costs of this regulatory function with extra scrutiny. In the Australian system, the accreditation councils are required to agree budgets with regulatory boards who do not fund the expenditure. In contrast, for other regulatory functions, the board will set expenditure unilaterally with their total budget for these other functions given to them. This asymmetry of budget setting may grant accreditation greater scope for increasing the cost of their part of the regulatory service.
- 8.29 As we have noted, accreditation in Australia is high cost in terms of total spend and proportion of spend. We have identified three possible reasons for this. Firstly, it has been noted that the accreditation cycle could lead to inconsistency across years, with some years seeing much more activity than others. This may be relevant to individual professions but unless professions are on a linked cycle is unlikely to explain the large mean difference for all professions between Australia and the UK.
- 8.30 A second explanation is that the process may be inefficient, with little incentive to minimise costs as the accreditation council face no competition to their services, and less budget control from the individual boards, than total board level expenditure must face from central Government to increase total spending. There is also likely to be minimal pressure from individual universities to improve efficiency as they will be able to pass on costs to students whose demand may be inelastic as they also face an imperfect market, in a large country with costly geographical immobility.
- 8.31 A third possibility is that the higher cost of accreditation in Australia could be because they provide a higher quality of service than exists in the UK. A more rigorous accreditation process would lead to better courses and produce an improved standard of practitioner for the Australian health care system. However there is no guarantee that the higher quality of accreditation offered will be at the socially optimal level. It is beyond the scope of this project to make that judgement.
- 8.32 In giving further consideration to this area of regulation we should of course seek to be sure that we are comparing like with like. We have acknowledged

that at least one task that is included in accreditation in Australia does not fall within quality assurance of higher education in the UK, the assessment of qualifications of overseas applicants for registration. We have also looked at descriptions of the function of quality assurance in the UK and accreditation in Australia in so far as it relates to higher education institutions. In Australia, AHPRA sets out<sup>16</sup> up to five activities that are undertaken, either by the council or board committee. These are:

- Development and review of accreditation standards
- Assessing programs of study and accreditation providers against the standards
- Assessing overseas assessing authorities
- Assessing overseas qualified practitioners
- Providing advice to board on accreditation functions.

8.33 Which committees and boards undertake which functions is set out at <http://www.ahpra.gov.au/education/accreditation-authorities.aspx>

8.34 In the UK, the Professional Standards Authority sets out the following standards against which regulators' performance in this regard is assessed annually, in the *Standards of Good Regulation*<sup>17</sup>. The standards state that "the regulator has a role in ensuring that students and trainees obtain the required skills and knowledge to be safe and effective. They also have a role in ensuring that, once registered, professionals remain up to date with evolving practices and continue to develop as practitioners. As part of this work, the regulators quality assure and where appropriate approve educational programmes which students must complete in order to be registered". The standards stress that the process for quality assuring should be "focused on ensuring that education providers can develop students and trainees so that they meet the regulator's standards for registration".

8.35 A paper<sup>18</sup> by the Council for Healthcare Regulatory Excellence<sup>19</sup> in June 2009 found that there was a range of approaches being taken in the UK to quality assurance of higher education, but stated that "the broad structure is the same, following a pattern of programme approval, monitoring and reapproval", which is consistent with the arrangements for accreditation in Australia as we understand them. However the paper also noted that "differences become clear both in the methods and frequency regulators adopt in employing these aspects of quality assurance. The rationale for different approaches in part can be explained by the different role played by undergraduate education in meeting pre-registration requirements, but also

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<sup>17</sup> Annual Report and Accounts and Performance Review Report Volume II 2013/2014 <http://www.professionalstandards.org.uk/docs/default-source/scrutiny-quality/performance-review-report-2013-2014.pdf?sfvrsn=0>

<sup>18</sup> Quality assurance of undergraduate education by the healthcare professional regulators, Council for Healthcare Regulatory Excellence, June 2009. <https://www.professionalstandards.org.uk/docs/psa-library/quality-assurance-of-education---advice.pdf?sfvrsn=0>

<sup>19</sup> The Council for Healthcare Regulatory Excellence was the previous name of the Professional Standards Authority

reflects difference between the professions and the regulators themselves”. It was noted that UK educational institutions are also audited by the Quality Assurance Agency<sup>20</sup> for Higher Education.

- 8.36 While the two systems clearly share a considerable overlap of purpose in this area, in order to draw any firm conclusions about the relative efficiency of the two a much more detailed analysis of the differences of performance, process and approach within and between them would be required, taking into account the considerations that we set out above. This analysis would also need to examine the context in which the councils are operating and their relationship with other organisations with a quality assurance role. We think this would be a valuable exercise, in order to understand more clearly the marked difference in the relative costs, and to see if there is potential for learning across the two systems.
- 8.37 To assist further analysis we have set out at Table 21 some calculations relating to a number of hypothetical future scenarios. The Table shows what the cost of the accreditation scheme could be if operating at the cost of the NMBA (the cheapest in Australia); if the six most expensive regulators can reduce accreditation costs to the average cost of \$67.14 and the rest continue at current levels; if operating at the average unit cost of accreditation within the UK of \$17.66 per head; and if operating at cost of the UK GOC (\$105.49 per head). It is understood that the councils are under contract to the AHPRA for four further years and that even if there was an intention to change the arrangements this could not be achieved quickly. However we hope that setting out these figures will be a useful contribution to further analysis of the costs of this area of health professional regulation.
- 8.38 In conclusion, while recognising the different organisational arrangements and that there may be differences of scope and approach, we feel that this striking area of cost difference between Australia and the UK warrants further investigation. We hope that the hypothetical future cost scenarios that we have set out will be a useful contribution to further analysis of the costs of this area of professional regulation.

## 9. Conclusions

- 9.1 We have discussed at a number of places in the report the cost of the accreditation function in general terms, and have also provided data on the fees being charged to higher education institutions. There is some evidence, where historical data is available, of fees rising in recent years. It seems to us that there may be an asymmetry of financial control on AHPRA’s part with respect to the way that this aspect of the Scheme is funded. Whereas for other regulatory functions, AHPRA and the boards can exercise financial discipline by virtue of their direct control of delivery, that is reinforced by a total spending constraint imposed at national level, here the way that delivery of the function is arranged with separate organisations and accountability arrangements may be resulting in less clear arrangements. It is less clear in

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<sup>20</sup> <http://www.qaa.ac.uk/en>

this format that each board is content that the share of all their regulatory spend that is allocated to accreditation is what they would choose. We recommend that this would be a useful area for further consideration in the review.

- 9.2 The accreditation function is considerably more expensive, as a proportion of total expenditure on the scheme, than the quality assurance of higher education courses by regulators in the UK. Recognising the different organisational arrangements, and recognising that there may be differences in scope and approach amongst other factors, still we feel that this striking cost difference would warrant further investigation, of the value of this higher accreditation expenditure to the Australian patient.
- 9.3 We have provided hypothetical savings for two scenarios involving the merger of boards and for the merger of specific regulatory functions, indicating that some savings may be possible as a result of mergers. We recommend that these are taken into account in ongoing discussion of options for mergers within the review.
- 9.4 We propose that a review of the remit and effectiveness of the 62 committees of the national boards would be timely, assessing the value that each adds to decision making, and whether these decisions could be made in a more cost-effective way.
- 9.5 We recommend that as well as reviewing merger options for boards, and options for the further integration of functions across professions, consideration is given to reviewing the arrangements for delegation, enabling staff to take decisions wherever possible.
- 9.6 We note that different areas of the boards' activities seem to be subject to different levels of financial control. This asymmetry particularly applies to accreditation. We recommend the development of more transparent cost benchmarking across the boards, supported by consistent financial management data and KPIs. This will enable areas of concern to be easily identified and internal control of costs improved.
- 9.7 Acknowledging the work that is already being done in this area, we encourage continuing efforts to identify cost reduction in the arrangements for meetings such as teleconferencing.
- 9.8 We understand that the notifications process is already subject to considerable review and analysis. Given the marked difference in unit cost set out at paragraph 4.9 between New South Wales and the rest of Australia, we think that the relative costs and benefits of these different arrangements should be the subject of further analysis.
- 9.9 We suggest that a particular area of focus should be to ensure the quality of assessment at the outset of the process, to reduce the prevalence of cases proceeding unnecessarily to investigation.
- 9.10 While recognising that legislative change would be required, nevertheless we think it would be valuable to assess the costs and benefits of vesting in the national boards the power to impose the full range of regulatory sanctions, up to and including removal from the register.

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- 9.11 We are aware that research is ongoing into the qualitative differences between the notifications arrangements in New South Wales and those in the rest of Australia. We hope that the comparative cost data that we have provided will be a useful contribution to that ongoing work and consequent policy discussions.



Centre for  
**Health Service Economics  
& Organisation**

**Centre for Health Service Economics  
& Organisation**

Nuffield Department of Primary Care Health  
Sciences  
University of Oxford  
New Radcliffe House  
Radcliffe Observatory Quarter  
Woodstock Road  
Oxford OX2 6GG

Telephone: **020 7972 5219**

Email: [webenquiries@chseo.org.uk](mailto:webenquiries@chseo.org.uk)

Web: <http://www.chseo.org.uk/>

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**Professional Standards Authority for  
Health and Social Care**

157-197 Buckingham Palace Road  
London SW1W 9SP

Telephone: **020 7389 8030**

Fax: **020 7389 8040**

Email: [info@professionalstandards.org.uk](mailto:info@professionalstandards.org.uk)

Web: [www.professionalstandards.org.uk](http://www.professionalstandards.org.uk)

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