

**4th Health Policy Roundtable: Regulation of the health professions
Background Paper
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1. INTRODUCTION

In March 2005, following a decision of the Council of Australian Governments (COAG), the Australian Government requested the Productivity Commission to undertake a research study¹. The aim of the study was to examine issues impacting on the health workforce, including the supply of, and demand for, health professionals, and propose solutions to ensure the continued delivery of quality health care over the next 10 years (Productivity Commission 2005b: 2).

In its final report, released in January 2006, the Commission recommended an integrated set of national actions, its objective, 'to develop a more sustainable and responsive health workforce while maintaining a commitment to high quality and safe health outcomes' (2005b: XIV).

The Commission proposed two reforms of particular relevance to regulation of the health professions. First, a staged introduction of a single national accreditation regime and agency to provide a basis for nationally uniform registration standards for the health professions, and second, provision for national registration standards for health professions through the creation of a single national registration board with supporting professional panels to replace state and territory registration boards (Productivity Commission 2005b: 111, 131). These proposals for reform of the regulatory system challenge traditional boundaries in regulation of the health professions, that is, the boundaries between states and territories and their respective regulatory authorities, but also, the boundaries between professions that are reflected in the profession specific regulatory structures.

The purpose of this paper is to foster debate about the rationale and options for reform of regulation of the health professions. Difficulties with the current arrangements for regulation of the health professions are outlined, and relevant developments in selected international jurisdictions are described. Some of the mechanisms through which reform might be implemented are discussed.

¹ The Productivity Commission is an independent agency set up under an Act of Parliament. It is the Australian Government's principal review and advisory body on microeconomic policy and regulation. It conducts public inquiries and research into a broad range of economic and social issues affecting the welfare of Australians (Productivity Commission 2005b).

2. CONCERNS ABOUT THE CURRENT REGULATORY ARRANGEMENTS

There are a number of concerns with the current arrangements for regulation of the health professions. These relate to the limitations of mutual recognition in affording sufficient mobility of practitioners who wish to work across state boundaries; the problems for practitioners, boards and health service managers arising from inconsistencies both in legislation and in the administration of registration and accreditation regimes across states and territories; the need for a regulatory system that operates effectively to protect the public and whether a system based on peer review is sufficiently transparent and accountable; and given the contested division of labour in health care, how to ensure that the regulatory regime facilitates and supports a flexible and responsive health workforce. These concerns are examined below.

Barriers to the mobility of practitioners

Under the Australian Constitution, power and responsibility is divided between the Commonwealth and the States/Territories with some functions also devolved to local government. The Constitution does not confer a direct head of power on the Commonwealth Government to legislate in relation to health. Therefore, states and territories are empowered to legislate to register and regulate their medical and other health professionals in such a manner as their parliaments see fit. The Commonwealth Mutual Recognition Act 1992 and reciprocal legislation in each state and territory reflects an attempt by governments to address the challenges that arise from our federal system.

Under the mutual recognition scheme, an individual registered to practise an occupation in one jurisdiction is able to obtain registration to practise an equivalent occupation in another participating jurisdiction². To do this, a health practitioner simply forwards details of their registration in the home jurisdiction to the registering authority in the second jurisdiction and signs a consent form enabling the authority to undertake reasonable investigations relating to their application. Subject to a checking process, during which they are able to practise, registration is granted by the second jurisdiction's authority (Department of Human Services 2004: 2). This means that practitioners do not need to demonstrate that they satisfy the requirements of the other jurisdictions regarding qualifications and experience in order to be registered in an equivalent occupation. However, practitioners do need to make a separate application and pay an additional fee³. They also need to comply with the local laws applying in each jurisdiction in which they practise.

Those most affected by the requirements of multiple registration Acts and registering authorities include practitioners who work in border towns, those who fill short-term locum positions in rural areas across state boundaries, and those from specialties such as pathology and radiology who commonly provide services in multiple jurisdictions and/or via telemedicine. Of particular concern, there is anecdotal evidence that for some practitioners, the cost of multiple registration fees acts as a disincentive to take up short-term locums in rural and remote areas outside their home state.

² All eight Australian states and territories are participating jurisdictions under the mutual recognition arrangements, and Trans-Tasman mutual recognition legislation has extended the mutual recognition scheme to include most New Zealand registered health professions.

³ Fees for medical registration in various states range from approximately \$230 to \$400 per annum.

Inconsistencies in legislative requirements across states and territories

Legislative mapping exercises conducted from time to time have identified significant variability across jurisdictions in the form and content of registration Acts, including, but not limited to the categories of registration that apply and the terminology used to describe these, the registration application and renewal requirements and processes, the continuing professional development and indemnity insurance requirements, as well as differences in how complaints of unprofessional conduct are investigated and prosecuted and the sanctions that may be imposed (La Trobe University 2004: 9). Board funding arrangements (and the level of registration fees charged) and the relationships between boards and the responsible ministers and their departments also vary:

Despite significant harmonisation of regulatory arrangements for registered professions as a result of the Mutual Recognition Scheme implemented in the early 1990s, there is increasing divergence in the arrangements as each state and territory implementations recommendations for reform arising from NCP legislative reviews (Department of Human Services 2003: 64).

In response to this diversity and the need to reduce duplication of effort in regulatory and accreditation functions, state and territory registration boards for each of the registered health professions have worked together to establish cooperative national structures and most have delegated certain statutory functions to these bodies⁴. For example, the Australian Medical Council, the Australian Dental Council, and The Optometry Council have assumed functions nationally on behalf of their respective registration boards, such as accreditation of undergraduate training courses for the purposes of registration of graduates, and examination of overseas trained practitioners.

Despite these efforts, there is broad agreement across governments and professional bodies that there is a need for greater uniformity in registration arrangements between Australian states and territories, and that the level of uniformity and mobility of practitioners afforded by the current mutual recognition system continues to be inadequate (Australian Medical Council & Committee of Presidents of Medical Colleges 2001, Australian Council for Safety and Quality in Health Care 2001, Australian Health Ministers Conference 2002, Australian Government Productivity Commission 2005b). Health practitioners and the health service managers who employ them are obliged to comply with the statutory and administrative requirements of registration in every jurisdiction in which they practise. Duplicative and inconsistent arrangements are complex for all involved, including the registration boards responsible for administering the schemes and consumers.

Ensuring effectiveness, quality assurance and consumer protection

The pressure to reform the regulatory arrangements is not just about reducing red tape so that practitioners can more easily work in more than one jurisdiction. Registration boards operate within an increasingly complex global environment. Inconsistencies in the development and application of standards by the various registration boards, for example in assessment of registration applications (for both domestic and international graduates), in application of registration renewal requirements, in the preparation and dissemination of codes and guidelines about what constitutes acceptable practice, and in the application of disciplinary powers have implications for quality assurance and consumer protection.

⁴ For a list of the various national bodies delegated some statutory functions by state and territory registration boards, see Appendix 10.1 of the Department of Human Services Discussion Paper *Regulation of the Health Professions in Victoria*, October 2003.

Ensuring that all practitioners are properly qualified, competent and of good character is increasingly complex given the staffing pressures in hospitals and in rural and remote areas, and the ongoing reliance on overseas trained practitioners. The Patel scandal in Queensland (Medical Board of Queensland 2005) and those in the United Kingdom (Harold Shipman, Alder Hey and Bristol Infirmary (Allsop & Saks 2002: 2)) have highlighted the need for more rigorous processes to assess the qualifications of practitioners and monitor their performance. There is potential for consumers to be placed at serious risk from practitioners who 'slip through the regulatory net' if proper checking procedures are not followed, registration boards fail to communicate effectively, or where practitioners are not rigorously supervised or monitored in the workplace. A practitioner who is motivated to conceal a poor disciplinary history, may obtain registration in one jurisdiction where procedures may be less rigorous or standards lower, and, through mutual recognition, be automatically eligible for registration in any other Australian jurisdiction, without further assessment. Registration boards have a fundamental quality assurance role to play, and failure to carry out this role effectively can have devastating consequences. Registration boards with a small practitioner base and limited administrative infrastructure are vulnerable, as are those better resourced boards that deal with large numbers of practitioners.

Concerns about the peer review model of regulation

Another concern in relation to the quality assurance of practitioners and consumer protection, is a model of regulation that is based on peer review (Thomas 2002, 2004). Under this model (known as 'statutory self-regulation' or 'professional self-regulation' in some international jurisdictions) governments effectively delegate to select members of a profession, statutory powers to 'self-regulate'. The 'statutory self-regulation' model enshrines the principle that a practitioner's peers are in the best position to judge what constitutes professional and unprofessional conduct, and also to know how best to protect the public. Although registration legislation in every Australian jurisdiction now makes provision for community and legal members on registration boards⁵, there are questions about the extent of influence a few non-practitioner members can have on boards that are made up primarily of practitioners, whether the community interest is afforded sufficient weight, and whether community members may be 'subject to capture' by the professions. In addition, practitioner members bring essential professional and clinical expertise, but may be ill-prepared for a role that requires an understanding of the principles of natural justice and procedural fairness, and they may, at times, lack insight where professional interests conflict with the broader public interest. Peer review as the basis for regulation of the professions has been increasingly challenged in many Western countries, with the medical registration boards a particular focus for this criticism (Thomas 2002, 2004, Allsop and Saks 2002). As Thomas observes, the first medical boards were established in an era pre-dating responsible government, when little or no accountability was expected from them:

For most of the 20th century and indeed, for several hundred years before that, medical professionals enjoyed a degree of autonomy which absolved them from accountability for their professional actions to anyone apart from their peers. This system of 'peer review' in fact meant that they were to all intents and purposes almost totally non-accountable for errors, negligence or incompetence that harmed their patients (Thomas 2002: 2)

⁵ Changes to legislation to make provision for registration boards to include community and legal (non-practitioner) members occurred progressively in all Australian jurisdictions through the 1980s and 1990s.

High profile cases such as the Bristol Infirmary have fuelled the notion that registration boards are, in fact, unable to properly deal with professionals whose conduct or performance is sub-standard, and that boards are failing in their duty to protect the public (Allsop & Saks 2002:2).

Professions have been much too reluctant to judge the performance of their members critically and exercise effective control over them (Freidson 1990: 441)

In explaining this phenomenon, a study by Rosenthal found that medical practitioners experience an 'overwhelming feeling of personal vulnerability' in their role, and 'identify strongly with their colleagues' situation when an accident occurs and are quick to forgive' (Rosenthal 1995: 21).

A study commissioned by the Victorian Department of Human Services found that many complainants to registration boards were dissatisfied with how their complaints were handled and view these boards as biased and lacking independence (Health Issues Centre et al 2004: 42, 50). Reforms introduced in Victoria with the passage of the Health Professions Registration Act 2005 allow for the Victorian Minister for Health to recommend for appointment up to half the members of a registration board who are not practitioners from the profession concerned and to appoint non-practitioners in office bearing roles on registration boards, where this is necessary for the effective operation of a board. These reforms 'are designed to ensure a proper balance is struck between the rights and interests of consumers and those of the practitioners who deliver health services' (VicHansard 27 October 2005).

Facilitating a flexible and sustainable health workforce

Perhaps the most significant imperative driving reform and rationalisation of the regulatory arrangements for the health professions is the need for a regulatory system that optimises the flexibility and sustainability of the health workforce. Daily newspapers report a crisis in our health care system with shortages of doctors, nurses and many other allied health professionals. The pressures are particularly acute in public hospitals, mental health and aged care. Shortages are projected grow over the next five to ten years (Productivity Commission 2005a:11-12).

Contributing factors include escalating demand for health services due to increases in population, the increasing proportion of older people, technological advances, improved treatment options and higher community expectations of health services (Victorian Government 2005: 6). Add to this the ageing of the current workforce, changing participation rates with health professionals choosing to work shorter hours or part-time, and continued workforce attrition.

The Productivity Commission identified a range of systemic impediments to efficient, responsive and sustainable health workforce arrangements, including:

- fragmented roles and responsibilities, with health workforce policy 'compartmentalised' by profession, even in circumstances when an integrated 'cross-profession' approach is clearly called for;
- inadequate co-ordination mechanisms, inflexible and inconsistent regulation, with a lack of collaborative policy efforts to improve co-ordination across the various parts of the system;
- inflexible and inconsistent regulation that is subject to considerable influence from the professional groups concerned, and widely perceived as inhibiting changes to scopes of practice and the development of new competencies that could help to better meet changing health care needs;

- perverse funding and payments incentives that may result in patients seeking treatment from a doctor, when (unsubsidised) treatment from another health professional may be more appropriate, and limited incentives for medical practitioners to delegate less complex service provision to other suitably skilled, but more cost-effective, health professionals; and
- entrenched workforce behaviours that are heavily influenced by 'custom and practice' (2005a: XXVII-VIII).

With over 90 separate regulatory authorities governing the registered health professions across eight states and territories (2005a: 255), the Productivity Commission formed the view that the current system presents significant structural impediments to promoting and maintaining a flexible and sustainable health workforce. The Commission's proposed workforce arrangements are designed to drive reform to scopes of practice, and job design more broadly, while maintaining safety and quality; deliver a more coordinated and responsive education and training regime for health workers; accredit courses and institutions and register health professionals in nationally consolidated and coherent frameworks; and provide the financial incentives to support access to safe and high quality care in a manner that promotes innovation in health workplaces (Productivity Commission Media Release 19 Jan 2006: 1).

A less fragmented and better co-ordinated registration system is expected to provide the levers required to improve workforce deployment, generate efficiencies and promote consumer protection (Productivity Commission 2005a: 106).

3. INTERNATIONAL DEVELOPMENTS

It is useful here to take a brief look at some developments internationally in regulation of the health professions. These developments are reducing the regulatory boundaries between jurisdictions and/or between professions. In some jurisdictions, regulatory functions have been consolidated across professions. In others, an overarching body has been established to scrutinize the operations of registering authorities and provide a cross profession focus.

In Canada, regulatory responsibility rests with the provincial governments. The province of Ontario, the Regulated Health Professions Act 1991 (RHP Act) established a Health Professions Regulatory Advisory Council. The Council is a peak statutory body whose role is to provide independent policy advice to the Minister for Health and Long Term Care on matters relating to the regulation of the health professions, including whether to regulate or deregulate health professions, amendments to the RHP Act and related Acts and regulations, and the quality assurance programs of health professional colleges (registration boards). The Council also has a monitoring role in relation to the professional colleges. In the United States, regulation of the professions is conducted at the state level. There appears to be similar challenges with the diversity of state laws, and efforts to achieve consistency, with national structures that have evolved through which state based registration boards cooperate on matters of common interest⁶.

Under New Zealand's unitary system of government, 2003 saw the passage of the Health Practitioners Competency Assurance Act and the consolidation of the legislative framework governing the health professions under a single Act of

⁶ See for example The Federation of State Medical Boards of the United States Inc. 2000, Report of the Special Committee on Physician Profiling, April 2000.

Parliament. The Act makes provision for the continued operation of separate registration boards for each regulated health profession, with a standard structure and functions, and a single tribunal to hear matters of serious professional misconduct. The Minister for Health has a statutory role to determine disputes between regulated health professions concerning legislated scopes of practice. The New Zealand Ministry for Health identified a range of benefits in a single Act: consistency – a uniform approach to all occupations with innovations automatically applying to all professions; flexibility – enabling greater ability to meet changing skill sets, diagnostic regimes and treatments; transparency – as to which occupations are regulated and how; efficient use of parliamentary time - simplification of regulating new professions; and economies of scale – through combining the disciplinary functions of different professions (Ministry of Health New Zealand 2000: 3).

In the United Kingdom (UK), there have been a number of developments of interest. First, in 2002, the Government passed the *National Health Service Reform and Health Care Professions Act*. The Act establishes an overarching Council for the Regulation of Health Care Professionals. The role of the Council is to build and manage a coordinated and consistent framework for regulation across health professions, and ensure open, transparent and consistent procedures within each regulatory body. The Council has commenced testing its new powers by challenging the leniency of disciplinary sanctions imposed, in one case by the Nursing and Midwifery Council, and in the other by the General Medical Council (British Medical Journal 2004; 328:541).

Second, the UK Health Professions Council, established under the UK Health Professions Order 2001, is responsible for the registration of more than 167,000 practitioners from 13 allied health professions, including podiatrists, physiotherapists and radiographers. The Council has 26 members, one from each of the professions regulated, and 13 lay members, plus a president. It carries out a similar range of functions to Australian state and territory registration boards but for multiple professions (Health Professions Council 2006).

Although the UK appears to be the only jurisdiction to date that has combined responsibility for registration of multiple professions under a single regulatory authority (the Health Professions Council), there are examples both internationally and in Australia, of central administrative bodies that carry out the administration of registration functions on behalf of a number of separate profession specific boards. New York State has an Office of the Professions within its Department of Education, which administers a registration scheme for 47 regulated professions including the health professions (New York State Education Department 2006). Some jurisdictions have also consolidated the investigative and/or disciplinary functions across professions. In New Zealand, a single tribunal is responsible for conducting disciplinary hearings into serious misconduct matters arising from all the regulated health professions.

In commenting on the establishment of the UK Council for the Regulation of Health Care Professionals, the British Medical Journal stated:

The Council confirms a permanent and welcome shift in power to a partnership of public, professions, and health services, all working under political scrutiny. But is there room for a more radical intent? The Council could mark the beginning of the end of single profession regulation. It could be the progenitor of a new type of inter-professional regulation which encompasses the reality of team based healthcare and the more flexible workforce needed to deliver it (British Medical Journal 2002: 379).

4. DISCUSSION

The contested division of labour in health care

The difficulties in achieving multi-skilling, task transfer and flexible service delivery are integrally bound up with the social control of work, that is, who controls the health care division of labour and in whose interest. For several hundred years, medical practitioners have sat at the peak of the hierarchy, with considerable autonomy and power, not only to control their own work, but also that of the allied health professions and various ancillary and support staff⁷ (Willis 1989). Since the 1960s, as traditional hierarchies in the health care have been increasingly challenged (Allsop & Saks: 2), demarcation disputes between occupational groups have become commonplace. Examples include in eye care - between ophthalmologists (medical specialists) and optometrists, and between optometrists and orthoptists; in dentistry - between dentists and dental therapists, hygienists, prosthetists and technicians; in medicine generally - between medical practitioners and nurses, and within nursing, between different levels of nurse.

In the past, legislation has underpinned and reinforced some of these rigidities in scope of practice and this has created legal barriers to task transfer. With the implementation of competition policy in the 1990s, jurisdictions removed any obviously anti-competitive legislative restrictions that did not demonstrate a net public benefit. Most registration Acts now simply provide for protection of professional titles, rather than defining scopes of practice of the professions that can confer monopoly practice for a profession or segment of a profession. However, it is unlikely that a unitary system of regulation with a single centralised administration could be slower to adopt and implement workforce reform than the current multi-jurisdictional system.

There is no doubt that workforce reform must be managed carefully, to ensure that staff have the skills, knowledge and attributes to safely carry out new or expanded health care roles. However, under current arrangements workforce reform is unnecessarily contested and slow (Department of Human Services 2005a: 3). In Victoria for example, it has taken more than 10 years to develop and implement the role of nurse practitioner⁸, and the same length of time to implement changes to the scope of practice of division 2 (state enrolled) nurses to allow them to administer medication to patients in Victorian aged care facilities (Department of Human Services 1998:12-14, Department of Human Services 2005: 22). Discipline specific registration boards dominated by a single professional voice, in concert with their respective professional associations, can operate to limit scopes of practice, block task transfer and fuel rather than resolve demarcation disputes.

Another indicator of the efficiency with which workforce reform is achieved, is how quickly extensions of practice - such as legislation to afford the allied health professions the right to prescribe restricted medicines - are adopted across all eight Australian jurisdictions. Extending prescribing rights to the allied health professions has been strongly opposed by the major professional bodies representing the medical profession (AMA Victoria 2003: 13-14). Despite this opposition, with the passage of the Optometrists Registration Act in 1996, Victoria was the first jurisdiction to amend its legislative scheme to allow suitably trained optometrists to prescribe ocular therapeutics, that is, ophthalmic drugs applied topically for the treatment of anterior eye disease.

⁷ For a discussion of these issues see Willis 1989, *Medical Dominance: the division of labour in Australian health care*.

⁸ Nurse practitioners are nurses trained for advanced clinical practice.

Following an eye examination, Victorian patients can now leave their optometrist with a diagnosis and medicine prescription if necessary, rather than requiring a second visit to their general practitioner. Ten years on, and despite a safe record of prescribing practice in Victoria, only Tasmania has fully implemented prescribing rights for the optometry profession, although the Tasmanian list of drugs that optometrists are legally authorised to prescribe is more limited than in Victoria. In 2005, the Queensland Government stepped back from introducing similar reforms, in the face of concerted opposition from ophthalmologists (medical specialists), who threatened to boycott work in the public health system if the reforms proceeded (Optometrists Association Australia 2005:1-3).

Some of the barriers to workforce reform and expanded scopes of practice, such as prescribing rights, require legislative change in eight jurisdictions. Where one or more of the health professions strongly opposes legislative change, the time lag for all jurisdictions to implement reforms can be considerable. In addition, barriers to more flexible scopes of practice are often contained in policies and guidelines issued by the various registration boards. It is here that boards have a critical role to play in facilitating workforce reform. Board policies and guidelines underpin or influence custom and practice in the workplace, and breach of a board issued code or guideline can result in disciplinary action.

Policy questions

One of the obstacles to progress with the nationally consistent medical registration legislation project appears to have been a lack of consensus among jurisdictions as to what 'nationally consistent' means and what is the best way of achieving it. For example, does 'nationally consistent registration' mean one piece of legislation applied throughout Australia, or eight separate pieces of legislation, either identical or containing common core provisions? If it means common core provisions, then how much commonality is necessary or desirable? Does it mean a single regulatory authority, or multiple authorities, one in each jurisdiction? If a single authority, then does this mean one national registering authority for each regulated profession, or one authority that registers multiple professions nationally? How is a preferred model to be given effect to legislatively, and how are interface issues to be managed, such as the interface with the court system in each jurisdiction and with state and territory based health complaints bodies, some of which carry out investigative functions on behalf of their registration boards.

There is likely to be a diversity of views about the role of registration boards in addressing workforce shortages and the need for structural reform (see Van Der Weyden in MJA 2006: 100-101, AMA Victoria 2005b). Any amalgamation of regulatory bodies across professions will be perceived by most from within the professions as a loss of professional control over standards. Before proceeding to focus on solutions, it is worthwhile examining the some of the policy questions that underpin the rationale for reform.

The proposals for reform appear designed, in general terms, to overcome the barriers created by Commonwealth/State boundaries and/or the boundaries between the health professions.

In relation to Commonwealth/State boundaries:

- Is consistency in regulatory arrangements desirable across states and territories and if so, how much consistency and for what purpose?
- Are structural solutions necessary or is it possible to achieve the policy objectives through better cooperation, communication and information sharing between state based regulatory authorities?

- Is structural reform, to establish one or a number of national authorities for registration and/or accreditation likely to contribute to an improvement in standards of care, or will it simply dilute the professional input that is critical to ensuring standards are well articulated, applied and maintained?
- What is the preferred model, if any, for reform?
- If a national regulatory and/or accreditation authority is to be established, then what is the legislative mechanism/s through which this is to be achieved and how are the best elements of the current system to be preserved?

In relation to the boundaries between professions:

- What are the strengths and weaknesses of professionalisation, professionalism and the existence of strong and distinct professional identities, in terms of standards of care and the effective operation of the health care system?
- What are the opportunities and threats associated with more flexible work roles, achieved, for example, through multi-skilling, task transfer and trans-disciplinary approaches to service delivery?
- Will a 'flexible and responsive' health workforce necessarily result in better quality care for patients - what are the potential risks and benefits, and how is it to be achieved in ways that protect consumers and safeguard standards of care?
- What is the nature of the relationship between regulatory structures and functions and ensuring a 'flexible and responsive' health workforce? What should be the role, if any, of registration boards in facilitating or supporting workforce reform?

Legislative reform mechanisms

Although the Productivity Commission envisaged its proposed new accreditation and registration agencies as exercising statutory powers, it did not specify a mechanism through which these statutory powers might be conferred. Even if a level of consensus is achieved on the policy questions and a proposed model, there are considerable challenges in achieving a statutory basis for a national regulatory authority. It is worthwhile here to explore some of the mechanisms through which national legislative schemes are effected.

In a paper titled *Implementation Options for National Legislative Schemes in Public Health*, prepared for the National Public Health Partnership by the Centre for Comparative Constitutional Studies at University of Melbourne, a useful framework was offered for identifying and assessing options for achieving uniform national regulatory arrangements. The paper identified that there is a spectrum of uniformity ranging from complete uniformity to no uniformity, with variations in between involving harmonisation, reciprocity, co-ordination of legislation/policy and exchange of information (The University of Melbourne 1999: 12).

The framework encourages policy-makers to consider the level of uniformity and co-ordination that is desirable, appropriate and achievable. Gaps are inevitable, even with highly uniform schemes, particularly if the administration of the scheme is not uniform, or there is not uniformity of associated matters such as Acts Interpretation Acts, ombudsman legislation, administrative and judicial review and judicial interpretation (1999: 13).

Nine options were identified for achieving uniform national legislative schemes (1999: 12-13) and three inter-governmental support mechanisms that can be used to achieve and maintain uniformity over time: Ministerial councils, inter-governmental agreements, and central administrative bodies. Appendix 1 below summarises the key features of each option and the level of uniformity that can be achieved.

In particular, the establishment of a central administrative body or national authority is a common mechanism through which cooperative legislative schemes seek to harmonise or make uniform the administration of the scheme.

Typically such a body is set up in legislation of one jurisdiction and invested with power by the others. A greater degree of uniformity in the operation of the law is likely if the administration is centralised in this way⁹ (1999: 16).

Approaches to reform

The history of health policy reform in Australia is one of incremental change. It is worthwhile exploring further the rationale for reform, and what might be some possible incremental steps in reducing the regulatory barriers between jurisdictions and between professions.

On the one hand, it is possible for the lack of consistency of regulation across jurisdictions to be addressed without structural or legislative change, through agreement on standards between jurisdictional regulatory authorities, improved communication, streamlined administrative processes, implementation of national databases, and government funding for workforce reform initiatives. Registration boards have shown a capacity to work cooperatively to establish national standards and guidelines in a range of policy areas. For example, the work to develop a 'National Index of Medical Registration'¹⁰ is designed to facilitate communication between boards on matters of registration application processing if all jurisdictions ensure the legislative framework for sharing of confidential information about practitioners is in place. In addition, decisions arising from the Australian Health Ministers' Conference and the Council of Australian Governments indicate a willingness to address the need for national standards for the recruitment and registration of international medical graduates in the public health system and in areas of need (AHMC 2004, COAG 2006). But is this enough?

While there continues to be 90 or so separate statutory authorities responsible for regulation of the health professions across Australia working under separate and inconsistent legislation, it is hard to see that workforce reform will be anything other than contested and slow.

Single national authorities responsible for registering practitioners from all the regulated health professions and accrediting their training courses is a radical option. There is a range of other structural reform options that could begin to address the problems identified, while moving in the direction of consolidation across state boundaries and across professions. For example, each jurisdiction could consolidate their health practitioner registration legislation (as exists in Northern Territory, ACT and most recently Victoria), and move incrementally to consolidate regulatory authorities across the professions at the state level while maintaining a commitment to supporting the existing national structures such as the Australian Medical Council, the Australian Dental Council, the Council of Pharmacy Registering Authorities etc. Alternatively, regulatory authorities could be consolidated within professions, at the national level.

⁹ Examples of central administrative bodies include Food Standards Australia New Zealand, National Registration Authority for Agricultural and Veterinary Chemicals, Therapeutic Goods Administration, Professional Standards Council, and the National Blood Authority.

¹⁰ The National Index of Medical Registration is a proposed new on-line database of registered medical practitioners, each with a unique identifier, created as a 'virtual index' to be linked to, and drawing its information from existing State and Territory medical registers and providing different levels of access to register information for the public, the medical boards and other approved agencies (AHMC 2004: 1).

Under yet another model, administration of regulatory functions could be centralised while maintaining state and territory statutory authorities. For example, the model adopted with the passage of professional standards legislation in states and territories has seen the establishment of mirror legislation in each jurisdiction and a central national administration achieved through the vehicle of an intergovernmental agreement. Although there are multiple statutory authorities empowered through various state and territory Professional Standards Acts, Ministers agree to appoint an identical list of members. Such an approach achieves a central administration while maintaining state sovereignty.

5. CONCLUSIONS

The various reforms being pursued internationally suggest a trend towards increased cross professional regulation, by way of consolidation of legislation, amalgamation of governance and/or administrative arrangements, consolidation of investigative and/or disciplinary functions, and/or the establishment of bodies with broad-ranging membership to scrutinize the operations of profession specific registration boards. The Productivity Commission has recommended major structural reform to consolidate state and territory registration and accreditation functions nationally and across the registered health professions. The Productivity Commission report identifies fragmented roles and responsibilities, inadequate co-ordination, and inflexible and inconsistent regulation that is subject to considerable influence from the professional groups concerned, and widely perceived as inhibiting changes to scopes of practice and the development of new competencies that could help to better meet changing health care needs.

With over 90 regulatory bodies and a regulatory system that reinforces 'professional silos' rather than encourages an inter-disciplinary approach, workforce reform across the nation is unnecessarily contested and slow. A single national authority responsible for registering practitioners from all the regulated health professions is a radical response, designed to break down both jurisdictional and professional boundaries and facilitate a more flexible and sustainable health workforce.

There is a diversity of views from the health professions, government and consumer groups about the desirability and necessity of workforce and regulatory reform. Some are of the view that the way registration legislation is framed and how regulatory powers are exercised by registration boards have the potential to impede rather than facilitate workforce flexibility, substitution and expansion of the scopes of practice of registered and unregistered practitioners (DHS 2005b:2). However, many in the professions question the link between the registration function and workforce shortages and argue that it is the role of governments not registration boards to address these problems (Vicdoc 2005: 5, Australian Dental Association Victorian Branch et al 2005: 2).

While there are some attractions with the reforms proposed by the Productivity Commission, there is likely to be considerable resistance from the major professional bodies to any structural reform that sees consolidation of registration or accreditation functions, amalgamation of profession specific registration boards or even the establishment of a single administrative secretariat to support multiple boards (ADA Victorian Branch et al 2005, AMA Victoria 2005b: 1).

There is a need for further debate about the nature of the current problems, the extent to which uniformity of regulatory arrangements on a national basis is a desirable as well as achievable goal, and whether amalgamation of registration structures and functions across professions at a national level is the best solution.

We need to be sure that there is, in fact a strong causal relationship between regulatory structures and functions and the flexibility and responsiveness of the workforce, and that the proposed solution will in fact achieve the desired benefits or at least lead to an improvement on the current arrangements.

If legislative reform is to be pursued, the various reform options should be assessed not only as to the extent to which the public policy goals such as consumer protection and flexibility in workforce arrangements are achieved, but also how efficiently the scheme works (that is the extent to which it can be initiated, amended and reliably maintained); the extent to which it preserves the rule of law; and how it affects the broader question of federal balance (1999: 17).

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Appendix 1: Implementation options for national legislative schemes

| No. | Option | Level of uniformity | Brief description | Examples |
|-----|--|---------------------|---|--|
| 1. | Unilateral exercise of power by the Commonwealth | High | Commonwealth legislates within current constitutional framework using indirect head of power (for example section 51(1) or 51(20); or, a new head of power is created covering health via alteration to the Constitution passed at referendum | |
| 2. | Reference of power to the Commonwealth | High | States refer power to Commonwealth under section 51(37) of the Constitution. Reference may be broad or specific, limited duration, involving one or more States, subject to conditions. States retain concurrent powers. | <ul style="list-style-type: none"> • Mutual recognition (some states) |
| 3. | Incorporation by reference | High | One jurisdiction enacts legislation with all substantive provisions, and legislation is adopted and applied in legislation enacted by other participating jurisdictions. Ministerial Council and intergovernmental agreement determines content of host legislation and processes for amendment and review. Amendments may or may not be adopted automatically. Usually includes central administrative body. | <ul style="list-style-type: none"> • Uniform consumer credit laws scheme • National corporations scheme • Mutual recognition (some states) |
| 4. | 'Roll back' schemes | Moderate | Commonwealth legislates to establish minimum standards on matters over which Commonwealth and States have concurrent power. States may legislate for and administer alternative rights and procedures. Commonwealth Senate can reject alternative provisions if considered not to comply with Commonwealth scheme. | <ul style="list-style-type: none"> • Native title scheme |
| 5. | Complementary legislative schemes | Moderate | Commonwealth and States reach agreement on policy, and each jurisdiction passes separate but totally consistent (although not necessarily identical) legislation. The key provisions are set by intergovernmental agreement and must be included. Format of specific legislation left to each jurisdiction and can be implemented when politically and administratively convenient. The inter-governmental agreement may or may not include the development of an agreed version of the Bill. Each parliament has an opportunity to consider and amend the Bill, and local concerns or drafting practices may have some influence on the final version. | <ul style="list-style-type: none"> • Therapeutic Goods regulation • Model Food Act and Food Regulation Agreement (2002) • Legal Professions legislation |
| 6. | 'Alternative consistent' legislative schemes | Moderate | Variation of Option 3. Participating jurisdictions pass legislation that is identical to but less extensive than host legislation. | <ul style="list-style-type: none"> • Uniform consumer credit laws scheme |
| 7. | Reciprocal legislative schemes | Moderate | Jurisdictions recognise on a reciprocal basis a status given by another jurisdiction, thereby extending national coverage rather than achieving uniformity. | <ul style="list-style-type: none"> • Mutual recognition scheme |
| 8. | Agreed legislation/policies | Low | Participating jurisdictions agree to implement similar legislation or policies via local legislation. The format of specific legislation is left to each jurisdiction, key provisions are set by Council/intergovernmental agreement & must be included. | <ul style="list-style-type: none"> • Agreement to regulate firearms (1996) |
| 9. | Exchange of information | Low | Ministers and/or public servants exchange information about policy initiatives and regulatory structures. | <ul style="list-style-type: none"> • Victoria's Tobacco Act 1987. • National Public Health Partnership (Phase 1). |

* This table has been compiled from information presented in the Centre for Comparative Constitutional Studies paper *Implementation options for national legislative schemes in Public Health*, 7 September 1999