Australia's National Registration and Accreditation Scheme for Health Practitioners: A National Approach to Polycentric Regulation?

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Abstract

This article analyses the National Registration and Accreditation Scheme ('NRAS') for Australian health practitioners that commenced in July 2010. The article argues that the Scheme represents not only an interesting case study in the development of a national approach to regulation within a federal legal system, but also an example of polycentric regulation given the complex and multilayered nature of health practitioner regulation in Australia. The article analyses the NRAS within the broader regulatory context for health practitioner regulation and the administration of public regulation more generally, and explores the challenges posed by polycentric regulation within a federal system.

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Competing interests: Mary Chiarella is a former member of the AHPRA-affiliated Nursing and Midwifery Board of Australia. Merrilyn Walton is a former member of the AHPRA Management Committee and was the founding Commissioner for the Health Care Complaints Commission in NSW (1994–2000). Belinda Bennett is a member of the AHPRA-affiliated Medical Board of Australia and a former member of the NSW Medical Board and the HPCA-affiliated Medical Council of NSW. The views expressed in this article are the personal views of the authors and should not be taken as representing the views of any of the organisations with which the authors have been or are affiliated.

I Introduction

On 1 July 2010, a new national model for registration and accreditation of Australian health practitioners began operation. The National Registration and Accreditation Scheme ('NRAS') was developed with the agreement of all the state and territory Ministers for Health. The NRAS initially encompassed 10 health professions[1] — with an additional four professions included in the Scheme since 2012 and a fifth soon to join.[2] National Boards were established for each regulated profession, and the Scheme is governed by new legislation: the *Health Practitioner Regulation National Law* ('*National Law*'), contained in the *Health Practitioner Regulation National Law Act 2009* (Qld). The *National Law* was initially introduced in, and adopted by, the Queensland Parliament. It was then adopted, in some cases with amendments,[3] in each Australian state and territory under an applied laws approach or, in the case of Western Australia ('WA'), through the enactment of mirror legislation.[4]

The development of a national approach to registration and accreditation of health practitioners in Australia represents an interesting case study in the development of a national approach to regulation within a federal legal system. However, the Scheme is also situated within a broader regulatory context for both health practitioner regulation and the administration of public regulation more generally. Considered in this context, the Scheme can be seen as an example of 'polycentric' regulation, where the regulatory landscape is populated by an increasingly complex array of regulatory bodies, agencies and objectives.

This article analyses the national regulation of health practitioners in Australia in terms of the move towards a national system of regulation and the polycentric setting of that system. Part II addresses the polycentric nature of health

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1 The professions are chiropractic, dental, medicine, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry, and psychology: AHPRA, *About the National Scheme* (27 August 2015) <www.ahpra.gov.au/About-AHPRA/What-We-Do/FAQ.aspx>. For an overview of the NRAS see Fiona McDonald, 'Regulation of Health Professionals' in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2nd ed, 2014) 611, 620.

2 Aboriginal and Torres Strait Islander health practice, medical radiation practice, occupational therapy, and Chinese medicine. Health Ministers have also decided to include paramedics in the NRAS and to establish a Paramedicine Board of Australia: COAG Health Council, *Communique: 24 March 2017* <http://www.coaghealthcouncil.gov.au/Announcements/Meeting-Communiques1>.

3 See McDonald, above n 1, 620; Gabrielle Wolf, 'Sticking Up for Victoria? Victoria's Legislative Council Inquires into the Performance of the Australian Health Practitioner Regulation Agency' (2014) 40(3) *Monash University Law Review* 890, 898–9. For discussion of the introduction of the *National Law* see generally Louise Morauta, 'Implementing a COAG Reform Using the National Law Model: Australia's National Registration and Accreditation Scheme for Health Practitioners' (2011) 70(1) *Australian Journal of Public Administration* 75.

4 *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW); *Health Practitioner Regulation National Law (ACT) Act 2010* (ACT); *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA); *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas); *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic); *Health Practitioner Regulation (National Uniform Legislation) Act* (NT). Western Australia joined the National Scheme in October 2010: *Health Practitioner Regulation National Law (WA) Act 2010* (WA) s 4. For discussion see Wolf, ibid, 899; Morauta, ibid; Senate, Finance and Public Administration References Committee, *The Administration of Health Practitioner Registration by the Australian Health Practitioner Regulation Agency (AHPRA)* (2011) 120.

practitioner regulation in Australia. Part III provides the background to the Scheme from the original recommendations of the Australian Government's Productivity Commission in 2005, through to the simplification of legislation governing health practitioner regulation in Australia with the enactment of the *National Law*. Part IV discusses: the national approach to legislation through use of an applied laws approach; the impact of the retention of a co-regulatory approach in New South Wales ('NSW') and its introduction in Queensland; and the potential for regulatory innovation under both the previous state-based approach to regulation and under the new national approach. Part V revisits polycentric regulation by examining its implications for regulators, governments and the public.

II Polycentric Regulation

The regulation of health professionals was traditionally referred to as 'the privilege of self-regulation'.[5] In discussing this, Cruess, Johnston and Cruess observed that

> members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.[6]

However, there has been ongoing debate as to whether professions should self-regulate, set their own standards and determine who is admitted and who must leave.[7] For example, there is concern that self-regulation can create monopolies and limit market competition — although such observations raise the question as to whether there ought to be a 'market' in the provision of health care services.[8] This debate began to gain momentum in recent decades with concerns expressed from a health workforce perspective about the controls imposed through professional self-regulation. In a 2002 publication by the Eastern Mediterranean Regional Office of the World Health Organization, it was observed that

> [t]he term 'professional regulation' is often misunderstood and interpreted as the imposition of bureaucratic, rule-bound requirements which constrain the activities of the profession concerned and serve to maintain the isolation and

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5 Sylvia R Cruess, Sharon Johnston and Richard L Cruess, 'Profession: A Working Definition for Medical Educators' (2004) 16(1) *Teaching and Learning in Medicine: an International Journal* 74, 74.

6 Ibid 74.

7 Richard J Baron, 'Professional Self-regulation in a Changing World: Old Problems Need New Approaches' (2015) 313(18) *Journal of the American Medical Association* 1807, doi:10.1001/jama.2015.4060. The meaning of professionalism has also been considered in other professions, including the legal profession: see, eg, Jim Varro and Paul Perell (Working Group on Professionalism) 'Elements of Professionalism' (Paper presented at the Chief Justice of Ontario's Advisory Committee on Professionalism Third Colloquium on the Legal Profession, Faculty of Law, University of Ottawa, 25 October 2004) <www.lsuc.on.ca/advisory-committee-professionalism/>.

8 Krystian Seibert, 'Time is Right to Break Monopoly of Regulators' (2006) *On Line Opinion* <http://www.onlineopinion.com.au/view.asp?article=4304>.

> separateness of the professional from the person for whom they care. Nothing could be further from the truth.[9]

Any analysis of the structure and development of Australian health practitioner regulation must consider the broader role of the historic regulatory environment in shaping the evolution of professional regulation.[10] Regulation of health practitioners in many countries is transitioning away from self-regulatory models dominated by members of the regulated profession. The decline of professional autonomy is increasingly being balanced by systems of 'networked governance',[11] of public, private, professional and non-governmental bodies that exert influence over the conduct of health professionals and services.[12] Complaints and disciplinary processes form one regulatory strategy in this potentially horizontally networked space,[13] which Trubek et al identify in the health arena as being populated by a growing plurality of players internationally:

> In the effort to respond to … deficits in health care governance, reformers have made changes that increase the pluralism of the system. These include different roles for government at all levels, a plethora of private organizations to produce and monitor standards, and the new tools for consumer/patient input. The emphasis is on tools such as economic incentives, statistical analysis, and comparative ratings, rather than on administrative controls that allow a closer relationship between enactment and implementation. There is also a shift from hierarchy to organizational networks.[14]

Regulatory developments in Australia have matched these international trends. We argue that the multiplicity of professional organisations and regulatory agencies involved in health practitioner regulation in Australia can be described as one of 'polycentric regulation'.[15] In this context, regulation and complaints handling

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[9] World Health Organization ('WHO') Regional Office for the Eastern Mediterranean and Regional Office ('EMRO') for Europe, **'**Nursing and Midwifery: A Guide to Professional Regulation' (EMRO Technical Series No 27, WHO, 2002) 11 <http://www.who.int/iris/handle/10665/119665>.

[10] For a review of the international literature on health complaints systems, see Fleur Beaupert et al, 'Regulating Healthcare Complaints: A Literature Review' (2014) 27(6) *International Journal of Health Care Quality Assurance* 505.

[11] Scott Burris, Peter Drahos and Clifford Shearing, 'Nodal Governance' (2005) 30 *Australian Journal of Legal Philosophy* 30, 38.

[12] For discussion, see Stephanie D Short and Fiona McDonald (eds), *Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients* (Ashgate, 2012); Mark Davies, *Medical Self-Regulation: Crisis and Change* (Ashgate, 2007).

[13] Varun Gauri, 'Redressing Grievances and Complaints Regarding Basic Service Delivery' (2013) 41 *World Development* 109.

[14] Louise G Trubek et al, 'Health Care and New Governance: The Quest for Effective Regulation' (2008) 2(1) *Regulation & Governance* 1, 3.

[15] Julia Black, 'Constructing and Contesting Legitimacy and Accountability in Polycentric Regulatory Regimes' (2008) 2(2) *Regulation & Governance* 137, 140. Black draws a distinction between 'decentred regulation' and 'polycentric regulation':

> 'Decentered regulation' draws attention away from the state — it denies that there is necessarily a central role for the state in regulation and seeks to draw attention from it; 'polycentric regulation' is a term which acts more positively to draw attention to the multiple sites in which regulation occurs at sub-national, national and transnational levels.

See also Judith Healy and Merrilyn Walton, 'Health Ombudsmen in Polycentric Regulatory Fields: England, New Zealand, and Australia' (2016) 75(4) *Australian Journal of Public Administration* 492.

for health practitioners are but a subset of the overall health governance mechanisms.[16] As Chiarella and White point out,

> [g]overnments already play a significant role in regulation of health professionals: through remuneration systems, both industrial and commercial; through legislation that grants access to the use of therapeutic drugs and devices; through admitting and visiting rights to hospitals and other health care facilities; and through processes such as routine adverse incident reporting, and also investigations and recommendations from Commissions of Inquiry.[17]

In recent decades, Australia and other countries have been debating the conceptualisation and operationalisation of regulatory powers. Regulatory theories of 'responsive regulation',[18] 'right-touch' regulation,[19] and 'risk regulation',[20] have influenced these debates, with each providing a theoretical framework for part of the regulatory task.

A traditional view of regulation includes a 'command and control' measure by government through the use of legal rules backed by criminal or other sanctions, presupposing the State's use of a unilateral approach to control conduct effectively.[21] Regulation by government or public agencies can also be construed as 'deliberate state influence' via actions designed to guide business and social activities.[22]

The concept of responsive regulation developed by Ayres and Braithwaite, in contrast to the traditional command and control paradigm, uses a 'hierarchy of regulatory strategies of varying degrees of interventionism',[23] operating under the umbrella of the State.[24] They argue that an appropriate response to improper or unlawful conduct must take into account individual circumstances and an attempt to secure compliance by persuasion, rather than punishment.[25] In refining their model of responsive regulation, Ayres and Braithwaite developed a pyramid of regulatory strategies with 'regulatory methods arranged along a continuum of coerciveness'.[26]

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16 Elke Jakubowski and Richard B Saltman (eds), 'The Changing National Role in Health System Governance' (Observatory Studies Series No 29, European Observatory on Health Systems and Health Policies, 2013) <http://www.euro.who.int/__data/assets/pdf_file/0006/187206/e96845.pdf?ua=1>.

17 Mary Chiarella and Jill White, 'Which Tail Wags Which Dog? Exploring the Interface between Professional Regulation and Professional Education' (2013) 33(11) *Nurse Education Today* 1274, 1274.

18 Ian Ayres and John Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate* (Oxford University Press, 1992). For a review and assessment, see Christine Parker, 'Twenty Years of Responsive Regulation: An Appreciation and Appraisal' (2013) 7(1) *Regulation & Governance* 2.

19 Popular in the allied health services literature, the term reprises notions of 'proportionate' and 'responsive' regulation. The term was first coined by the UK Council for Healthcare Regulatory Excellence ('CHRE') in its report 'Right-touch Regulation' (August 2010). For a review, see Douglas Bilton and Harry Cayton, 'Finding the Right Touch: Extending the Right-touch Regulation Approach to the Accreditation of Voluntary Registers' (2013) 41(1) *British Journal of Guidance & Counselling* 14.

20 Malcolm K Sparrow, *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance* (Brookings Institution Press, 2000).

21 Julia Black, *Critical Reflections on Regulation* (Centre for Analysis of Risk and Regulation, London School of Economics, 2002) 2.

22 Robert Baldwin, Martin Cave and Martin Lodge, *Understanding Regulation: Theory, Strategy, and Practice* (Oxford University Press, 2nd ed, 2012) 23.

23 Ayres and Braithwaite, above n 18, 6.

24 Peter Grabosky, 'Beyond *Responsive Regulation*: The Expanding Role of Non-State Actors in the Regulatory Process' (2013) 7(1) *Regulation & Governance* 114.

25 Ayres and Braithwaite, above n 18, ch 2.

26 Arie Freiberg, *The Tools of Regulation* (Federation Press, 2010) 97.

Healy further expanded this model for the health care context, by introducing the idea of networked escalation of pressure on the regulated.[27] Responsive regulation addresses the interaction between regulators and those regulated, with decisions about regulatory action conceptualised 'responsively' within a pyramid of possible regulatory actions and interventions. Ayres and Braithwaite use the term 'tripartism' to broaden the perspective of responsive regulation from a binary regulator/regulatee approach to include a third party in the regulatory process.[28] It has been argued that '[t]he use of patients' complaints for regulatory purposes can be considered as a form of tripartism in which the services learn from their users.'[29]

The theory of 'right-touch' regulation focuses on the philosophy underpinning regulation, one that is 'based on a proper evaluation of risk, is proportionate and outcome-focussed; [and] creates a framework in which professionalism can flourish and organisations can be excellent'.[30] Quantification and qualification of risk are important elements of right-touch regulation; without an evaluation of risk 'it is impossible to judge whether regulatory action is necessary or whether other means of managing issues are better used.'[31] 'Risk-based regulation' focuses on the nature of harms, identification of risk, and the best means of controlling it.[32] Thus, a close relationship exists between risk and regulation. As Freiberg points out,

> [u]nder modern risk management approaches, rather than regarding regulation as a series of ad hoc and episodic responses to harms as they occur, risk assessment and management are regarded as the central organising principles underpinning regulatory strategy.[33]

Right-touch regulation and risk-based regulation are regulatory approaches designed to inform regulatory priorities by ensuring regulatory authority is guided by an evaluation of the risks that is proportionate. While responsive regulation, right-touch regulation, and risk-based regulation focus on the *ways* regulators regulate, the concept of polycentric regulation[34] focuses on the *regulatory setting*, the impact of complexity on the regulatory tasks and the challenge complexity poses for regulatory legitimacy.[35]

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27 Judith Healy, *Improving Health Care Safety and Quality: Reluctant Regulators* (Ashgate, 2011) 5.

28 Ayres and Braithwaite, above n 18, 56–7.

29 Renée Bouwman et al, 'Patients' Perspectives on the Role of Their Complaints in the Regulatory Process' (2016) 19(2) *Health Expectations* 483, 485.

30 CHRE, above 19, 8.

31 Ibid 10.

32 Sparrow, above n 20; Malcolm K Sparrow, *The Character of Harms: Operational Challenges in Control* (Cambridge University Press, 2008).

33 Freiberg, above n 26, 12.

34 The concept of polycentric regulation describes an approach to, or characteristic of, complex regulatory systems. The concept is to be distinguished from the application of the term to describe complex *disputes* or problems that render them less amenable to traditional forms of adjudication and more responsive to alternative dispute resolution: see, eg, Carrie Menkel-Meadow, 'Alternative and Appropriate Dispute Resolution in Context: Formal, Informal, and Semiformal Legal Processes' in Peter T Coleman, Morton Deutsch and Eric C Marcus (eds), *The Handbook of Conflict Resolution: Theory and Practice* (Wiley, 3rd ed, 2015) ch 50.

35 Black, above n 15.

In Australia, in addition to health practitioner regulation and complaints, professional education plays a role,[36] as do bodies that accredit professional education,[37] governing boards of hospitals and health services,[38] and the Australian Commission on Safety and Quality in Health Care.[39] Most health complaints entities ('HCEs') in Australia are broadly comparable to the Patients' Ombudsman systems utilised in European countries,[40] and form an integral part of Australia's regulation of the health care sector.[41] Indeed, Healy and Walton argue that '[t]he establishment of statutory ombudsmen and other authorities as independent avenues of appeal has made government health departments and professional boards more accountable for responding to complaints about their services and members.'[42] This wide range of players in health regulation was commented on by Trubek et al:

> Regulatory pluralism is one of health care's most striking features … This includes institutional pluralism or the proliferation of special purpose institutions of all kinds that operate in one way or another as sources of regulatory ordering: organized medical staffs, institutional review boards, medical disciplinary boards, state licensing boards, accrediting bodies, professional associations, standards-making organizations, and health care research organizations, to name just a few.[43]

While this plethora of regulatory bodies can be seen as a strength, the reality is much more challenging. Healy and Walton note that this diffusion of responsibility within polycentric regulatory systems brings new challenges, 'because no one entity is responsible'.[44] Furthermore, Black has noted that polycentric forms of regulation

> are marked by fragmentation, complexity and interdependence between actors, in which state and non-state actors are both regulators and regulated,

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36 Chiarella and White, above n 17.

37 Under the NRAS, accreditation authorities play an important role in the current regulatory framework for regulated health professions: see *National Law* pt 6.

38 Marie M Bismark and David M Studdert, 'Governance of Quality of Care: A Qualitative Study of Health Service Boards in Victoria, Australia' (2014) 23(6) *BMJ Quality & Safety* 474; Marie M Bismark, Simon J Walter and David M Studdert, 'The Role of Boards in Clinical Governance: Activities and Attitudes among Members of Public Health Service Boards in Victoria' (2013) 37(5) *Australian Health Review* 682.

39 This existing agency was made permanent and given expanded advisory responsibilities (akin to the UK Care Quality Commission) under the 2011 health coordination and performance initiatives of the Rudd/Gillard Government: Gianluca Veronesi et al, 'Governance, Transparency and Alignment in the Council of Australian Governments (COAG) 2011 National Health Reform Agreement' (2014) 38(3) *Australian Health Review* 288.

40 Lars Fallberg and Stephen Mackenney, 'Patient Ombudsmen in Seven European Countries: An Effective Way to Implement Patients' Rights?' (2003) 10(4) *European Journal of Health Law* 343.

41 The HCEs are: Health Services Commissioner (within the ACT Human Rights Commission); Health Care Complaints Commission (NSW); Health and Community Services Complaints Commission (NT); Office of the Health Ombudsman (Qld); Health and Community Services Complaints Commissioner (SA); Health Complaints Commissioner (Tas); Health Complaints Commissioner (Vic) and Mental Health Complaints Commissioner (Vic); Health and Disability Services Complaints Office (WA): see AHPRA, *Other Health Complaint Organisations* (9 January 2018) <http://www.ahpra.gov.au/Notifications/Further-Information/Health-complaints-organisations.aspx>.

42 Healy and Walton, above n 15, 503.

43 Trubek et al, above n 14, 2–3.

44 Healy and Walton, above n 15, 503.

> and their boundaries are marked by the issues or problems which they are concerned with, rather than necessarily by a common solution.[45]

Grabosky observed a common feature of polycentric regulation is that the State no longer holds a monopoly over regulation, raising the importance of 'orchestration' of the roles played by the various State and non-State actors.[46]

Though we argue that the regulatory framework for registration and accreditation of health practitioners in Australia is an example of polycentric regulation, we recognise the influence that the constitutional division of powers as well as historic practices have played. In the remaining parts of this article we explain why this is the case.

III Background to the National Scheme

In 2005, Australia's Productivity Commission recommended a new national scheme for registration of health practitioners, with the terms of reference including:

> to undertake a research study to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals, and propose solutions to ensure the continued delivery of quality health care over the next 10 years.[47]

The Commission noted Australia's health workforce shortages,[48] and the 'complex and interdependent' health workforce arrangements.[49] It recommended a national approach to health practitioner registration, with a single national cross-profession registration board, supported by professional panels 'to advise on specific requirements, monitor codes of practice and take disciplinary action'.[50]

The Productivity Commission report also recommended uniform national standards for registration within a health profession.[51] The option of multiple national profession-specific registration boards was seen by the Commission as having advantages such as: national standards; national registration; facilitation of the adoption and revision of national registration standards; administrative efficiencies, reduced compliance burden and easier compilation of data; and opportunity to give greater weight to the public interest.[52] However, the Commission thought there were even greater benefits to a single national cross-profession registration board, including 'efficiencies in liaising with other bodies', greater administrative efficiencies, and 'reinforcement of a whole of workforce approach to improving efficiency and effectiveness of service delivery'.[53]

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45 Black, above n 15, 137.
46 Grabosky, above n 24, 115.
47 Productivity Commission (Cth), *Australia's Health Workforce*, (Research Report, 2005) iv.
48 Ibid xv.
49 Ibid xix.
50 Ibid xxv.
51 Ibid 140.
52 Ibid 141–2.
53 Ibid 142.

The Commission's proposed single national registration board reflected the public interest and the minimisation of domination by profession-specific membership:

> In the Commission's view, membership of the new national registration board must be constituted to reflect the broader public interest, rather than directly represent particular stakeholders. Thus, while the new board will require an appropriate mix of people with the necessary qualifications and experience to guide its work, members should be appointed in their own right, through a transparent appointment process, rather than as representatives of particular organisations. The board should include at least one member with appropriate consumer knowledge and expertise, reflecting the principal purpose of registration.[54]

When the NRAS was introduced in Australia in 2010, the model implemented did not adopt the Productivity Commission's recommendation for a single, national, cross-profession board. Instead, 10 new national, profession-specific Boards, comprising both practitioner members and community members, were established, with a further four new National Boards established for the professions that later joined the scheme in 2012 (Table 1 below).

Table 1: National Boards

Aboriginal and Torres Strait Islander Health Practice (2012)	Aboriginal and Torres Strait Islander Health Practice Board of Australia
Chinese Medicine (2012)	Chinese Medicine Board of Australia
Chiropractic (2010)	Chiropractic Board of Australia
Dental (2010)	Dental Board of Australia
Medical Radiation Practice (2012)	Medical Radiation Practice Board of Australia
Medicine (2010)	Medical Board of Australia
Nursing and Midwifery (2010)	Nursing and Midwifery Board of Australia
Occupational Therapy (2012)	Occupational Therapy Board of Australia
Optometry (2010)	Optometry Board of Australia
Osteopathy (2010)	Osteopathy Board of Australia
Pharmacy (2010)	Pharmacy Board of Australia
Physiotherapy (2010)	Physiotherapy Board of Australia
Podiatry (2010)	Podiatry Board of Australia
Psychology (2010)	Psychology Board of Australia

In 2015, the Council of Australian Governments ('COAG') Health Council, comprising federal, state and territory health ministers, agreed to move towards

[54] Ibid 144.

regulation of paramedics within the NRAS.[55] In 2016, a Senate Committee report recommended that paramedics be registered and accredited nationally and that a paramedic Board be established as part of the Scheme.[56] The reasons stated by the Senate Committee included the complexity of the tasks performed by paramedics, the other professions that are already regulated in the National Scheme, and the desirability of nationally consistent professional standards for paramedics.[57] However, broader debates remain about the role of professional regulation and registration and the inclusion of other professions.[58] These debates are not unique to Australia, with similar debates in the United Kingdom ('UK') over the inclusion of a number of other professions into professional registration schemes, including dance movement therapists, hearing aid dispensers, complementary and alternative medicine practitioners, psychologists, counsellors and psychotherapists, and social workers.[59] In the UK, voluntary registers have been introduced as an alternative to formal statutory regulation,[60] and the option of developing voluntary registers in Australia for self-regulated professions was raised in the Independent Review of the NRAS.[61]

The NRAS covers both registration and accreditation. The National Boards register health practitioners and establish registration standards.[62] The *National Law* also establishes an accreditation system for assessment of programs of study offered by education providers, assessment of overseas programs of study or examination, and assessment of qualifications for overseas-trained health practitioners.[63] The broad objectives of the Scheme are set out in s 3(2) of the *National Law* and demonstrate the range of priorities encompassed:

> The objectives of the national registration and accreditation scheme are:
>
> (a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
>
> (b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

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55 COAG Health Council, *Communique: 6 November 2015* <https://www.coaghealthcouncil.gov.au/Announcements/Meeting-Communiques1>. See also Senate Legal and Constitutional Affairs References Committee, Parliament of Australia, *Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety* (2016) 3; COAG Health Council, above n 2.

56 Senate Legal and Constitutional Affairs References Committee, above n 55.

57 Ibid ch 4.

58 For discussion, see Australian Health Ministers' Advisory Council, *Independent Review of the National Registration and Accreditation Scheme for Health Professions*, (Final Report, 2014) 24–7 <www.coaghealthcouncil.gov.au/Projects/Independent-Review-of-NRAS-finalised>. See also Jonathan Lee Wardle et al, 'Is Health Practitioner Regulation Keeping Pace with the Changing Practitioner and Health-Care Landscape? An Australian Perspective' (2016) 4 *Frontiers in Public Health* <http://journal.frontiersin.org/article/10.3389/fpubh.2016.00091/full>.

59 Health and Care Professions Council, *The Making of a Multi-Professional Regulator: The Health and Care Professions Council 2001–15* (Research Report, 2015) 23–7 <http://www.hpc-uk.org/assets/documents/10004DAEThemakingofamulti-proefessionalregulator-TheHCPC2001-2015.pdf>.

60 Ibid 28; Australian Health Ministers' Advisory Council, above n 58, 26.

61 Australian Health Ministers' Advisory Council, above n 58.

62 *National Law* s 35.

63 Ibid pt 6.

(c) to facilitate the provision of high quality education and training of health practitioners; and

(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and

(e) to facilitate access to services provided by health practitioners in accordance with the public interest; and

(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

The *National Law* also created a new agency, the Australian Health Practitioner Regulation Agency ('AHPRA'), to administer the NRAS. Importantly, although profession-specific Boards were retained in the Scheme, AHPRA is a cross-profession agency that works with all 14 boards. As discussed above, the NRAS is a COAG initiative established using an 'applied law' model of state and territory (not Commonwealth) laws, rather than the more usual avenue of 'model' legislation to serve as a basis for 'uniform' legislation. Each state and territory adopts and applies the *National Law* as a law of that jurisdiction. This enables the NRAS (and National Boards and AHPRA) to operate nationally within and across every participating state and territory in Australia in order to achieve national regulation under the constitutional framework of Australia's federal legal system.[64] However, the use of an applied laws approach, rather than the adoption of uniform laws, does leave scope for individual jurisdictions to enact variations on the *National Law*. This has happened in the case of mandatory reporting of practitioners, with WA and Queensland both enacting variations to these provisions in the *National Law*.[65]

Although NSW joined the National Scheme in relation to registration and accreditation, the State retained its long-established co-regulatory approach to complaints about health practitioners. Changes included NSW's former health practitioner boards becoming health professional councils, with the Health Professional Councils Authority supporting the work of the Councils in NSW.[66] Thus, in NSW, while AHPRA and the new National Boards manage the registration of NSW health practitioners, complaints are managed jointly by the Councils with the Health Care Complaints Commission under NSW-specific provisions to the *National Law*.[67] Queensland is also a co-regulatory jurisdiction under the *National Law*, with the establishment of the Office of the Health Ombudsman in 2014.[68]

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64 Western Australia did not use an applied laws approach and instead adopted mirror legislation: see above n 4.

65 *Health Practitioner Regulation National Law* (Queensland) s 141(5); *Health Practitioner Regulation National Law* (WA) s 141(4)(d). These provisions, which are not identical, specify certain exceptions from the mandatory reporting requirements for a practitioner who is treating another practitioner who would otherwise be the subject of a mandatory notification: see Wolf, above n 3, 915–16. There are, however, moves towards addressing this inconsistency, with Health Ministers deciding to explore a nationally consistent approach to mandatory reporting: COAG Health Council, *Communique: 4 August 2017* <http://www.coaghealthcouncil.gov.au/Announcements/Meeting-Communiques1>.

66 Health Professional Councils Authority ('HPCA'), *Welcome to the Health Professional Councils Authority* <www.hpca.nsw.gov.au>.

67 *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) s 6.

68 *Health Ombudsman Act 2013* (Qld); *Health Practitioner Regulation National Law* (Queensland) s 5 (definition of 'co-regulatory jurisdiction').

Moving to a national approach to registration and accreditation was a significant undertaking. Australia has a large and diverse health workforce. The 2016/17 AHPRA Annual Report reports that there were 678 938 registered health practitioners in Australia,[69] with the size of the professions ranging from 386 629 nurses and midwives,[70] and 111 166 medical practitioners,[71] to 608 Aboriginal and Torres Strait Islander health practitioners,[72] and 4860 Chinese medicine practitioners.[73] In addition, the number of regulatory bodies at state and territory level prior to the introduction of the NRAS made the task of consolidation into a national scheme a complex one. Data for over 550 000 registered health practitioners, with more than a million registration records from 37 databases transitioned to the new National Scheme.[74] The state-based and territory-based nature of professional regulation prior to 2010 meant that each state and territory had their own regulatory schemes, as constitutional powers relating to health remain predominantly with the states and territories.[75] Prior to the commencement of the NRAS on 1 July 2010, an extensive and complex set of regulatory legislation for health practitioners existed at state and territory level. Although there was a 12-month lead-in to the implementation of the Scheme, the state-based and territory-based staff moved to working in the national system overnight.[76] Prior to 1 July 2010, more than 50 pieces of legislation governed the registration of health practitioners throughout Australia (Table 2 below). That number was even greater prior to the Australian Capital Territory ('ACT'), the Northern Territory ('NT') and Victoria each introducing single statutes to govern the registration of health practitioners within their respective jurisdictions.[77]

Of the Acts listed in Table 2, only the Health Practitioners Act (NT), the Pharmacists Registration Act 2001 (Tas) (now the Pharmacy Control Act 2001 (Tas)) and the Pharmacists Registration Act 2001 (Qld) (now the Pharmacy Business Ownership Act 2001 (Qld)) remain current, although with amendments. Most of the remaining statutes in Table 2 were repealed as a consequence of the adoption of the National Law in each jurisdiction, although a few were repealed separately. The repeal or amendment of these statutes decommissioned state and territory health practitioner boards (Table 3) in all states except NSW, where the previous boards became professional Councils under new regulatory arrangements as part of the National Scheme.[78]

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69 AHPRA, *AHPRA Annual Report 2016/17* (2017) summary.
70 Ibid 22.
71 Ibid 19.
72 Ibid 15.
73 Ibid 16.
74 Legal and Social Issues Legislation Committee, Legislative Council, Parliament of Victoria, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, (Report No 2, 2014) 41.
75 McDonald, above n 1, 614–15.
76 Legal and Social Issues Legislation Committee (Vic), above n 74, 41–2; AHPRA, *Annual Report 2009/10* (2010) 9–11.
77 *Health Professionals Act 2004* (ACT); *Health Practitioners Act* (NT); *Health Professions Registration Act 2005* (Vic).
78 See above nn 66–7.

Table 2: State and territory legislation regulating health practitioner registration prior to 1 July 2010.[79]

ACT	*Health Professionals Act 2004*
NSW	*Chiropractors Act 2001; Dental Practice Act 2001; Dental Technicians Registration Act 1975; Medical Practice Act 1992; Nurses and Midwives Act 1991; Optical Dispensers Act 1963; Optometrists Act 2002; Osteopaths Act 2001; Pharmacy Practice Act 2006; Physiotherapists Act 2001; Podiatrists Act 2003; Psychologists Act 2001*
NT	*Health Practitioners Act*
Queensland	*Chiropractors Registration Act 2001; Dental Practitioners Registration Act 2001; Dental Technicians Registration Act 2001; Medical Practitioners Registration Act 2001; Medical Radiation Technologists Registration Act 2001; Nursing Act 1992; Occupational Therapists Registration Act 2001; Optometrists Registration Act 2001; Osteopaths Registration Act 2001; Pharmacists Registration Act 2001; Physiotherapists Registration Act 2001; Podiatrists Registration Act 2001; Psychologists Registration Act 2001; Speech Pathologists Registration Act 2001*
South Australia ('SA')	*Chiropractic and Osteopathy Practice Act 2005; Dental Practice Act 2001; Medical Practice Act 2004; Nursing and Midwifery Practice Act 2008; Occupational Therapy Practice Act 2005; Optometry Practice Act 2007; Pharmacy Practice Act 2007; Physiotherapy Practice Act 2005; Podiatry Practice Act 2005; Psychological Practices Act 1973*
Tasmania	*Chiropractors and Osteopaths Registration Act 1997; Dental Practitioners Registration Act 2001; Dental Prosthetists Registration Act 1996; Medical Practitioners Registration Act 1996; Medical Radiation Science Professionals Registration Act 2000; Nursing Act 1995; Optometrists Registration Act 1994; Pharmacists Registration Act 2001; Physiotherapists Registration Act 1999; Podiatrists Registration Act 1995; Psychologists Registration Act 2000*
Victoria	*Health Professions Registration Act 2005*
WA	*Chiropractors Act 2005; Dental Act 1939; Dental Prosthetists Act 1985; Medical Practitioners Act 2008; Medical Radiation Technologists Act 2006; Nurses and Midwives Act 2006; Occupational Therapists Act 2005; Optometrists Act 2005; Osteopaths Act 2005; Pharmacy Act 1964; Physiotherapists Act 2005; Podiatrists Act 2005; Psychologists Act 2005*

[79] Table adapted and updated from Meg Wallace, *Health Care and the Law* (Lawbook, 3rd ed, 2001) 418–20.

Table 3: State and Territory Health Practitioner Boards[80]

ACT	Chiropractors and Osteopaths Board of the ACT; ACT Dental Board; ACT Dental Technicians and Dental Prosthetics Board; ACT Medical Board; ACT Medical Radiation Scientists Board; ACT Nursing and Midwifery Board; ACT Pharmacy Board; ACT Optometrists Board; ACT Physiotherapists Board; ACT Podiatrists Board; ACT Psychologists Board
NSW	Chiropractors Registration Board; Dental Board; Dental Technicians Registration Board; NSW Medical Board; Nurses and Midwives Board; Optical Dispensers Licensing Board; Optometrists Registration Board; Osteopaths Registration Board; Pharmacy Board of NSW; Physiotherapists Registration Board; Podiatrists Registration Board; Psychologists Registration Board
NT	Aboriginal Health Workers Board of the NT; Chiropractors and Osteopaths Board of the NT; Dental Board of the NT; Medical Board of the NT; Nursing and Midwifery Board of the NT; Occupational Therapists Board of the NT; Optometrists Board of the NT; Pharmacy Board of NT; Physiotherapists Board of the NT; Psychologists Registration Board of the NT
Queensland	Chiropractors Board of Queensland; Dental Board of Queensland; Dental Technicians Board of Queensland; Medical Board of Queensland; Medical Radiation Technologists Board of Queensland; Queensland Nursing Council; Occupational Therapists Board of Queensland; Osteopaths Board of Queensland; Optometrists Board of Queensland; Pharmacists Board of Queensland; Physiotherapists Board of Queensland; Podiatrists Board of Queensland; Psychologists Board of Queensland; Speech Pathologists Board of Queensland
SA	Chiropractic and Osteopathy Board of SA; Dental Board of SA; Medical Board of SA; Nursing and Midwifery Board of SA; Occupational Therapy Board of SA; SA Optical Dispensers Registration Committee; Optometry Board of SA; Pharmacy Board of SA; Physiotherapy Board of SA; Podiatry Board of SA; South Australian Psychological Board
Tasmania	Chiropractors and Osteopaths Registration Board of Tasmania; Dental Board of Tasmania; Dental Prosthetists Registration Board; Medical Council of Tasmania; Medical Radiation Science Professionals Registration Board Tasmania; Nursing Board of Tasmania; Optometrists Registration Board; Pharmacy Board of Tasmania; Physiotherapists Registration Board of Tasmania; Podiatrists Registration Board; Psychologists Registration Board of Tasmania

[80] Table adapted and revised from Productivity Commission (Cth), above n 47, 359–60.

Victoria	Chinese Medicine Registration Board of Victoria; Chiropractors Registration Board of Victoria; Dental Practice Board of Victoria; Medical Practitioners Board of Victoria; Medical Radiation Practitioners Board of Victoria; Nurses Board of Victoria; Optometrists Registration Board of Victoria; Osteopaths Registration Board of Victoria; Pharmacy Board of Victoria; Physiotherapists Registration Board of Victoria; Podiatrists Registration Board of Victoria; Psychologists Registration Board of Victoria
WA	Chiropractors Registration Board of WA; Dental Board of WA; Dental Prosthetists Advisory Committee; Medical Board of WA; Nurses and Midwives Board of WA; Occupational Therapists Registration Board of WA; Optical Dispensers Licensing; Optometrists Registration Board of WA; Osteopaths Registration Board of WA; Pharmaceutical Council of WA; Physiotherapists Registration Board of WA; Podiatrists Registration Board of WA; Psychologists Registration Board of WA

While the regulatory frameworks prior to 2010 were profession-specific, they were not uniform across jurisdictions, meaning that health practitioners working in more than one jurisdiction could be subject to different regulatory requirements.[81] Despite improvements, including the introduction of mutual recognition laws in Australia to facilitate interstate recognition of qualifications,[82] state-based and territory-based regulation remained fragmented. This meant a lack of uniformity between the state-based and territory-based Acts governing each profession, and a barrier to interstate workforce movement with practitioners needing to apply for separate registration in each state and territory in which they wished to practise.[83]

The NRAS developed against a backdrop of increasing external scrutiny, with profession-led regulation no longer in step with contemporary expectations by governments and the community for greater accountability of regulators.[84] Within Australia and overseas, the dominance of a profession-led system shifted as lay membership became a common feature of regulatory bodies.[85] In NSW, boards

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81 Productivity Commission (Cth), above n 47, 136–7; Anne-Louise Carlton, 'National Models for Regulation of the Health Professions' (2005) 23(2) *Law in Context* 21, 25.

82 *Mutual Recognition Act 1992* (Cth); *Mutual Recognition (Australian Capital Territory) Act 1992* (ACT); *Mutual Recognition (New South Wales) Act 1992* (NSW); *Mutual Recognition (Northern Territory) Act* (NT); *Mutual Recognition (Queensland) Act 1992* (Qld); *Mutual Recognition (South Australia) Act 1993* (SA); *Mutual Recognition (Tasmania) Act 1993* (Tas); *Mutual Recognition (Victoria) Act 1998* (Vic); *Mutual Recognition (Western Australia) Act 2010* (WA). See Wallace, above n 79, 420.

83 Productivity Commission (Cth), above n 47, 135–8. For discussion of the work of the Productivity Commission more generally see Helen Silver, 'Getting the Best Out of Federalism — The Role of the Productivity Commission and the Limits of National Approaches' (2010) 69(3) *Australian Journal of Public Administration* 326; Lyria Bennett Moses, Nicola Gollan and Kieran Tranter, 'The Productivity Commission: A Different Engine for Law Reform?' (2015) 24(4) *Griffith Law Review* 657.

84 Davies, above n 12.

85 For discussion of lay membership in the UK, see ibid ch 14. Lay membership was also a feature of the former state and territory boards: see eg, *Nurses and Midwives Act 1991* (NSW) s 9(2)(k); *Health Professions Registration Act 2005* (Vic) s 120(2)(c); *Dental Practice Act 2001* (SA) s 6(1)(d). It is also a feature of the NSW Councils: see HPCA, above n 66. Although the *National Law* currently

voluntarily moved away from self-regulation towards a shared or co-regulatory protective approach,[86] with the NSW Department of Health's independent Complaints Unit first established in 1984. The Complaints Unit was transformed into an independent regulatory agency in 1993 with the establishment of the Health Care Complaints Commission.[87] This was the beginning of co-regulation in Australia.[88]

A key feature of co-regulation is the move away from the traditional profession-led approach to regulation. Established in legislation, co-regulation 'obliges the medical board to share the execution of medical disciplinary processes with a "lay" body known [in NSW] as the Health Care Complaints Commission'.[89] Co-regulation thus represents a major conceptual shift. As discussed above, membership of profession-based boards now includes lay or community members. In addition to sharing disciplinary decisions, co-regulation seeks to provide an additional layer of external oversight, representing a significant departure from traditional peer-review and professional autonomy.[90]

In Australia, since 1984 HCEs[91] have emerged as a primary place for patients and their families to make complaints about their health care.[92] Most complainants want some action taken to address problems relating to treatment by a health service or professional,[93] which is why HCEs are designed to encompass a far wider range of concerns and remedies than litigation.[94] The operation of HCEs is essentially based on one of three models. One model that applies in most states and territories focuses on complaint resolution services, including conciliation or mediation processes as a primary method of resolving a complaint;[95] referrals may also be made to more appropriate professional regulation or other bodies.[96] Serious complaints about health facilities or services can be investigated, but if the serious matter

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requires that the position of Chair of a National Board be held by a practitioner member (*National Law* s 33(9)), Health Ministers have agreed to reforms of the *National Law*, including proposed amendments that would allow the position of Chair of a National Board to be held by a community member or a practitioner member of the Board: COAG Health Council, above n 2.

86 For discussion of co-regulation as a regulatory model in NSW, see David Thomas, 'The Co-Regulation of Medical Discipline: Challenging Medical Peer Review' (2004) 11(3) *Journal of Law and Medicine* 382.

87 *Health Care Complaints Commission Act 1993* (NSW).

88 For discussion of the co-regulatory approach in NSW see Thomas, above n 86.

89 Ibid 383.

90 Ibid.

91 'Health complaints entity' is defined in the *National Law* as 'an entity — (a) that is established by or under an Act of a participating jurisdiction; and (b) whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system': *National Law* s 5 (definitions).

92 Merrilyn Walton et al, 'Health Complaint Commissions in Australia: Time for a National Approach to Data Collection' (2012) 11(1) *Australian Review of Public Affairs* 1.

93 David Thomas, 'Walking through Minefields: Health Complaints Commissions in Australia' (2003–2004) 1 *The Australian Health Consumer* 12; Walton et al, ibid.

94 Marie M Bismark et al, 'Remedies Sought and Obtained in Healthcare Complaints' (2011) 20(9) *BMJ Quality & Safety* 806.

95 Kim Forrester, 'Nursing Issues: "I Want You to Listen to My Side of This": Is There a Role for Mediation Early in the Health Care Complaints Process?' (2011) 18(4) *Journal of Law and Medicine* 701, 702; Joanna Manning, 'Access to Justice for New Zealand Health Consumers' (2010) 18(1) *Journal of Law and Medicine* 178.

96 McDonald, above n 1, 651.

concerns a health practitioner, it will be referred to AHPRA and the relevant practitioner board. Although only NSW and Queensland are formally co-regulatory jurisdictions under the *National Law*,[97] the role of HCEs is nonetheless an important aspect of practitioner regulation in all states and territories, with the *National Law* requiring both HCEs and National Boards to notify each other of complaints they received about health practitioners.[98] A second model — the co-regulatory model as it exists in NSW — has all these functions plus investigative and prosecutorial powers independent from AHPRA and the professional Councils in NSW. The third model is that operating in Queensland and is a mix of the other two models. In Queensland, the Health Ombudsman receives all complaints about health practitioners in Queensland[99] and manages complaints that may amount to professional misconduct or that may be grounds for suspension or cancellation of a practitioner's registration.[100]

IV A National Approach?

The move to a National Scheme for health practitioner regulation is part of broader efforts in Australia to develop harmonised regulatory approaches to overcome practical challenges posed by multiple jurisdictions within a federal system. While state-based and territory-based regulation is diverse, 'Australia is a federation with a long history of cooperation'.[101] Accordingly, although the move to a national system is a significant achievement, it sits with the broader federal trends of cooperation and harmonised regulatory solutions. The harmonisation of occupational health and safety laws is another example of this trend.[102] Attempts to develop a *National Law* approach to regulation of the legal profession have proven less successful,[103] although some harmonisation had been achieved through implementation at state and territory level of model laws.[104] New South Wales and Victoria decided to continue the reform process within their jurisdictions and have enacted a Uniform Law that establishes a common approach to legal services across the two states.[105]

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97 *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW); *Health Practitioner Regulation National Law* (Qld).

98 *National Law* s 150.

99 *Health Ombudsman Act 2013* (Qld) s 25(a).

100 Ibid s 91(1).

101 Cheryl Saunders, 'Collaborative Federalism' (2002) 61(2) *Australian Journal of Public Administration* 69, 69.

102 Richard Johnstone, 'Harmonising Occupational Health and Safety Regulation in Australia: The First Report of the National OHS Review' (2008) 1 *Journal of Applied Law and Policy* 35; Eric Windholz, 'The Evolution of Australia's Harmonised OHS Laws: Questions for Today and Tomorrow' (2011) 39(6) *Australian Business Law Review* 434.

103 Reid Mortensen, 'Australia: The Twain (and Only the Twain) Meet — The Demise of the Legal Profession National Law' (2013) 16(1) *Legal Ethics* 219.

104 Ibid 219.

105 Law Society of NSW, *Legal Profession Uniform Law* <https://www.lawsociety.com.au/practising-law-in-NSW/rules-and-legislation/legal-profession-uniform-law>. NSW and Victoria have both enacted legislation for the application of the Legal Profession Uniform Law in their jurisdictions: *Legal Profession Uniform Law Application Act 2014* (NSW); *Legal Profession Uniform Law Application Act 2014* (Vic).

Achieving harmonised, consistent or uniform legal or regulatory approaches is challenging within federal legal systems. Given that health is largely regulated at the state and territory level for constitutional reasons,[106] it is not surprising there are jurisdictional differences. A federal system gives rise to a number of possible approaches to achieve nationally consistent regulation. These include: the development of reciprocal schemes in which jurisdictions recognise a status conferred by another jurisdiction, as is the case in mutual recognition laws; the adoption of mirror legislation in each jurisdiction, although the uniformity of the laws introduced through such an approach tends to weaken over time; the applied laws model; agreement on policy by the various jurisdictions with separately drafted laws; complementary schemes of Commonwealth and state/territory legislation; the establishment of joint federal/state bodies; or referral of powers to the Commonwealth.[107] In the case of the new NRAS for health practitioners, a national law or 'applied laws' approach was used.[108]

The governance arrangements for the NRAS are complex, with the regulatory landscape now comprising a new national agency (AHPRA) (under the management of the Agency Management Committee), which supports National Boards and state/territory or regional boards. Other actors include accreditation bodies for each profession, and HCEs.[109] The complexity of the new system represents a challenge for AHPRA's engagement with the public and the regulated professions. A 2014 Victorian Parliamentary Committee review of the NRAS concluded that

> [d]espite the consolidation of numerous State and Territory health profession boards and administrations into one National Registration and Accreditation Scheme, the scheme managed by AHPRA remains a large and complex bureaucracy with potential confusion over lines of responsibility and accountability.[110]

Additional complexities arise because NSW and Queensland have opted out of the Scheme for complaint handling with separate processes and legislation governing the handling of complaints in each of those jurisdictions. The result of this is that Australia does not have a uniform national system for complaints about health practitioners.[111] On the other hand, with the adoption of the *National Law*, uniform laws now operate across the country for registration and accreditation of the 14 regulated professions, along with new requirements for criminal history checks,[112] requirements for mandatory reporting by practitioners (although these are not uniform),[113] and a national, publicly available register.[114] The national collection of data through the NRAS also enables an evidence-based approach to regulation of

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106 McDonald, above n 1, 614–15.

107 Brian Opeskin, 'The Architecture of Public Health Law Reform: Harmonisation of Law in a Federal System' (1998) 22(2) *Melbourne University Law Review* 337, 349–52.

108 Morauta, above n 3, 76.

109 See Legal and Social Issues Legislation Committee (Vic), above n 74, 15–21.

110 Ibid 26 (finding 2.4). For further discussion of the report see Wolf, above n 3.

111 Legal and Social Issues Legislation Committee (Vic), above n 74, 90.

112 *National Law* ss 79, 135. Ibid 89–90.

113 *National Law* ss 140–143. Queensland and WA have both enacted variations to these provisions in the *National Law*. However, as discussed above (n 65), there are moves towards a nationally consistent approach to mandatory reporting.

114 Ibid s 222.

health practitioners[115] and more accurate calculation and tracking processes for the regulated health workforce.[116]

The new *National Law* was introduced and passed initially in Queensland and then adopted, with amendments in some jurisdictions, by the rest of Australia.[117] As Morauta notes, there are significant advantages with this approach, as it provides for greater national consistency than other approaches and the law can be drafted centrally:

> The main policy advantage of the national law model over the mirror legislation model is greater national consistency. Subject to the decisions of parliaments, every jurisdiction adopts the law passed in the lead jurisdiction in exactly the same form.
>
> Another advantage of the model is that the national law is centrally drafted under the auspices of the APCC [Australasian Parliamentary Counsel Committee] on the basis of instructions issued jointly by all jurisdictions. In the case of the NRAS project a single dedicated drafter was provided by APCC and funded from the project budget. This relieved individual jurisdictions of a major drafting task since it is the role of the APCC to clear the national law in a form acceptable in a technical sense to all parliaments. With large and complex legislation this is a significant efficiency. The *Health Practitioner Regulation National Law Act 2009* ran to over 300 pages.[118]

The *National Law* approach 'requires a degree of national consensus which other legislative models do not',[119] as the proposed law must be passed by the Parliament in each state and territory. Morauta notes that the *National Law* approach

> places a heavy burden on governments and their ministers in the development phase to achieve detailed national agreement. There is nowhere for anyone to hide: full agreement has to be reached. The national law requires a major effort in the development phase and close attention from ministers to succeed.[120]

However, while the applied laws model is the most efficient way of introducing a common national approach, it is no guarantee against *subsequent* fragmentation. Paradoxically, while public law scholars rate Australia as having 'one of the most centralized federations in the world',[121] on an overall index of the degree

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115 Marie M Bismark et al, 'A Step Towards Evidence-based Regulation of Health Practitioners' (2015) 39(4) *Australian Health Review* 483.

116 Australian Government Department of Health, *Health Workforce Data* (21 January 2017) <http://www.health.gov.au/internet/main/publishing.nsf/Content/health_workforce_data>.

117 McDonald, above n 1, 620. As mentioned previously, WA enacted mirror legislation rather than adopting an applied laws model: see text accompanying above n 4.

118 Morauta, above n 3, 76.

119 Ibid 77.

120 Ibid 82. This can present challenges, though, as individual jurisdictions have less autonomy in a *National Law* approach than they did under the previous state-based and territory-based regulation. In its inquiry into AHPRA, a Victorian Legislative Council report found that 'The Victorian Minister for Health has less control over the registration and regulation of Victorian health practitioners than existed prior to the commencement of the National Scheme in 2010': Legal and Social Issues Legislation Committee (Vic), above n 74, 31 (finding 2.5). For discussion of this report see Wolf, above n 3, 908–9. For discussion of the governance arrangements in the NRAS see, Fiona Pacey et al, 'National Health Workforce Regulation: Contextualising the Australian Scheme' (2017) 22(1) *International Journal of Health Governance* 5.

121 Cheryl Saunders and Michelle Foster, 'The Australian Federation: A Story of the Centralization of Power' in Daniel Halberstam and Mathias Reimann (eds), *Federalism and Legal Unification* (Springer, 2014) 87, 102.

of uniformity across the whole legal system, Australia is placed quite low.[122] Comparative studies have found that the options for promoting harmonisation of so-called 'private law' areas such as health tend to be rather bare (and more prone to be shaped by political or cultural considerations), leaving more weight to be carried by measures such as intergovernmental coordination or civil society agency lobbying.[123] So the governance challenge of preserving a harmonised national scheme of health practitioner regulation and complaints management in health will be an ongoing one. The focus for state and territory ministers remains on the management of complaint/notifications. NSW is the jurisdiction with the largest number of health practitioners, and a well-established co-regulatory system for managing complaints.[124] Queensland amended its processes for handling of complaints about health practitioners, when it created the Office of the Health Ombudsman to be a co-regulator in conjunction with AHPRA.[125]

A long-recognised feature of federalism is the potential for states to act as 'laboratories' for testing new ideas and approaches.[126] The NSW co-regulatory scheme is one such example; another was the introduction by medical practitioners' boards of programs to address impaired[127] or poorly performing practitioners,[128] in Victoria and NSW. Yet one cannot presume that regulatory innovation is the sole preserve of state-based and territory-based regulation. In a review of health care quality in Australia, a recent Organisation for Economic Co-operation and Development ('OECD') report commented favourably on the development of the NRAS and associated innovations:

> Australia's move from a state-based to a national system, linked to annual CPD [continuing professional development] requirements, now makes it a leader in the OECD in the regulation of health professionals. It is also an example of what can be achieved when the federal and state and territory governments work collaboratively. Another innovation worthy of praise is an online register of practising and cancelled health practitioners. Employers and consumers can use it to check a health professional's registration status.[129]

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122 Australia ranked 14 out of 19 countries in a recent study, not far above Canada in (ranked 16), the USA (ranked 18) and the EU (ranked last): Daniel Halberstam and Mathias Reimann, 'Federalism and Legal Unification: Comparing Methods, Results, and Explanations across 20 Systems' in Daniel Halberstam and Mathias Reimann (eds), *Federalism and Legal Unification* (Springer, 2014) 3, 33.

123 Ibid 31–2.

124 *Health Practitioner Regulation National Law Act* (NSW).

125 Kim Forrester, 'Nursing Issues: A New Beginning for Health Complaints in Queensland: The *Health Ombudsman Act 2013* (Qld)' (2013) 21(2) *Journal of Law and Medicine* 273.

126 Shannon K McGovern, 'A New Model for States as Laboratories for Reform: How Federalism Informs Education Policy' (2011) 86(5) *New York University Law Review* 1519, 1549. 'At their best, federal systems constitute a "natural laboratory", in which different policy or service delivery approaches can be observed in action, providing the opportunity for learning about what works and what does not': Gary Banks and Lawrence McDonald, 'Benchmarking and Australia's Report on Government Services' in Alan Fenna and Felix Knüpling (eds), *Benchmarking in Federal Systems: Roundtable Proceedings* (Productivity Commission, 2012) 199, 201.

127 Naham (Jack) Warhaft, 'The Victorian Doctors Health Program: The First Three Years' (2004) 181(7) *Medical Journal of Australia* 376.

128 Alison Reid, 'To Discipline or Not to Discipline? Managing Poorly Performing Doctors' (2005) 23(2) *Law in Context* 91.

129 OECD, *OECD Reviews of Health Care Quality: Australia 2015: Raising Standards* (15 November 2015) 61 <http://www.oecd.org/australia/oecd-reviews-of-health-care-quality-australia-2015-9789264233836-en.htm> referred to in AHPRA, *Annual Report 2015/16* (2016) 7.

Clearly there is the potential for regulatory innovations to arise within either system.

V Polycentricity of Australian Health Practitioner Regulation

The transition from the state and territory system to the new national system can be seen as simply a *continuation* of the polycentric nature of Australian regulation of health practitioners. With the exception of the health practitioner registration boards, many regulatory actors (state-based and territory-based HCEs, professional colleges, health departments, hospital accreditation requirements) have not changed. It could be argued that the introduction of the NRAS brought little change apart from the *locality* of the regulation. Yet such a conclusion would fail to appreciate the scale of the regulatory change brought about by the introduction of the Scheme.

First, by bringing the 14 regulated professions into a common scheme, each National Board for each profession has become a regulatory actor vis-à-vis each of the other National Boards. This shared regulatory enterprise can be seen in the development of cross-profession registration standards,[130] and the development and implementation of regulatory principles to govern the work of AHPRA and the National Boards.[131] Previous state and territory, profession-specific legislation governing practitioner boards facilitated independence from other practitioner boards within their jurisdiction — a situation very different from the national scheme under the umbrella of AHPRA or in NSW under the umbrella of HPCA.

Second, the introduction of the NRAS moved the locality of regulation of health practitioners from practitioner boards at the state and territory level to new National Boards. Yet some National Boards established state or regional committees of the National Board,[132] meaning that even within the NRAS, the regulation by the National Boards may have a local presence.

Third, the National Scheme is a product of the agreement of State and Territory Health Ministers. From the outset, the Scheme has been shaped by the decisions of State Ministers. This shaping is evident in the decision by Queensland and WA to vary the application of mandatory notification laws,[133] the decision by NSW not to join the provisions of the *National Law* for the handling of complaints about health practitioners,[134] and more recently, by Queensland with the establishment of the Office of the Health Ombudsman.[135] These decisions highlight the multilayered nature of regulation of the *National Law* within Australia's federal legal system and the continued relevance of individual jurisdictions in the shaping of the NRAS.

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130 See, eg, the English language skills registration standard and the criminal history registration standard: AHPRA, *Annual Report 2014/15* (2015) app 3. See also AHPRA, *Registration Standards* (30 October 2015) <http://www.ahpra.gov.au/Registration/Registration-Standards.aspx>.

131 AHPRA, *Annual Report 2014/15*, ibid 8. See also AHPRA, *Regulatory Principles for the National Scheme* (23 November 2015) <http://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>.

132 Legal and Social Issues Legislation Committee (Vic), above n 74, 18.

133 See above n 65.

134 See above n 67.

135 See above n 68.

Fourth, the regulation of health practitioners, irrespective of regulatory or co-regulatory systems must be situated within broader developments about regulatory governance. While the regulation of health practitioners is itself polycentric, it too sits within broader regulatory frameworks that provide oversight to the administration of regulatory functions by regulatory agencies. Internationally, the governance arrangements to support good regulation by regulators,[136] and the mechanisms whereby regulators can achieve the right balance between competing regulatory priorities[137] have attracted attention in recent years. These trends have also been evident in Australia, with the Australian Government's *Guide to Regulation* setting out 10 principles for Australian Government policymakers, aimed at reducing the burdens of regulation.[138] In the context of health practitioner regulation, AHPRA and the National Boards have a set of regulatory principles to guide their work,[139] which includes a risk-based approach to regulation.[140]

Fifth, government oversight also constitutes a major feature of the regulatory landscape in this area in Australia. The high-profile nature of health care within the Australian political landscape means that governments may feel the need for a more hands-on form of oversight beyond that of governance frameworks for regulators. Thus, although the NRAS is only eight years old, there have been a number of reviews of the Scheme and its operation, including the required review,[141] as well as inquiries on specific issues such as the registration of international medical graduates,[142] and the handling of complaints under the *National Law*.[143]

Each of the elements outlined above adds a new set of regulatory actors to be considered as part of the regulatory task, and/or extra layers of complexity. This is not necessarily a criticism of the polycentricity of the system. It does mean that regulators need to remain attuned to the orchestration[144] and other demands this complexity makes upon them in terms of their engagement with their various constituencies: different levels of government, the regulated professions, other regulatory actors such as HCEs, and the general public. This goes back to the introduction of the article and Part I and the nature of the regulatory task for regulators in terms of identifying their regulatory priorities and strategies, and in communicating them effectively to the public and the professions they serve.

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136 OECD, *The Governance of Regulators: OECD Best Practice Principles for Regulatory Policy* (OECD Publishing, 2014).

137 See, eg, Sparrow, above n 20; Sparrow, above n 32; CHRE, above n 19.

138 Australian Government, *The Australian Government Guide to Regulation* (2014) 2 <https://www.pmc.gov.au/resource-centre/regulation/australian-government-guide-regulation>.

139 AHPRA, *Annual Report 2014/15,* above n 130, 8.

140 Ibid.

141 Australian Health Ministers' Advisory Council, above n 58.

142 House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *Lost in the Labyrinth: Report on the Inquiry into Registration Processes and Support for Overseas Trained Doctors* (2012).

143 Senate Community Affairs References Committee, Parliament of Australia, *Medical Complaints Process in Australia* (2016).

144 Grabosky, above n 24, 115.

VI Conclusion

The regulatory system for health practitioners in Australia is complex and multilayered. Much of the complexity arises from the wide array of institutional actors within the NRAS, within the health system (HCEs, co-regulatory bodies, health departments, professional organisations), and within the system of public regulation more generally. The introduction of the NRAS has simplified the regulatory landscape for health practitioners by moving from state-based and territory-based regulation to national registration standards overseen by National Boards. Yet at the same time as State- and Territory-based regulators have largely been replaced by the Scheme, new regulatory actors have entered with the establishment of National Boards, AHPRA, HPCA in NSW, and the Health Ombudsman in Queensland.

Australian regulation of health practitioners can be characterised as a form of polycentric regulation. Of note is that this polycentric regulation has developed within a federal legal system that itself adds layers of polycentricity to the system. As the NRAS continues to mature, the ways in which regulators, governments and the public navigate this complex landscape will continue to provide new insights into Australia's regulation of health practitioners and polycentric regulation within a federal system.