

Policy, politics and power in health practitioner regulation: Perspectives and experiences of healthcare stakeholders regarding the occupational regulation of non-registered health professions

by Jennifer Mary Carè

Thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

under the supervision of
Professor Jon Wardle, Associate Professor Amie Steel, and
Dr Anne-Louise Carlton

University of Technology Sydney
Faculty of Health
Australian Research Consortium in Complementary and
Integrative Medicine

May 2025

Certificate of original authorship

I, Jennifer Mary Carè, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

This research was supported by an Australian Government Research Training Program (RTP) Scholarship, doi.org/10.82133/C42F-K220.

Production Note:

Signature: Signature removed prior to publication.

Date: 1 May 2025

Acknowledgements

*"I can no other answer make but thanks,
And thanks; and ever thanks"*

William Shakespeare, Twelfth Night, Act III, Scene 3.

My first 'ever thanks' goes to my supervisors, Professor Jon Wardle, Associate Professor Amie Steel, and Dr Anne-Louise Carlton. I come from an ordinary Australian family of immigrant background. What you have helped me achieve is something extra-ordinary. A long-held dream you have helped me to realise. Each of you has brought something unique to this work, and each has been crucial to its completion. For your vision and guidance, your deep knowledge of the field and of research, and for the many opportunities for personal and professional growth, my ever thanks.

I would like to thank the many, many scholars whose works I have read and leaned on so heavily to produce this thesis. I salute you. You have educated me, 'introduced' me to other scholars, enabled me to develop my own insights, and helped me find a way through. Many of you have made your way into these pages. Through your works, my work becomes meaningful. Through your works lighting my way, I have been able to cast the light of knowledge a little further.

To my sister, Eleanor Carè, and my friends, particularly Merri-Lyn Clark, Fi McCormick, and Rose Cornelissen, who read drafts of this work in part or in full, my everlasting thanks, not only for your feedback on this work but for your constant companionship, encouragement, and optimism. To friends on both sides of the Tasman: especially (soon to be Dr) Jill Dunn, Dr Angela Doolan, Dr Areej Asaad, Dr Kim Graham, and Dr Glenys Frank, whom I've known from early in my candidature, you have all given so much in friendship and support, and have always had confidence in me; to the Wonderful Write Bunch with whom I have spent many hours learning the craft of writing and whose encouragement I will always remember and appreciate; and to Dr Lyn Lavery and the Research Accelerator community, too numerous to mention but so dear to my heart. Rarely has a day gone by in these past years without contact with one or more of you

while I made my way through all the phases of this research. To all of you, your friendship, encouragement and support, the shared laughter and tears, the learning, advice and ideas will never be forgotten. Thank you mostly for giving me a sense of place in the field of academia, a place where I was seen to belong.

I also owe a huge debt of gratitude to the participants who took part in this study. Thank you for your generous contributions, your candid responses, and for immeasurably enriching this research.

I also thank the Australian Government and UTS for the Research Training Program Scholarship that sustained me during my candidature.

To the Ngangkari traditional healers, part of the Anangu people of Central Australia whose healing practices live on today. To the Bunurong traditional owners, part of the Kulin nation who have walked the lands of Wonga for tens of thousands of years, these lands where I live and where this thesis was commenced and completed. Thank you for holding me in your embrace, nurturing me through these long years, and inspiring me with the beauty of your lands, seas, and waterways.

Finally, to my mother, Palma Carolina Ieraci, long passed but ever-present. And to Rod, my love, my lifelong partner, my steadfast companion, my compass pointing to the light at the end of the tunnel. For your enduring support, your endless encouragement, and your undying love. For always cheering me on to greater achievements. You have been the rock at my back when I needed rest and the wind beneath my wings when I decided to fly. My ever thanks can never be enough.

Format of the thesis

This work is structured in the format of a conventional thesis comprising a series of chapters, none of which have yet been published.

A note on the use of quotations

In this thesis, direct quotations from the works of other writers are italicised and placed in double speech marks. Indented quotations are italicised. All emphases, parentheses, and ellipses are in the original work except for notations on missing words placed in square brackets [...] or added letters and words placed in square brackets, for example, [r]egistration. Single speech marks are used for colloquial terms or to emphasise particular terminology.

Statement of impact of COVID-19

The global SARS-Cov-2 (COVID-19) pandemic over the period 2020 to 2022 impacted this research, particularly the interview data collection. Even though interviews were held two years into the pandemic, they were conducted via videoconference or telephone, where the original intention was to interview participants face-to-face, wherever possible.

The pandemic may have dictated which personnel were interviewed. I interviewed government health policy stakeholders in one of the most challenging periods of health policy upheaval. Within the departments of health, there may have been staffing movements, changes, and secondments due to the mobilisation of personnel to respond to the health crisis. The pandemic may have also affected participants who were interviewed in other stakeholder groups, as professional or consumer advocacy leaders may have been dealing with issues related to the pandemic on behalf of their organisations.

Published and unpublished works not forming part of the thesis

Publications related to the research study

Journal articles

Carè, J., Steel, A., & Wardle, J. (2021). Stakeholder attitudes to the regulation of traditional and complementary medicine professions: A systematic review. *Human Resources for Health*, 19(1), 42. <https://doi.org/10.1186/s12960-021-00579-y>

Leslie, K., Bourgeault, I.L., Carlton, A-L., Balasubramanian, M., Mirshahi, R., Short, S., Carè, J., Cometto, G., & Lin, V. (2023). Design, operation and strengthening of health practitioner regulation systems: A rapid integrative review. *Human Resources for Health*, 21(1), 72. <https://doi.org/10.1186/s12960-023-00848-y>

Published conference abstracts

Carè, J. (2021). Stakeholder attitudes to the statutory regulation of traditional and complementary medicine professions: A critical systematic review. National Symposium on Herbal and Naturopathic Medicine, Gold Coast, Australia. 1-2 May 2021. Abstract published: *Australian Journal of Herbal and Naturopathic Medicine*, 2021, 33(1):23.

Research Reports

Carlton, A-L., Leslie, K., Bourgeault, I.L., Balasubramanian, M., Mirshahi, R., Short, S., Carè, J., & Lin, V. (2024). *Health practitioner regulation systems: A large-scale rapid review of the design, operation and strengthening of health practitioner regulation systems*. Working Paper Series, January 2024. Canadian Health Workforce Network. https://www.hhr-rhs.ca/images/PDFs/HPRS_Report_Jan.2024.pdf

Carlton, A-L., Ridoutt, L., Carè, J., Atkinson, N., & Nancarrow, S. (2024). *Ministry of Health Malaysia. Technical support to develop a comprehensive/sustainable credentialing, competency and capability framework for the Allied Health Professions*. June 2024. AHP Workforce.

Ridoutt, L., Carlton, A-L., Carè, J., Atkinson, N., & Nancarrow, S. (2024). *Ministry of Health Malaysia. Allied Health Workforce Capability Framework*. June 2024. AHP Workforce.

Carlton, A-L., Carè, J., Myers, S.P., Doolan, A., Gerontakos, S., & Steel, A. (2025). *Assuring safe and integrated health care. A review of the risks, benefits, and regulatory requirements for the professions of naturopathy and Western herbal medicine*. A research report commissioned by the members of the Australian Naturopathic Council. April 2025. Australian Naturopathic Council.

Presentations

Carè, J. (2021, May 1-2). *Stakeholder attitudes to the regulation of traditional and complementary medicine professions: A systematic review* [Conference presentation]. National Symposium on Herbal and Naturopathic Medicine, Naturopaths and Herbalists Association of Australia, Gold Coast, Australia.

Carè, J. (2024, November 1-5). *Policy, politics and power in health practitioner regulation: Policy stakeholder perspectives regarding the occupational regulation of non-registered allied health professions* [Conference presentation]. International Allied Health Conference 2024, National University Health System, Singapore.

Carè, J. (2025, February 13). *Policy, politics and power in health practitioner regulation: Stakeholder perspectives regarding the occupational regulation of non-registered allied health professions* [Online presentation]. Allied Health Perspectives Series, The Allied Health Academy.

Invited lectures

Carè, J. (2024, February 23). *Perspectives of health care stakeholders regarding the occupational regulation of non-registered health professions* [Online guest lecture]. Health Law and Ethics, Flinders University, Adelaide, Australia.

Presentations and submissions

Carè, J., & Carlton, A-L. (2024, April 2). *Perspectives of health care stakeholders regarding the occupational regulation of non-registered health professions* [Online presentation to the Victorian Chief Allied Health Officer and staff].

Carè, J. (2024, October 13). Submission to the Independent Reviewer. Regulating for results. Review of complexity in the National Registration and Accreditation Scheme. Consultation paper 1. Australian Government, Department of Health and Aged Care.

Publications unrelated to the research study

Journal articles

Aucoin, M., Cooley, K., Saunders, P.R., Carè, J., Anheyer, D., Medina, D.N., Cardozo, V., Remy, D., Hannan, N., & Garber, A. (2020). The effect of *Echinacea* spp. on the prevention or treatment of COVID-19 and other respiratory tract infections in humans: A rapid review. *Advances in Integrative Medicine*, 7(4):203-217. <https://doi.org/10.1016/j.aimed.2020.07.004>

Barnes, L.A., Leach, M., Anheyer, D., Brown, D., Carè, J., Lauche, R., Medina, D.N., Pinder, T-A., Bugarcic, A., & Steel, A. (2020). The effects of *Hedera helix* on viral respiratory infections in humans: A rapid review. *Advances in Integrative Medicine*, 7(4):222-226. <https://doi.org/10.1016/j.aimed.2020.07.012>

Harnett, J., Oakes, K., Carè, J., Leach, M., Brown, D., Cramer, H., Pinder, T-A., Steel, A., & Anheyer, D. (2020). The effects of *Sambucus nigra* berry on acute respiratory viral infections: A rapid review of clinical studies. *Advances in Integrative Medicine*, 7(4):240-246. <https://doi.org/10.1016/j.aimed.2020.08.001>

Manuscripts under peer review

Steel, A., Lee, W., Xu, Z., Carè, J., Cortez Ramirez, J., Thomson-Casey, C., & Vilcins, D. (2025). The influence of environmental exposures during the preconception period on offspring outcomes: A systematic review. *BMC Public Health*.

Book chapters

Carè, J., Smith, C., Burgos-Arias, A., & Seely, D. (2021). Complex Naturopathic Interventions. In I. Lloyd, A. Steel, and J. Wardle (Eds). *Naturopathy: practice, effectiveness, economics and safety* (pp. 385-412). *World Naturopathic Federation*.
<https://worldnaturopathicfederation.org/project/health-technology-assessment-naturopathy/>

Invited conference presentations

Carè, J. (2022, October 22). *Complex naturopathic interventions* [Recorded conference presentation]. Presentation to the International Day of Natural Medicine. Institute of Natural Medicine in Chile, and the Naturopaths Foundation for Chile, Chile.

TABLE OF CONTENTS

Certificate of original authorship	i
Acknowledgements	ii
Format of the thesis	iv
A note on the use of quotations.....	v
Statement of impact of COVID-19	vi
Published and unpublished works not forming part of the thesis	vii
List of tables	xvi
List of figures	xvii
List of textboxes	xviii
Abbreviations	xix
Definitions	xxii
Abstract	xxiv
CHAPTER 1. INTRODUCTION	1
1.1 Introduction	1
1.1.1 Background	1
1.1.2 Research aim and objectives	4
1.1.3 Significance and scope of the research	5
1.1.4 Thesis structure and outline	7
1.1.5 Contribution to knowledge.....	9
1.2 Professions and professionalisation	10
1.2.1 Definitional orientation	11
1.2.2 Theories of the professions	11
1.2.3 Professionalisation and the role of licensure	18
1.2.4 The role of professional associations	20
1.3 Policy-making theories of regulation	22
1.3.1 Public interest theories.....	23
1.3.2 Private interest theories	23
1.3.3 Structural interests theory.....	25
1.4 Strategies of regulation.....	26
1.4.1 Responsive regulation	26
1.4.2 Smart regulation	26
1.4.3 Really responsive regulation.....	27
1.4.4 Risk-based regulation	27
1.5 Regulation and governance	28
1.6 Global trends in health practitioner regulation	30
1.7 Health practitioner regulation in Australia	33
1.7.1 Self-regulation	34
1.7.2 Credentialling.....	35
1.7.3 Co-regulation	35
1.7.4 Negative licensing.....	35
1.7.5 Statutory registration	36
1.7.6 Comparison of health practitioner regulation systems	37
1.8 Chapter summary	38
CHAPTER 2. ENGAGING WITH THE LITERATURE.....	40
2.1 Introduction	40
2.2 Selection of professions	41
2.3 Scoping review methods.....	41
2.3.1 Review protocol and search strategy	41
2.3.2 Study selection and eligibility criteria.....	43
2.3.3 Data extraction and appraisal.....	43
2.3.4 Data analysis and synthesis	43
2.4 Findings.....	44
2.4.1 Study characteristics.....	45

2.4.2	Quality appraisal	47
2.4.3	Findings from respondent surveys	48
2.4.4	Findings from interviews, focus groups, and qualitative results of surveys	53
2.5	Discussion	67
2.5.1	Key findings.....	67
2.5.2	Professions examined.....	72
2.5.3	Stakeholders investigated	74
2.5.4	Interpretive frameworks and theories in HPR research	76
2.5.5	HPR research agenda for non-registered health professions in Australia	77
2.6	Chapter summary	78
CHAPTER 3. PHILOSOPHY AND THEORY		80
3.1	Introduction	80
3.2	Philosophical orientation and research paradigm	82
3.2.1	Overview.....	82
3.2.2	Critical social research	82
3.2.3	Ontology and epistemology.....	84
3.3	Theoretical framework	87
3.3.1	A review of class and boundary theories of the professions.....	87
3.3.2	Neo-Weberian social closure theory	88
3.3.3	Giddens' structuration theory	89
3.3.4	Bourdieuian theory	92
3.4	Chapter summary	105
CHAPTER 4. RESEARCH DESIGN AND METHODS		106
4.1	Introduction	106
4.2	Research Design.....	107
4.2.1	Research approach, strategy, and logic of inquiry	107
4.2.2	Qualitative multi-method sequential research design	109
4.2.3	Selection of professions for investigation	110
4.3	Methods of data generation, analysis, and interpretation.....	113
4.3.1	Research Phase 1: Document analysis – mapping the HPR field	115
4.3.2	Research Phase 2: Document analysis – positions on and perspectives of HPR	118
4.3.3	Research Phase 3: Key informant interviews – perspectives and experiences of HPR	122
4.3.4	Research Phase 4: Theoretical analysis and interpretation of study results	134
4.4	Research quality and validity	137
4.4.1	Researcher position	137
4.4.2	Research rigour.....	138
4.4.3	Triangulation.....	140
4.4.4	Ethical considerations and procedures.....	140
4.5	Power balance	140
4.6	Chapter summary	142
RESEARCH PHASE 1. THE REGULATORY FIELD.....		143
CHAPTER 5. MAPPING THE HEALTH PRACTITIONER REGULATION FIELD IN AUSTRALIA		145
5.1	Key players in health practitioner regulation	145
5.1.1	Statutory governance arrangements underpinning the National Scheme.....	145
5.1.2	Statutory codes and bodies regulating health practitioners	149
5.1.3	Non-statutory health practitioner regulation bodies	151
5.2	Policy and regulatory contexts for Health Practitioner Regulation	157
5.2.1	The Australian Constitution and Health Practitioner Regulation	157
5.2.2	Setting the ground rules – mutual recognition legislation 1992	158
5.2.3	Genesis of a national law – Productivity Commission Review	161
5.2.4	Paving the way for a national registration scheme for health professionals	162
5.2.5	The road to registration – agreement for a single national registration scheme.....	163
5.2.6	Commencement of the National Scheme	166
5.2.7	Non-registered health professions	168
5.2.8	Regulatory stewardship	174
5.3	Institutional contexts for regulating non-registered health practitioners.....	175

5.3.1	Statutory regulators.....	177
5.3.2	National co-regulation arrangements	182
5.3.3	Other institutional recognition	193
5.4	Mapping the non-registered healthcare workforce	195
5.4.1	Size of the workforce	195
5.4.2	Consumer consultations	197
5.4.3	Public spending.....	198
5.4.4	Registered professions nationally and internationally	199
5.5	Summary of institutional mapping	201
5.6	Chapter summary	207
RESEARCH PHASE 2. DESCRIPTIVE AND QUALITATIVE ANALYSIS OF DOCUMENT SOURCES		209
CHAPTER 6. DOCUMENTED STAKEHOLDER POSITIONS ON REGULATION		210
6.1	Introduction	210
6.2	Overview of the document corpus	214
6.3	Stakeholder positions on health practitioner regulation.....	215
6.3.1	Stakeholders taking a consistent position or dual positions on regulation	225
6.3.2	Positions on regulation not stated or unclear/ambiguous	228
6.3.3	Positions on regulation – professions with single and multiple representation	228
6.3.4	Positions on regulation – consumer bodies, government, and individuals	229
6.3.5	Member views of health practitioner regulation	230
6.4	Stakeholder perspectives of health practitioner regulation	230
6.4.1	Perspectives of registration	230
6.4.2	Perspectives of self-regulation	232
6.4.3	Perspectives of co-regulation	233
6.4.4	Perspectives of dual regulation arrangements.....	234
6.4.5	Perspectives of negative licensing and the National Code of Conduct	234
6.4.6	Perspectives of regulation for position not stated or unclear/ambiguous.....	236
6.5	Stakeholder assessments against the Intergovernmental Agreement assessment criteria	236
6.5.1	Criterion 1. Is it appropriate for Health Ministers to exercise responsibility for regulating the profession in question, or does the profession more appropriately fall within the domain of another Ministry?.....	243
6.5.2	Criterion 2. Do the activities of the profession pose a significant risk of harm to the health and safety of the public?	243
6.5.3	Criterion 3. Do existing regulatory or other mechanisms fail to address health and safety issues?	245
6.5.4	Criterion 4. Is regulation possible to implement for the profession in question?.....	246
6.5.5	Criterion 5. Is regulation practical to implement for the profession in question?	247
6.5.6	Criterion 6. Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?.....	248
6.6	Chapter summary	249
CHAPTER 7. DOCUMENTED STAKEHOLDER PERSPECTIVES OF REGULATION		250
7.1	Introduction	250
7.2	Theme 1. Strong regulation is better for consumers	256
7.2.1	Registration is about protecting the public	262
7.2.2	It's the government's job to protect consumers	263
7.2.3	Stronger regulation inspires trust and confidence	264
7.2.4	Conflicting perspectives on the adequacy of complaints handling	265
7.2.5	Registration may deliver better healthcare.....	268
7.3	Theme 2. Strong regulation is better for practice and practitioners	269
7.3.1	Strong regulation protects professional titles and practice entry	274
7.3.2	Strong regulation upholds professional integrity	278
7.3.3	Registration fosters interprofessional cooperation.....	283
7.3.4	Registration mitigates against practice risks	284
7.4	Theme 3. Statutory registration is better for professions	285
7.4.1	Registration elevates practitioner and professional standing	290
7.4.2	Registration provides independent and transparent governance.....	291

7.4.3	Registration facilitates workforce planning and mobility.....	294
7.5	Theme 4. In the wake of the NRAS	296
7.5.1	The fears of inclusion.....	301
7.5.2	The fallout from exclusion.....	304
7.5.3	We're compelled to take matters into our own hands	309
7.6	Chapter summary	311
RESEARCH PHASE 3. QUALITATIVE ANALYSIS OF STAKEHOLDER INTERVIEWS		314
CHAPTER 8. NO PLACE IN THE FIELD. PERSPECTIVES OF CONSUMER ADVOCATES.....		317
8.1	Introduction	317
8.2	Theme 1. I want to be able to trust my practitioner.....	318
8.2.1	"Protecting the public is a fundamental point of government"	319
8.2.2	Consumers expect and assume practitioners are registered	320
8.3	Theme 2. Government regulation affects my care	322
8.3.1	Government regulation promotes practitioner integrity and quality	323
8.3.2	Registration may deliver better care, exclusion hinders access to care.....	325
8.4	Theme 3. I don't want "boys' club" regulation	329
8.4.1	No logic, no consistency about who is registered	329
8.4.2	Trust in governments to regulate practitioners	334
8.4.3	Distrust of government decision-making about who to register.....	339
8.5	Chapter summary	341
CHAPTER 9. KEEPERS OF THE FIELD. PERSPECTIVES OF HEALTH POLICY ACTORS.....		343
9.1	Introduction	343
9.2	Theme 1. Statutory registration serves a purpose.....	344
9.2.1	"The fundamental purpose is to protect the public"	345
9.2.2	Registration promotes practitioner reputability	346
9.2.3	Registration brings professional recognition but not necessarily acceptance	350
9.3	Theme 2. Regulation may or may not be fit for purpose.....	352
9.3.1	Regulation mechanisms "perform reasonably well"	352
9.3.2	"Undoubtedly, there's inconsistencies" between who is and is not registered.....	357
9.3.3	Debating disadvantage experienced by non-registered professions	362
9.4	Theme 3. The written and unwritten rules of NRAS entry	364
9.4.1	The long road to registration.....	365
9.4.2	Courting people in high places	377
9.4.3	The unwritten rules for NRAS entry	386
9.4.4	Statutory registration as a last resort	390
9.5	Chapter summary	394
CHAPTER 10. A PLACE IN WHICH FIELD? PERSPECTIVES OF PROFESSION REPRESENTATIVES.....		397
10.1	Introduction	397
10.2	Theme 1. Strong regulation is better for consumers	399
10.2.1	Statutory registration is about protecting the public	400
10.2.2	Stronger regulation inspires trust and confidence	401
10.2.3	Statutory registration provides somewhere to go when things go wrong.....	404
10.3	Theme 2. Strong regulation is better for practitioners and professions.....	406
10.3.1	Conflicting perspectives on the adequacy of self-regulation	407
10.3.2	Stronger regulation is essential to professional integrity.....	413
10.3.3	We're compelled to take matters into our own hands	418
10.3.4	Deemed or doomed to be considered low risk?	421
10.4	Theme 3. Needing recognition, wanting to be heard	423
10.4.1	Registration is a club and we're not invited	424
10.4.2	Wanting a "seat at the table" to avoid exclusion	428
10.4.3	No logic, no consistency about who is registered	432
10.5	Theme 4. The unwritten rules for NRAS entry.....	434
10.5.1	The unwritten 'criteria' for club membership	435
10.5.2	Courting people in high places	442
10.5.3	We're on a road to nowhere	447

10.6 Chapter summary	450
RESEARCH PHASE 4. THEORETICAL ANALYSIS AND INTERPRETATION OF STUDY RESULTS ..	452
CHAPTER 11. A BOURDIEUSIAN ANALYSIS AND INTERPRETATION OF STAKEHOLDER PERSPECTIVES OF REGULATION	453
11.1 Introduction	453
11.2 The influence of economic capital on stakeholder perspectives	453
11.2.1 The costs of registration	454
11.2.2 The costs of self-regulation	454
11.2.3 Potential economic rewards from registration	457
11.2.4 Weighing up the costs and benefits of registration	457
11.3 The importance of cultural capital to professions	459
11.3.1 The institutionalised cultural capital of standards, titles, registers, registration, and qualifications	459
11.3.2 The embodied cultural capital of evidence-based practice	467
11.4 The need to cultivate social capital to progress professional claims	470
11.4.1 Social capital as a source of power	470
11.4.2 Social capital and symbolic violence	472
11.4.3 Social capital and cross-jurisdictional agreement	475
11.4.4 Intra-professional social capital	477
11.5 The ‘capital’ of risk in demonstrating registration worthiness	480
11.5.1 Definitional ambiguity of risk	481
11.5.2 Risk and risk assessment	482
11.5.3 Risk and standards of education and training	487
11.5.4 Risk and self-regulation	488
11.6 Where capital meets power: symbolic capital in health practitioner regulation	492
11.6.1 The symbolic capital of registration	493
11.6.2 The symbolic capital of co-regulation, self-regulation, and Medicare	495
11.6.3 The symbolic power of the state and state agents	497
11.7 A Bourdieusian analysis and interpretation of the health practitioner regulation field in Australia	503
11.8 Chapter summary	509
CHAPTER 12. DISCUSSION	511
12.1 Introduction	511
12.2 Key findings from primary studies of stakeholder perspectives	511
12.3 Key findings from an analysis and interpretation of stakeholder perspectives	513
12.4 Towards a health practitioner regulation reform agenda	517
12.4.1 Amplifying the consumer voice	518
12.4.2 Minimising the reliance on ‘focusing events’	521
12.4.3 Enhancing registration assessment guidelines	524
12.4.4 Re-establishing government stewardship of HPR reform	527
12.4.5 Reviewing the regulatory settings of non-registered professions	531
12.5 Recommendations	536
12.6 Limitations	541
12.7 Future research	542
12.8 Reflections on the use of Bourdieusian theory in HPR research	543
12.9 Chapter summary	544
CONCLUSION	545
Research contribution	546
Significance	550
Research impact	550
Concluding statements	551
APPENDICES	552
Appendix 1: Search protocol for scoping review	552
Appendix 2: Scoping review study characteristics and summary of findings	562

Appendix 3: Scoping review critical appraisal summary tables.....	574
Appendix 4: Eligibility criteria for assessing professions for study inclusion.	576
Appendix 5: Document sources for mapping events and decisions relating to HPR.	584
Appendix 6: Data sources for documents included in document analysis.....	593
Appendix 7: Professional bodies excluded from the interview recruitment schedule.	600
Appendix 8: Interview guides for stakeholder interviews.....	602
Appendix 9: Events and policy decisions regarding health practitioner regulation.	610
Appendix 10: Workers' compensation arrangements for naturopaths in Australia.	616
Appendix 11: Table of documents meeting inclusion criteria for document analysis.	618
Appendix 12: Documents retrieved for the Australian Association of Social Workers.	657
REFERENCES	659

List of tables

Table 1.1: Non-registered health professions examined in the research study.	4
Table 1.2: Workforce data for selected professions.	6
Table 1.3: Regulation status of selected health practitioners in selected countries.	32
Table 1.4: Comparison of key features of four types of occupational regulation.	39
Table 2.1: Search terms used in MEDLINE (via Ovid).	42
Table 2.2: Study characteristics.	46
Table 2.3: Themes and sub-themes found in each study in the review.	54
Table 4.1: Non-registered health professions in Australia as of 1 July 2012.	111
Table 4.2: Assessment domains and criteria used for selection of health professions.	112
Table 4.3: Health professions meeting the eligibility criteria for study inclusion.	113
Table 4.4: The four phases of the study design.	114
Table 4.5: Data sources and analysis approaches for data collection.	114
Table 4.6: Summary of search strategy for document analysis.	120
Table 4.7: Professional bodies included in the recruitment schedule and the profession represented.	126
Table 4.8: Professions represented by peak professional and voluntary registering bodies.	128
Table 4.9: List of registered and non-registered practitioners presented to interview informants.	131
Table 5.1: Representative arrangements for non-registered professions included in the research.	155
Table 5.2: Registered professions prior to and following the establishment of NRAS.	167
Table 5.3: Health complaints entities, commencement year, portfolio responsibilities, and reporting.	179
Table 5.4: Jurisdiction and year the National Code of Conduct was legislated and adopted.	181
Table 5.5: Professional associations recognised for government benefits to consumers/practitioners.	184
Table 5.6: Eligibility criteria for Medicare-eligible non-registered professions.	187
Table 5.7: The five largest private health insurers in Australia by market share.	189
Table 5.8: Professional associations recognised by private health insurers.	191
Table 5.9: Institutions recognising non-registered professions as allied health and occupations.	194
Table 5.10: Workforce numbers for registered allied health professions from Census data and the Ahpra Annual Report, and calculated rate of difference.	196
Table 5.11: Estimated number of practitioners in specified non-registered professions.	197
Table 5.12: Consumer consultations with non-registered practitioners.	198
Table 5.13: Public spending on specified non-registered professions.	199
Table 5.14: Regulation status of selected health practitioners in selected countries.	200
Table 5.15: Consolidated map of institutional recognition for non-registered professions.	203
Table 6.1: Documents classified by document type, profession, and organisation type.	212
Table 6.2: Documents categorised by organisation.	213
Table 6.3: Documents categorised by profession and position on regulation.	217
Table 6.4: Documents categorised by organisation and position on regulation.	218
Table 6.5: Documents addressing assessment criteria categorised by profession and organisation.	238
Table 7.1: Document frequency counts for themes by profession and organisation.	253
Table 7.2: Document frequency counts for Theme 1 by profession and organisation.	257
Table 7.3: Document frequency counts for Theme 2 by profession and organisation.	271
Table 7.4: Document frequency counts for Theme 3 by profession and organisation.	287
Table 7.5: Document frequency counts for Theme 4 by profession and organisation.	298
Table 8.1: Summary of stakeholder interview schedule.	315

List of figures

Figure 1.1: Regulation terms relevant to Australian health practitioners.	3
Figure 2.1: PRISMA flowchart of literature search and study selection.	44
Figure 2.2: Stakeholder attitudes presented as percentages reported in included studies.	50
Figure 2.3: Themes and sub-themes generated from included studies.	53
Figure 2.4: Theme 1. Regulating entry to and conduct of practice.	56
Figure 2.5: Theme 2. Implications for practitioners and professions.	60
Figure 2.6: Theme 3. Regulating for public safety, consumer protection, and quality of patient care.	65
Figure 3.1: Critical realism domains.	85
Figure 3.2: The relationship between structure and agency potentially operating in health practitioner regulation.	90
Figure 4.1: Workflow of phases of analysis linking research objectives to study outputs.	108
Figure 4.2: Model of interview styles generally employed in stakeholder interviews.	131
Figure 5.1: Governance arrangements underpinning the National Scheme.	146
Figure 5.2: Name changes of government bodies and date of change.	146
Figure 5.3: Summary of key events and decisions in health practitioner regulation 1992–2024.	159
Figure 6.1: Selection process for document sources.	211
Figure 7.1: Themes and sub-themes generated from document sources.	251
Figure 7.2: Theme 1. Strong regulation is better for consumers.	256
Figure 7.3: Theme 2. Strong regulation is better for practice and practitioners.	270
Figure 7.4: Theme 3. Statutory registration is better for professions.	286
Figure 7.5: Theme 4. In the wake of the NRAS.	297
Figure 8.1: Themes and sub-themes generated from interviews with consumer advocates.	318
Figure 8.2: Theme 1. I want to be able to trust my practitioner.	319
Figure 8.3: Theme 2. Government regulation affects my care.	322
Figure 8.4: Theme 3. I don't want "boys' club" regulation.	329
Figure 9.1: Themes and sub-themes generated from interviews with health policy actors.	344
Figure 9.2: Theme 1. Statutory registration serves a purpose.	345
Figure 9.3: Theme 2. Regulation may not be fit for purpose.	352
Figure 9.4: Theme 3. The written and unwritten rules for NRAS entry.	365
Figure 10.1: Themes and sub-themes generated from interviews with profession representatives.	399
Figure 10.2: Theme 1. Strong regulation is better for consumers.	400
Figure 10.3: Theme 2. Strong regulation is better for practitioners and professions.	407
Figure 10.4: Theme 3. Needing recognition, wanting to be heard.	424
Figure 10.5: Theme 4. The unwritten rules of NRAS entry.	435
Figure 11.1: A Bourdieusian conceptual model of the health practitioner regulation field in Australia.	504
Figure 12.1: Themes generated from stakeholder perspectives of regulation (documents and interviews).	514

List of textboxes

Textbox 4.1: Data analysis procedure for mapping the field.	119
Textbox 4.2: Data analysis procedure for stakeholder document sources.....	123
Textbox 4.3: Data analysis procedure for stakeholder interviews.	133
Textbox 11.1 Health practice activities and procedures used to assess risks of a profession.....	483

Abbreviations

AA	Audiology Australia
AACHP	Australian Association of Clinical Hypnotherapy and Psychotherapy
AASW	Australian Association of Social Workers
ABC	Australian Broadcasting Corporation
ABS	Australian Bureau of Statistics
ACA	Australian Counselling Association
ACAU	Australasian Council of Ambulance Unions
ACAud	Australian College of Audiology
ACCA	Australian Community Counselling Association
ACCC	Australian Competition and Consumer Commission
ACP	Australasian College of Paramedicine
ACPP	Australasian College of Paramedic Practitioners
ACT	Australian Capital Territory
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHMAC	Australian Health Ministers' Advisory Council
AHPA	Allied Health Professions Australia
Ahpra	Australian Health Practitioner Regulation Agency (Ahpra uses sentence case for its acronym)
AIHW	Australian Institute of Health and Welfare
AHWMC	Australian Health Workforce Ministerial Council
AMA	Australian Medical Association
AMT	Association of Massage Therapists
ANC	Australian Naturopathic Council
ANPA	Australian Naturopathic Practitioners Association
ANTA	Australian Natural Therapists Association
ANZCPerf	Australian and New Zealand College of Perfusionists
ANZPara	Australian and New Zealand College of Paramedicine
AOB	Australian Orthoptic Board
AQF	Australian Qualifications Framework
ARCAP	Australian Register of Counsellors and Psychotherapists
ARONAH	Australian Register of Naturopaths and Herbalists
ASA	Australasian Sonographers Association
ASAR	Australian Sonographer Accreditation Registry
ASCPV	Australasian Society of Cardiovascular Perfusionists
ASMIRT	Australian Society of Medical Imaging and Radiation Therapy

ASUM	Australasian Society for Ultrasound in Medicine
ATMS	Australian Traditional Medicine Society
ATO	Australian Taxation Office
CAA	Council of Ambulance Authorities
CCAA	Christian Counsellors Association of Australia
CHC	COAG Health Council
CHCA	Complementary Healthcare Council of Australia
CMA	Complementary Medicine Association
COAG	Council of Australian Governments
CPD	Continuing professional development
DA	Dietitians Australia
DOHAC	Australian Government, Department of Health and Aged Care
DPMC	Australian Government, Department of the Prime Minister and Cabinet
DVA	Department of Veterans' Affairs
ESSA	Exercise and Sports Science Australia
GPs	General practitioners
GST	Goods and Services Tax
HAASA	Hearing Aid Audiology Society of Australia
HCE	Health complaints entity
HCEF	Health Chiefs Executive Forum
HCCC	Health Care Complaints Commission of New South Wales
HCPC	Health and Care Professions Council
HMM	Health Minister's Meeting
HPR	Health practitioner regulation
IAA	Independent Audiologists Australia
IGA	Intergovernmental Agreement
MA	Massage Australia
MAA	Myotherapy Association Australia
MMA	Massage and Myotherapy Australia
MRA	Mutual Recognition Act
NASRHP	National Alliance of Self Regulating Health Professions
National Law	Health Practitioner Regulation National Law
NCAU	National Council of Ambulance Unions
NCC	National Code of Conduct
NHAA	Naturopaths and Herbalists Association of Australia
NRAS	National Registration and Accreditation Scheme

NSW	New South Wales
NSW HCCC	New South Wales, Health Care Complaints Commission
NZ	New Zealand
NZ MOH	New Zealand Ministry of Health
NT	Northern Territory
OA	Orthoptics Australia
OBPR	Office of Best Practice Regulation (now known as OIA)
OIA	Office of Impact Analysis (formerly OBPR)
OSCA	Occupation Standard Classification for Australia
OTBOQ	Occupational Therapists Board of Queensland
PA	Paramedics Australasia
PACFA	Psychotherapy and Counselling Federation of Australia
Parliament of COA	Parliament of the Commonwealth of Australia
PC	Productivity Commission
PRISMA	Preferred reporting items for systematic reviews and meta-analyses.
PROSPERO	International prospective register of systematic reviews
Qld	Queensland
RACGP	Royal Australian College of General Practitioners
SA	South Australia
SDC	Social Development Committee
SPA	Speech Pathology Australia
Tas	Tasmania
TGA	Therapeutic Goods Administration
UK	United Kingdom
UK DOH	UK Department of Health
UK PSA	United Kingdom Professional Standards Authority
Vic	Victoria
Vic DOHS	Department of Human Services Victoria
Vic HCC	Victorian Health Complaints Commissioner
WA	Western Australia
WHM	Western herbal medicine
WHO	World Health Organization

Definitions

Accreditation	Refers to a process for assessing practitioners against required standards. Accreditation may refer to assessing that a person meets the required standards for acceptance to a professional body. Accreditation may also refer to a process through which qualifying courses are assessed as meeting acceptable standards required of a graduate of the course.
Co-regulation	A type of regulation where government and non-government institutions delegate or recognise certain functions performed by self-regulating professional bodies, which may be conditional on the professional body meeting governance and certification standards and processes. Co-regulation may be statutory or non-statutory.
Credentialling	A process of verifying practitioner qualifications or experience to assess suitability and competence for a role as a healthcare provider. Credentialling has no statutory basis and is used by employers, governments, and other institutions to assess the eligibility of practitioners not registered under the National Registration and Accreditation Scheme, generally for employment purposes or to provide funded health services.
Health practitioner regulation	A subset of occupational regulation that encompasses the statutory and non-statutory regulation mechanisms that apply to health practitioners.
Negative licensing	An arrangement where there is no legal restriction on practice entry, irrespective of training or skill level. Practitioners may be prohibited from practising if they are found to be in breach of the standards set by the legislation and their continued practice is deemed to present a serious risk to the public.
Occupational regulation	Refers to the statutory and non-statutory mechanisms directed at regulating entry to and practice of an occupation.
Non-registered practitioner	A health practitioner not registered under the <i>Health Practitioner Regulation National Law</i> .
Registered practitioner	A health practitioner registered under the <i>Health Practitioner Regulation National Law</i> .

Self-regulation	A type of health practitioner regulation where a group of persons or bodies perform a regulatory function with respect to themselves and others who accept their authority. Also referred to as voluntary certification or voluntary self-regulation.
Statutory registration	A type of health practitioner regulation where the regulatory functions are set out in legislation and a government regulatory body is established independently of the profession with powers to regulate and register practitioners. It involves the granting of a license to practice an occupation (occupational licensure).
Statutory regulation	A type of health practitioner regulation where the state or a state agency specifies, administers, and enforces the regulation of health practitioners. In Australia, statutory regulation includes statutory registration and negative licensing.
Voluntary regulation/ certification	A type of health practitioner regulation where a group of persons or bodies perform a regulatory function with respect to themselves and others who accept their authority. Also referred to as self-regulation or voluntary self-regulation.

Abstract

Background: This research examines the perspectives and experiences of healthcare stakeholders: consumer advocates, government health policy officers, and professional body representatives, regarding the occupational regulation of fifteen health professions not registered under Australia's *Health Practitioner Regulation National Law* as of 1 July 2012.

Theory and methods: A qualitative research design comprising four analytic research phases was employed: descriptive analysis of the key policies and decisions leading to the *National Law* and the regulation arrangements governing non-registered professions; descriptive and thematic analyses of 560 documents identifying stakeholder positions and perspectives regarding occupational regulation; thematic analysis of 42 interviews with 46 key informants to ascertain stakeholder perspectives and experiences of regulation; and analysis and interpretation of stakeholder perspectives using the theoretical concepts of Pierre Bourdieu within a critical realist meta-theory.

Results: Statutory registration was commonly perceived as protecting the public. The Scheme giving effect to the *National Law* was considered to promote consumer trust and confidence in practitioners, assure quality and competence, uphold professional integrity, and elevate professional standing. There were mixed views on the type of occupational regulation that best protected the public from non-registered practitioners. There was little agreement within and between stakeholder cohorts about which professions should be registered. Consumer advocates and most profession representatives considered health practitioner regulation the responsibility of governments. Policy actors and profession representatives commonly regarded the decision-making processes for assessing professions for registration as complex. Political and professional lobbying were considered to influence government decision-making. While most respondents perceived further regulatory measures necessary for certain non-registered professions, there was no consistent view on what those measures should be or for which professions. Respondents drew on concepts such as registration costs, decision-making complexity, practitioner qualifications, evidence-based practice, and professional disunity to argue for or against registration. A Bourdieusian theoretical

analysis and interpretation of stakeholder perspectives sheds light on the potential dynamics and politics of health practitioner regulation policy-making. The theoretical analysis offers insights into the motives and methods used by stakeholders to support their views on health practitioner regulation. The findings and interpretation support the premise of this thesis that health practitioner regulation in Australia operates as a Bourdieusian field of conflict and contestation between field occupants. Stakeholders used their position and power to argue for regulation arrangements according to their views, summoning Bourdieusian capitals to support their arguments.

Discussion and conclusion: Findings from this research indicate that while the policies, processes, and criteria exist to facilitate objective assessments of professions for statutory registration, the primary influence informing stakeholder perspectives is the politics surrounding health practitioner regulation. For health practitioner regulation policy to meet the needs of health consumers, reforms are needed to minimise the subjective nature of policy decision-making and limit the ability of social actors to influence policy outcomes for reasons inconsistent with the assessment criteria. To maintain consumer safety, it is the responsibility of governments to proactively assess non-registered health professions to ensure appropriate regulatory settings are in place. This is a responsibility in keeping with Australian health policy regulatory stewardship principles and the public protection paramount guiding principle of the *Health Practitioner Regulation National Law*.

Chapter 1

INTRODUCTION

1.1 Introduction

1.1.1 Background

Health practitioners in Australia are regulated through both statutory and non-statutory mechanisms. The primary statutory mechanism for occupational regulation is the *Health Practitioner Regulation National Law (National Law)*, which established the National Registration and Accreditation Scheme (NRAS) through which sixteen health professions are regulated in Australia¹. In this thesis, this mechanism is referred to as statutory registration or registration and the professions regulated under this mechanism are referred to as registered professions. Health professions not regulated under the NRAS, referred to in this thesis as non-registered professions, are regulated through two main mechanisms. These are statutory negative licensing arrangements under which practitioner codes of conduct are legislated in each Australian state and territory² and voluntary certification, referred to in this thesis as self-regulation³. These mechanisms are the key regulatory arrangements for health practitioner regulation in Australia. They are elaborated on in Section 1.7 of this chapter.

¹ The professions regulated under the NRAS are Aboriginal and Torres Strait Islander health practice, Chinese medicine, chiropractic, dental practice, midwifery, medical practice, medical radiation practice, nursing, occupational therapy, optometry, osteopathy, paramedicine, pharmacy, physiotherapy, podiatry, and psychology.

² Under state and territory negative licensing health complaints laws, a code of conduct sets minimum standards that must be met by any person who provides a health service. The laws include prohibition order powers to remove unfit persons from the health workforce if a breach of the code of conduct is sufficiently serious. Statutory codes of conduct apply to health services provided by non-registered practitioners and to registered practitioners providing health services unrelated to their registration (CHC, 2015d: 51).

³ The term 'self-regulation' is used in some international jurisdictions to refer to the statutory registration of practitioners, for instance, in Canada and the USA.

Two key terms are used in this thesis to describe the regulation of health practitioners: ‘occupational regulation’ and ‘health practitioner regulation’. Before defining these terms, there is a need to clarify what ‘health practitioner’ means in this thesis because the term has a legal definition in Australia. The *National Law* defines a health practitioner as “*an individual who practises a health profession*” and lists as a health profession 16 registered occupations (*Health Practitioner Regulation National Law Act 2009* (2024) (Qld): 32-33). Legal definition notwithstanding, the term ‘health practitioner’ is widely used to refer to registered and non-registered practitioners. For instance, the *Health Care Complaints Act 1993* in the Australian state of New South Wales (NSW) defines a health practitioner as “*a natural person who provides a health service (whether or not the person is registered under the Health Practitioner Regulation National Law)*”, and lists several non-registered professions providing health services (*Health Care Complaints Act 1993* (NSW): 12). The *NSW Public Health Act 2010* (2024) uses the same definition of health practitioner as the *NSW Health Care Complaints Act 1993* (*Public Health Act 2010* (2024), (NSW): 11). An Australian cross-jurisdictional ministerial advisory council reviewing the regulation arrangements of non-registered professions during 2011 and 2013 referred to non-registered healthcare providers as “*health practitioners*” (AHMAC, 2011b: 1, passim; AHMAC, 2013: 5, passim). These uses are in accordance with World Health Organization (WHO) terminology, which states that ‘health practitioner’ encompasses:

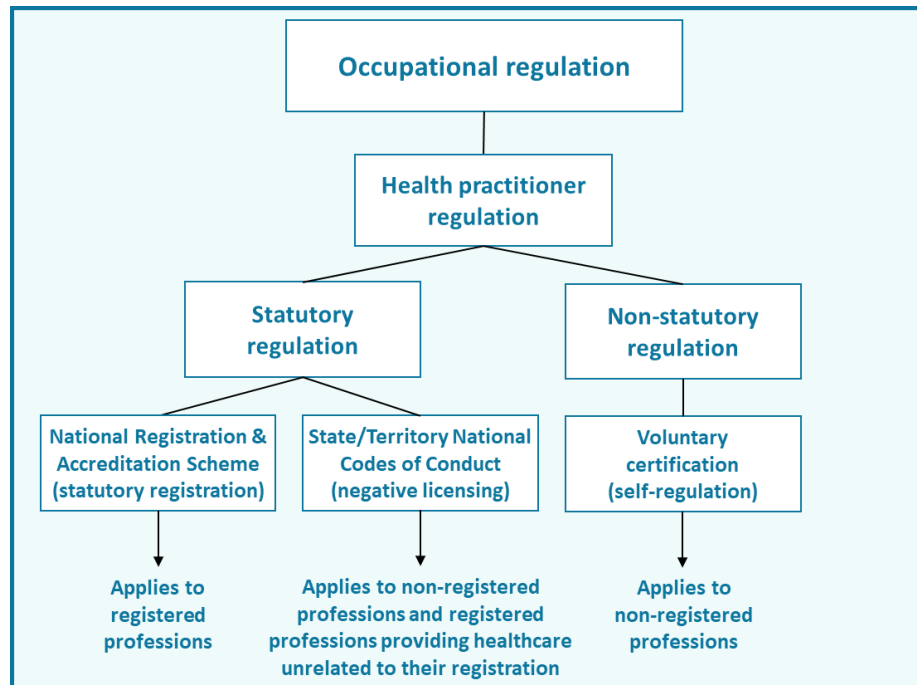
all health professionals, associate health professionals, including community health workers, personal care workers in health services (allopathy as well as traditional, complementary and integrative medicine), health assistants, the public health workforce, and other health practitioners who are yet to be officially classified, but who are directly involved in patient diagnostics or care.
(WHO, 2024: ix)

In this thesis, the term ‘health practitioner’ will be used to refer to both registered and non-registered health practitioners.

The terms occupational regulation and health practitioner regulation (HPR) also require clarification in this thesis, as the terms have been applied inconsistently in the literature. Koumenta et al. referred to occupational regulation as the “*legally defined requirements or rules that govern entry into occupations and subsequent conduct within them*” (2014:

16). In contrast, Carlton et al. defined occupational regulation in broader terms, incorporating both non-statutory and statutory mechanisms (2024: 35). In this thesis an expansive definition of occupational regulation is adopted that includes statutory and non-statutory arrangements regulating entry to and practice of an occupation. HPR is the subset of occupational regulation encompassing statutory and non-statutory regulation mechanisms that apply to health practitioners. Figure 1.1 presents a schematic summarising the different regulation terms, their relationship, and the key occupational regulation mechanisms that apply to Australian health practitioners.

Figure 1.1: Regulation terms relevant to Australian health practitioners.



In addition to taking an expansive perspective of occupational regulation in this thesis, I resolved to take a broad view of healthcare stakeholders as described by Freeman, who viewed governments as stakeholders because of their “stake” in the affairs of organisations (1984: 25). Therefore, in this study, government health policy officers were considered healthcare stakeholders.

This research investigates the perspectives of healthcare stakeholders regarding the regulation arrangements for 15 health professions that were not subject to regulation

under the *National Law* on 1 July 2012. The non-registered professions included in this study are listed in Table 1.1 (see Chapter 4, Section 4.2.3 for the selection procedure).

Table 1.1: Non-registered health professions examined in the research study⁴.

Audiology	Clinical perfusion
Counselling	Dietetics
Exercise physiology	Massage therapy
Myotherapy	Naturopathy
Orthoptics	Paramedicine ⁵
Psychotherapy	Social work
Sonography	Speech pathology
Western herbal medicine	

1.1.2 Research aim and objectives

This research investigates the perspectives and experiences of three stakeholder cohorts: consumer advocates, government health policy officers, and professional body representatives regarding the occupational regulation of 15 non-registered health professions in Australia. To achieve this aim, the research addresses the following four objectives:

1. To describe the regulatory policy and institutional history, contexts, and frameworks for the occupational regulation of health professions in Australia and the decision-making criteria and processes for determining the registration of professions under the *Health Practitioner Regulation National Law*.
2. To identify and describe publicly documented positions and perspectives of healthcare stakeholders regarding the occupational regulation of non-registered health professions.
3. To explore and describe the perspectives and experiences of healthcare stakeholders regarding the occupational regulation of non-registered health

⁴ In this thesis, references to ‘non-registered professions’ or ‘non-registered practitioners’ refer specifically to the fifteen professions listed in the table, as opposed to all non-registered health professions and practitioners practising in Australia.

⁵ Paramedicine was included as a ‘non-registered’ profession since it was not registered on 1 July 2012, the date set for selecting non-registered professions examined in this research.

professions, including perspectives of the policy and decision-making frameworks.

4. To theoretically analyse and interpret stakeholder perspectives of HPR, including the perceived complexities, challenges, and opportunities associated with regulating non-registered health professions in Australia and the perceived adequacy of and gaps in the current regulatory policy framework within which regulatory policy decision-making occurs.

This thesis does not aim to identify or recommend appropriate occupational regulation arrangements for specific non-registered health professions or the non-registered healthcare workforce as a whole. Instead, this research seeks to elicit and present the stances taken on occupational regulation by healthcare stakeholders based on their perceptions and experiences, the reasons for taking a particular position, and propose how these may influence HPR decision-making.

1.1.3 Significance and scope of the research

Globally, the health workforce is projected to rise to eighty million workers by 2030, almost double that of 2013 (Liu et al., 2017: 7). In Australia, healthcare and social assistance employment is forecast to increase by 25.9% to almost 2.9 million workers between 2024 and 2034 (Jobs and Skills Australia, n.d.). One of the fastest-growing cadres in the healthcare sector is allied health, with an expected 422,000 workers in 2034, an increase of 27.4% over ten years (Jobs and Skills Australia, n.d.). A sizeable proportion of this workforce is likely to be non-registered. While the number of non-registered practitioners in the 15 professions examined in this research is difficult to determine with accuracy, there are at least 160,000 practitioners and as many as 240,000 workers⁶ (ABS, 2021a; Ahpra, 2021a). This is around 20% to 30% of the size of the registered workforce.

⁶ No data repositories exist that accurately identify the number of non-registered health practitioners. To estimate the workforce numbers, data for registered allied health professions from the 2021 Australian Census was compared with registrant data for these professions reported in the 2021 Ahpra Annual Report and the percentage difference was calculated. Lower, median, and upper percentage rates of difference were applied to the 2021 Australian Census data for the non-registered professions included in this research. See: Chapter 5, Section 5.4.1 for further details.

Table 1.2 presents a selection of non-registered professions for which data are available, showing workforce increases over time. The number of registered health practitioners with similar or overlapping scopes of practice is included, where available, for comparison purposes. The available data suggest that some non-registered professions may be comparable in size to related registered professions.

Table 1.2: Workforce data for selected professions.

Non-registered practitioners Estimated number, % increase	Registered practitioners Actual number, % increase
Counsellors: 30,000 practitioners (AIHW, 2023: 260) 125% increase over ten years to 2018 (AIHW, 2019)	Psychologists: 48,240 practitioners 52.1% increase over ten years to 2024 (Ahpra, 2014; Ahpra, 2024a)
Social workers: 34,000 practitioners 101% increase over ten years to 2022 (AIHW, 2023: 256, 260)	
Naturopaths: 3,000 practitioners 56% increase over ten years to 2006 (ABS, 2008)	Chinese medicine practitioners: 4,853 practitioners 13.6% increase over ten years to 2024 (Ahpra, 2014; Ahpra, 2024a)
Speech pathologists: 11,470 practitioners 27% increase over three years to 2021 (SPA, 2023: 4, 13)	No comparable registered profession

In addition to the size of the non-registered workforce, National Health Survey data indicate that these professions have an extensive consumer reach in Australia. In 2014–2015, eight of the fifteen professions examined in this research consulted with an estimated 10% of the Australian population, or around 2.4 million consumers (ABS, 2017)⁷. Given that this estimate encompasses half the professions examined and is based on a survey conducted a decade ago, it is plausible that non-registered practitioners consult with well in excess of five million consumers annually.

In terms of public spending on health services provided by non-registered professions, data from three government-subsidised programs (Medicare, Department of Veterans’

⁷ Australian Bureau of Statistics National Health Survey 2014 provides data for consumers consulting with counsellors, audiologists, dietitians, herbalists, naturopaths, social workers, sonographers, and speech pathologists. No data could be located identifying the consultation rates for clinical perfusionists, exercise physiologists, massage therapists, myotherapists, orthoptists, paramedics, or psychotherapists.

Affairs, and National Disability Insurance Scheme) shows at least AUD\$367 million of public funding is spent annually on services provided by six of the fifteen professions under study (DVA, 2021: 8; AIHW, 2022; NDIA, 2023: 44)⁸. This figure excludes the hundreds of millions of dollars of private funding in out-of-pocket expenses consumers incur on a range of health services provided by non-registered practitioners. To illustrate, the out-of-pocket spending by Australians with a mental health disorder on treatment from massage therapists, naturopaths, and Western herbalists combined was estimated at AUD\$277 million in 2017 (McIntyre et al., 2021: 11).

These data indicate that a study investigating the occupational regulation arrangements of non-registered health professions is an important line of research from the perspectives of millions of consumers who use and may pay out-of-pocket for these health services, the professional bodies involved in regulating thousands of non-registered practitioners, and governments providing hundreds of millions of dollars in funding for health services provided by those practitioners.

Exploring stakeholder perspectives of occupational regulation for non-registered professions will assist in understanding how views and attitudes may inform decision-making and contribute to the policy process. Insights generated from this work can be used to inform policy decision-makers and professional leadership groups regarding enablers and constraints to evidence-informed regulatory policy-making. The findings may be used by government policy officers and researchers to develop plans or solutions to address identified issues. Findings from this research have the potential to inform WHO HPR policy guidance.

1.1.4 Thesis structure and outline

This work is in the form of a traditional thesis organised into thirteen chapters.

Chapter 1 (this chapter) gives an overview of the research, including the research aims and objectives. The project scope is specified, statements of the significance of the

⁸ This information was derived by aggregating data obtained from Medicare, the Department of Veterans' Affairs, and the National Disability Insurance Agency for the professions of audiology, counselling, dietetics, exercise physiology, social work, and/or speech pathology.

research are detailed, and the original contribution this research makes to HPR scholarship is described. The chapter introduces foundational definitions, concepts, frameworks, and theories to facilitate a better understanding of HPR in the Australian context and to inform subsequent chapters. An overview of international trends in HPR is also provided to situate the present research in a global context.

Chapter 2 presents a systematic scoping review of the literature on healthcare stakeholder attitudes to regulating non-registered professions in Australia. The review explores what is currently known regarding stakeholder perspectives. It establishes the territory this research will occupy. This chapter identifies the areas in need of further examination, including the stakeholders whose perspectives require further examination, the non-registered health professions requiring investigation, and the need for a conceptual theory to understand and explain stakeholder perspectives.

Chapter 3 describes the philosophical orientation and theoretical framework, including my ontological position and epistemological stance. It introduces the concepts of the social theorist and philosopher, Pierre Bourdieu, as the analytical and explanatory theory for the study.

Chapter 4 expands on the methodology underpinning the research. It details the qualitative research strategy, study design, and methods. The four phases of the research are set out. Methods are described for determining which non-registered professions were examined, how documents were sourced and selected, and how stakeholder participants were selected, recruited, and interviewed. Procedures for analysing the collected data and theoretically analysing and interpreting the study results are detailed.

Chapters 5 to 10 present the study results organised into three research phases. Phase 1, *Chapter 5 - Mapping the field*, analyses the HPR field in Australia. A narrative synthesis of key events and decisions leading up to and beyond the establishment of the NRAS is detailed. The statutory and co-regulatory mechanisms that regulate non-registered professions are charted. Estimates are presented on the size of the non-registered workforce, the number of consumer consultations, and the public funding received by

these professions. Phase 2 of the research comprises two chapters presenting an analysis of document sources. *Chapter 6* presents a descriptive analysis of the positions held by stakeholders regarding HPR. *Chapter 7* offers a thematic analysis of the reasons offered by stakeholders in support of their positions on HPR. In the third research phase, I present results from a thematic analysis of interviews with consumer advocates in *Chapter 8*, government health policy actors in *Chapter 9*, and profession representatives in *Chapter 10*.

Chapter 11 reports on the fourth phase of the research in which the study results presenting stakeholder perspectives are theoretically analysed and interpreted. *Chapter 11* applies Bourdieusian concepts to the findings from the document analysis and stakeholder interviews to arrive at a theoretical explanation for stakeholder perspectives of HPR. It presents a conceptual model of the HPR field based on and informed by the perspectives of stakeholders in this study.

Chapter 12 presents an integrated discussion in which I synthesise stakeholder perspectives drawn from the six results chapters and summarise the theoretical analysis and interpretation presented in *Chapter 11*. I describe the insights from the findings regarding potential enablers and barriers to HPR policy reform for non-registered health professions. Recommendations arising from the research are offered, study limitations are specified, and opportunities for further research are detailed. In this chapter, I also reflect on using Bourdieusian theory to analyse and interpret stakeholder perspectives of HPR in Australia.

The **Conclusion Chapter** summarises the key findings and discusses their implications and significance to HPR in Australia and internationally. The chapter concludes by reaffirming the contribution this research makes to HPR scholarship.

1.1.5 Contribution to knowledge

This research makes an original contribution to knowledge in the discipline of HPR in five primary research areas:

- A review of the published literature regarding attitudes to the regulation of 15 non-registered health professions in Australia.
- A comprehensive mapping of the events and decisions leading to the NRAS, the legislative and implementation status of the National Code of Conduct in Australia's eight jurisdictions, and the eligibility of non-registered practitioners for benefits and entitlements by seven national-level government and non-government institutions.
- The first examination of publicly documented positions and perspectives of healthcare stakeholders regarding the regulation of non-registered professions.
- The first investigation of the perspectives and experiences of consumer advocates, government health policy officers, and a range of professional body representatives regarding the regulation of non-registered health professions.
- An analysis and interpretation of stakeholder perspectives of regulation using Bourdieusian theory, the establishment of a conceptual model of the HPR field in Australia based on and informed by these perspectives, and advancing a theoretical proposition of the forces and causal mechanisms to explain perspectives of HPR as they relate to non-registered professions.

1.2 Professions and professionalisation

The central concerns of this thesis are the perspectives and experiences of stakeholders regarding the occupational regulation of non-registered health professions. Professionalisation is part of occupational regulation through actions taken by professional bodies in pursuit of professional advancement or actions by the state to formalise statutory mechanisms to regulate a profession. The following section presents the foundational concepts of professions, professionalisation, and the role of the state and professional associations in regulating health practitioners.

To analyse stakeholder perspectives of HPR for non-registered professions, it is first necessary to understand the meaning of the term 'profession'. An extensive body of research is devoted to defining and describing professions, only a portion of which will be reviewed in this thesis. This section does not attempt to provide an exhaustive

examination of the literature on professions. Instead, the purpose of this section is to précis the literature on the theory of the professions by briefly explaining specific concepts and theories to the extent necessary to situate the ideas within the present research context. Furthermore, this research does not promote or adhere to a particular theoretical school in the profession's literature, as each theory offers concepts relevant to this research. Having an appreciation of the sociological literature on professions assists in better understanding the perspectives of stakeholders, including non-registered professions as they pursue their professionalisation goals, and the responses of other stakeholders to these actions.

1.2.1 Definitional orientation

For this research, Freidson offers a helpful definition of professions that excludes state licensure as a defining characteristic (1994). In Freidson's view, a profession is *"an occupation that controls its own work, organized by a special set of institutions sustained in part by a particular ideology of expertise and service"* (1994: 10). Despite this definition, Freidson avoided the term 'profession', considering it a pretentious designation applied to workers who were granted a *"special position in the political economy"* compared to other occupations with whom he considered they had much in common (2001: 13). Freidson argued:

The future of profession lies in embracing the concept as an intrinsically ambiguous, multifaceted folk concept, of which no single definition and no attempt at isolating its essence will ever be generally persuasive. (Freidson, 1994: 25)

This ambiguity is pertinent to the present research in which non-registered professions share many characteristics with registered professions, except for statutory registration.

1.2.2 Theories of the professions

Various categories, typologies, theories, and conceptualisations exist regarding professions and professionalisation, including ideas about which types of workers fall within this occupational class. Definitions have been offered and disputed, and typologies have been constructed and criticised. As Freidson observed, *"while the*

literature on professions has burgeoned over the past few decades [...] conceptualization has been scattered and typologies have proliferated to the point of confusion” (2001: 4).

In attempting to summarise the literature on professions, it is helpful to draw on the work of Saks (2016), who distilled the profession's literature into several categories, six of which will be considered here: trait theory, functionalist theory, symbolic interactionism, Marxist theory, neo-Weberian theory, and institutionalism (2016: 172ff). A seventh category, Bourdieu's concept of field, will also be presented because of its relevance to this research and conceptualisations of professions.

The trait approach

The early part of the twentieth century was dominated by studies seeking to understand the essential characteristics of professions that set them apart from other occupations in the social division of labour. Carr-Saunders and Wilson were among the earliest writers to define the archetypal professions of law and medicine according to common attributes thought to distinguish them from non-professional groups (1964: 284-285). The 'trait' attributes identified by Greenwood include an occupational systematic body of theory, a regulatory code of ethics, professional authority and culture, and approval from the community (1957: 45, *passim*).

However, trait approaches were criticised for having inherent weaknesses. Weaknesses include disagreement over the characteristics a profession was understood to possess (Habenstein, 1963: 292; Johnson, 1972: 23; Saks, 2016: 172), a disregard for the historical contexts of professional attributes (Johnson, 1972: 26; Saks, 2012: 2), and the absence of a theory underlying the approach (Johnson, 1972: 24; Saks, 2016: 172). Johnson was particularly critical of trait theorists for assuming the characteristics of archetypal occupations could be generalised to all professions (1972: 23-24). Abbott, too, was critical of trait theorists for their politicised use of specific attributes to exclude occupations from the professional class (1988: 4).

The functionalist school

Major proponents of the structural-functionalist school include Talcott Parsons (1964) and Bernard Barber (1993). This approach emphasised the functional relevance of professions to the professional-client relationship or society as a whole (Johnson, 1972: 23; Saks, 1995: 12). Functionalists claimed that as occupations professionalised, they assumed certain features and functions. Barber defined these as a high degree of generalised and systematic knowledge, community orientation, self-discipline through codes of ethics, and a system of monetary and honorary rewards (1963: 672). Other functionalist features of professions were the establishment of training standards set by the profession, greater socialisation of members, increased professional autonomy, the pursuit of licensure and higher income, and more power and prestige (Goode, 1960: 903).

The functionalist school fared little better than trait theory. Saks characterised as untenable the functionalist claim that serving the public interest equates to fulfilling the functional needs of the common interest, since it is unlikely that societies can be viewed as entities with common needs (1995: 46-47). Saks was also critical of the functionalist approach that ignored the actions of individuals pursuing personal interests and neglected any consideration of the tension between the public interest and professional self-interest (1995: 46-47). McCauley maintained that Parsons' approach disregarded the influence of the state in preserving occupational dominance (2006: 69). Sciulli considered the main weaknesses of the functionalist approach to be the vagueness of Parsons 'social order' concept and the lack of specificity regarding the contribution that professions were said to make to the social order (2009: 26).

Even though this school has been criticised, many of the functionalist concepts of professionalisation are relevant to this research. The relevance lies in stakeholder perspectives of the features and functions of professionalisation as detailed by functionalist writers. These features include training standards, statutory registration, and increased rewards, status, and prestige, particularly concerning non-registered professions that may be seeking to secure some or all of these attributes.

The symbolic interactionist tradition

Challenges to the trait and functionalist schools came from contributors in the symbolic interactionist tradition who questioned whether the assumed traits of professions reflected the reality of professional work (Coburn & Willis, 2000: 380). Interactionists, such as Becker (2017) and Hughes (1958), conceptualised occupations not by their professional characteristics or the type of work performed but through their socially negotiated understandings (Becker, 2017: 92-96; Hughes, 1958: 76-77). Macdonald described this negotiation as *“the actions and interactions of individuals and groups, how they constituted their social worlds as participants and how they constructed their careers”* (1995: 4).

Becker viewed the term ‘profession’ as *“an honorific symbol”*, the features of which present an ideal image of what professional groups should be but are not necessarily like (2017: 93). Accordingly, the reality of professions and their work differs from the ideal because professions do not operate as autonomously as is assumed, may not possess a complete monopoly over a body of knowledge and scope of work, or have equally competent professionals who all abide by a code of ethics (Becker, 2017: 99-101). Furthermore, consumers are considered to exercise judgement rather than placing complete trust and faith in the professionals they consult (Becker, 2017: 99).

This approach also fell out of favour because of insufficient empirical research supporting interactionist claims (Saks, 2016: 173) and because its exponents were unable to account for the temporal stability of social interactions in which professions were thought to engage (Abbott, 1988: 113). The theory is also considered to lack relevance since it is aimed at the relationship between professionals and clients, to the neglect of institutional and social dimensions (Saks, 1995: 19; 2016: 173). These dimensions include the influence of power in the success or failure of groups to achieve professionalisation (Saks, 2021: 55).

However limited interactionist claims may be, the concepts of ‘profession’ and ‘professionalism’ and the socially negotiated meanings of these terms are pertinent to the present research. Stakeholder attitudes to non-registered professions include

perspectives on how these professions conceptualise and approach their professionalisation trajectories and the influence of these perspectives on attitudes to the regulation of these professions.

The Marxist perspective

Marxist theories place health professions within a class structure where the medical profession may be viewed as part of the capitalist class, and capital accumulation is the aim of professionalisation (Nancarrow & Borthwick, 2021: 10-11; Saks, 2003: 43). Navarro contended that the state's primary role under capitalism was to reinforce the class structure and hegemony of the elite, whose members dominate the medical profession and state bureaucracies (1986: 54-55). Navarro claimed this tendency explained the bias of the state towards the dominant class (1986: 55).

A critique of this perspective came from Saks, who argued that Marxist theories generally attempt to use explanations for the state's function in maintaining capitalist hegemony rather than identifying the mechanisms by which dominance is reproduced, thereby offering few fruitful analytical research avenues (2016: 174). Nevertheless, the concept of class structure has relevance to this research due to the professional hierarchy widely understood to exist in healthcare (Essex et al., 2023; Fernandopulle, 2021; UK Care Quality Commission, 2018: 4, 6). Whether healthcare stakeholders in this research perceive that a class structure exists and how this may inform attitudes to regulating non-registered professions is a consideration for the present study.

Neo-Weberian approaches

The neo-Weberian approach to the professions is based on several concepts, with social or exclusionary closure being the most relevant to this research. Closure strategies describe the actions of an occupational group to restrict access to their profession by gaining a state-sanctioned monopoly over work performed (Saks, 2012: 4, 5; 2016: 175). These strategies effectively close the market to competitors. According to neo-Weberian theory, professional standing depends on the actions of the state to create boundaries that carve out an occupational niche of exclusive practice (Saks, 2012: 4).

For neo-Weberians, achieving state-sanctioned professionalisation is the mark of occupational success (Saks, 2016: 177).

Saks argued that the neo-Weberian approach overcomes many of the weaknesses of other theoretical schools but is not itself immune to criticism regarding the application of the theory (2016: 175-178). Such weaknesses, though, relate more to the operationalisation of the theory rather than a flaw in the theory itself (Saks, 2021: 75). Criticisms of the theory include the frequent absence of empirical rigour in studies using neo-Weberian frameworks (Saks, 1983: 9-11, 16; 2021: 73) and the overly critical and unsupported claims made by proponents regarding the self-interest of professions to the exclusion of the public interest (Saks, 1998: 355; 2021: 73-74). Neo-Weberians have also been criticised for limiting research to professions having already achieved social closure through state licensing, while ignoring occupations pursuing licensure (Saks, 2016: 179; 2021: 74).

In this research, statutory registration is considered an occupational closure strategy. The views of healthcare stakeholders regarding registration, along with other forms of occupational regulation, are the central concerns of this investigation. The research addresses one of the perceived limitations of neo-Weberian theory by turning its attention to non-registered professions that may or may not be seeking registration or other closure strategies.

Neo-institutionalism

Institutionalist approaches conceive of professions as institutions (Suddaby & Muzio, 2015: 34-35). Institutionalist writers have observed that professions compete with other types of professions and institutions for occupational jurisdiction and social status while cooperating with yet other institutions to embed their professionalisation activities “*in a related project of institutionalization*” (Suddaby & Muzio, 2015: 36).

Professional service firms represent a departure from the simple construct of the representative organisation or regulatory body (Saks, 2016: 180). Even though, according to this approach, these firms are considered large business corporations to which a degree of professional control has shifted (Saks, 2016: 180), the institutions

comprising professional associations and other professional bodies are a focus of this research. The views of representatives from these institutions and other professions and organisations with which they compete or cooperate, the motives and methods used by their representatives to support particular perspectives of HPR and how this affects their professionalisation activities are central concerns of this research.

Bourdieuian theory

Bourdieu claimed that the concept of profession, with its socially constructed classifications and typologies, masked the more relevant concept of a field of conflict in which professions compete (1992: 242-243). He recommended the term “*field*” be substituted for professions, which he conceived of as “*a structured space of social forces and struggles*” (Bourdieu & Wacquant, 1992: 242-243).

Several authors have engaged with Bourdieu’s work in the context of professions. Nancarrow and Borthwick, writing about allied health professions, stated that Bourdieu’s work is concerned with the struggle for power and the generative nature of privilege (2021: 22-23). Schinkel and Noordegraaf argued that by considering professions as “*field[s] of power*” and sites for the pursuit of social status, a Bourdieusian approach to the study of professionalisation is possible (2011: 80, 86-87). King et al. considered Bourdieu’s theoretical concepts relevant to contemporary studies of the professions and the symbolic power struggles that draw attention to the competition and contestation between health professions (2018: 2-3). In examining the cultural capital of medical doctors, McDonald engaged with the concept of a class-based “*habitus*”, the learned preferences and habits that shape agent perceptions and practices, to highlight the importance of class and status when exploring professional prestige (2014: 902, 903). Borthwick, Boyce, and Nancarrow declared that Bourdieu’s concept of symbolic capital is a useful analytic tool for understanding and explaining conflict and contests between professions over professional titles (2015: 318). Saks proposed that Bourdieusian theory may offer additional tools to augment neo-Weberian analyses of professions (2021: 49-50, 76-77). These tools offer this research the theoretical concepts that allow for an analysis and interpretation of stakeholder perspectives of HPR.

1.2.3 Professionalisation and the role of licensure

In the latter half of the 20th century, the question of defining a profession made way for more fundamental concerns. The essential question proposed by Hughes was, “[w]hat are the circumstances in which the people in an occupation attempt to turn it into a profession, and themselves into professional people?” (1984: 340). Carr-Saunders and Wilson stated that a profession comes into existence when practitioners form bonds to establish a “*formal association*” (1964: 298). Moran asserted that “[r]egulation’ *virtually defines a profession*” and stressed that professionalisation was increasingly used as a regulatory strategy by professions to control the labour market (2002: 19). This view of professionalisation was previously noted by Johnson, who characterised the attributes of professions and the process of professionalisation as historically situated institutionalised forms of occupational control (1972: 27). Johnson also wrote of the predictable stages of organisational change through which an occupation passes to achieve professionalisation (1972: 22). Similarly, Millerson described professionalisation as the steps an occupation takes to transform into a profession (1998: 10).

Lipsig-Mumme described three stages of professionalisation: forming a professional identity to distinguish the occupation from other groups; establishing a professional association to advance professional interests and advocate for state regulation and recognition; and carving out a “*relational space*” of “*regulatory power*” between the state, the association, and other entities (2006: 476-477). Wilensky specified a more detailed classification comprising five stages of professionalisation (1964). According to Wilensky, professionalisation begins with developing a full-time occupation and the staking out of an occupational territory. Thereafter, training schools are established within or in close connection with the university sector, and training and practice standards are adopted. Following this, workers begin to unionise, and professional associations are formed. The fourth stage is the drive for legislative protection of job roles through occupational licensing and practice scope restrictions. The final stage in Wilensky’s professionalisation process is adopting a formal code of ethics (1964: 142-146).

While it is unknown if the professional groups examined in this research have moved through these professionalisation stages or if they desire to, the concepts presented by Wilensky and Lipsig-Mumme are key considerations for professional groups. This is particularly relevant if they have not achieved statutory occupational closure, as is the case with the professions examined in the present study. This research seeks to identify stakeholder perspectives on elements of professionalisation that touch on occupational regulation, including attitudes to registration.

The term Larson used to refer to occupational professionalisation is *“the professional project”*. Larson regarded the professional project as a process *“by which producers of special services sought to constitute and control a market for their expertise”*, reinforce their social status, and promote upward mobility as *“a new form of structured inequality”* based on education and credentialling (1977: xvi-vii). Larson viewed the professional project as an organisational project to coordinate and manage the production of workers and their transactions operating through and resulting in the establishment of professional schools and associations (1977: 74).

Freidson maintained that the basis of any analysis of professions is *“its relationship to the ultimate source of power and authority in modern society – the state”*. He argued that much of the medical profession's authority derives from the state-sponsored monopoly over its scope of practice (1970: 83). Roth offered another perspective on professions and professionalisation by stating that the emphasis on professional attributes and professionalisation:

deflected concern from the more crucial problems created by professionalization, such as the avoidance of accountability to the public, the manipulation of political power to promote monopoly control, and the restriction of services to create scarcities and increase costs. (Roth, 1974: 18)

Contrasting much of the literature which views professionalisation as being driven by occupations, McClelland distinguished between professionalisation promoted *“from within”* an occupational group to manipulate the market and professionalisation imposed *“from above”* by dominating forces outside the occupation (1990: 107-108). These concepts were taken up by Evetts, who observed that the *“appeal of*

professionalism” depended on its source (2003: 409). When driven from within, the appeal for the professions includes benefits such as establishing an occupational identity, improving professional image, and securing or maintaining statutory governance. When driven from above, the appeal for professions was autonomous decision-making, status, and rewards in exchange for occupational change (Evetts, 2003: 409). By identifying the attitudes of healthcare stakeholders, this research seeks to explore any professionalisation strategies in operation and from which source the strategies are being driven, from within or above.

1.2.4 The role of professional associations

Many theorists have described the role and functions of associations in the professionalisation of an occupation. Carr-Saunders and Wilson asserted that a *“profession can only be said to exist when there are bonds between the practitioners, and these bonds can take but one shape – that of formal association”* (1964: 298). They observed that as professional functions became more distinct and occupational techniques more specialised, associations formed (1964: 300). Other writers have also viewed the establishment of professional associations as a key stage in professionalisation (Lipsig-Mumme, 2006: 476-477; Wilensky, 1964: 144). The functions of associations in occupational professionalisation include advancing professional knowledge through research, expanding the scope of occupational practice (Merton, 1969: 640), establishing and enforcing high education, practice, and ethical standards, organising and unifying the profession, advocating on behalf of members, and raising professional status and social standing (Merton, 1969: 639-41; Millerson, 1998: 28-32). By setting high standards and ensuring qualified membership, associations act to protect the profession and the public, qualify and register competent practitioners, and control occupational entry (Millerson, 1998: 30-31).

In their analysis of the rise of professional associations, Carr-Saunders and Wilson noted that in the medical profession, associations were established to ensure unskilled workers could not lay claim to medical practice (1964: 298). The authors argued that once qualifications and competency standards are set and an occupational title is established, it becomes necessary to construct professional boundaries to restrict

admission to qualified and competent professionals and assure the public of the bona fides of practitioners (Carr-Saunders & Wilson, 1964: 301-302). Once established, the association's focus moves from professional respectability and status to protecting members' interests. This includes raising member remuneration to enhance public standing and moving into the public sphere to offer views on policies concerning their occupational domain (Carr-Saunders & Wilson, 1964: 303). Becker made a similar observation, stating:

Professional associations are thought of as important public institutions, similarly entitled to a voice in public affairs, particularly (although not exclusively) with respect to those issues which touch on their professional concerns or competence. (Becker, 2017: 96)

Abbott contended that a profession's social organisation affects the likelihood of success in achieving professional aims. Consequently, claims-making is likely more successful if a profession is strongly organised and has a single representative professional body (Abbott, 1988: 82-83). Freidson, however, maintained that while professional associations have a role in establishing control over professional work, theorists have exaggerated their importance in professionalisation since it is policy advisers and government officers who play a critical role in formulating and implementing the "substance" of government policy (2001: 145-146). This view assumes that associations seek to achieve professionalisation through licensure, although this might not always be the case. Commentators have introduced the notion of "regulatory chill" to health policy-making to describe the anticipatory or reactive deferral, attenuation, or discontinuation of government regulation because of other regulatory measures proposed or in place (Brooks & Lauber, 2024: 748). Applying this concept to the present research, associations may strengthen or enhance their regulatory functions for a profession, either reluctantly or enthusiastically, to avert regulatory action by the state.

Gunningham and Rees have noted another aspect of associations that draws on the idea that associations have "multiple selves", where:

regulatory associations are driven by private interests, but it is also the case that they are motivated by ideals, principles, and values. They embody contrary tendencies – the push of self-serving economic (or political) interests and the pull of moral aspirations. (Gunningham & Rees, 1997: 372-373)

Of the diverse functions, features, and attributes of professional associations, the most relevant to this research is the regulatory role assumed by associations and other professional bodies representing non-registered professions in the absence of registration. This regulatory role includes setting and enforcing education, practice, and ethical standards, qualifying practitioners for association membership, and setting ongoing professional development and other practice requirements. These functions are performed for two primary purposes: to qualify applicants for association membership and to qualify members for benefits and entitlements provided by government and non-government institutions. Other functions of concern to this research include the role of associations in pursuing registration or other professionalisation strategies, the organisational strength and effectiveness of associations as a representative voice for the profession, regulatory activities the associations may carry out, the engagement of associations in professional boundary construction, and the extent to which associations demonstrate 'multiple selves'. Specifically, the attitudes of healthcare stakeholders to these regulation-related activities are key considerations for this research.

The approach associations and governments take to their regulatory roles has been examined by various commentators, and some have developed regulation theories describing the motivations and objectives of policy-making in regulation. These are covered in the next section.

1.3 Policy-making theories of regulation

Mitnick stated, "[t]o a large extent, theories of regulation have always been theories of 'interest'" as actors seek to pursue personal gain or satisfaction (1980: 84). As well as considering the perspectives of those seeking regulation, Mitnick emphasised the interests of those served by it (1980: 84). Lewis argued that policy-making in liberal democracies is characterised by competing interest groups negotiating with government to achieve their own goals (2005: 5). Considerations of regulatory policy-making that serve the public interest or professional self-interest are complex since what constitutes the public interest may be unclear, and the interests of social agents may vary or change over time (Mitnick, 1980: 84, 91).

Various ‘interest’ based accounts of regulation have been proposed, three of which are considered here: public interest theories, private interest theories, and structural interests theory.

1.3.1 Public interest theories

Public interest theories assume the objectives of regulation are largely to benefit the public, and regulation left to market forces may not achieve the desired public interest objectives (Baldwin et al., 2012: 40-41; Mitnick, 1980: 91). In this conceptualisation, the needs and protection of consumers are paramount, and the market, unfettered by regulation, would fail to achieve the desired public interest goals required by governments. When deciding on matters of regulation in the public interest, regulatory actions are considered to be founded on objective standards and based on dispassionate expertise by government officials (Baldwin et al., 2012: 41).

Clouding this theory of regulation is that considerations of the public interest may be ill-defined (Baldwin et al., 2012: 41; Noll, 1985: 18), may not be widely agreed (Mitnick, 1980: 91), or may raise uncertainty about whether government regulation delivers the required public interest outcomes for which it was established (Baldwin et al., 2012: 42).

1.3.2 Private interest theories

Ogus claimed that scepticism regarding the singular interest of the state in promoting the public good, disappointment in the functioning of regulatory mechanisms, and an acknowledgement that regulation can benefit groups other than the community led to the development of private interest theories (2004: 4, 56). This school encompasses private interest and group interest theories, as well as the related concept of regulatory capture.

Private interest theories are based on the idea that specific individuals and groups, which in this research may be considered to be non-registered health practitioners and professional associations, derive benefit from regulation or that regulation is used to protect the interests of the regulated (Mitnick, 1980: 109-110). Regulatory capture describes circumstances in which state agencies do not act in the public interest.

Instead, agencies operate in support of private interests, and private interests work to shape regulation primarily for their own benefit, effectively acquiring it (Stigler, 1971: 3, 4). This framing of regulation assumes all actors within a regulatory arena pursue outcomes that meet their material and economic interests (Baldwin et al., 2012: 43). Mitnick (1980: 80) and Ogus (2004: 57) argued that once captured, regulation may cease to fulfil its public protection function due to the pressure and influence that protects the interests of the regulated. In Mitnick's view, regulatory capture includes:

a theory of how regulators may acquire predispositions to add new regulation that serves the regulated interest, or to produce ongoing regulatory activities that serve the regulated interest rather than public interest ends. (Mitnick, 1980: 80)

An example of this is illustrated by Yackee, who found that comments offered by interest groups in the course of policy-making often directly influenced bureaucratic policy outputs, resulting in changes to the content of government regulation (2006: 117, 119).

Stigler maintained that organisations and professions with sufficient power strive for monopoly positions through state-controlled barriers to occupational entry (1971: 5). Within the health field, Baggott noted that those privileged by regulatory protection argue that entry barriers are needed to protect the public by barring rogue or incompetent providers (2002: 37, 38). Some researchers, however, consider that professions have appropriated regulation to control education, limit the supply of practitioners, and raise incomes (Baggott, 2002: 37, 38).

Several authors have been sceptical of private interest theories. Baggott viewed the theory as too simplistic in its interpretations of the motivations of professional groups. He maintained that the desire for control over a profession may not be entirely due to self-interest because theorists have disregarded the ethical dimensions of health professions (2002: 38). Baldwin, Cave, and Lodge also criticised private interests theory, stating it has overlooked agent motivations, including concepts such as "*ideology*", "*prejudice*", "*policy goals*", and "*moral stances*" (2012: 46).

1.3.3 Structural interests theory

Alford's theory of structural interests focuses on the politics of healthcare policy (1975: 10), which Lewis viewed as emphasising power based on professional position (2005: 57). Alford identified three groups of players competing within the healthcare system: dominant, challenging, and repressed structural interests (1975: 13-17). Dominant structural interests are professional monopolisers who benefit from existing structures and institutions. They have little need to exert power to influence decision-making unless their dominance is threatened (Alford, 1975: 6, 14). Alford viewed the medical profession as the archetypal professional monopoliser. Even though conflicts can occur between groups, such as professions, in the dominant structural interest class, this does not challenge the principle of *"professional monopoly – just who is going to have it"* (Alford, 1975: 14). In other words, according to Alford, even subordinate professions are considered part of the dominant structural interests class. Challenging structural interests, or corporate rationalisers, which in Alford's view included public health agencies and researchers, seek to break down the professional monopoly of the dominant structural interests (1975: 14-15). Repressed structural interests, which Alford viewed as the community population of varied interest groups, are not served by existing institutions unless considerable political pressure is brought to bear (1975: 15-16). In this research, dominant interests may be viewed as the registered and non-registered professions. Challenging structural interests may be seen as government health policy officers and the researchers investigating HPR, who potentially challenge the status quo. Repressed structural interests may be considered the consumer advocacy bodies.

Policy-making theories, in part, identify the orientation of the state towards specific objectives or outcomes regulators wish to achieve from public policy. Another way the state seeks to achieve policy objectives is through the type of approach governments take to regulation. Several of these approaches are described in the next section.

1.4 Strategies of regulation

Regulatory strategies describe policy-making approaches to regulation and the actions and choices made to achieve public policy objectives (Freiberg, 2017: 441). Governments have adopted different strategies to achieve regulatory policy objectives, four of which are considered here: responsive regulation, smart regulation, really responsive regulation, and risk-based regulation.

1.4.1 Responsive regulation

Ayres and Braithwaite introduced the concept of 'responsive regulation' to overcome the opposing forces of state regulation and deregulation (1992: 3). Responsive regulation is an enforcement model that seeks to increase compliance behaviour by proposing that state regulators apply different interventions for different industry structures in response to the conduct of those industries (Ayres & Braithwaite, 1992: 35-36). In this model, the state assumes that regulatees are ethical and responsible corporate citizens and takes action only when necessary (Freiberg, 2017: 443). Actions by the state are proportionate to the offence, varying according to an enforcement pyramid, ranging from persuasion and education at the base of the pyramid and escalating to licence revocation at its peak (Ayres & Braithwaite, 1992: 35-36).

1.4.2 Smart regulation

Another approach to regulation, 'smart regulation', advocated by Gunningham and Grabosky (2004), extends on Ayres and Braithwaite's concept of regulatory responsiveness. The approach considers a broader range of regulatory actors (Gunningham & Sinclair, 1999: 306) and draws on diverse solutions to deal with the complex and multi-dimensional issues relating to regulation (Freiberg, 2017: 466). Gunningham and Sinclair proposed that smart regulation may be operationalised by parties other than the state, including professional bodies and industry associations as "*surrogate regulators*" or "*quasi-regulators*" (1999: 306, 307; 2004: 397-398). Regulatee compliance is encouraged through various coercive instruments according to a three-sided pyramid in which responses escalate up a single pyramid face corresponding to the controls available to regulatees and to the extent necessary to achieve policy goals.

If this fails and further controls are required, action can move to another face of the pyramid to execute a range of controls by other parties, such as corporations or the state (Gunningham & Sinclair, 1999: 308-312; 2004: 397-400).

1.4.3 Really responsive regulation

A third type of regulatory approach, referred to as 'really responsive regulation', was developed by Baldwin and Black in response to the limitations of responsive regulation (2008). The authors noted that regulators are required to respond to a broader range of issues than regulatee attitudes as posited by Ayres and Braithwaite (Baldwin & Black, 2008: 69). In this framework, regulators should consider the "*motivational postures*" of regulatees towards internal and external regulatory relationships, the opportunities and constraints of regulatee environments, the logics of different regulatory tools and strategies, the effectiveness of regulatory instruments used, and the changing regulatory landscape, objectives, and priorities (Baldwin & Black, 2008: 69-73). Freiberg contended that despite the challenges of operationalising the approach, really responsive regulation provides a structured and transparent mechanism for addressing the complexity of regulation (2017: 454).

1.4.4 Risk-based regulation

Black stated that risk-based approaches to regulation arose, in part, from political and organisational pressures on governments for more cost-effective regulatory strategies (2005: 512). Baldwin, Cave, and Lodge described this approach as applying regulatory actions commensurate with the risk for which regulation is required (2012: 281). Hutter observed that risk-based regulation "*takes the principles of risk management as a framework for governance, the organization of regulatory work, and an agency's resources*" (2015: 3). The approach uses various tools "*to achieve outcomes that can be characterised in risk terms*" (Rothstein et al., 2006: 1057).

Risk-based frameworks vary considerably. They typically include five elements: a set of risk-based objectives to be controlled; a determination of the risk appetite of the regulator; an assessment of the likelihood and impact of the risks; a rating or rank of risks based on risk assessments; and a process for allocating resources based on risk

ratings (Black & Baldwin, 2010: 184-185). A key element of the approach is that it *“facilitates a tolerance of risk in meeting regulatory objectives by prompting regulators to recognise that elimination of all risk is likely to be an uneconomical aspiration”* (Productivity Commission, 2013: 271). Freiberg considered a risk-based approach the dominant regulation model in Australia (2017: 456). It is the approach taken in Australian health regulation policy design and implementation (DOHAC, 2020: 22) and the registration of health professions under the NRAS (Ahpra, 2023c).

The regulatory approaches outlined above do not constitute the full range of possible approaches to regulation, nor are they stand-alone strategies. Freiberg maintained that while responsive regulation assumes good corporate citizenship and seeks to achieve compliance, risk-based regulation aims to proactively assess and identify risk and apply solutions to avoid or minimise harm (2017: 471). The New Zealand Productivity Commission pointed out that no one regulatory strategy is superior to another, each having strengths and weaknesses and providing effective regulation in different contexts (2014: 73). The Commission argued that the regulatory task is to understand and adjust strategies with due consideration to the *“influences and dynamics of the many different contexts”* in which the strategies are employed (2014: 73).

At a macro level, regulatory strategies are employed to achieve particular outcomes, which may be enhanced through appropriate governance mechanisms.

1.5 Regulation and governance

Braithwaite, Coglianese, and Levi-Faur argued that the act of governance is broader than regulation (2007: 3). According to these authors, governance involves:

providing, distributing, and regulating. Regulation can be conceived as that large subset of governance that is about steering the flow of events and behavior, as opposed to providing and distributing. (Braithwaite et al., 2007: 3)

Some writers, such as Das and Quintyn, viewed regulatory governance as applying to institutions possessing *“legal powers to regulate, supervise and/or intervene”* (2002: 7). In this thesis, however, the idea of regulatory governance accords with the perspectives of other writers who take a broader view. For instance, Jessop has noted a shift from

the “*narrow concern with government to a broad concern with a wide range of political governance mechanisms with no presumption that these are anchored primarily in the sovereign state*” (1995: 310-311). Kjaer and Vetterlein described regulatory governance as governance through regulation performed by both government and non-government institutions (2018: 498, 499). These considerations are expanded on by Bevir, who stated that governance refers to:

all processes of governing, whether undertaken by a government, market, or network, whether over a family, tribe, formal or informal organization, or territory, and whether through laws, norms, power, or language. Governance differs from government in that it focuses less on the state and its institutions and more on social practices and activities. (Bevir, 2012: 1)

Other commentators have likewise taken a more liberal view of regulation, acknowledging both state and non-state actors in the performance of regulatory functions (Black, 2002; Braithwaite et al., 2007: 3; Freiberg, 2017: 5). Black advocated for a “*decentred*” approach to regulation in which “*different configurations*” of actors are considered by policy-makers “*to deliver public policy goals*” (2002: 8). For Black:

regulation is the sustained and focused attempt to alter the behaviour of others according to defined standards or purposes with the intention of producing a broadly identified outcome or outcomes, which may involve standard-setting, information-gathering and behaviour-modification mechanisms. (Black, 2002: 20)

This thesis takes a decentred view of regulation and a more liberal view of governance and regulatory governance. It recognises and acknowledges mechanisms delivered by state and non-state institutions, comprising a broad range of actions and actors involving laws and norms established by government and non-government entities to govern social practices performed by individuals and groups delivering healthcare. Drawn from the preceding literature, a working definition of regulation for this thesis is the activities of rulemaking, monitoring, and enforcement undertaken by public or private institutions to ensure health practitioners comply with specified requirements, standards, and codes.

The regulation literature offers a variety of typologies for categorising HPR (Baldwin et al., 2012: 137-164; Bartle & Vass, 2005: 29; Freiberg, 2017: 304-321; Ross, 2017: 2).

These generally range along a continuum according to the degree of state intervention from professional autonomy or self-regulation to state-controlled regulation (Dubois et al., 2006: 174). Some writers, such as Benton et al. (2013: 23-24) and Bartle and Vass (2005: 29), proposed a three-stage or four-stage typology of self-regulation, which includes various levels of autonomous mechanisms and state involvement. Levi-Faur identified four “*hybrid*” forms of regulation: co-regulation, enforced self-regulation, meta-regulation, and multi-level regulation (2010: 13-14). Priest described a five-model typology of regulation involving voluntary codes of conduct, statutory self-regulation, firm-defined regulation, supervised self-regulation, and regulatory self-management (1998: 242-244). Given the varying views among writers, there appears to be no agreed-upon ideal typology for HPR. Before describing the typology of regulation used in this thesis, some global trends in the HPR literature are presented.

1.6 Global trends in health practitioner regulation

In the past decade, authors such as Bennett et al. (2018: 162) and Yam et al. (2016: 19-21) have reported a move away from self-regulatory HPR models. Bennett et al. noted a general transition from the professional autonomy of self-regulation in many countries. This move has led to a rise in “*networked governance*” regulation models comprising “*public, private, professional and non-governmental bodies that exert influence over the conduct of health professionals and services*” (2018: 162).

Yam et al. (2016) reviewed trends in medical regulation across eight countries. The authors identified a general shift towards co-regulatory operating models, creating partnerships between the public, the profession, and regulators (2016: 22). They reported that reforms to medical regulation were often found to require government legislation, with increasing instances of lay representation on boards, review panels, and regulation inquiries (Yam et al., 2016: 19-22). Yam et al. also found that, increasingly, international jurisdictions were separating complaint investigation and disciplinary functions. These functions were being organised independently of each other to minimise conflicts of interest and promote confidence in the impartiality, fairness, and transparency of these functions (Yam et al., 2016: 23-24).

Research by Mahat et al. highlighted the need to align HPR to a contemporary understanding of the public interest (2023: 597). The public interest was considered to include efficiency, cost-effectiveness, regulatory responsiveness to health system needs, the quality and safety of health services, and regulation proportionate to practice risks. The researchers stressed the need for HPR to be more easily updated, flexible, and aligned with national health priorities (Mahat et al., 2023: 597).

A global review of HPR by Carlton et al. found that some governments had taken action to reform HPR systems in response to health system challenges (2024: 7). These reforms aimed to better serve the public interest, assure the safety and effectiveness of the workforce, foster flexibility and innovation in meeting population needs, and support workforce availability, quality, and sustainability (Carlton et al., 2024: 7). The authors concluded that HPR systems internationally are situated in different socio-legal and political contexts, health workforces consist of different occupations with different scopes of practice, and there is insufficient evidence to promote a single regulation system that works best in each of those contexts (Carlton et al., 2024: 163). Yet certain trends in HPR were evident: greater use of umbrella laws governing the health workforce; increasing instances of multi-profession regulatory agencies; the introduction of innovative regulatory models, such as negative licensing and quality-assured voluntary registers; better use of data collected by regulatory agencies for improved workforce planning; and greater use of data generated from complaint handling and disciplinary systems (Carlton et al., 2024: 163). These trends, though, have not necessarily led to improved consumer outcomes. Based on the findings from the global review, a WHO global guidance on HPR systems concluded there was “little evidence on how effective regulatory systems are in influencing patient health outcomes” (WHO, 2024: x).

In reviewing global trends, regulation mechanisms for non-registered health practitioners in jurisdictions other than Australia are relevant. Table 1.3 lists a range of health professions and their regulation arrangements in four anglophone countries, including the fifteen professions that are the subject of investigation in the present research.

Table 1.3: Regulation status of selected health practitioners in selected countries.

Health practitioner	Australia	Canada ^a	Aotearoa/ New Zealand	United Kingdom
Indigenous health practitioners	• ^b			
Art therapists				•
Acupuncturists	•	• (ABOQ)		c
Audiologists		• (ABOQ)		c
Chinese medicine practitioners	•	• (BO)	•	
Chiropractors	•	• (ABOQ)	•	•
Clinical perfusionists			d	c
Counsellors				c
Dental practitioners	• ^e	• (ABOQ)	•	•
Dietitians		• (ABOQ)	•	•
Exercise physiologists				c
Massage therapists		• (BO)		c
Myotherapists				
Medical imaging/radiation practitioners	•	• (AOQ)	•	•
Medical laboratory scientists, anaesthetic technicians		• (AOQ)	•	
Medical practitioners	•	• (ABOQ)	•	•
Midwives	•	• (ABOQ)	•	•
Naturopaths		• (ABO)		c
Nurses	•	• (ABOQ)	•	•
Occupational therapists	•	• (ABOQ)	•	•
Optometrists	•	• (ABOQ)	•	•
Orthoptists				•
Osteopaths	•		•	•
Paramedics	•	• (ABOQ)	•	•
Pharmacists	•	• (ABOQ)	•	•
Physiotherapists	•	• (ABOQ)	•	•
Podiatrists	•	• (ABOQ)	•	•
Psychologists	•	• (ABOQ)	•	•
Psychotherapists		• (OQ)	•	c
Social workers		• (ABOQ)	• ^f	•
Sonographers		• (OQ)	•	c
Speech pathologists		• (ABOQ)		•
Western herbal medicine practitioners				

 Practitioners in the scope of the research study.

Notes:

- a. Registered in Alberta (A), British Columbia (B), Ontario (O), Quebec (Q) (the four largest provinces by population).
- b. In Australia, these practitioners are known as Aboriginal and Torres Strait Islander health practitioners.
- c. A government-accredited register is in place for this profession, which practitioners may voluntarily join if they meet requirements. Exercise physiologists are regulated under the Healthcare Science register. Sonographers are regulated under the Clinical Technology register.
- d. Preparation of a registration regulation impact statement for Cabinet agreement is underway (NZ MOH, 2023a).
- e. Includes dentists, dental specialists, dental hygienists, dental prosthetists, dental, and oral health therapists.
- f. Registered under the Ministry of Social Development and not under the health portfolio (NZ MOH, 2023b).

(Ahpra, 2024a; Health Canada, 2021–2024; NZ MOH, 2023b; UK PSA, 2024a; UK PSA, 2024b).

Three jurisdictions, Australia, Aotearoa/New Zealand, and the United Kingdom, have national HPR mechanisms, while Canada regulates its health workforce at the provincial/territorial level. All four jurisdictions have statutory mechanisms for regulating health practitioners. Fewer than half the professions are registered in all four countries. The substantial variation across the four jurisdictions indicates this research area warrants greater attention to understand the potential reasons for these differences.

There are key differences in HPR operating in Australia compared with other jurisdictions. These differences include the terminology used and the regulation arrangements in place. While each jurisdiction uses different terms to describe regulatory mechanisms, a prime example being the use of self-regulation to refer to statutory regulation in Canada, but in Australia, it denotes voluntary certification, the terms used in this thesis will reflect their Australian usage. Even though each country has its own unique HPR settings, the purpose of this thesis is to examine perspectives and experiences of the regulation arrangements for non-registered health practitioners in the Australian setting. Nevertheless, findings from the present research may have important implications internationally.

As outlined in Section 1.1 of this chapter, health practitioners in Australia practice under two regulatory mechanisms, statutory and non-statutory. The following section elaborates on HPR mechanisms operating in the Australian context and the regulation terminology used in this thesis.

1.7 Health practitioner regulation in Australia

As with other countries, there are specific arrangements to regulate the health workforce in Australia. Various terms are used to describe regulation mechanisms. These generally exist on a continuum ranging from self-regulation to government regulation (Taskforce on Industry Self-Regulation, 2000: 1). The categories of regulation described in the Australian literature range from three (Taskforce on Industry Self-Regulation, 2000: 1) to six (ACMA, 2015: 9). An applicable classification for HPR in the Australian context comes from the Australian Health Ministers' Advisory Council

guidance document (AHMAC, 2018a). The guidance document describes five types of regulation: self-regulation/voluntary certification, credentialling, co-regulation, negative licensing, and statutory registration (AHMAC, 2018a: 11-13).

1.7.1 Self-regulation

Self-regulation is also referred to as voluntary certification or voluntary self-regulation (AHMAC, 2018a: 11; Carlton et al., 2024: 40). Black describes this type of regulation as a *“process of collective government”*, that is, *“a group of persons or bodies, acting together, performing a regulatory function in respect of themselves and others who accept their authority”* (1996: 27).

The defining feature of this type of regulation is the absence of a statutory basis for the licensing of practitioners. Regulation is operationalised by a professional body such as an association that typically establishes a constitution, bylaws, codes, and rules by which practitioner members are bound. The codes and rules established by the association generally relate to education entry requirements, practice standards, professional indemnity insurance requirements, continuing education standards, and codes of conduct. Associations usually maintain a list of practitioner members on a web-based register. The association may receive and investigate complaints and can apply sanctions against a practitioner who has breached the code or rules of the association. The most significant penalty an association can impose is cancellation of membership. Common law and consumer protection laws are other avenues for consumer redress, and associations may refer a complainant or matters arising from a complaint to the police. Membership of an association is voluntary, and practitioners whose membership has been cancelled can join another association (for professions with multiple representative bodies) or may continue practising without association membership. Professional registering bodies may also exist that maintain a practitioner register. Registration with these bodies is voluntary (AHMAC, 2018a: 11; Carlton et al., 2024: 40). The distinction between a professional association and a voluntary professional registering body is that the association represents the interests of its members, while the primary purpose of the registering body is to register and regulate practitioners rather than to represent their interests.

1.7.2 Credentialling

Credentialling is a formal process of verifying practitioner qualifications or experience to assess suitability and competence for a role as a healthcare provider. Credentialling has no statutory basis and is used by employers, governments, and other institutions to determine the eligibility of practitioners not registered under the NRAS, generally for employment purposes or to provide funded health services. Under these arrangements, employers, for example, hospitals, may directly credential practitioners or require membership of specific professional associations to be admitted to practice in the health setting. A variation to credentialling by employers and institutions is performed by professional associations as part of their membership entry requirements and assessment for eligibility of co-regulatory entitlements and benefits (AHMAC, 2018a: 11).

1.7.3 Co-regulation

Co-regulation describes a type of regulation where government and non-government institutions delegate or recognise certain functions performed by self-regulating professional bodies. Co-regulation may be statutory or non-statutory. It establishes a partnership between professional bodies and governments or other institutions to grant association members certain financial entitlements or benefits. Recognition by the co-regulation partner may be conditional on the professional body meeting governance and certification standards and processes. Co-regulation arrangements incentivise practitioners to join a recognised professional body to avail themselves of benefits in return for complying with the professional body's self-regulating standards (AHMAC, 2018a: 11-12; Carlton et al., 2024: 40). Co-regulation arrangements relevant to non-registered professions are discussed in greater detail in Chapter 5, Section 5.3.2.

1.7.4 Negative licensing

Negative licensing is a regulation arrangement with no legal restriction on practice entry, irrespective of training or skill level. However, practitioners may be prohibited from practising if they are found to breach the standards set by the legislation and their continued practice is deemed to present a serious risk to the public.

In Australia, negative licensing is legislated separately in each state and territory as the National Code of Conduct (NCC). The NCC sets out minimum statutory standards of conduct and practice for health practitioners. Under the legislation, the statutory regulator is empowered to receive and investigate complaints about practitioner conduct or treatment, establish any breach of the code, and apply sanctions. A public register is maintained to identify prohibited practitioners. Prohibition orders are mutually recognised in each Australian jurisdiction in which the legislation has been enacted, preventing prohibited practitioners from moving between jurisdictions to continue practising (AHMAC, 2018a: 12-13; Carlton et al., 2024: 40). Further information on the NCC in Australia can be found in Chapter 5, Sections 5.1.2 and 5.3.1.

1.7.5 Statutory registration

Statutory registration is a type of occupational regulation where the regulatory functions are set out in legislation, and a government regulatory body is established independent of the profession (AHMAC, 2018a: 12). Statutory registration is legislated by parliament and administered by a regulator with powers to regulate, including registering practitioners. Under the terms of the *National Law*, entry is limited to persons the regulating body considers appropriately qualified and of good character. It is illegal to practice as a registered practitioner or use a protected occupational title without the required NRAS registration. The statutory agency charged with administering the NRAS, the Australian Health Practitioner Regulation Agency (Ahpra⁹) has the power to prosecute a non-registered person who uses a protected title or otherwise holds out as a registered practitioner. The National Boards for each registered profession have disciplinary powers to take action against registered practitioners whose conduct or practice falls below the required standards (AHMAC, 2018a: 12; Carlton et al., 2024: 40).

⁹ The Australian Health Practitioner Regulation Agency uses sentence case for its acronym. See: <https://www.ahpra.gov.au/About-Ahpra.aspx>.

1.7.6 Comparison of health practitioner regulation systems

The type of HPR that works best for a particular occupation or industry sector has generated much commentary in the regulation literature (see, for example, Bartle & Vass, 2005; Black, 2002; Levi-Faur, 2010; Lipsig-Mumme, 2006; Ogus, 1995). Dubois et al. claimed that regulation from outside the profession achieves a better balance between professional and public interests (2006: 175). Priest argued that even though voluntary codes of conduct can be efficient, flexible, and provided at low cost, they may also be less effective as they have limited accountability mechanisms and may lack enforcement systems, compliance incentives, and consumer participation (1998: 301). Gunningham and Bluff cautioned that it is unwise to rely on an association to uphold the public interest through voluntary self-regulatory mechanisms *“unless there is considerable external pressure on it to do so”* (2008: 94-95). Moreover, Gunningham contended that unless adherence to voluntary codes of practice could be assured through alignment between regulatory compliance requirements and professional self-interest, it is unlikely they would be effective in upholding the public interest (2004: 327). Similarly, Freiberg observed that the effectiveness of regulation depended on the congruency between the law and the ethical beliefs of regulatees, such that *“where there is conflict between a regulatee’s norms or ethics and formal rules, non-compliance may be more likely”* (2017: 225). Even so, voluntary industry codes were considered by Freiberg to have certain benefits, including being more transparent, customer-focused, nimble, and of greater relevance to the profession (2017: 217-218).

An Australian government-commissioned review of self-regulation mechanisms found that *“self-regulation is most effective where there are clearly defined problems and low risk of serious or widespread harm to consumers”* (Taskforce on Industry Self-Regulation, 2000: 44). One of the review members, Louise Sylvan, later stated at a conference, *“in markets that are characterised by information asymmetries [...] or where public health and safety is an issue, these are all situations where self-regulation is entirely inappropriate”* (Sylvan, 2002, September 2-3: 9).

As part of a global review of HPR systems commissioned by WHO, Carlton et al. examined the approaches and tools used by different jurisdictions to design and deliver

more effective HPR systems and improve the safety and effectiveness of health workforces (2024). The authors compared the key features of four types of occupational regulation. Table 1.4 presents the results of this comparative analysis. The review authors concluded that:

Only statutory registration schemes provide enforceable minimum qualification and probity standards for entry to practice in a profession or occupation and powers for the regulator to actively monitor compliance with standards. (Carlton et al., 2024: 41)

1.8 Chapter summary

This chapter has presented an overview of the regulation and professions literature and a definitional summary of HPR terms. It has set out the different types of occupational regulation arrangements and outlined the primary HPR mechanisms in place for non-registered and registered professions in Australia. The summary shows the diversity of and differences in the definitional terms used, the variety of frameworks and theories in the regulation, professions, and professionalisation literature, and the range of regulatory models governing the health workforce, each of which has relative strengths and weaknesses. The chapter has summarised some global trends in HPR. It has presented a comparison of the occupational regulation mechanisms in force in four anglophone jurisdictions, including Australia, and illustrated the heterogeneity of health practitioner regulation decision-making in different countries.

Now that these foundational concepts, theories, frameworks, and definitions have been detailed, the next chapter reviews the existing literature on stakeholder attitudes to the regulation of fifteen non-registered health professions in Australia.

Table 1.4: Comparison of key features of four types of occupational regulation.

Feature/Capability	Type of occupational regulation			
	Self-regulation	Co-regulation	Negative licensing	Statutory registration
Statutory basis		Maybe	•	•
Enforceable minimum qualifications for entry to practice				•
Probity checking of persons prior to entry to practice				•
Accreditation of qualifying programs for entry to practice	•	Maybe		•
Enforceable minimum standards of practice			•	•
Mandatory continuing professional development (CPD)	• (for members)	Maybe		•
Legal obligation to report professional misconduct by fellow practitioners			•	•
Powers to monitor practitioner compliance with practice standards				•
Powers to impose conditions or limitations on a practitioner's practice			•	•
Power to issue practice guidelines/codes	•			•
Complaint and disciplinary powers	• (for members)	Maybe	•	•
Powers to remove unfit practitioners from practice			•	•
Offences and penalties for unauthorised use of professional titles				•
A publicly accessible register of qualified practitioners	Maybe	Maybe		•
A publicly accessible register of disqualified or barred practitioners			•	•
Publication of disciplinary decisions			•	•
Protection from civil liability for board members and staff discharging regulatory functions			•	•

(Carlton et al., 2024: 41, adapted with permission from the Canadian Health Workforce Network).

Chapter 2

ENGAGING WITH THE LITERATURE

Attitudes to the regulation of non-registered health professions in Australia

2.1 Introduction

Governments worldwide face challenges associated with regulating the health workforce. Challenges include growing concerns and demands relating to non-regulated and newly emerging health professions, accelerating workforce mobility internationally, a greater focus on team-based and integrated health service delivery models, rising consumer expectations, increasing privatisation of health practitioner education, and managing emerging health crises (WHO, 2021: 6).

As part of the global strategy on human resources for health, the World Health Organization (WHO) urges member states to establish policies for regulating the health workforce (WHO, 2016: 15). WHO considers appropriate health practitioner regulation (HPR) settings are needed to ensure workforce quality, competency and adherence to standards, enable formal recognition of practitioners, allow practitioners to work to their full scope of practice, and achieve the United Nations Sustainable Development Goals (WHO, 2016: 17-25). HPR responds to the imperative of patient safety and is increasingly recognised *“as a core mechanism to ensure health workforce availability, accessibility, acceptability, quality, and sustainability”* (WHO, 2021: 6).

There is considerable research globally on approaches taken to HPR and how these may support the health workforce and health system goals (Leslie et al., 2023). Less research effort has been directed towards identifying the attitudes of governments and other healthcare stakeholders to HPR, particularly concerning the non-registered workforce.

Some international research has examined perspectives regarding the occupational regulation of certain health workforce cadres (Carè et al., 2021; Liu et al., 2021). However, no research to date has focused specifically on identifying stakeholder perceptions of HPR for non-registered health professions in the Australian context. By

drawing attention to the attitudes and perceptions of HPR, insights into the challenges observed by WHO may become apparent, and ways of addressing them may be identified.

This scoping literature review examines the research literature on stakeholder perceptions of HPR. The chapter presents a systematic examination of perspectives regarding the occupational regulation of fifteen non-registered health professions in Australia. The relevant literature has been reviewed to identify areas of scholarship for which there is little or no research that this doctoral thesis aims to address.

2.2 Selection of professions

The health professions examined in this review and the broader doctoral research were chosen from a total of 67 health professions not registered under the National Registration and Accreditation Scheme (NRAS) on 1 July 2012 (AHMAC, 2013: 10, 59-60, 91-94). The protocol and eligibility criteria for selecting professions are detailed in the research methods, Chapter 4, Section 4.2.3. The health professions included in this review were presented in Section 1.1, Table 1.1¹⁰.

2.3 Scoping review methods

2.3.1 Review protocol and search strategy

The review protocol was developed in accordance with the PRISMA extension for scoping reviews (Tricco et al., 2018). It was registered in PROSPERO on 7 July 2022 (Registration number: CRD42022344660).

A literature search was conducted in nine databases (AMED, CINAHL (EBSCO), Embase (via Ovid), Informit, MEDLINE (via Ovid), ProQuest Dissertations and Theses, PsycINFO (EBSCO), PubMed, and Scopus). The search was conducted on 1 July 2022 for literature published between 2000 and 2022. A second search was performed on 4 August 2024

¹⁰ The non-registered professions examined in the review and in the doctoral research study were: audiology, clinical perfusion, counselling, dietetics, exercise physiology, massage therapy, myotherapy, naturopathy, orthoptics, paramedicine (included because it was not registered on 1 July 2012, the date set for selecting professions for investigation), psychotherapy, social work, sonography, speech pathology, and Western herbal medicine.

in the same databases using the same search terms for additional research published since the first search.

The search strategy consisted of free text and medical subject heading terms. Boolean operators were used within concept groups (using 'OR') and between concept groups (using 'AND'). Table 2.1 lists the search terms used in MEDLINE (via Ovid). The search protocol for all databases interrogated is available in Appendix 1 and can be found at: https://www.crd.york.ac.uk/PROSPEROFILES/344660_PROTOCOL_20220707.pdf.

Table 2.1: Search terms used in MEDLINE (via Ovid).

CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
ambulance/ ambulance.mp. paramedic*.mp. audiology/ audiologists/ audiolog*.mp. counseling/ counselors/ counsel*.mp. dietetics/ dietitian/ dietetic*.mp. dietician*.mp. dietitian*.mp. "exercise physiol*".mp. "herbal medicine".mp. "herbal medicine practitioner*".mp. herbal medicine/ phytotherapy/ phytotherap*.mp. herbalis*.mp. massage.mp. myotherap*.mp naturopath*.mp. orthopti*.mp. perfusion* exp psychotherapy/ psychotherapists/ psychotherap*.mp. exp social worker/ "social work*".mp. "welfare work*".mp sonograph*.mp. ultrasound*.mp. ultrasonograph*.mp. exp speech therapy/ "speech patholog*".mp. "speech therap*".mp. Speech Therapy/	professionalisation professionalization ((government OR profession* OR practitioner OR profession* OR workforce OR statutory) AND (regulat* OR regist* OR accredit* OR certification OR credential* OR licens* OR licenc* OR legislati*))	exp attitude/ attitude*.mp. belief*.mp. experience*.mp. opinion*.mp. perception*.mp. perspective*.mp. reflection*.mp. view*.mp.	exp Australia/ Australia*

The database interrogation was supplemented by a search of Google Scholar using the keywords “statutory regulation” and “statutory registration” combined with the keywords “allied” and “complementary”. A location delimiter, “Australia”, and a general exclusion term, “NOT trial registration”, completed the search string. For each search combination, the first 200 retrieved records were checked against the inclusion criteria for relevancy.

2.3.2 Study selection and eligibility criteria

Records were imported into EndNote X9 (Clarivate Analytics, 2018) reference management software for assessment, deduplication, and screening for inclusion or exclusion by title and abstract. Screened records were reviewed in full text, and those meeting the selection criteria were included for review. The criteria used to determine inclusion eligibility were that publications were original research, were in English, described the perspectives or experiences of any person or group, and examined the regulation of the included health professions in Australia. Review articles, narrative research, commentaries, editorials, and non-English language articles were excluded. Reference lists of included studies were manually searched for additional titles. Figure 2.1 summarises the literature search and study selection procedure.

2.3.3 Data extraction and appraisal

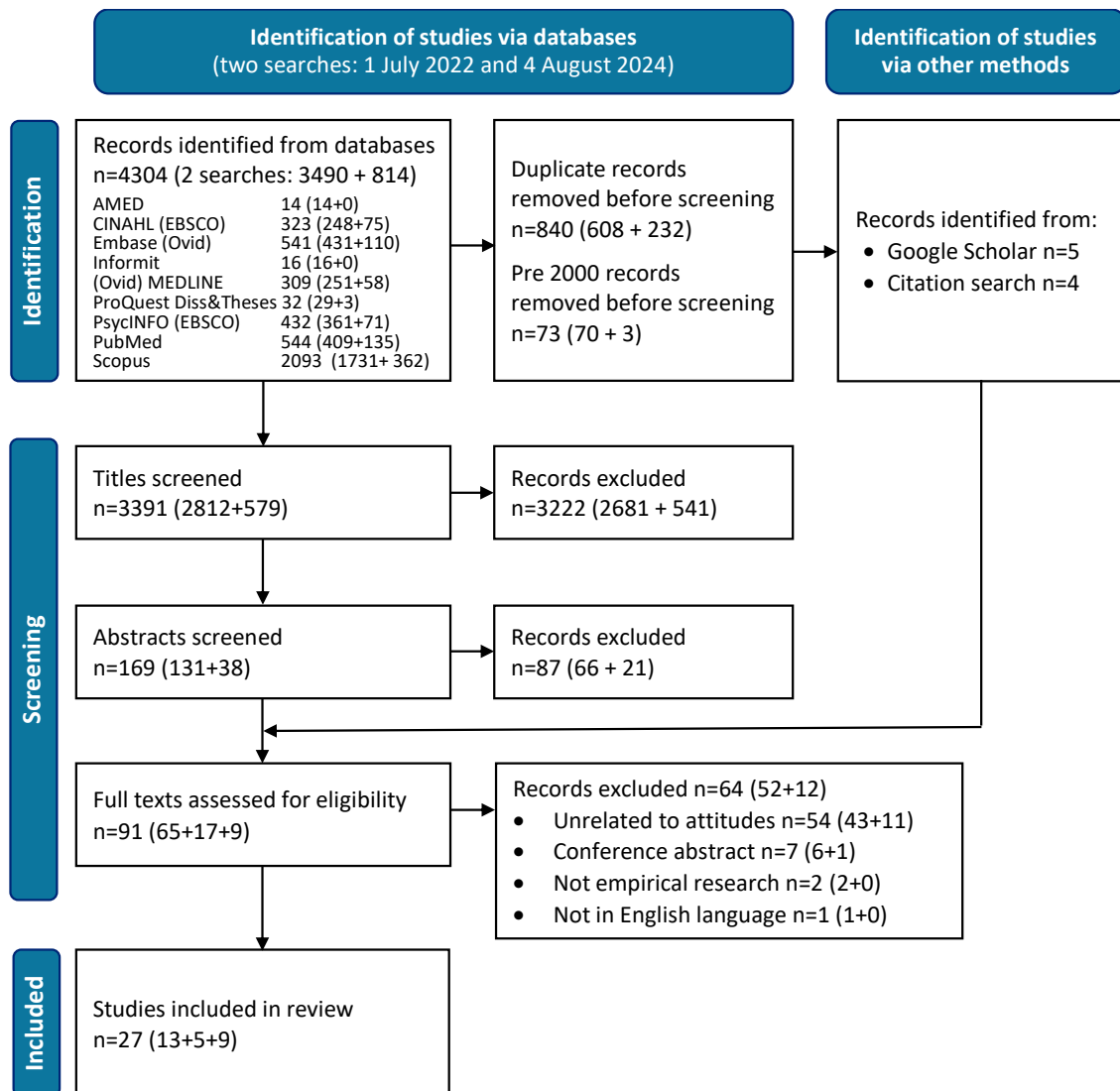
Study attributes of interest were extracted into a Microsoft Excel® (Microsoft 365) spreadsheet from a detailed reading of included studies. Relevant data were transferred to the spreadsheet under categories generated from previously conducted reviews. Included studies were appraised for research quality using Hoy et al.’s checklist for population-based studies (Hoy et al., 2012). For qualitative design studies, the Joanna Briggs Institute checklist was used (Lockwood et al., 2015).

2.3.4 Data analysis and synthesis

All data from the included studies were inductively analysed. Narrative and descriptive analyses were used to draw out the salient features of included studies. Qualitative data were narratively synthesised to summarise and present the results (Popay et al., 2006:

5). Descriptive statistics were used to summarise quantitative data and present simple graphs of study results (Trochim et al., 2016: 291). Due to the considerable heterogeneity of study designs, populations investigated, and health professions examined, a meta-analysis was not considered possible.

Figure 2.1: PRISMA flowchart of literature search and study selection.



2.4 Findings

The bibliographic, Google Scholar, and citation searches yielded 3391 non-duplicated records from the two searches performed. Title, abstract, and full-text screening excluded all but 27 publications meeting the eligibility criteria. Figure 2.1 summarises the reasons for study exclusion.

2.4.1 Study characteristics

Most studies employed a quantitative study design (n=17) using online or print-based surveys. Just over one-third used a qualitative design (n=10) employing interviews, focus groups, and textual analyses of free-format fields in surveys. All but two of the quantitative studies contained qualitative data amenable to thematic categorisation and narrative synthesis.

The theories and methods used in the included studies were: thematic analysis (Canaway, 2009; Cohen et al., 2005; James, 2013; Livingston et al., 2010; Wardle et al., 2013); interpretive phenomenological analysis (Reed et al., 2024; Reed et al., 2022); framework method (Steel et al., 2023; Steel et al., 2020a); modified grounded theory (Malhotra et al., 2020); and content analysis (Ung et al., 2017).

The 27 included studies canvassed the views of seven stakeholder groups: consumers (n=2 studies), practitioners of non-registered health professions (n=14), student practitioners (n=2), other healthcare providers (general practitioners (GPs) and pharmacists) (n=5), pharmacy assistants (n=1), educators (n=2), and professional association representatives (n=1)¹¹.

The professions examined in almost two-thirds of all studies were naturopathy and/or Western herbal medicine (WHM) (n=17). Fewer studies investigated paramedicine (n=8), counselling (n=2), massage therapy (n=1), and social work (n=1). No studies were found in the published literature for the remaining nine professions: audiology, clinical perfusion, dietetics, exercise physiology, myotherapy, orthoptics, psychotherapy, sonography, and speech pathology.

Table 2.2 sets out a summary of study characteristics. Appendix 2 presents further details of study characteristics and a summary of findings from included studies.

¹¹ One published paper by Cohen et al. (2005) reported on three professions of interest to this research: massage therapy, naturopathy, and Western herbal medicine. Data from the article relating to the three professions are reported separately in this literature review, and hence, at times, the frequency counts reported may be greater than the number of publications included in the review.

Table 2.2: Study characteristics.

Professions	Quantitative design (n=17)							Qualitative design (n=10)			Total
	Counselling	Massage therapy	Naturopathy	Naturopathy and Western herbal medicine	Paramedicine	Social work	Western herbal medicine	Naturopathy	Naturopathy and Western herbal medicine	Paramedicine	
Healthcare stakeholders											
Consumers	1								1		2
Practitioners			1	2	3	1		5		2	14
Student practitioners					1					1	2
General practitioners	1	1*	1*	1			1*	1			4
Pharmacists				1							1
Pharmacy assistants				1							1
Education providers				1	1						2
Professional associations of non-registered professions				1							1
Total	2	1*	1*	7	5	1	0*	6	1	3	27

* The study by Cohen et al. (2005) reported on the results of three professions: massage therapy, naturopathy, and Western herbal medicine. These are listed separately in the table but counted as one study under massage therapy.

A government-commissioned report (Lin et al., 2005), found through a Google Scholar search and published in summarised form (Lin et al., 2009), included five separate stakeholder studies: consumers, naturopaths/WHM practitioners, general practitioners, education providers, and professional associations. Two of these studies were published in peer-reviewed journals with their complete datasets (Bensoussan et al., 2004; Cohen et al., 2005). The remaining were published without complete datasets relating to stakeholder perspectives of regulation (McCabe, 2008) or were not published in peer-reviewed journals (Hill et al., 2005; McCabe, 2005a), confirmed by contacting the first documented author. These studies were analysed for this review using the data provided in the relevant chapters of the report (Hill et al., 2005; McCabe, 2005a, 2005b).

The terminology describing statutory registration varied across the studies. The descriptors used were:

- formal registration (Braun et al., 2013; Dooley et al., 2010; Tiralongo et al., 2010);
- government regulation (Bensoussan et al., 2004; Cohen et al., 2005; Hill et al., 2005);
- professional/full profession (Williams et al., 2010: 4; 2012: 77; Williams & Webb, 2015: 121)¹²;
- registration or national registration (Canaway, 2009; James, 2013; Livingston et al., 2010; Reed et al., 2023, 2024; Reed et al., 2021; West et al., 2009);
- registration/regulation (Reed et al., 2022; Wardle et al., 2013);
- state registration (Sharpley & Agnew, 2003; Sharpley et al., 2004);
- statutory registration (Steel et al., 2023; Steel et al., 2020a; Steel et al., 2020b); and
- statutory regulation (Malhotra et al., 2020; McCabe, 2005a, 2005b; Ung et al., 2017).

The term registration will be used in this chapter to refer to the regulation of health professions under the NRAS. The term regulation will indicate the broader field of HPR that includes non-statutory regulation arrangements and statutory mechanisms outside of NRAS.

2.4.2 Quality appraisal

The included studies were subjected to quality appraisal. Almost two-thirds of qualitative design studies were assessed as exhibiting a low overall risk of bias. The remaining four studies were assessed as being at moderate risk of bias. Six studies did not locate the cultural or theoretical position of the researchers or were unclear in their theoretical/cultural position (domain item 6). Five studies did not adequately address the potential influence of the researcher's position in the methods (item 7). One study

¹² In these studies, the researchers used the terms 'professional' or a 'full profession' to refer to statutory registration. See: Williams et al. 2010: 4; Williams et al. 2012: 77-78; Williams & Webb, 2015: 121.

did not include participant quotations to support thematic findings (item 8) (James, 2013).

Most quantitative design studies exhibited a low overall risk of bias; five were assessed as being at moderate risk of bias, and one study was considered to demonstrate a high risk of bias (Sharpley & Agnew, 2003). Five studies performed poorly in the external validity domains because of inadequate reporting on methods relating to the target population (item 1) and/or analysis of non-response bias (item 4). Almost all studies performed well on the internal validity domain items. Three studies did not provide the raw data to validate the reported percentages (item 10).

Appendix 3 presents full details of quality appraisal assessments.

2.4.3 Findings from respondent surveys

Thirteen of 17 quantitative research studies reported the proportion of respondents supporting or opposing registration. Across all relevant studies, between 36.0% and 94.6% (median 73.0%) of surveyed respondents supported registration for specific professions. Between 2.0% and 36.0% (median 11.0%) did not support registration for the specified professions. Figure 2.2 charts the percentage of respondents indicating support for, uncertainty about, or lack of support for registration of specified health professions.

In the studies located, there appears to be broad stakeholder support for registration for most non-registered health professions. A study involving GPs reported a high degree of support for the registration of counsellors, with over 90% preferencing registration (Sharpley & Agnew, 2003). Another study found that a smaller proportion of almost half of the surveyed GPs supported the registration of massage therapists, while one-third did not (Cohen et al., 2005). Studies sampling GPs, pharmacists, pharmacy assistants, naturopaths, and Western herbalists reported considerable support for the registration of naturopaths and/or WHM practitioners, with between 65% and 92% in favour (Braun et al., 2013; Cohen et al., 2005; Dooley et al., 2010; Livingston et al., 2010; Steel et al., 2020b; Tiralongo et al., 2010). After the introduction of registration, more than two-thirds of surveyed paramedics held positive views

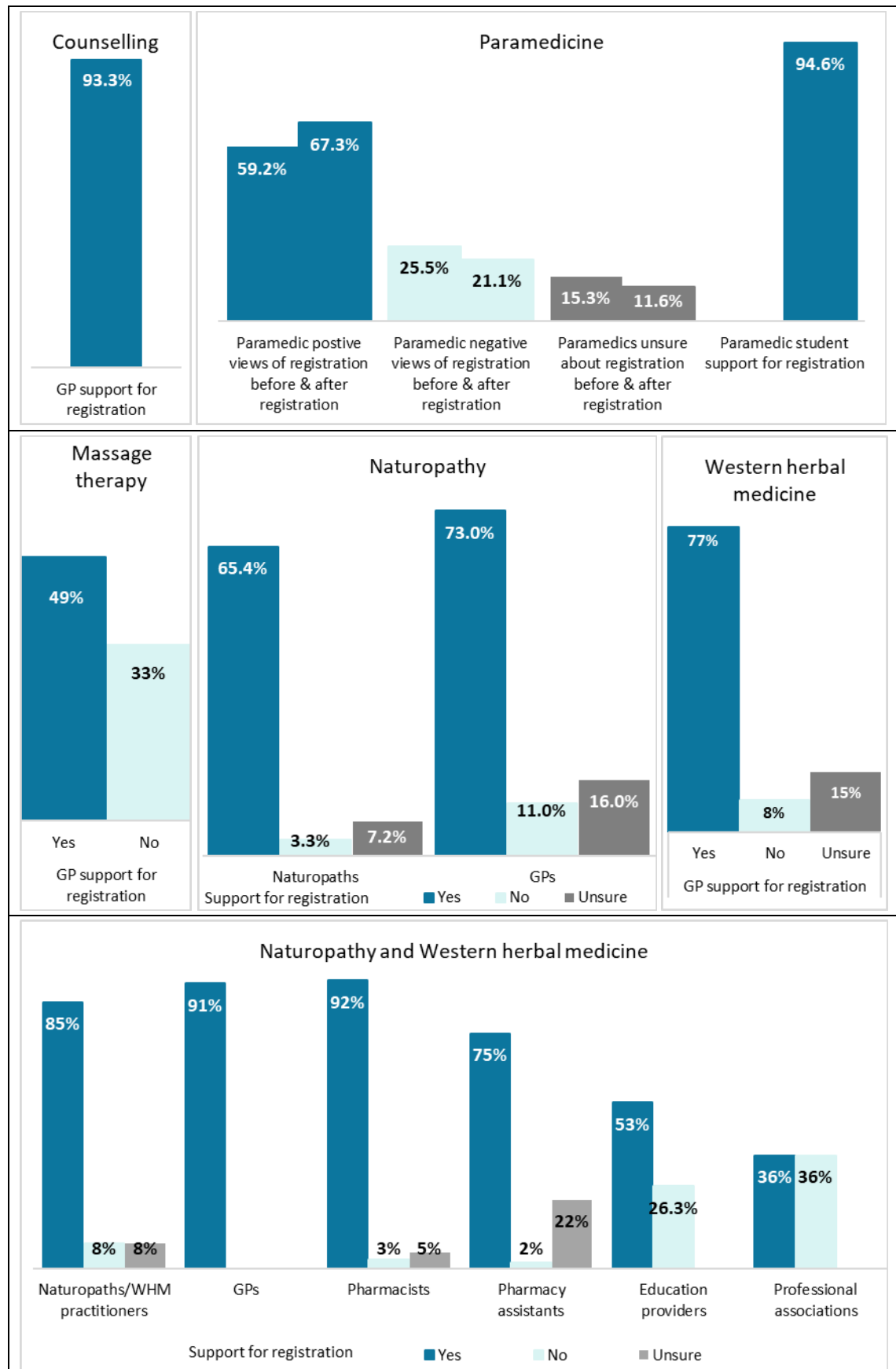
regarding registration, almost 10% more than was reported before its introduction (Reed et al., 2023; Reed et al., 2021). In the same studies, around one-quarter of paramedics reported negative views about registration before it was introduced, falling to around one in five after registration (Reed et al., 2023; Reed et al., 2021). In a separate study, well over 90% of surveyed paramedicine students supported registration (Williams et al., 2015).

A single study of professional associations representing naturopaths/WHM practitioners indicated substantial opposition to registration compared to almost all other stakeholder groups, with more than one-third of the eleven surveyed associations supporting self-regulation and over one-third supporting registration (McCabe, 2005a: 173). This compares to around one-quarter of surveyed naturopathic/WHM education providers who supported self-regulation and well over half who supported registration (McCabe, 2005b: 141). Further details on these and other findings are presented in the following sections.

Consumers

In the only consumer survey located, Sharpley et al. distributed a questionnaire in Northern New South Wales (NSW) and the Gold Coast, Queensland, seeking views from the general public about counsellors (2004). *Inter alia*, the researchers asked whether counsellors should be registered members of a government-approved association and/or state-registered. Eighty-three per cent of respondents indicated counsellors should be members of a professional organisation, which the authors reported as a preference “*that counsellors (like psychologists) are registered with either a recognised professional association or a statutory body*” (Sharpley et al., 2004: 107).

Figure 2.2: Stakeholder attitudes presented as percentages reported in included studies.



Practitioners and student practitioners of non-registered professions

Six studies sampling practitioners and students reported survey findings that generally favoured registration. Braun et al. surveyed naturopaths/WHM practitioners, reporting that 85% agreed/strongly agreed they should be registered, and 8% disagreed (2013). A separate survey of naturopaths by Steel and colleagues indicated that registration was “*definitely needed*” by 65.4% of respondents, “*might be needed*” by 24.2%, and 3.3% of respondents reported registration was not needed (2020b: 4-5). A study led by Williams surveyed paramedic students enrolled at universities in NSW, Victoria, and New Zealand¹³ (2015). Almost all respondents (98.7%) agreed/strongly agreed that members of the public expected paramedics to be registered, and 94.6% agreed/strongly agreed it was important for paramedics to have a protected register. A second study by Williams et al. found that most of the 870 surveyed paramedics across Australia¹⁴ held a strong belief that paramedicine “*would benefit from being recognised as a full profession*” (mean: 4.75; standard deviation: 0.54) (2012: 79). Two studies by Reed et al. involving paramedics reported positive views regarding registration, increasing from 59.19% before the registration of paramedicine to 67.3% following the introduction of registration (2023; 2021).

GPs, pharmacists, and pharmacy assistants

Five survey studies reported opinions about registration from the perspectives of GPs, pharmacists, and pharmacy assistants. In three of these studies, GPs conveyed varying levels of support for registration depending on the profession. Sharpley and Agnew reported that 93.3% of surveyed GPs from NSW and Queensland agreed with “*registration*” for counsellors (2003), although it was unclear from the authors’ reporting whether this should be through statutory or another type of registration. A second survey of GPs conducted by Livingston et al. found that 91% of practitioners located in Sydney, NSW, supported the establishment of a national register requiring

¹³ Of the 479 respondents surveyed in this study, 12.9% were enrolled at a New Zealand university. The nationality of surveyed respondents was not reported in the study results.

¹⁴ Of the 872 respondents surveyed in this study, two were located outside Australia (one in New Zealand and another in South Africa).

naturopaths and WHM practitioners to hold qualifications in order to be listed as “licensed” (2010). Cohen and colleagues surveyed a nationally representative sample of Australian GPs about various health professions (2005). The researchers found 77% of respondents agreed herbal medicine practitioners should be registered and 8% disagreed, 73% favoured registration of naturopaths and 11% did not, and 49% of GPs supported registration for massage therapists, while 33% indicated massage therapists should not be registered. Similar to the views of GPs, a national survey conducted by Tiralongo et al. found that 92% of pharmacists agreed/strongly agreed with registration for naturopaths/WHM practitioners, while 3% disagreed/strongly disagreed (2010). Dooley et al. noted lower but substantial support from pharmacy assistants in Melbourne, Wagga Wagga, and Gold Coast for the registration of naturopaths/WHM practitioners, with 75% agreeing, 2% disagreeing, and 22% reporting uncertainty about registration for these professions (2010)¹⁵.

Education providers and professional associations

Two studies surveyed the views of Australian education providers about the regulation of naturopaths/WHM practitioners and paramedics. A study by McCabe showed that 53% of educators preferred registration for naturopaths/WHM practitioners (2005b: 141). Williams and colleagues reported that a majority of educators (mean: 4.62; standard deviation: 0.771) considered paramedicine would benefit from being “recognised as a profession” (2010: 4)¹⁶.

In the only study surveying professional associations, McCabe reported that although 64% of eleven association representatives held negative views about the current attempts to self-regulate, 36% favoured existing self-regulation arrangements, 36% preferred registration, and 27% supported a stronger, unspecified type of regulation for naturopaths/WHM practitioners (2005a: 173)¹⁷.

¹⁵ The data do not add up to 100% but are reported as given in the publication (see Table 21, Dooley et al., 2010: 70).

¹⁶ In this study, 12% of the sample population (n=8) were New Zealand educators.

¹⁷ The data do not add up to 100% but are reported as given in the publication (see McCabe, 2005a: 173).

2.4.4 Findings from interviews, focus groups, and qualitative results of surveys

Twenty-five of the 27 studies in this review reported on reasons for stakeholder views regarding practitioner regulation. From these studies, 49 thematic categories were generated, of which 31 were classified as perceived advantages of registration and 18 as perceived disadvantages. The 49 categories were distilled into ten sub-themes and grouped again into three higher-order themes: regulating entry to and conduct of practice, implications for practitioners and professions, and regulating for public safety, consumer protection, and quality of patient care.

Figure 2.3 presents the themes and sub-themes generated from the included studies. Table 2.3 presents the themes and sub-themes found in each study included in the review.

Figure 2.3: Themes and sub-themes generated from included studies.

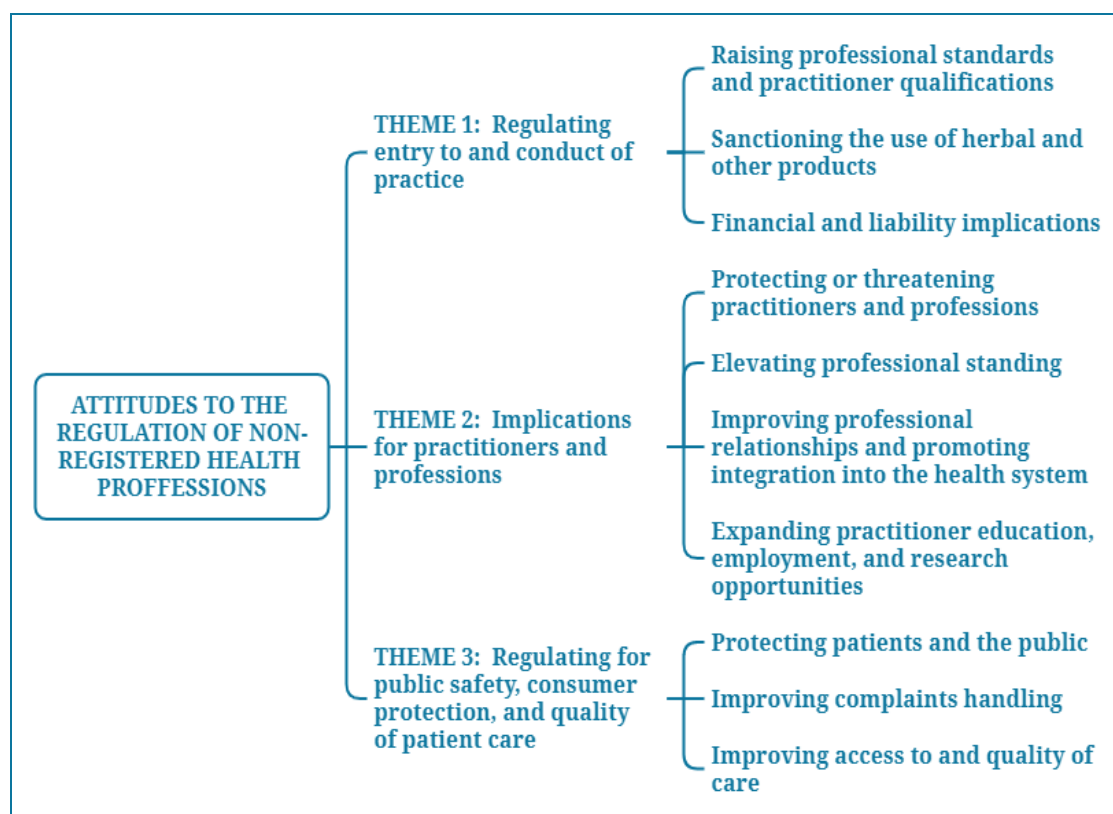


Table 2.3: Themes and sub-themes found in each study in the review.

First author Year	Profession examined	Stakeholder investigated	Entry to and conduct of practice			Implications for practitioners and professions				Public safety, consumer protection, and patient care		
			Standards & qualifications	Practice products	Financial & liability	Protection or threat	Elevate standing	Relationships & integration	Practitioner opportunities	Public safety	Complaint handling	Patient care
Sharpley 2004	Counselling	Consumers	•									
Cohen 2005	Massage, Naturopathy, WHM	General practitioners		•						• ¹⁸		
Hill 2005	Naturopathy, WHM	Consumers	•			•	•			•	•	•
Livingston 2010		General practitioners	•			•						
Bensoussan 2004		Naturopaths, WHM	•	•	•	•	•		•			
Braun 2013		Naturopaths, WHM	•			•	•	•		•		
Tiralongo 2010		Pharmacists								•		
Dooley 2010		Pharmacy assistants								•		
McCabe 2005a		Professional associations	•	•		•		•		•		
McCabe 2005b		Educators	•									
Canaway 2009	Naturopathy	Naturopaths	•	•	•	•	•	•		•	•	
Malhotra 2020		Naturopaths	•				•	•				
Steel 2020a		Naturopaths	•									•

¹⁸ In this study, public safety was identified by GPs as a reason for supporting the registration of naturopaths/WHM, but not of massage therapy.

First author Year	Profession examined	Stakeholder investigated	Entry to and conduct of practice			Implications for practitioners and professions				Public safety, consumer protection, and patient care		
			Standards & qualifications	Practice products	Financial & liability	Protection or threat	Elevate standing	Relationships & integration	Practitioner opportunities	Public safety	Complaint handling	Patient care
Steel 2023		Naturopaths	•			•	•	•		•		
Wardle 2013		Naturopaths	•			•	•	•				
Ung 2017		Pharmacy stakeholders	•						•			
James 2013	Paramedicine	Paramedic students	•				•			•		•
Reed 2021		Paramedics				•	•		•	•	•	
Reed 2022		Paramedics	•		•	•		•	•	•	•	
Reed 2023		Paramedics				•	•		•	•	•	
Reed 2024		Paramedics	•		•	•	•	•	•	•		
Williams 2010		Educators	•					•				
Williams 2012		Paramedics	•					•				
Williams 2015		Paramedic students				•	•					
West 2009	Social work	Social workers				•		•				

WHM: Western herbal medicine.

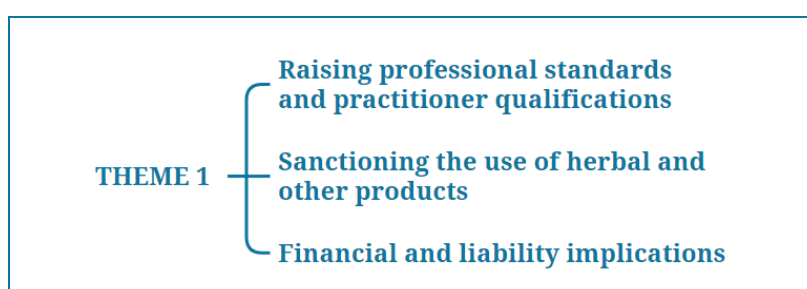
Note: Two of the 27 studies included in this review did not report any qualitative data to support thematic categorisation (Sharpley & Agnew, 2003; Steel, 2020b). These studies are excluded from this table and the qualitative analysis.

Theme 1. Regulating entry to and conduct of practice

Nineteen of 27 studies reported on stakeholder views relating to regulating entry to and conduct of practice from the perspectives of consumers (n=2), practitioners (n=10), student practitioners (n=1), GPs (n=2), pharmacists (n=1), educators (n=2), and professional association representatives (n=1).

The three sub-themes generated for this theme are presented in Figure 2.4.

Figure 2.4: Theme 1. Regulating entry to and conduct of practice.



Raising professional standards and practitioner qualifications

Eighteen studies reported the perceived benefits and drawbacks of registration to practitioner qualifications, education standards, or practice standards.

Sharpley et al. reported that 75.3% of surveyed members of the general public considered that counsellors should be tertiary trained, 45.1% preferred postgraduate qualifications, 41.6% favoured an undergraduate university degree, and 16.3% supported certificate qualifications (2004)¹⁹. Hill et al. reported findings from consumer focus groups in which several respondents expressed the need for naturopaths/WHM practitioners to possess qualifications in order to practise, some consumers identifying the requirement for practitioners to have a minimum standard of training (2005: 247).

Livingston and colleagues found that 91% of surveyed GPs supported the establishment of a national register in which certain qualifications were required for “licensed” naturopaths and WHM practitioners to practise (2010). A survey of paramedics by Reed

¹⁹ Percentages add up to more than 100, but are reported as given in the published article (Sharpley et al. 2004: 101).

et al. reported that before registration, some respondents noted registration would provide clear national standards on who could practise (2022). A follow-up survey after paramedics were registered found respondents commonly considered registration was introduced to ensure standardisation of the profession (Reed et al., 2024).

Four studies involving naturopaths and WHM practitioners reported on views relating to training and practice standards. Findings indicated that practitioners considered registration would provide a guarantee of practitioner training standards (Canaway, 2009), ensure minimum education standards (Steel et al., 2023), raise or maintain practice, professional, or ethical standards (Braun et al., 2013; Canaway, 2009), or would lead to positive changes to practice standards (73.0%) (Bensoussan et al., 2004). In two separate qualitative studies, naturopaths indicated that registration would overcome conventional provider concerns regarding naturopathic training and education (Steel et al., 2020a; Wardle et al., 2013). Naturopaths expressed similar views in interviews with Malhotra et al. where practitioners regarded the lack of a well-defined curriculum and an absence of standard training competencies as impediments to their acknowledgement as a “*legitimate*” profession (2020). James also reported a relationship between education standards and professional acknowledgement from focus group interviews with paramedicine students (2013). Respondents indicated that continuing education was a characteristic of credible registered professionals, such as doctors and nurses. They viewed ongoing education as a key registration requirement to ensure standards were being met (James, 2013). Two studies led by Williams, one surveying paramedics (2012) and the other sampling paramedicine educators (2010), reported that most respondents perceived the higher education sector had an essential role in achieving registration for the profession.

A majority of pharmacy stakeholders interviewed by Ung and colleagues considered the variation in naturopathy education standards, leading to inconsistent naturopathic advice given to consumers, was associated with the absence of registration (2017). At a time when both bachelor’s degrees and advanced diploma training were available to prospective students, some surveyed representatives of naturopathy/WHM associations perceived registration would lead to raised education standards (McCabe,

2005a: 173), while two-thirds of surveyed educators supported a bachelor's degree for practice entry as a naturopath/WHM practitioner (McCabe, 2005b: 146). In these studies, educational qualifications were reported to be a matter of debate or a source of friction among education providers and professional associations. Respondents described ongoing conflicts over minimum requirements and the commercialisation of education that were seen to lower education standards (McCabe, 2005a: 175-176; 2005b: 146). To deal with these perceived conflicts, some educators saw the need for an independent oversight body to set training standards (McCabe, 2005b: 146).

Sanctioning the use of herbal and other products

In four studies, GPs and practitioners of non-registered professions indicated that registration would affect access to or the use of therapeutic treatments such as herbal and other products. Their use by practitioners was one reason given by respondents for supporting registration. A survey of GPs conducted by Cohen et al. found many respondents considered practices such as herbal medicine and naturopathy required registration due to the potential for interactions with conventional medicines (2005). Studies by Bensoussan et al. (2004) and Canaway (2009) found that some naturopathic/WHM practitioners perceived registration could facilitate access to restricted or scheduled herbs and other products. In one of these studies (Bensoussan et al., 2004), 58.4% of respondents indicated that greater access to herbal products was likely to be a positive outcome of registration. Similarly, McCabe reported that some representatives of naturopathy/WHM professional associations supported registration to give practitioners access to scheduled herbs (2005a: 173-174). These representatives considered restrictions on product access resulting from self-regulation denied consumers the use of such herbal medicines.

Financial and liability implications

Five studies described the perceived implications of registration or its absence on financial, ethical, or legal concerns.

In interviews with naturopaths, Canaway reported practitioner concerns regarding the costs of registration, including increases in professional indemnity insurance, where

costs might be passed onto consumers (2009). In the same study, some naturopaths identified a potential financial benefit of registration if it offered a pathway to Medicare²⁰ rebatable consultations (Canaway, 2009). Bensoussan and colleagues reported that 56.1% of surveyed naturopaths/WHM practitioners were uncertain about the impact of registration on practitioner incomes, and 51.2% were unsure about the implications of registration on patient costs (2004). The study also found that 26.7% of naturopaths/WHM practitioners indicated there would be negative consequences for consumer litigation if practitioners were registered and a further 54.0% were uncertain about how registration would affect the litigation intentions of consumers (Bensoussan et al., 2004).

Surveys conducted before the introduction of registration indicated that the costs associated with registration were regarded as unfair by many paramedics (Reed et al., 2022). Despite this, 68.5% of paramedics reported the expectation that registration would not affect remuneration (Reed et al., 2021). In the follow-up survey conducted after registration was introduced, some paramedics regarded registration costs as part of the system, while others viewed the costs as unnecessary and punitive or as revenue raising by “*taxing*” practitioners for the right to practise (Reed et al., 2024).

One study identified liability concerns because of non-registered practitioners. From interviews with pharmacy stakeholders, Ung et al. reported that stakeholders considered the employment of non-registered naturopaths in pharmacy settings would mean pharmacists were responsible, and therefore liable, for any advice naturopaths gave to consumers (2017).

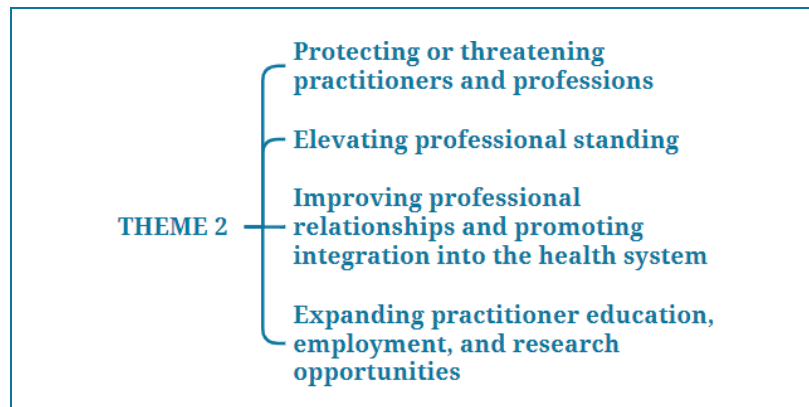
Theme 2. Implications for practitioners and professions

Nineteen studies described the perceived advantages or disadvantages of registration for practitioners and professions. These studies involved consumers (n=1), practitioners (n=12), student practitioners (n=2), GPs (n=1), pharmacy stakeholders (n=1), educators (n=1), and professional association representatives (n=1).

²⁰ Medicare is Australia’s universal healthcare system providing free or subsidised health services. See: Chapter 5, Section 5.3.2 for more information on Medicare.

The four sub-themes generated for this theme are set out in Figure 2.5.

Figure 2.5: Theme 2. Implications for practitioners and professions.



Protecting or threatening practitioners and professions

Fourteen studies reported respondent views on whether registration offered protection or posed a threat to practitioners and professional practice.

Several survey, interview, and focus group studies reported the views of practitioners and professional association representatives regarding the need for registration to protect practitioners from inadequately trained, incompetent, fraudulent, or unscrupulous social workers (West et al., 2009) or naturopaths/WHM practitioners (Braun et al., 2013; Canaway, 2009; McCabe, 2005a: 175; Wardle et al., 2013).

West et al. reported on focus group interviews with social workers, finding that registration was considered to protect professional practitioner identities due to the many professional titles in use (2009). In these interviews, participants indicated that identity protection was a priority because of ethical concerns regarding unqualified workers. In other focus groups, Hill and colleagues reported a consumer desire for approved qualifications to stop unethical practice by naturopaths/WHM practitioners (2005: 247). Interviewed naturopaths commented that registration would guard against misappropriation of naturopathic practice (Canaway, 2009), protect against co-option of the naturopath title (Steel et al., 2023; Wardle et al., 2013), and facilitate the removal of unsafe practitioners from practice (Steel et al., 2023). Williams and colleagues reported that paramedic students supported paramedicine registration with provision

for a protected register (2015). A survey by Reed et al. conducted before registration found that 78.04% of paramedics indicated they would be more individually accountable under registration (2021), falling to 74.3% following the introduction of registration (Reed et al., 2023). A proportion of these paramedics viewed the additional accountability measures as a tool or “*trap*” designed to punish paramedics (Reed et al., 2024; Reed et al., 2022).

Canaway reported that some interviewed naturopaths were critical of the claimed advantages of statutory title protection because a protected title was not perceived to prevent the use of different titles by unsafe practitioners (2009). In the same study, some practitioners commented on the risks of registration to the “*holistic approach*” of naturopathic practice, fearing it might lead to an emphasis on scientific principles and the erosion of practice philosophy. A related concern was reported by Hill et al. who reported consumer comments that registration might result in the loss of an intuitive approach to naturopathic/WHM practice (2005: 248). Comments about practice principles were also reported by some surveyed professional association representatives, who cautioned that changes to education resulting from registration should not diminish the underlying naturopathic/WHM philosophy (McCabe, 2005a: 175).

As well as concerns over the potential erosion of naturopathic philosophy, some naturopaths expressed apprehension over the possible loss of practitioners due to registration ineligibility (Canaway, 2009). These practitioners were concerned that registration might attract different types of individuals motivated more by status and personal gain. They perceived registration could result in the closure of some training colleges unable to meet statutory standards, with the subsequent loss of livelihood for college owners (Canaway, 2009).

Three studies described uncertainty from some practitioners over the potential external influences on naturopathic/WHM practice because of registration. Concerns were expressed about who naturopaths would be answerable to (Canaway, 2009), that practitioners from outside the profession would be regulating naturopaths/WHM practitioners (Braun et al., 2013), and the increasing medical influence on practice

(44.3% of survey respondents) (Bensoussan et al., 2004). In contrast, Wardle reported that interviewed naturopaths perceived registration would overcome what was described as the challenges of increasing external influences on the profession (2013). Other concerns relating to the potential intrusion of registration on professional practice included the prospect of practice standardisation or other restrictions on naturopathic/WHM practice and the possible loss of freedom to practice (Bensoussan et al., 2004; Canaway, 2009). Similar issues were raised by consumers who indicated that registration might restrict naturopathic/WHM practices or inhibit practitioners from trying new treatments (Hill et al., 2005: 248).

Elevating professional standing

Twelve studies reported perspectives regarding the potential advantages of registration to professional status, prestige, credibility, recognition, or legitimacy of practitioners and professions.

In focus groups with Hill et al. consumers commented that registration implied recognition of naturopathic/WHM practices (2005: 247). James reported on focus group interviews with paramedicine students who considered registered practitioners, such as doctors and nurses, to be credible professionals (2013), while Williams et al. found that 98.7% of surveyed paramedic students agreed that members of the public expected paramedics to be professional (2015). A survey conducted before registration showed that 25.53% of paramedics considered registration to be very/extremely important to their professional identity, and 41.05% did not consider registration important to their identity (Reed et al., 2021). After registration, the importance of registration to paramedicine professional identity rose to 36.9%, and its unimportance fell to 30% (Reed et al., 2023). In a qualitative analysis of the post-registration survey, Reed et al. found that some paramedics perceived registration as advancing the professionalisation of paramedicine and, in particular, promoting their status to other established health professions (2024).

Surveys and interviews with naturopaths/WHM practitioners indicated that registration was considered to elevate professional status (Bensoussan et al., 2004; Canaway, 2009), raise professional credibility, and increase professional confidence (Braun et al., 2013).

Interviewed naturopaths commented that registration would promote professional legitimacy and acceptance by the medical profession (Canaway, 2009), overcome perceived obstacles to professional acceptance from conventional providers (Wardle et al., 2013), promote respect, increase professional recognition, and elevate the profession within healthcare (Steel et al., 2023). Naturopaths interviewed by Malhotra et al. regarded a poorly defined education curriculum and inadequate training competencies, perceived to characterise self-regulation, as a barrier to professional legitimacy (2020).

The enhanced prestige assumed to derive from registration was not viewed positively by some naturopaths and paramedics. These practitioners commented that the conferred status and raised self-esteem were not the purposes of registration, making further regulation unnecessary (Canaway, 2009), or was considered to support the *“egos of members of the paramedicine establishment”* (Reed et al., 2022: 341).

Improving professional relationships and promoting integration into the health system

Eleven studies identified the potential for registration to improve intra- or inter-professional relationships between professions and practitioners or promote integration of practices into the health system.

Interviewed naturopaths perceived that registration would improve relationships with medical professionals, promote intra-professional unity (Canaway, 2009), overcome the division and fragmentation considered to beset the profession, and remove impediments to communicating with conventional professionals (Wardle et al., 2013). In reviewed studies, many naturopaths/WHM practitioners expressed the view that registration would promote the integration of practitioners into the healthcare system (Braun et al., 2013), eliminate barriers preventing integrative models of care (Malhotra et al., 2020; Wardle et al., 2013), provide possible entry into the hospital sector, and allow the profession to capture a greater share of the healthcare market (Canaway, 2009).

Surveyed paramedics perceived registration would promote the value of practitioners in the health system (Reed et al., 2022) and many expressed the hope they would be

used more effectively, creatively, and flexibly within the health system (Reed et al., 2024).

The role of professional associations in regulating the profession or pursuing registration on behalf of professions was also considered in some studies. West et al. reported that 14.3% of surveyed social workers gave unsolicited feedback that registration should be an objective of the association (2009). Canaway found that some interviewed naturopaths viewed registration as necessary because regulation was not considered the responsibility of the associations, while others viewed registration as unnecessary because most practitioners were perceived as being members of an association that monitored standards (2009). Similarly, Braun and colleagues found that some surveyed naturopaths/WHM practitioners regarded registration as unnecessary because association membership was considered the same as registration (2013).

McCabe reported that naturopathy/WHM association representatives were critical of self-regulation because it had failed to deliver a national, consistent, or effective regulation system (2005a: 178). Some representatives in this study commented on potential conflicts of interest if professional bodies were perceived to be *“associated with private education providers”* whose commercial interests conflicted with the registration requirement to raise education standards (McCabe, 2005a: 175).

Expanding practitioner education, employment, and research opportunities

Six studies described perceived practitioner education, employment, and research opportunities arising from registration or disadvantages resulting from its absence.

Bensoussan and colleagues found that 59.6% of surveyed naturopaths/WHM practitioners expected positive changes to post-graduate education from registration, and 58.4% expected positive changes in access to research infrastructure (2004). Some interviewed pharmacy stakeholders commented that an absence of registration and a corresponding lack of standardised naturopathic advice given to consumers hindered the employment of naturopaths in pharmacy settings (Ung et al., 2017), suggesting that registration and a uniform training curriculum might improve practitioner employment prospects.

Surveys of paramedics indicated that 54.88% considered employment opportunities would increase following the introduction of registration, 31.03% responded there would be no change to employment, and 8.59% responded there would be fewer employment opportunities (Reed et al., 2021). After registration was introduced, a greater proportion of paramedics (60.7%) perceived that employment opportunities would increase, and fewer paramedics responded that there would be no change to opportunities (27.5%) or that employment opportunities would decline (6.2%) (Reed et al., 2023). Paramedics also indicated that registration would provide a range of career options, enable practitioners to work in a wider range of health settings, allow for performing a broader range of functions (Reed et al., 2022), and offer more opportunities outside of traditional paramedic roles (Reed et al., 2024).

Theme 3. Regulating for public safety, consumer protection, and quality of patient care

Fourteen studies identified the perceived effects of registration on public safety and quality of care from the perspectives of consumers (n=1), practitioners (n=8), student practitioners (n=1), GPs (n=1), pharmacists (n=1), pharmacy assistants (n=1), and professional association representatives (n=1).

The three sub-themes generated for this theme are set out in Figure 2.6.

Figure 2.6: Theme 3. Regulating for public safety, consumer protection, and quality of patient care.



Protecting patients and the public

Thirteen studies reported respondent views that the objectives of registration were to protect patients or maintain public safety.

Several studies involving naturopaths, paramedicine students, pharmacists, pharmacy assistants, and WHM practitioners found that respondents considered registration as necessary to safeguard the public or promote public safety (Braun et al., 2013; Canaway, 2009; Dooley et al., 2010; James, 2013; Steel et al., 2023; Tiralongo et al., 2010). In surveys conducted by Reed et al. paramedics indicated registration was a safety mechanism for the community (2024; 2022). Before registration, 47.0% of paramedics considered that patients would be safer under registration, and 47.4% responded that there would be no change to patient safety (Reed et al., 2021). Following registration, 50.7% perceived that patients would be safer, and 40.9% responded there would be no change to patient safety (Reed et al., 2023). Cohen and colleagues found that many surveyed GPs supported registration of practitioners because of perceived patient harm relating to naturopathy/WHM practice, such as incorrect, inadequate, or delayed diagnosis, risks of interactions between complementary and pharmaceutical medicines, and patient non-disclosure of complementary medicine use to medical practitioners (2005). McCabe reported that some surveyed professional association representatives associated naturopathy/WHM education levels with consumer protection by regarding bachelor's degree training as the minimum requirement for maintaining public safety (2005a: 175).

Not all practitioners agreed that registration was required to maintain public safety, however. In focus group interviews with Hill et al. consumers expressed mixed feelings regarding the need for more public protection and government regulation of naturopaths/WHM practitioners (2005: 247). Some interviewed naturopaths remarked in interviews with Canaway that registration inappropriately identified the profession as unsafe, did not necessarily make for a safe profession, and was unnecessary because natural therapies were safe when offered by trained professionals (2009).

Improving complaints handling

Five studies described the concerns of some study respondents regarding complaints handling and the effect registration was perceived to have on the management of complaints about practitioners. Before registration, many surveyed paramedics considered that complaints handling would be biased against paramedics (Reed et al.,

2022). In this survey, 39.86% anticipated that fairness in complaints handling would improve following registration, and 28.88% responded that complaints fairness would decline (Reed et al., 2021). Following registration, 40.3% of paramedics expected complaints fairness to improve, and 21.8% indicated it would worsen (Reed et al., 2023).

Some naturopaths interviewed by Canaway stated registration was necessary to ensure transparent complaint handling, while others in the same study commented that complaints were adequately managed under existing self-regulation mechanisms (2009). In a separate study, consumers identified the need for a body to hear complaints and deal with consumer issues due to concerns about professional associations inadequately investigating complaints about their members (Hill et al., 2005: 248). In this study, consumers expressed concerns that poorly performing practitioners could readily leave one association or be forced to leave, only to join another and continue practising.

Improving access to and quality of care

Three studies reported respondent expectations of improved patient care resulting from practitioner registration. James reported the perspectives of paramedicine students in focus group interviews that registration could improve clinical practice (2013), while Steel et al. found that interviewed naturopaths perceived registration could enhance patient access to naturopathic care (2020a). Consumers communicated their scepticism regarding improvements to practitioner quality if naturopaths/WHM practitioners were registered but nonetheless considered registration necessary to ensure consistency of patient care (Hill et al., 2005: 247-248).

2.5 Discussion

2.5.1 Key findings

In included studies, registration for non-registered professions appears to be broadly supported by most study participants for most professions identified in the review. Findings from this review indicate that registered and non-registered practitioners largely supported registration for naturopaths, paramedics, and WHM practitioners, but less than half of GPs supported registration for massage therapists. There was greater

diversity of opinion on the registration of naturopaths and WHM practitioners among educators and association representatives. These findings are reflected in research found in the wider literature. A global systematic review of stakeholder attitudes to the regulation of traditional and complementary medicine professions reported broad support for practitioner registration (Carè et al., 2021). In overseas studies, support for registration is also found for professions such as counselling (Montgomery et al., 2018) and social work (Hobbs & Evans, 2017; Miller et al., 2015). The reasons offered for supporting registration are comparable to findings from this review: risk of patient harm, maintaining qualification standards, establishing title protection, and distinguishing between qualified and unqualified practitioners (Montgomery et al., 2018).

Twenty-five of the 27 studies in this review reported at least one expected benefit from registration, including elevating practitioner prestige, raising practice standards, and, to a lesser extent, promoting consumer protection. These benefits are analogous to those reported in an unpublished survey of registered practitioners in Australia on reputational insights into registration (Ahpra, 2021b: 12, 40). This suggests the benefits of registration identified by this review are similar to the benefits registered professionals perceive they have realised from being registered. This is also illustrated by findings from this review, where surveyed paramedics responded more favourably to professional identity issues following the introduction of registration (Reed et al., 2023, 2024) compared with responses before registration (Reed et al., 2021, 2022).

Regarding the perceived disadvantages of registration, these were reported in around one-third of all publications (n=10), although most were reported in one study involving interviews with seven naturopaths (Canaway, 2009), limiting its generalisability.

This review finds that attitudes regarding regulation were often focused on practitioner, practice, or profession-related concerns, which could be due to the questions asked of respondents drawing attention to personal and professional matters. Nevertheless, study respondents paid less attention to patient and consumer-related registration outcomes than to practitioner and professional issues. In reviewed studies, the focus of many stakeholders on professional rather than patient concerns stands in contrast to

the objectives of the *National Law*, where the “*paramount*” guiding principle is the protection of the public and public confidence in the safety of registered health practitioners (*Health Practitioner Regulation National Law and Other Legislation Amendment Act 2022* (Qld): 33-34). Tensions between the public and professional interests in healthcare have previously been reported for registered professions (Aldridge, 2008: 9; Coburn, 1993: 137; Timmermans & Oh, 2010: S101). The degree to which these tensions exist for professions in the present research is unknown and warrants further exploration. This may reveal diverse opinions among stakeholders representing professional bodies, consumer advocacy organisations, and government institutions that may give rise to stakeholders prioritising professional or personal interests over the public interest.

There may be historical explanations for the apparent attention given to professional issues, such as the recognition and elevation of practitioner status afforded by registration, as reported by many studies in this review. Registration has often been described as conferring recognition and legitimacy rather than as a mechanism for public protection. An early example of this phenomenon comes from a 1977 Australian Government *Commonwealth Committee of Inquiry*. The Inquiry recommended registration of chiropractors and osteopaths but not naturopaths as the Committee considered “*that such licensing may give a form of official imprimatur to practices which the Committee considers to be unscientific*” (Parliament of Australia, 1977: 99). Despite the review objectives, which included identifying evidence of direct harms of treatment (Parliament of Australia, 1977: 16), the Committee appears to have disregarded risk considerations, opting for decision-making based on approbation. Another example comes from a 2010 UK review of herbalists, which recommended practitioner registration with the statutory regulator, the Health Professions Council, which also registers dietitians, occupational therapists, and physiotherapists (UK DOH, 2008: 3)²¹. Despite this recommendation, herbal medicine practitioners were regulated under the voluntary registering body, the Complementary and Natural Healthcare Council. At the

²¹ The UK Health Professions Council is now known as the Health and Care Professions Council. It currently registers 15 professions in the UK (UK HCPC, 2024).

time, the Health Secretary for England stated, *“the introduction of such a register will increase public protection, but without the full trappings of professional recognition which are applied to practitioners of orthodox health care”* (Kmietowicz, 2010: 1). This positions registration as a distinction professions are granted to achieve professional acceptance, a perspective criticised by the UK Professional Standards Authority as *“reflecting an out-of-date view that regulation is a badge of professional status and something to be achieved, rather than a system to be applied where risks justify its intervention”* (2015: 9). Moreover, a 2014 consultation paper for a review of the NRAS included a reminder that registration was *“not to provide status and credibility to health practitioner groups”* (AHMAC, 2014a: 11). In a submission to the NRAS Review, the Australian Medical Association objected to including additional professions in the *National Scheme* because it *“would give health care workers undue status and credibility”* (AHMAC, 2014b: 26). Contemporary criticisms regarding registration for some professional cadres, solely because it offers legitimacy that certain parties believe is undeserved, are still common in Australia. This has been particularly pronounced in objections to the registration of so-called complementary medicine professions such as Chinese medicine, chiropractic, and osteopathy (Brosnan, 2015; Dwyer, 2019). Opposition to the registration of some professions persists despite analysis demonstrating the public protective nature of registration of such professions in Australia (Lin & Gillick, 2011) and the significantly higher rate of removal from practice of complementary medicine practitioners compared with medical professionals following registration board disciplinary processes (Millbank et al., 2017: 802).

There are also references in the published literature to the legitimisation associated with statutory schemes and the pressure exerted by other health professions to prevent registration for professions deemed unworthy of such legitimisation (Kelner et al., 2004b: 87). Cruess, Johnston, and Cruess described professions as *“privileged”* when granted statutory licensing (2002: 208). References to granting privilege, entry to an exclusive club, or, as one writer described it, a *“prize”* awarded to those who attain registration (Wardle et al., 2016: 4) are also evident in Australia. One example is the *“recognition”* Chinese medicine practitioners were considered to attract on their registration in the

Australian State of Victoria (Freckelton, 2000: 13). Another is that non-registered professions are expected to lodge a submission 'applying' for NRAS inclusion (COAG, 2008a: 22) suggesting registration is granted to the 'worthy'. The requirement to apply for registration is not limited to Australia, however. For instance, health professions seeking statutory occupational regulation in Aotearoa/New Zealand must also apply (NZ MOH, 2023a). The requirement for professions to lodge a submission for registration suggests governments may view registration as membership of an exclusive 'club' awarded to successful applicants. It also appears that registration may have become conflated with approval, recognition, and prestige. Evidence from the literature indicates that stakeholders associate registration with increased professional status and legitimacy, a perspective that appears widespread and is evident in government reports and research studies alike. Such a view is inconsistent with the stated policy position of governments that the purpose of registration is to protect the public and reduce the risks of health practices rather than promote the professions' interests.

An assessment process for registration was developed with the establishment of the Intergovernmental Agreement (IGA) assessment criteria in 1995 (AHMAC, 2018a: 7). Since the commencement of the NRAS, only three government reviews assessing single professions are known to exist, and only one profession has been included in the National Scheme since 2012. The review of paramedics proceeded through to registration (AHMAC, 2015). The review of audiology has recommended and has in-principle agreement for registration with further consultation ongoing to inform a final decision (Queensland Government, 2024b: 3). The third assessment is understood to have been of social work; however, no information could be located regarding the assessment other than a Ministerial Council decision not to proceed with registration (COAG, 2016: 2). Furthermore, other government or government-commissioned reports have advanced a case for or recommended further consideration of registration for non-registered professions such as counselling, naturopathy, social work, and WHM but have failed to progress (Australian Government, Expert Committee, 2003: 23; COAG, 2016: 2; Lin et al., 2005: 14-15; NSW Joint Committee, 2006: xi; SA SDC, 2009: 5). Although the IGA assessment criteria exist to assess health professions for registration, they are of

little use if recommendations go unheeded. By investigating stakeholder perspectives and experiences, the present research will explore reasons for the progression to registration of some professions while others appear to have failed. The present investigation will examine the IGA assessment criteria and other decision-making protocols to clarify areas of concern for healthcare stakeholders. Examining the extent to which evidence and criteria inform stakeholder perceptions regarding the regulation of non-registered health professions is essential if HPR policy-making is to fulfil its obligations to its citizens.

Over half of all included studies reported information relating to public safety, patient care, access to care, or consumer complaints (Braun et al., 2013; Canaway, 2009; Cohen et al., 2005; Dooley et al., 2010; Hill et al., 2005; James, 2013; McCabe, 2005a; Reed et al., 2023, 2024; Reed et al., 2021, 2022; Steel et al., 2023; Steel et al., 2020a; Tiralongo et al., 2010). Relatively few studies conducted any focused examination of attitudes to regulation (Braun et al., 2013; Canaway, 2009; Cohen et al., 2005; Hill et al., 2005; James, 2013; McCabe, 2005a; Reed et al., 2023, 2024; Reed et al., 2021, 2022). The research objectives of studies for which regulation was not the main focus included views about integrating the professions into mainstream health provision or knowledge about and the challenges faced by the professions. In some studies, the broad research aims resulted in limited relevant information on perspectives regarding regulation and reasons for stated views (Dooley et al., 2010; Steel et al., 2020a; Steel et al., 2020b; Ung et al., 2017; Williams et al., 2015). The objective of the present research centres on the regulation of non-registered health professions, stakeholder support for different models of HPR, the reasons offered for held views, an analysis of collected data, and an interpretation of study results.

2.5.2 Professions examined

This review identified many non-registered professions where no published research on attitudes to HPR could be located. Of the 15 professions in the scope of this investigation, less than half (n=6) featured in at least one study identified by this review. Of these, three professions, counselling, massage therapy, and social work, were each examined in one or two studies, paramedicine was examined in eight, and almost two-

thirds of all studies (n=17) examined attitudes regarding just two health professions, naturopathy and WHM. This leaves nine professions for which no published research was located regarding stakeholder attitudes to their regulation (audiology, clinical perfusion, dietetics, exercise physiology, myotherapy, orthoptics, psychotherapy, sonography, and speech pathology). The dominance of certain professions in the published literature may be due to policy-makers active consideration of professions such as naturopathy and paramedicine for registration (AHMAC, 2012: 3; Lin et al., 2005: 21). It is also possible that research about a profession was being conducted by researchers with professional affiliations in that occupational field, but why this may be so for some professions and not others is unclear.

This scoping review limited its search to the academic literature, but it is evident that the available research does not encompass the full complement of non-registered health professions examined. Factors contributing to the considerable research for some professions and a paucity for others may be that researchers of professions such as naturopathy and paramedicine have directed much of their research effort regarding regulation towards the academic literature, which has the advantage of being transparent, accessible to a broad audience, and subject to peer review. Researchers in other professions may have pursued different avenues for information dissemination. For instance, research reports presenting Australian data on consumer or practitioner perceptions, including perceptions regarding the regulation of counsellors, social workers (Craig Hodges Consulting, 2011), sonographers (ASA, 2019), and speech pathologists (SPA, 2025) are found in the grey literature but not the academic literature.

The available empirical research for so few professions may indicate a need for greater research effort encompassing non-registered professions for which little research currently exists. The scant research suggests a lack of any planned HPR reform agenda by governments, which may have acted as a stimulus for empirical research. Saks and Allsop observed that studies of professions seldom research occupations outside of mainstream professions (2007: 175). Findings from this review support this observation in the Australian HPR context, a situation that the present research aims to remedy.

2.5.3 Stakeholders investigated

The widespread support from several stakeholder groups for the registration of some non-registered professions raises the question of why so many remain non-registered when there is evidence of support for greater regulation. While stakeholder attitudes do not determine decisions to regulate health professions, the reasons offered in the literature and summarised in this review regarding the potential for patient harm suggest an examination against the IGA assessment criteria may be justified.

Since 2012, paramedicine has been included in the National Scheme and audiology has recently been recommended and received ministerial in-principle agreement for registration (Queensland Government, 2024b: 3). Several other reviews for professions such as counselling, naturopathy, social work, and WHM have failed to progress (Australian Government, Expert Committee, 2003: 23; COAG, 2016: 2; Lin et al., 2005: 14-15; NSW Joint Committee, 2006: xi; SA SDC, 2009: 5).

One way of identifying possible reasons for the different outcomes of government reviews may be by examining the attitudes of stakeholder groups for which no research has been conducted. Examination of the stakeholder cohorts whose views were canvassed in the 27 studies in this review reveals that some stakeholders in the field of HPR in Australia, such as government policy stakeholders, have not previously been investigated, and others, such as consumer and professional body stakeholders, have been examined to a limited extent.

Government policy stakeholders are central players in HPR but were absent from the stakeholder groups investigated in studies located by this review. Despite their potential influence on policy outcomes, the views of government health policy officers regarding the regulation of non-registered health professions appear to be unexamined to date. In contrast, research from Canada, for example, has investigated the views of federal and provincial policy-makers and officials regarding the statutory licensing and accreditation of complementary and alternative medicine practitioners (Kelly et al., 2005; Kelner et al., 2004b). Adams and Saks contended that the actions of state actors

have frequently been ignored in studies of professions (2018: 66). These writers call for theoretical and empirical research on:

the interests, values, and formal constraints and considerations shaping state actor activity, and consider when – and the extent to which – the interests and values of state actors coincide with professional groups in policy-making. (Saks & Adams, 2019: 7)

Policy officers are key stakeholders in HPR, and their absence from research scholarship, as suggested by these writers, is a limitation to current knowledge. So, too, are the views of officers from the Australian Health Practitioner Regulation Agency, which the research community has also overlooked. The emphasis of governments on evidence-informed decision-making in HPR suggests that examining the views of government actors is an important topic of research to provide insights into what evidence, information, ‘interests’, and ‘values’ may shape or influence decision-making about HPR policy.

The voices of consumers were not broadly canvassed in the literature, with only two consumer studies located by this review (Hill et al., 2005; Sharpley et al., 2004) and another study capturing the opinions of a single consumer advocate among other pharmacy stakeholders (Ung et al., 2017). The present investigation aims to explore the perspectives of consumer advocates representing consumers whose organisations often interact with governments on matters affecting their constituents. This avenue of research was considered more fruitful than engaging with individual consumers to identify perspectives of healthcare professions with its attendant limitations of scope and breadth. Researching the views of consumer advocates may also offer insights into the receptivity and responsiveness of governments to consumer advocacy perspectives regarding HPR.

In Australia, non-registered health practitioners are represented by non-statutory bodies that tend to fall into one of three groups:

- professional associations representing practitioner members;
- voluntary practitioner registering bodies for practitioners of a profession, for example, the Australian Orthoptic Board (AOB, n.d.); and

- other professional bodies, such as peak professional advocacy organisations, for example, Allied Health Professions Australia (AHPA, 2025a) and the voluntary professional association standard-setting body, the National Alliance of Self Regulating Health Professions (NASRHP, 2025).

The database search for this review located one Australian study surveying the views of professional associations representing two of the 15 health professions included in this research (McCabe, 2005a: 157). This leaves 13 professions for which no research was found in the published literature regarding the opinions of associations about the regulation of practitioners they represent. Nor was any published research found regarding the views of peak professional or voluntary registering bodies. Given the governance and advocacy roles played by professional bodies and the quasi-regulatory role these organisations have assumed in the absence of statutory forms of registration, the dearth of literature makes investigating the perspectives of these groups a crucial line of research.

2.5.4 Interpretive frameworks and theories in HPR research

The final area of interest for the present research is in connection with the frameworks and theories employed by researchers to analyse stakeholder perspectives of HPR. However extensive or limited the research concerning the regulation of non-registered health professions, and however detailed or brief the commentary about attitudes to HPR in the published literature, what remains unknown are explanations for these views.

Five studies in this review identified the epistemological underpinnings for the research using constructivist approaches (Malhotra et al., 2020; Reed et al., 2023, 2024; Reed et al., 2021, 2022). Four of these studies were from the same research project, two of which also used a theoretical framework, interpretive phenomenological analysis, to analyse and interpret study findings (Reed et al., 2024; Reed et al., 2022). The literature reports stakeholder positions on occupational regulation and reasons for held views, but few studies offer potential causal explanations for stakeholder positions and perspectives. It appears that applying theoretical frameworks in the Australian context

has largely escaped the attention of HPR scholarship. This contrasts with international research in which theories and frameworks have been used to analyse stakeholder perspectives of HPR (Boon et al., 2004; Kelner et al., 2004a; Kelner et al., 2006; Welsh et al., 2004). This establishes a priority for the present investigation to apply a suitable theory or framework through which to view, understand, and explain perspectives of and positions on the regulation of non-registered health professions in Australia.

2.5.5 HPR research agenda for non-registered health professions in Australia

This review has identified limited research in the scholarly literature regarding the attitudes of a range of healthcare stakeholders to the regulation of a range of non-registered health professions. The available research provides instructive, predominantly profession-focused perspectives of HPR from some stakeholder groups for a few non-registered professions. However, the literature lacks breadth and depth to inform evidence-informed public policy. A contemporary research agenda is needed to canvass perceptions from various stakeholders about a broader range of non-registered health professions to understand the enablers and constraints to effective HPR policy-making. A systematic, proactive research agenda is necessary if HPR in Australia is to meet its stated goals of protecting the public, supporting workforce mobility, facilitating high-quality education and training, promoting access to health services, and enabling the continuous development of a flexible, responsive, and sustainable workforce (AHMAC, 2018a: 4).

In contributing to a more rigorous and systematic research agenda, the present investigation intends to examine three components that may be used to guide or facilitate evidence-informed HPR regulatory policy decision-making. The first will identify stakeholder positions on HPR from diverse stakeholder cohorts regarding 15 non-registered health professions. The second will determine the stated rationales for held positions, including motivations and aspirations. The final component will apply a theoretical framework to generate an understanding of and explanations for the attitudes and perspectives.

Limitations

One-third of all studies in this review were identified through Google Scholar (n=5) and citation searching (n=4). The relatively low proportion of articles found in the bibliographic databases may be due to variations in terminology, as evidenced by the diverse terms used in reviewed studies to describe statutory registration. The paucity of studies found in the databases may also indicate the immaturity of HPR research in Australia regarding non-registered professions or limitations with established medical subject headings that may be more focused on research involving registered professions, most notably medicine and nursing. Additionally, the critical appraisal tool for qualitative research was not suited to the predominantly descriptive studies found through the literature search or the heterogeneity of approaches used in identified studies. This led to the inclusion of all studies irrespective of research quality. Although this was appropriate for a scoping literature review, it calls for caution when considering the findings from the qualitative analysis due to the potential for bias.

2.6 Chapter summary

The present research investigation aims to address the knowledge gaps in HPR policy scholarship in the Australian setting by attending to areas where no research currently exists, expanding on existing knowledge where there is little research, and examining the barriers to translating such knowledge into policy or practical outcomes. A greater understanding of the attitudes to HPR from the perspectives of consumer advocates, government health policy actors, and professional body representatives is needed to provide insights into the complexities, challenges, and opportunities associated with regulating non-registered health professions in Australia.

Appropriate regulatory settings are essential for public safety and cost efficiency. The present research may uncover potential deficiencies in the current regulatory policy framework within which HPR decision-making occurs. Despite its importance, the evidence thus far suggests regulation of non-registered professions is often overlooked and potentially neglected. To date, this research area has attracted little empirical research, as shown by this review, and what exists is imbalanced in terms of

stakeholders investigated and professions examined. There is a pressing need for rigorous and wide-ranging research to contribute to evidence-informed policy development and implementation, without which appropriate policy for non-registered health professions is impeded. This is the task of the present research.

A methodological approach is required that guides the researcher from study objectives to research conclusions, informed by a comprehensive review of existing literature as provided in this chapter. A methodological approach is the focus of the next two chapters, in which I detail the theory underpinning the research in Chapter 3 and methods for the research investigation in Chapter 4. These theories and methods were aimed at addressing the considerable gaps in current research scholarship on the perspectives and experiences regarding the regulation of non-registered health professions in Australia.

Chapter 3

PHILOSOPHY AND THEORY

3.1 Introduction

This research was designed to address objectives regarding stakeholder perspectives and experiences of occupational regulation. It examines the structures and mechanisms maintaining health practitioner regulation (HPR) by investigating, describing, analysing, and interpreting the patterns of perspectives and experiences of healthcare stakeholders regarding the regulation of 15 health professions not registered under Australia's National Registration and Accreditation Scheme (NRAS) on 1 July 2012. In particular, the research examines the views of consumer advocates, government health policy actors, and professional body representatives and aims to propose potential causal mechanisms for these views.

This chapter presents the philosophical orientation, meta-theory, and theoretical framework adopted as structural elements and explanatory concepts that guided the conduct of the research. The chapter begins by describing the critical social research approach taken and how this shaped the research investigation. Next, I position the research within a critical realist meta-theory as the rationale for the existence of a singular reality with multiple stakeholder interpretations of this reality. Following this, I outline several theories considered during the research and argue for the most promising explanatory theoretical framework to meet the research objectives. The class and power theories of Pierre Bourdieu (1977a) are used to explain the motivations, methods, and justifications of stakeholders relating to their perspectives and experiences of regulation ascertained through documentary and interview sources.

Table 3.1 presents an overview of the research design and approach to meet the research objectives.

Table 3.1: Overview of study design.

Thesis title	Policy, politics and power in health practitioner regulation: Perspectives and experiences of healthcare stakeholders regarding the occupational regulation of non-registered health professions.	
Research aim and objectives (Chapter 1)	Investigate the perceptions and experiences of consumer advocates, government health policy actors, and professional body representatives regarding the occupational regulation of 15 non-registered health professions in Australia. 1. Describe the regulatory policy and institutional history, contexts, and frameworks for the occupational regulation of health professions in Australia and the decision-making criteria and processes for determining the registration of professions under the <i>Health Practitioner Regulation National Law</i> . 2. Identify and describe publicly documented positions and perspectives of healthcare stakeholders regarding the occupational regulation of non-registered health professions. 3. Explore and describe the perspectives and experiences of healthcare stakeholders regarding the occupational regulation of non-registered health professions, including perspectives of the policy and decision-making frameworks. 4. Theoretically analyse and interpret stakeholder perspectives of HPR, including the perceived complexities, challenges, and opportunities associated with regulating non-registered health professions in Australia and the perceived adequacy of and gaps in the current regulatory policy framework within which regulatory policy decision-making occurs.	
Philosophical orientation and theoretical framework (Chapter 3)	Research orientation	Critical social research focuses on ideology, hegemony, and power and aims to reveal and challenge power structures and cultures (Crotty, 1998: 157).
	Ontology and epistemology	Critical realism is an alliance between ontological realism and epistemological relativism (Bhaskar, 2008: 15). Critical realists hold that although reality exists independently of individual consciousness, it is culturally, socially, and historically situated and epistemologically created (Botha, 2021: 9).
	Theoretical framework	Bourdieu's theory of practice using the concepts of field, capital, symbolic power, symbolic violence, habitus, doxa, and illusio (Bourdieu & Wacquant, 1992).
Methodology and methods (Chapter 4)	Research approach and strategy/logic of inquiry	Applied policy analysis is focused on the context in which social actors engage and the political and professional issues they navigate in the engagement (Cairney, 2023: 1822). Inductive research strategy (from data to theory) and abductive research strategy (a search for meaning and interpretation) (Blaikie, 2010: 83-92).
	Research methodology	Qualitative multi-methods, sequential research design, descriptive, analytic, and explanatory research comprising four study phases: 1. Mapping the HPR field and co-regulation arrangements. 2. Analysis of publicly accessible documentary sources reviewed from a search of the grey literature, including the websites of government departments/agencies, professional bodies, and archival repositories. 3. Analysis of stakeholder perspectives from semi-structured interviews. 4. Theoretical analysis and interpretation of stakeholder perspectives.
	Sampling	1. The HPR field: 107 documents retrieved and analysed. 2. Documentary sources: 560 documents retrieved and analysed. 3. Stakeholder interviews: 42 interviews with 46 participants: a. Consumer advocates (n=5 participants); b. Government health policy actors (n=15 participants); c. Peak professional and voluntary registering body representatives (n=6 participants); d. Professional association representatives (n=20 participants).

Thesis title	Policy, politics and power in health practitioner regulation: Perspectives and experiences of healthcare stakeholders regarding the occupational regulation of non-registered health professions.	
	Data analysis and interpretation	1. Documentary sources for mapping the HPR field: READ descriptive approach to policy research (Dalglish et al., 2020). 2. Documentary sources: applied thematic analysis (Guest et al., 2012). 3. Stakeholder interviews: applied thematic analysis (Guest et al., 2012). 4. Study results from all stakeholder data sources: theoretical analysis and interpretation using Bourdieusian concepts.

(Adapted from Bright, 2018: 29).

3.2 Philosophical orientation and research paradigm

The following section describes the philosophical paradigm upon which the research sits. It positions the study within a critical social research approach and situates it within a critical realist meta-theory.

3.2.1 Overview

Scholars such as Archer (1995: 57-58) and Creswell (2013: 15) have observed that research is underpinned by certain assumptions. These assumptions require researchers to explicitly consider and specify their ontological and epistemological positions and acknowledge how these positions may influence the research conduct. The following section elaborates on the approach taken to this research inquiry and the ontological and epistemological philosophy underlying the research investigation.

3.2.2 Critical social research

Writers have argued that individuals and groups occupy more or less privileged positions in society, which are often considered natural or unalterable (Kincheloe & McLaren, 1994: 140). Morrow and Brown noted that the manifestation of privileged status and domination of subordinate groups takes many forms, and the arenas in which they operate are sites of social struggle between classes (1994: 10). Critical social research locates phenomena within their social structures and related phenomena. These structures and phenomena become the focus of an investigation. Several authors have posited that critical research is concerned with how privilege, empowerment, disadvantage, and disempowerment are maintained, resisted, or accepted (Bhavnani et

al., 2014: 171; Kincheloe & McLaren, 1994: 139-140). The objectives of critical research are to question, explain, and challenge forms of power, the inequality that power breeds, and the enabling structures and actions of individuals and groups within political, social, and cultural arenas (Bhavnani et al., 2014: 166-167, 171). Harvey contended that the social fabric of structures is maintained through political and other forms of power and is legitimated by ideology (1990: 19).

Underlying critical research are assumptions regarding human thought processes. Kincheloe and McLaren claimed these thought processes are “*mediated by power relations*”, where facts are inseparable from values, and ideology and language play a central role in forming conscious and unconscious awareness (1994: 139-140). Considerations of individual perceptions, shaped by language, influenced by power, and strengthened by ideology and how these mediate perspectives of reality have driven a desire to understand, from a critical perspective, stakeholder perspectives of regulation for non-registered health professions.

Ideology is core to comprehending attitudes. Harvey stated that the ideology of some social actors reflects a hegemonic worldview that legitimates dominant interests, transforming class differences from distorted reality to one accepting such distortions as normal and rational because they are reproduced and reinforced through everyday practices (2022: 148). Bourdieu observed that ideologies supporting sectional interests are typically portrayed as serving universal interests (1977b: 114). Alvesson and Deetz argued that these normative framings masked the arbitrary, discretionary, and mostly unchallengeable decisions made by the dominant class, with “*consent*” by the dominated classes (2006: 84-88). Over time, dominant interests are refashioned into universal interests; they are in “*everyone’s interests*”, while opposing interests are disregarded or suppressed (Alvesson & Deetz, 2006: 85-86).

In this research, the concept of ‘critical’ “*emphasizes the need to engage with power, inequality, and social relations in the arenas of the social, political, economic, cultural, and ideological*” (Bhavnani et al., 2014: 167). The research seeks to analyse the ideological perceptions of stakeholders, the mechanisms, and maintaining structural forces related to HPR policy, and the universal or sectional interests that may be at play.

My aim is to reveal potential privilege and hegemony, disadvantage, and subordination through exploring stakeholder perspectives.

Critical realism has been associated with critical theories of society and critical research generally (Blaikie & Priest, 2017: 182-183). Critical realism is the philosophy underlying the present research.

3.2.3 Ontology and epistemology

One of two ontological positions is commonly taken by researchers. Those taking a realist position contend that only observed and experienced phenomena constitute reality, and these exist independent of human thought or influence (Blaikie, 2010: 93). Relativists claim reality is the product of the human mind and is created from the characterisations and interpretations of social actors (Blaikie, 2010: 93).

Critical realism²² was proposed as an alternative philosophical position by Roy Bhaskar in the 1970s. It has been described as a meta-theory, *“the theory and the philosophy behind our theories”* (Archer et al., 2016: 4). Bhaskar conceptualised critical realism as an alliance of the philosophies of empirical and social science, between the natural and social worlds (Bhaskar, 1986: 6-8). The position advanced by Bhaskar and other critical realists is of ontological realism coupled with epistemological relativism (Archer et al., 2016: 4-6; Bhaskar, 2008: 15). Proponents claimed that critical realism bridges the divide between the ostensibly irreconcilable dichotomies of ontological realism versus interpretivism and epistemological objectivism versus subjectivism (Archer et al., 2016: 4-6; Bhaskar, 1986: 12).

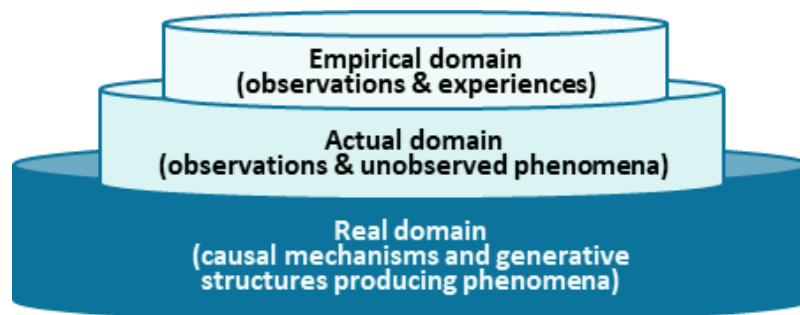
Maxwell claimed our knowledge of the world is influenced by and constructed from particular points of view and so is always *“theory-laden”* (2012: vii). He stated that critical realists reject the notion of multiple ontological realities but accept there are different perspectives of it mediated by language and culture (Maxwell, 2012: 9). For critical realists, reality exists independent of human consciousness, but knowledge

²² Bhaskar originally conceptualised the concept of ‘Transcendental Realism’ in his treatise *A Realist Theory of Science* (1975). He expanded this concept to the social sciences in *The Possibility of Naturalism*, using the term ‘Critical Naturalism’ (Bhaskar, 1979). These two terms were subsequently elided to form the term ‘critical realism’ (Archer et al., 1998: ix; Bhaskar, 1989: 190).

about reality is socially, culturally, and historically situated; “[a]s such, while there is one reality, there are multiple interpretations of that reality” (Botha, 2021: 9).

The reality Bhaskar proposed was to substitute the “*flat ontology*” of the empiricists with a stratified and multi-dimensional configuration of ontological reality (2008: 57, 91). In this depiction, Bhaskar recognised three distinct domains: the domain of the empirical (our observations and experiences), the domain of the actual (the events and phenomena whether observed/experienced or not), and the domain of the real (the causal mechanisms and generative structures producing the events and phenomena) (Bhaskar, 2008: 2-4, 46-47). See Figure 3.1 for a diagrammatic representation of critical realism domains.

Figure 3.1: Critical realism domains.



As reality is accessed through the domain of the empirical, it can only ever be approximated because of the mediating effect of human cognition and “*flawed human intellectual mechanisms*” (Guba & Lincoln, 1994: 110). These imperfect human processes, the mental constructions forming our ideas, thoughts, and intentions, were considered by Maxwell as inseparable from the determinative processes central to causal explanations of social and behavioural phenomena (2012: 16).

Adopting a critical realist ontological position in this research acknowledges the materiality of structures and processes comprising HPR, such as the regulation mechanisms for registered and non-registered professions, the policies governing these professions, the criteria for assessing professions for registration, and the institutions supporting HPR both within and outside government. While the structures and

processes can be 'known', knowing of the structures/processes is subject to interpretation as they are mediated through the cognitions of those doing the interpreting. My intent is to access what stakeholders 'know' about the structures and processes of HPR relating to non-registered professions.

Elder-Vass viewed society as an interwoven social fabric where actors socially bond to form collectives with structural causal powers (2010: 4). He claimed these structural causal powers influenced the behaviours of group actors. Interactions between actors, in turn, affect the collective, such that group members also possess causal powers and the capacity for individual agency. Thus, social phenomena *"are produced by the interaction of both structures and agential causal power"* (Elder-Vass, 2010: 4). Bhaskar viewed the critical realist conceptualisation of structure and agency as existing in dynamic interdependence, where structure is a condition of agency, while the action of agency can reproduce or transform structures (1989: 4; 1998: 37-38). The mental constructions of agents, the interactions between structures and social actor agency, and the identification of causal mechanisms are central to explaining social phenomena, including the phenomenon relating to HPR for non-registered health professions.

This research will investigate these concepts by exploring perceptions and experiences. It aims to identify the mechanisms and causal processes in the domain of the real. Reality, however, can only be apprehended indirectly through the empirical domain, and the empirical domain is socially produced, partial, and incomplete, a flawed field subject to varying perceptions of reality that are *"always fallible"* (Danermark et al., 2019: 13). To ascertain the likely mechanisms and causal processes producing phenomena calls for the use of *"judgemental rationality"* (Archer et al., 2016: 6; Bhaskar, 1986: 85-86). Critical realists described judgemental rationality as a conscious and reflexive engagement with analytical methods and the application of rational criteria to assess what evidence and theories most plausibly explain a phenomenon given competing or contested accounts (Archer et al., 2016: 6; Bhaskar, 1986: 85-86). Danermark and colleagues emphasised that reality or phenomena cannot be analysed, understood, or explained without the aid of theoretical concepts (2019: 136). In this research, I will apply judgemental rationality to analyse stakeholder perspectives regarding the

regulation of non-registered health professions and apply a theoretical framework providing the greatest explanatory power in interpreting those perspectives.

3.3 Theoretical framework

Bhaskar observed, “[t]heory without experiment is empty. Experiment without theory is blind” (2008: 182). He noted that judgements cannot be made “outside some particular theory and some particular position in theoretical time” (2008: 182). Silverman argued that “without a theory, there is nothing to research” (1993: 1). He contended that theories give life to research and embed data interpretation within a theoretical context (Silverman, 1993: 1-3). Danermark et al. conceived of theory as a language used to translate, interpret, and explain social reality (2019: 139). Keat and Urry maintained that in critical realist research, theories assist in identifying mechanisms and structures causally generating phenomena, enabling the researcher to arrive at explanations for what is observed (1982: 5). Theories provide analytical frames through which investigators view phenomena to understand and interpret observations and patterns. Theories offer researchers the concepts to explain these patterns and events.

3.3.1 A review of class and boundary theories of the professions

Many theories have been used in scholarly debates regarding the sociology of the professions. Theories include: the ‘system of professions’ (Abbott, 1988), knowledge-power theories (Foucault, 1982), boundary work theories (Fournier, 2000; Gieryn, 1983), professional dominance (Freidson, 2001), functionalist theory (Parsons, 1964), the professional project (Larson, 1977), Marxist class theory (Macdonald, 1995: 22-24, 41-42), Giddens’ structuration theory (Hotho, 2008), and neo-Weberian social closure theory (Parkin, 1974, 1979). Although these theories offer valuable insights into HPR and possess conceptual and practical utility for the present research, none were considered to provide the breadth of conceptual tools offered by Pierre Bourdieu as an organising theoretical framework to account for the complexity of stakeholder perspectives of HPR. To support this view, I briefly review two sociological theories considered as alternative organising frameworks for this research, neo-Weberian social closure theory and Giddens’ structuration theory, contrasting them with Bourdieusian theory.

3.3.2 Neo-Weberian social closure theory

Neo-Weberian professionalisation theories have been widely reviewed or applied in research on professions (Adams & Saks, 2018; Gale, 2014: 808; King et al., 2018; Macdonald, 1995: 27; Nancarrow & Borthwick, 2021: 17; Parkin, 1974; Saks, 1983, 1999, 2003, 2010, 2012, 2014, 2015, 2016; Saks & Adams, 2019). Scholars described the neo-Weberian approach as emphasising the dual notions of self-interest and group competition in establishing and maintaining professional boundaries to enact exclusionary closure and capture the professional market (Adams & Saks, 2018: 63; Nancarrow & Borthwick, 2021: 17). Saks stated that neo-Weberian perspectives identify the source of professional power as originating from state-supported mechanisms such as occupational licensing (2003: 48-63; 2021: 63). However, neo-Weberian approaches tend to be less attentive to the role of the state and its social actors in the professionalisation process, requiring a return to Weber's original theories, in which he did not directly consider professions (Saks & Adams, 2019: 3).

In contrast, Bourdieu wrote extensively on the state and its relationship with its citizens (Bourdieu, 1994; Champagne et al., 2014). Some writers have noted the relevance of Bourdieu's concept of capital to the social classifications of professions (Macdonald, 1995: 48-49). Saks pointed out that Bourdieusian theory can potentially complement neo-Weberian approaches by extending the tools available to analyse professions (2021: 49-50, 76-77). Schinkel and Noordegraaf stated that a *"Bourdieuian understanding of professionalism strengthens our explanatory capacities"* (2011: 71). Even though Bourdieu did not write directly about the state's role in occupational regulation, the depth and breadth of his work are readily transferable to this research field. While rich in explanans regarding professional class structures, the historical-structural neo-Weberian approach to professions and professionalisation is not entirely suited to the present research, as it does not fully explore the potential methods of social closure used by social actors as conveyed through their perceptions of HPR. Nancarrow and Borthwick posited that neo-Weberian perspectives are *"the most useful for understanding and explaining the motives, actions and intentions of professions"* (Nancarrow & Borthwick, 2021: 17). Even so, I consider Bourdieusian theory offers

insight into both the motives of social actors and the methods they employ to rationalise their perspectives of HPR.

3.3.3 Giddens' structuration theory

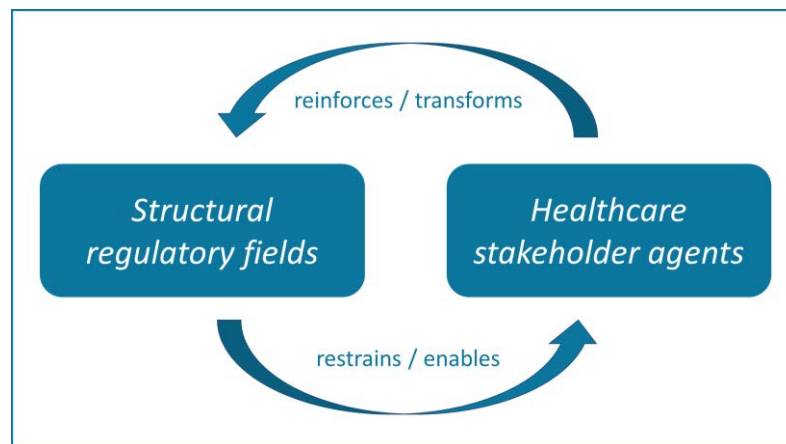
Although the debate regarding the relative influence of structure and agency on human action and behaviour is far from over (Danermark et al., 2019: 71; Tan, 2011), two of the more enduring theories regarding their operation come from Anthony Giddens and Pierre Bourdieu (Whittington, 2010: 109). Both Giddens (1984) and Bourdieu (1977a) explored the relationship between individuals and institutions, the effects of structure on agency and the ability of social agents to alter structures where individuals produce and are produced by the social institutions in which they are situated (Whittington, 2010: 115).

Giddens explored the duality of the structure-agency dichotomy (1984: 15, 25-31). He regarded structure and agency as inseparable halves of a unitary whole (Danermark et al., 2019: 71; Giddens, 1984: 15, 25). Giddens emphasised the mutual dependence of structure and agency, where agents draw on resources and rules of systems to create, perpetuate, or change social structures (Whittington, 2010: 112). In Giddens' view, even though structures both constrain and enable the behaviour of social actors (1984: 25), social actors have considerable capacity for reflexivity and choice-making (Giddens, 1991: 2, 5).

Conversely, Bourdieu viewed structure and agency as a dualism, separate phenomena yet closely related (2000: 155-157). In Bourdieu's view, social actors exercise choice but are constrained in those choices by social structures (Bourdieu & Wacquant, 1992: 136-137). Bourdieu considered the relationship between structure and agency to be dynamic; structures exert an influence on individual actions, while individuals act to reinforce or transform social structures (2000: 155-157). This view is akin to the critical realist conceptualisation of structure and agency as existing in dynamic interdependence (Bhaskar, 1989: 4; 1998: 37-38).

See Figure 3.2 for a diagrammatic representation of the relationship between and influence of structure and agency potentially operating in HPR.

Figure 3.2: The relationship between structure and agency potentially operating in health practitioner regulation.



Like the critical realist concept of a stratified configuration of reality, Bourdieu considered that social reality existed “*twice, in things and in minds*” (1992: 127). He viewed the social world as “*a multi-dimensional space that can be constructed empirically by discovering the main factors of differentiation*” (Bourdieu, 1987: 3-4). It is this differentiation that this research seeks to uncover by exploring stakeholder perceptions and experiences.

Some authors, such as Elder-Vass (2010: 4) and Jenkins (1982: passim), viewed Bourdieu as a structuralist rather than an agent-oriented theorist. Others, such as Harker (1984: 117-122), Mills (2008: 81-82), and Morrow and Brown (1994: 133-134), drew attention to Bourdieu’s abiding interest in human agency. Johnson noted Bourdieu’s dissatisfaction with structuralism (1993: 3-4). The discontentment led Bourdieu to develop the concepts of field and habitus to provide a balance between structure and agency (Salve et al., 2018: 3) and overcome the antinomies between objectivism and subjectivism (Nicolaescu, 2010: 4-5). Bourdieu was aware of the criticisms characterising his theories as structuralist. He clarified his views by stating:

the use of the notion of habitus [...] can be understood as a way of escaping from the choice between a structuralism without subject and the philosophy of the subject. [...] Unfortunately, people apply to my analyses – and this is the principal source of misunderstanding – the very alternatives that the notion of habitus is meant to exclude, those of consciousness and the unconscious, of explanation by determining causes or by final causes. (Bourdieu, 1990a: 10)

Bourdieu's work offers an organising conceptual framework for analysing agent practices. The Bourdieusian concept of structure-agency as a dualism sits comfortably with the critical realist view of structure-agency as separate phenomena but inextricably linked, each having causal powers over the other (Danermark et al., 2019: 79-82). Vandenberghe claimed Bourdieu's theories represented a version of critical realism where the researcher's task is to propose a model of generative mechanisms producing phenomena, thereby making them visible (2014: 12-13).

Bourdieu's approach to class structure and power dynamics has its roots in Marxist and Weberian concepts of power, class, and hierarchies (Swartz, 1997: 38-45). Indeed, writers have acknowledged Bourdieu's intellectual debt to Marx and Weber (Brubaker, 1985: 747; Özpolat & Arap, 2023: 200-210). However, Bourdieu's concepts differ substantially from both theorists. Marx placed class within a capitalist mode of production, and Weber made the case for social class based on market positioning (Brubaker, 1985: 761-762). While these approaches may be construed as the Bourdieusian concept of field, Bourdieu defined class structures in terms of the broader social relations and shared identities and conditions of existence that determine the distribution of power among group members (Brubaker, 1985: 761-762). Bourdieu also expanded on the Marxist concept of capital to encompass all forms of power, including the cultural, social, and symbolic, and the significance of symbolic forms of capital that function to reproduce social inequalities (Özpolat & Arap, 2023: 205). While clearly influenced by Weber's model of political economy, Bourdieu extended the concept beyond religion as a social domain to include a broader range of social sectors in an endeavour to identify the mechanisms by which dominated social actors accept their domination (Özpolat & Arap, 2023: 207, 209).

Bourdieu's concepts provide a comprehensive framework that is applied in the present research to draw out the motivations (the why) and methods (the how) of social actors as they attempt to maintain or improve their position in the HPR field. My objective is to explore agent justifications for their perspectives regarding HPR and examine the social structural forces and mechanisms of class struggle that function to reproduce or transform HPR. Compared with other theoretical approaches, Bourdieusian and critical

realist concepts were considered more applicable to the present research because they offer greater explanatory power than Anthony Giddens, Karl Marx, and Max Weber.

3.3.4 Bourdieusian theory

Bourdieu viewed society as a social system striving to balance the tension between the subjective and objective, where the social and cultural reinforcement of power is an ongoing and self-sustaining process (Morrow & Brown, 1994: 134). Social class was a particular analytical focus of Bourdieu (Weininger, 2005: 82); his research was fundamentally about class struggle, competition between social actors, and agential power (Brubaker, 1985: 769-770). Bourdieu conceptualised social class as a social space of differentiated individuals (1987: 3). For Bourdieu, class was situated in a social matrix of relationships that takes account of shared social conditions and common ways of being that produce and maintain power (Brubaker, 1985: 762).

A Bourdieusian approach examines agent attributes and practices and the restraining effects of social structures (Bourdieu, 1989: 18). The practices and actions of agents in pursuit of personal objectives are a product of these attributes and structures. In certain circumstances, agent practices modify social structures, while social structures, particularly institutions, were seen by Bourdieu as exerting restraining influences on agents (Harker, 1984: 118-122; Mills, 2008: 81-83). The most powerful institution, from Bourdieu's viewpoint, is the state (Bourdieu, 1989: 22; 1994: 4-9). Drawing on Weberian concepts, Bourdieu defined the state as an entity *"which successfully claims the monopoly of the legitimate use of physical and symbolic violence over [...the...] population"* (1994: 3). By 'symbolic violence', Bourdieu referred to the differentiation, domination, oppression, or coercion exerted by powerful groups, such as the state (1990a: 111; 2000: 169-170, 174-175, 181; 1992: 115, 119). It is a demonstration of power (Bourdieu, 1999: 126) where the state can convince the population of the legitimacy of its power to structure society according to a particular worldview (Bourdieu, 1989: 21-23). Symbolic violence is not necessarily exercised forcefully but is often subtle, invisible, and therefore unrecognised (Bourdieu, 1990b: 127). It includes state actions, such as *"official nomination"* or granting of a title or qualification, an act of symbolic violence because such bestowals are the preserve of the state and its

representatives (1989: 21; 1990a: 135-136). Outside the state, 'symbolic violence' describes the dominance exercised by certain individuals and organisations over less powerful actors and groups (Bourdieu & Wacquant, 1992: 167-168). It manifests as an unequal distribution of resources (Everett, 2002: 69).

In the present research, regulatory governance mechanisms, policies, and processes constitute the structures in which various stakeholders and stakeholder groups operate. In this research, social actors representing government departments and agencies, professional bodies, and consumer advocacy groups occupy different positions in the HPR arena. Stakeholder practices are the actions of social actors as they pursue their interests, where these relate to HPR. Pursuing these interests may, in part, involve Bourdieu's concept of symbolic violence, either from the state or other powerful groups. If exercised by the state, symbolic violence can include actions such as denying registration to certain professions. Registration may manifest in attracting a greater distribution of resources to these professions. These concepts will be explored in this research through the perspectives and experiences of stakeholders to ascertain if they conform to Bourdieu's theories.

To elucidate the effects of restraining structures, agent attributes and practices, class distinctions, and the reproduction of power, Bourdieu introduced or expanded on several conceptual tools through his concepts of field, capital, symbolic power, symbolic violence, habitus, doxa, and illusio.

Field

Bourdieu viewed society as a multi-layered system of physical or social arenas, which he referred to as "*fields*" (1985: 736). Social fields are structures of relationships, a social space providing a context for agent actions and behaviours (Bourdieu & Wacquant, 1992: 96-97). Entities such as agents and groups occupy and maintain specific positions in a field and are positioned relative to others where they hold dominant or subordinate positions (Bourdieu & Wacquant, 1992: 97). Bourdieu regarded fields as sites of conflict and competition between agents and groups, which he likened to a game (Bourdieu & Wacquant, 1992: 98). Success in the field depends on the capital resources possessed

by occupants (Bourdieu, 1999: 128). The objective of players in the game, what they compete for, is the accumulation of capital resources perceived as valuable (Everett, 2002: 60; Thomson, 2014: 67). Valuable resources include material and social assets such as profit, prestige, personal advantage, and field domination (Bourdieu & Eagleton, 1992: 116). Hence, accruing valuable resources is necessary to secure the most sought-after position in a field (Bourdieu, 1996a: 151; 1999: 126-127).

A field is not a static site but a contested terrain. It operates as a political arena, a dynamic territory where positions are continually fought over and defended in what Bourdieu described as a “*field of struggles*” (Bourdieu, 1998: 32). Bourdieu noted several ways in which field repositioning may occur. These disruptions occur through entry to the field by admitting new players, progression in the field through usurpation or co-option by dominant actors, or exit from the field by expulsion or exclusion (Bourdieu, 1999: 126). Social arrangements or positioning in the field are maintained through differentiation from those perceived as inferior or by association with dominant individuals and groups (Bourdieu, 1996a: 246; 1999: 127). Fuchs proposed several tactics of differentiation/association used by field players to facilitate upward mobility, including imitation, pretension, protectionism, segregation, symbolic distinctions, and discrimination (2003: 403).

In this research, HPR is conceived of as a Bourdieusian field in which stakeholder actors within and outside the professions are located. As no single occupational regulation mechanism covers the entire HPR field in Australia, the regulatory field is viewed as a series of distinct smaller fields. HPR constitutes the broad, overarching social field. The different regulatory arrangements governing health professions constitute fields in their own right, with the NRAS, comprising registered professions, potentially considered the most dominant. Other fields include the different types of regulation arrangements, such as negative licensing and profession-led self-regulation. In addition, professional bodies are each considered an occupational field, as is the bureaucratic field of government health policy officers.

Competition in the field is dependent on agents perceiving the conflict as worthwhile. Contesting a place in the field relies on agents having a stake or being invested in the

‘game’. Bourdieu used the term “*illusio*” to describe the tendency of actors to engage in conflict and invest in securing its potential rewards (1998: 76-77; 1992: 98). Dominant actors in the HPR field hold positions of power and authority, offering more opportunities to exercise agency to advance their cause and field position by accumulating capital resources. These actors might be said to be invested in or subject to the *illusio* of the regulation ‘game’. There may also be actors whose purpose is to protect or act as gatekeepers to the field to maintain the power and privilege of the professional elite. They, too, may be invested in the HPR field. Non-dominant actors, who may also be subject to *illusio*, may expend political and professional effort to acquire capital and seek to improve their position in the registration field. Other actors, eschewing the registration *illusio*, may accept the regulatory status quo and their position in the field while seeking capital accumulation in other fields.

Who these actors are, the structures they sit within, the agency they exercise, the perceptions and attitudes they hold, and the interpretations, choices, and decisions they make are the subject of this research study.

Capital

Bourdieu developed the concept of ‘capital’ to describe material and non-material assets or resources possessed and acquired by individuals and groups (1986: 242). As a fundamental force influencing field dynamics, capital holds a central position in the theoretical underpinnings of this research. Rather than being intrinsically valuable, Bourdieu argued that the value of capital is socially and arbitrarily determined; it can be exchanged or transformed by agents within and between different fields and bestows advantages to those who possess it (1986: 254). Bourdieu claimed that the advantages granted by capital defined the position or status of actors in the field and their future positioning (1989: 17; 1992: 99).

Bourdieu distinguished between four main capital classes: economic, cultural, social, and symbolic (Bourdieu, 1986: 243). Economic capital comprises cash, assets, and property. Cultural capital consists of the education agents gain, the qualifications they hold, and the knowledge and skills they acquire. Social capital includes the networks and

social circles in which individuals and social groups circulate. Symbolic capital derives from the prestige, recognition, or reputation accorded to those possessing sufficient capital of a particular type when these are valued and perceived as legitimate (Bourdieu, 1986: 243). Individuals and groups draw on the resources or assets embodied by one or more of these capital resources to gain entry to specific fields (Lynam et al., 2007: 29). They may also draw on capital concepts to discredit rivals with insufficient or the wrong type of capital (Bourdieu & Wacquant, 1992: 99). Agents with similar capital profiles have an affinity for each other and agents are attracted to fields “*congruent*” with their habitus (Drummond, 1998: 104). Possessing certain capital may be a prerequisite for entry to particular fields. For instance, social and cultural capital may be required to participate in the political field (Webb et al., 2002: 94). Consequently, engaging with political players may depend on one’s social or political contacts, holding the ‘right’ cultural credentials, and possessing a certain cultural savviness for the ‘game’ or field of politics. Conversely, having little social and cultural capital is unlikely to advance one’s cause with political players.

The forms and functions of capital are critical to the success of agents and groups in advancing their interests. A closer examination of the composition and functioning of capital will help identify how and why agents accumulate, use, and reproduce capital to further their advantage in the field.

Economic capital

Bourdieu considered economic capital the primary capital because of its association with wealth, financial resources, and property. Economic capital may be converted to all other capital classes by purchasing material and non-material resources (Bourdieu, 1986: 243, 247, 252). These conversions aim to increase capital accumulation, raise profit, and advance one’s interests in the field (Bourdieu, 1986: 252-253). Other capital resources may be converted, either directly or indirectly, to economic capital (Bourdieu, 1986: 253). The relevance of economic capital to HPR lies in the financial rewards potentially accruing to certain professions regulated under particular types of mechanisms and having access to government and other entitlements. Such a situation may give rise to contests over admission to schemes (fields) with greater perceived

economic rewards or for a more lucrative position in an existing field. Remuneration paid to certain field occupants and financial entitlements for providing particular healthcare services are also forms of economic capital.

One resource readily acquired by economic means is cultural capital in the form of education, skills, qualifications, and other credentials.

Cultural capital

Bourdieu proposed three variants of cultural capital: embodied, institutionalised, and objectified. The two variants most relevant to this research are embodied cultural capital, the knowledge, information, and skills possessed by social actors, and institutionalised cultural capital, academic qualifications including degrees, diplomas, and certificates, and other types of credentialling such as licences (Bourdieu, 1986: 247-248; 1996a: 36-38)²³.

Qualifications held particular importance for Bourdieu, who declared, *“academic qualifications are to cultural capital what money is to economic capital”* (1977a: 187). Bourdieu maintained that agents with the same qualifications are held to a common standard that distinguishes the qualified from the unqualified (Bourdieu, 1977a: 187). Qualified individuals can undertake similar types of work, and standard qualifications facilitate the establishment of a specific market, thereby *“guaranteeing the convertibility of cultural capital into money”* (Bourdieu, 1977a: 187). In this research, cultural capital encompasses educational qualifications, professional credentials, and occupational licences. Statutory registration, which is a type of licence, may be considered by some stakeholders as a valued cultural capital asset in HPR. Others may seek to pursue other forms of cultural capital. Such differences, if they exist, form part of the present research investigation. Contests over cultural capital give rise to what Bourdieu described as:

²³ Objectified cultural capital includes cultural goods such as artwork, books, dictionaries, instruments, and machines (Bourdieu, 1986: 243). These types of artefacts and this form of cultural capital were not considered relevant to this research.

conflicts of competence – conflicts over the qualifications for the legitimate practice of the occupation and the legitimate scope of practice – between agents possessing different qualifications. (Bourdieu, 1996a: 244)

Similar conflicts may also be operating in the HPR field in Australia. They may be used to assess who may legitimately qualify to practise a profession and which professions may legitimately qualify for specific credentials, including registration. Bourdieu contended that dominant groups use cultural capital to increase personal advantage, pursue their interests, distance themselves from the culturally impoverished, recruit prospective entrants to their field, or exclude the culturally unworthy (Bourdieu, 1999: 128-129; Lamont & Lareau, 1988: 158). When employed in this way, cultural capital becomes a weapon of symbolic violence.

The actions of players to differentiate themselves from others in the field through cultural resources were viewed by Bourdieu as being intrinsic to the habitus, the inculcated tendencies and preferences of individuals, such that they were perceived as legitimate (1996a: 246-247). Differentiation precedes exclusion. Lamont and Lareau described four mechanisms by which Bourdieu contended exclusion from the field was accomplished (Lamont & Lareau, 1988: 158-159). Self-elimination occurs when agents adjust their aspirations according to the perceived likelihood of success; if success seems unlikely, they exclude themselves or leave the 'game'. In over-selection, the culturally disadvantaged are required to meet or perform to the same exacting standards as the culturally privileged, limiting their chances of success. Relegation refers to agents being consigned to less favourable positions in the field. Direct exclusion is where the culturally deficient are ostracised (Lamont & Lareau, 1988: 158-159). The power to orchestrate the exclusion of individuals and groups from a field was regarded by Lamont and Lareau as particularly pervasive (1988: 159). The degree to which this pervasive influence exists in HPR in Australia to orchestrate these strategies and the extent to which differentiations and exclusion, as indicated by Bourdieu, operate in this field are unknown and require further examination. Whether professions self-select out of a field or dominant agents execute over-selection, relegation, or direct exclusionary strategies remains to be tested in the present investigation.

Social capital

While the previous section considered cultural capital as the source of power to enact exclusionary strategies, other forms of capital are also implicated in these actions. This includes social capital that deals directly with the power of relationships and how these facilitate the acquisition of further capital and function to influence field positions.

Social capital derives from the power and resources of the social networks in which agents move and the institutional memberships they carry (Bourdieu, 1986: 248-249; Bourdieu & Wacquant, 1992: 119). Bourdieu stated that social capital depends on the size and strength of the network or membership group. It is accrued by groups such as elite clubs, which enjoy high levels of prestige and are organised to concentrate social capital and reap the resulting benefits (Bourdieu, 1986: 249).

The notion of select clubs is readily transferrable to the HPR context, exemplified by professional associations and public sector institutions such as government departments and agencies. Registration through the NRAS is, arguably, the archetypal club whose 'membership' is determined by a range of entry requirements, including 'membership' of certain professions. The club metaphor also applies to professions enjoying a high status in the healthcare division of labour, where members of certain occupations may enjoy professional prestige, high standing, and repute. The elite standing of some professions makes membership keenly sought after, such that professional entry is closely screened and monitored. These actions reinforce professional selectivity and serve to maintain economic, cultural, and social capital.

Bourdieu perceived the possession of social capital as the most unjust and inequitably distributed form of capital. High social capital bestows distinction and worth to the possessor, the advantages of *"social importance and of reasons for living"* (Bourdieu, 2000: 241). According to Bourdieu, there was no worse fate for those deprived of or with little social capital, for these individuals are *"forced to stick with the most undesirable and the least rare persons or goods. The lack of capital intensifies the experience of finitude: it chains one to place"* (1999: 127). Ultimately, Bourdieu considered these individuals and groups *"losers in the symbolic struggle for recognition, for access to a socially recognized social being, in a word, to humanity"* (2000: 241).

Governed as it is by “*the logic of knowledge and acknowledgement*”, social capital always operates at the symbolic level due to its socially constructed nature (Bourdieu, 1986: 252, 257). Therefore, the perceived need for social capital by agents in the field may also be a struggle for symbolic capital.

Symbolic capital, symbolic power, and symbolic violence

Symbolic capital is the form other types of capital assume when perceived as valuable (Bourdieu, 1985: 724; 2000: 242). The recognition and importance endowed by social actors elevate capital to the symbolic level (Bourdieu, 1994: 8-9; 1998: 47). Hence, symbolic capital always exists as a perception of others. For Bourdieu, symbolic capital:

is not a particular kind of capital but what every kind of capital becomes when it is misrecognized as capital, that is, as force, a power or capacity for (actual or potential) exploitation, and therefore recognized as legitimate. (Bourdieu, 2000: 242)

As well as potentially functioning as a cultural capital resource, registration may be misrecognised or misperceived as symbolic capital by stakeholder agents. Some agents may comprehend that whatever symbolic capital is applied to registration is a misrecognition by misguided individuals. In this research, I wish to understand and interpret whether these perceptions and misperceptions exist among stakeholders in the HPR field and explore how these may drive stakeholder perceptions and attitudes.

Symbolic capital may be elevated above all other forms of capital as a source of power and influence, potentially rendering it the most valuable (Bourdieu, 1977a: 179) because of the ease with which it transforms into symbolic power (Bourdieu, 1989: 23). Certain types of capital, such as qualifications, may be raised to the symbolic level and given official sanction by the state or state agents, a move bringing with it legitimated power and dominance (Bourdieu, 1989: 21). Consequently, where the origins of symbolic capital are found in other capital forms, symbolic capital is the source of symbolic power and symbolic violence (Bourdieu, 1989: 21, 23).

Bourdieu maintained that dominant groups use symbolic capital, power, and violence to impose and legitimate a particular view of reality in a field. He considered the greatest concentrations of symbolic capital, symbolic power, and symbolic violence resided with

the most powerful of institutions, the state and its representatives (1994: 4, 9; 1998: 41-42); “[i]t is the state, acting in the manner of a bank of symbolic capital, that guarantees all actions of authority” (Bourdieu, 1998: 51).

Bourdieu and the state

Bourdieu viewed the political field as a “*field of forces and as a field of struggles*” (1991: 171). He argued that the rise of the modern state coincided with the establishment of a “*field of power*” (Bourdieu, 1994: 4-5) in which the state “*wields a genuinely creative, quasi-divine, power*” (Bourdieu, 1994: 12). The state exercises symbolic power over different fields and types of capital, presides over capital conversion, and directs the relations of agents within the field (Bourdieu, 1998: 41-42). Social actors may cognitively construct their social world, but the state has a major influence on those constructions, most notably through the “*rites of institutions*” to organise, authorise, classify, and constrain elements of the social order (Bourdieu, 1994: 13). Bourdieu claimed the state and its agents possessed the power to establish social groups, name categories of classes, and impose a vision of the social world and its divisions and classifications (Bourdieu, 1987: 13-14; 1989: 23).

Webb et al. claimed that state bureaucracies do more than give effect to government policy; they interpret it and occasionally generate it (2002: 98). This bestows upon state agents power separate from but under the authority of the state. Hence, the functions performed by state agents come with the authority of state-derived symbolic power. In discharging their functions, a question considered by Bourdieu is the objectivity of bureaucrats and whose interests they serve, those of the public or their own (Bourdieu, 1994: 16-17). Beyond the state, an elite institution or organisation may also operate as a field of power, where the dominant entity of one field may exercise power over other groups in the field (Bourdieu, 1998: 33-34). Regulation schemes governing healthcare professions are institutional entities. Some institutions of regulation, being a product of the state through government legislation, may have greater symbolic or ‘quasi-divine’ power than non-state institutions. They may, therefore, inherit greater volumes of capital. Moreover, elite institutions, such as the medical profession, may also operate as a field of power, exerting their influence over other fields, such as the NRAS field.

The state is considered a major stakeholder in this research because it occupies the bureaucratic field that presides over decisions affecting HPR. The structures of HPR sit within a Bourdieusian state-institution field formed by entities including consumer advocacy groups, professional bodies, and the state apparatus administering government policy. The state possesses considerable power and exercises significant influence over the HPR field. The current examination encompasses the most prominent field, the NRAS, and other HPR fields. These structural fields are the institutions populated by stakeholders with varying volumes of capital and possessing greater or lesser degrees of symbolic capital and symbolic power to influence HPR decision-making. The struggle for power and dominance of institutional players in the field may be influenced by the type and volume of capital possessed. This research aims to understand the role of state and non-state actors in the HPR fields, whether these operate as fields of power and of forces, the extent of engagement in intra- and inter-group contests, and the source of symbolic violence, if it exists. Whether or not these stakeholders conform to Bourdieu's theoretical concepts is unknown. This forms part of the present research by exploring stakeholder perceptions and experiences. Identifying which institutions command more power and operate as stronger fields of power and how this power, through symbolic violence, may structure the field to conform to a particular view of reality lies at the heart of this investigation.

The power held by certain stakeholders is also dependent on the habitus, the ingrained tendencies of individuals, and doxa, the belief systems and worldviews of social actors. These concepts are central to Bourdieu's theoretical conceptualisations because of how they maintain and reproduce capital and influence field positioning. To understand the implications of agential habitus, the mediating effect of doxa on capital accumulation, and the configuration of individuals and group positions in the field, these core Bourdieusian concepts are considered next.

Habitus and doxa

Bourdieu claimed individuals, groups, and institutions possess an identity, character, or habitus. He viewed habitus as the acquired characteristics of inculcated tendencies, propensities, and preferences (Bourdieu, 2005: 43-45). Habitus is the socially

enculturated, distinctive, and mostly unconscious ways of thinking, feeling, and behaving. It includes the habits and practices embodied by individuals to guide responses in the social world (Bourdieu, 1990b: 54-55; 2005: 43). Bourdieu viewed the habitus as giving a *“sense of place”* for oneself and others in the established order (Bourdieu, 1989: 19). At a group or institutional level, the habitus encompasses the social and cultural practices and values characterising how groups interact (Bourdieu, 2005: 44-46; Claussen & Osborne, 2012: 59).

The habitus mediates between objective reality and subjective action. Habitus was Bourdieu’s solution to overcome the dichotomy between structure and agency (Bourdieu, 1990a: 10; 2000: 156). Bourdieu conceived of the habitus as a systematically ordered configuration of systems and practices that was both structured and structuring (Bourdieu, 1990b: 53; Maton, 2014: 50). It is structured from past experiences, including the formative experiences of family upbringing and early schooling, and is shaped by present circumstances, including one’s position in the social hierarchy. It is structuring in its ability to shape, but not determine, future practices and life trajectories (Bourdieu, 1990b: 53-56; 2005: 45-47). Implicit in this structured/structuring dynamic is a habitus that does not operate in isolation (Bourdieu, 2005: 47). Actions and behaviours arise from the interplay between the habitus and the position in the field. Bourdieu noted that as agents make their way in the world, subjected to new experiences, fluctuating capitals, and altered positions in social fields, the habitus is constantly being reinforced or remodelled (Bourdieu, 2005: 47; Bourdieu & Wacquant, 1992: 133). Knowledge about the characteristics and preferences shaping the habitus of consumer advocates, policy actors, and professional body representatives is essential to this study because these may inform perspectives on regulation and the reasons offered for held views. The doxa of these agents is also of interest because of its mediating effect on the habitus and the fields agents occupy.

While the habitus refers to the structured ways agents think and behave, doxa refers to the unconscious and unquestioned fundamental beliefs and rule systems informing agents’ actions (Bourdieu, 2000: 15). Deer referred to doxa as the taken-for-granted assumptions and norms operating in a field and internalised in the habitus (2012: 115).

Bourdieu viewed doxa as a form of ideology or dogma (Bourdieu, 2000: 15; Bourdieu & Eagleton, 1992: 113). The term 'ideology', though, was not one favoured by Bourdieu because it limited the consideration of other mechanisms for maintaining the social order and enacting symbolic violence (Bourdieu, 2000: 181). Nevertheless, ideology is commonly used to describe individual belief systems and worldviews that determine their perspectives of phenomena. For Bourdieu, doxa permits agents to accept as natural and legitimate the dominance of 'superior' or 'elite' classes in the social order (Bourdieu, 1977a: 166) even when this reinforces the subordination of others in the field (Bourdieu & Eagleton, 1992: 114). Sayer referred to this tendency for self-deprecation as a habitus adapted to an inferior field position (2018: 118). Loyal claimed that doxa sustains the social reality of individuals (2017: 70) even though, as Bourdieu maintained, the prevailing doxa is an arbitrary social construction designed to maintain the power and privilege of the dominant class (Bourdieu, 1977a: 164-165). As such, it is misperceived by all classes as self-evident, a matter of common sense, or a universal truth (Bourdieu, 1977a: 165-166; Bourdieu & Eagleton, 1992: 113-114).

Summary of Bourdieusian theory

Society comprises social spaces or fields in which social actors, groups, and institutions occupy certain positions depending on the types and volume of capital held. Capital may be material or symbolic. Social actors use capital to reinforce their position in the field and discredit rivals. Elite actors use symbolic capital, power, and violence to reproduce the unequal distribution of capital, maintain dominance over perceived inferior groups, improve their position in the field, legitimate their doxa and reinforce their habitus. Exploring the habitus of individuals, institutions, and organisations is essential to understanding the perspectives of consumer advocates, policy actors, and professional body representatives. The habitus generates stakeholder perceptions, attitudes, and everyday practices in accordance with their ideological doxa, accumulated capital, and structural location in the HPR field (Bourdieu, 1990b: 54-56; 2005: 47-48). These Bourdieusian concepts are matters of concern to this research because of the potential they hold for offering plausible explanations for the prevailing circumstances of HPR in

Australia for non-registered health professions. This research will test these concepts to identify the potential forces exerted on and in the HPR field.

3.4 Chapter summary

The ontological and epistemological positions taken in this research have been reviewed in this chapter, and the philosophical paradigm, research strategy, and theoretical framework have been described. This study takes a critical social research approach with the aim of revealing power structures and cultures. It adopts a critical realist meta-theory to distinguish and detail the structures and processes of the actual HPR domain, explore and describe stakeholder perceptions and experiences of HPR by investigating the empirical domain, and theoretically analyse and interpret the study results to ascertain the likely causal mechanisms in the domain of the real. I introduced Bourdieu's concepts of field, capital, habitus, doxa, illusio, and symbolic power and violence as a theoretical framework for elucidating these causal mechanisms.

To investigate phenomena in the empirical domain, a suitable methodological approach is required. The next chapter presents the research methodology, including the strategy of inquiry, procedures, and methods for identifying, selecting, collecting, and analysing the research data in the empirical domain of social actors in the HPR field.

Chapter 4

RESEARCH DESIGN AND METHODS

4.1 Introduction

My intention in this research was to describe, analyse, and interpret the epistemologically relativist perspectives of healthcare stakeholders regarding health practitioner regulation (HPR) for non-registered health professions. There was no intention to determine the applicability of particular regulation mechanisms for these professions. Instead, I directed my attention to identifying the factors contributing to the regulatory status quo for non-registered health professions and the explanatory mechanisms potentially underlying those factors. To achieve this intent, it was necessary to explore the policy imperative of the *National Law*, the events, policies, and decisions leading up to and beyond the establishment of the National Registration and Accreditation Scheme (NRAS) and the Intergovernmental Agreement (IGA) assessment criteria informing government policy decisions to register professions under the NRAS.

Walker stated:

Qualitative research reaches parts that other techniques don't. What qualitative research can offer the policy maker is a theory of social action grounded on the experiences – the world view – of those likely to be affected by a policy decision or thought to be part of the problem. (Walker, 1985: 18-19)

Due to the paucity of research on some stakeholder groups shown by the scoping review (see Chapter 2, Section 2.5.3), I resolved to canvass the perspectives of different stakeholder groups, those affected by, advising on, or executing the HPR policy decisions and guidelines. To explore these perspectives, I engaged with three primary areas of research: the HPR context, the perspectives of stakeholders regarding HPR from documentary sources, and stakeholder perspectives of HPR from informant interviews. The aim was to generate data on the placement of non-registered professions in the HPR field, stakeholder perspectives and experiences of the regulation of these

professions, and infer causal explanations from the results obtained, aided by a theoretical framework. I considered these goals were best achieved through a qualitative research methodology.

The current chapter describes the research design and methods applied in the investigation. I specify how document artefacts were located and analysed, how stakeholder informants were selected and interviewed, how resulting transcripts were analysed, and how the data were theoretically analysed and interpreted using Bourdieusian theoretical concepts. I also describe my positionality in the research study and the methods I employed to maintain research rigour.

Figure 4.1 sets out a summarised workflow of the four phases of the analysis, linking the research objectives to the expected outputs of the study.

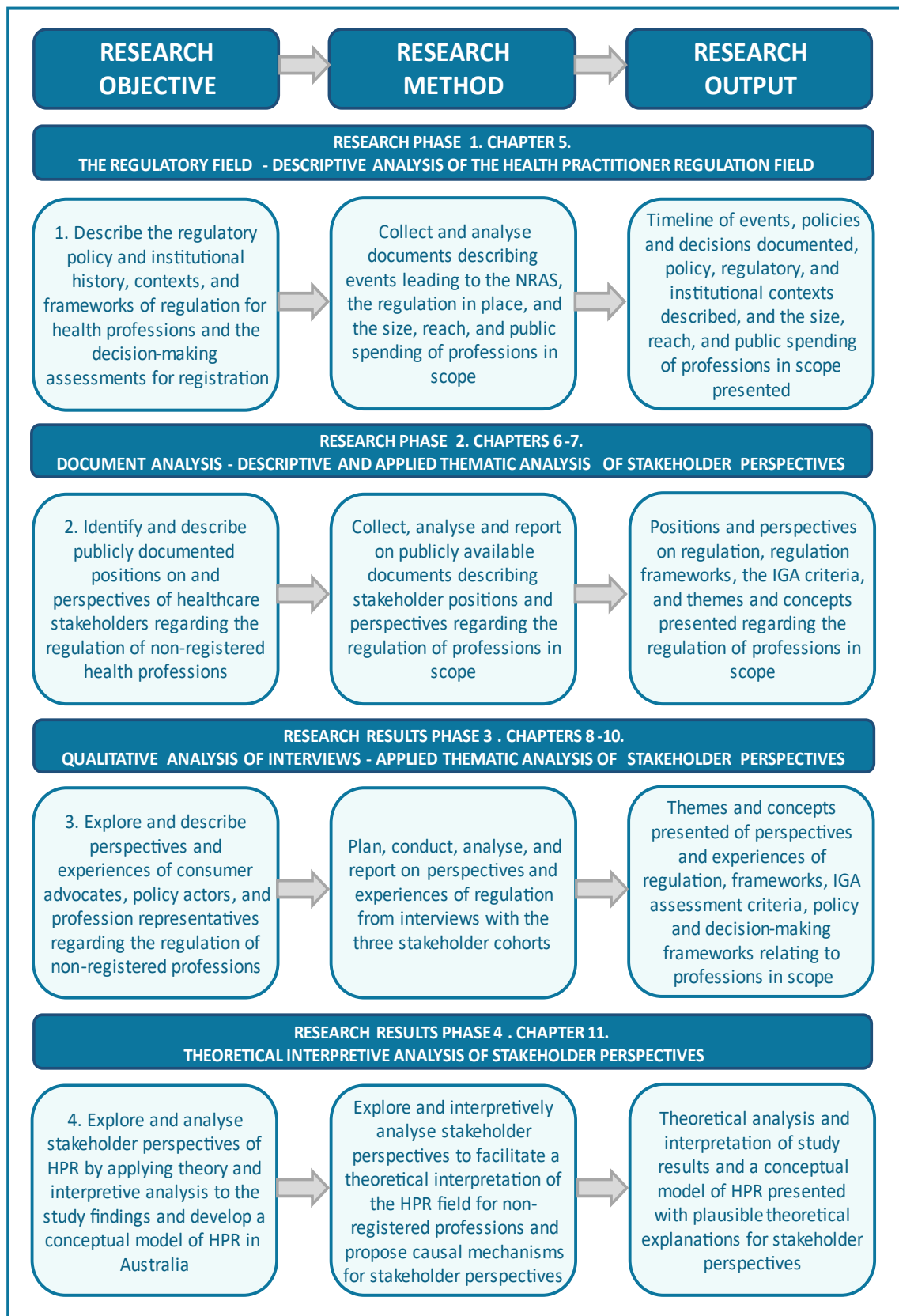
4.2 Research Design

4.2.1 Research approach, strategy, and logic of inquiry

Policy process research is an approach that focuses on the “*context in which policy actors engage, and the political issues that they navigate during that engagement*” (Cairney, 2023: 1822). Applied policy analysis may be conducted *ex-ante* to identify problems with, generate solutions for, and make recommendations regarding proposed policy change, or *ex-post* to monitor or evaluate existing policy (Cairney, 2023: 1822). Applied policy analysis has a role in using theories to offer explanations for and generate insights into policy-making (Cairney, 2023: 1829, 1830). This research evaluated attitudes to policy decisions concerning HPR for non-registered professions by identifying the perspectives and experiences of healthcare stakeholders. It was an *ex-post* analysis.

Buse, Mays, and Walt contended that even though public policy refers to policy established by governments, other institutions, such as corporations, local businesses, and schools, also engage in policy-making (2012: 6). This research took a similarly broad view of policy-making by government and non-government institutions, including professional bodies and consumer advocacy organisations.

Figure 4.1: Workflow of phases of analysis linking research objectives to study outputs.



(Adapted from Orrock, 2017: 13).

In this investigation, I used a research strategy to answer three types of questions: what, why, and how (Blaikie, 2010: 104-108), corresponding to “contextual”, “diagnostic”, and “evaluative” analyses, respectively (Ritchie & Spencer, 1994: 174). The contextual question, ‘What are the attitudes to and experiences of HPR?’ was answered by exploring and describing the perspectives of HPR communicated in documents and interviews. The diagnostic question, ‘Why do stakeholders hold these views?’ was answered by exploring and describing the reasons given by stakeholders for their perspectives through themes identified in the stakeholder documents and interviews. The evaluative question, ‘How are held beliefs and attitudes rationalised in stakeholder discourse?’ was answered by interpreting the study results within a Bourdieusian theoretical framework described in the previous chapter, Section 3.3.4. The logic of inquiry most suited to answering these questions is inductive and abductive research strategies²⁴ (Blaikie, 2010: 105).

Analysis of collected data proceeded inductively, from documents to description and synthesis and from documents and interview transcripts to coding and categorisation. No *a priori* theory was used to hypothesise an explanation of the results. An abductive research strategy was used to draw content from documents and transcripts to derive meaning and understanding from the data. Bourdieu’s power and class concepts used to theoretically analyse and interpret the results were informed by the data and selected after all data were collected, stakeholder interviews were completed, and preliminary primary analysis drew to a close.

4.2.2 Qualitative multi-method sequential research design

A qualitative, multi-method, sequential research design was used to facilitate a thorough understanding of the phenomenon investigated (Hesse-Biber et al., 2015: 11). This approach involved collecting and analysing data from multiple sources using

²⁴ Inductive logic aims to answer ‘what’ questions (Blaikie, 2010: 83, 85). It was applied in this research to draw insights from the data relating to stakeholder attitudes and the stated reasons for stakeholder perspectives. Abductive logic aims to answer why and how questions (Blaikie, 2010: 89-102). Abductive logic facilitated data interpretation and identification of the most plausible theory to explain stakeholder motivations and intentions.

qualitative methods (Hunter & Brewer, 2015: 187). Multi-methods leverage the complementary strengths of each method while compensating for the limitations of other methods in the research design (Brewer & Hunter, 2006: 4). The multi-methods used in this investigation involved two data sources and three analytic techniques to engage with the data in diverse ways. These methods are expanded on in Section 4.3.

4.2.3 Selection of professions for investigation

In April 2013, the Australian Health Ministers' Advisory Council released its final report on *Options for the Regulation of Unregistered Health Practitioners* (the Options Report) (AHMAC, 2013). The Options Report was commissioned to review, assess, and advise governments on the most appropriate form of regulation for health professions that were not regulated under the NRAS at that time²⁵. The Options Report listed 67 'unregistered' professions, that is, professions providing health services and operating outside the remit of the NRAS (AHMAC, 2013: 10, 59-60, 91-94). Of the professions reviewed in the Options Report, fifteen are the subject of the present study. Table 4.1 presents the 67 non-registered professions identified in the Options Report and highlights the fifteen health professions examined in the current study.

A broad representation of non-registered professions was required to gain an understanding of the diverse views of HPR for the non-registered workforce. Selection criteria were established to determine which health professions would be included. I applied criterion-based sampling (Creswell & Poth, 2018: 159) to screen professions for study inclusion using a range of indicators established specifically for this study. Three domains, each having up to three criteria based on government and non-government sources of information, were established to assess the range, reach, and recognition of non-registered health professions. Where there was more than one criterion in a domain, the profession was required to meet at least one to justify progression to the next assessment domain. If not met, the profession was excluded from the study.

²⁵ The 15 health professions registered under the NRAS between 1 July 2010 and 1 July 2012 and therefore excluded from the Options Report review were Aboriginal and Torres Strait Islander health practice, Chinese medicine, chiropractic, dental practice, medical practice, medical radiation practice, nursing, midwifery, occupational therapy, optometry, osteopathy, pharmacy, physiotherapy, podiatry, and psychology.

Table 4.1: Non-registered health professions in Australia as of 1 July 2012.

Professions		
Ambulance officer/paramedic	Anaesthetic technician	Anatomist/physiologist
Art therapist	Aromatherapist	Assistant in nursing
Audiologist	Audiometrist	Ayurvedic practitioner
Biomedical engineer	Bioresonance practitioner	Cardiac technician
Clinical perfusionist	Complementary and alternative medicine practitioner	Counsellor
Dance therapist	Dental assistant	Dialysis technician
Diabetes educator	Dietitian	Diversional therapist
Drama therapist	Drug and alcohol counsellor	EEG technician
Environmental health officer	Family and marriage counsellor	Exercise physiologist/fitness instructor
Health information manager	Health practice manager	Health promotion officer
Homoeopath	Hospital orderly	Hypnotherapist
Lactation consultant	Medical laboratory scientist	Medical laboratory technician
Medical scientist	Massage therapist	Music therapist
Myotherapist	Naturopath	Neurophysiology technician
Nutritionist	Occupational health and safety adviser	Operating theatre technician
Optical dispenser	Optical mechanic	Orthoptist
Orthotic/prosthetic technician	Orthotist or prosthetist	Pharmacy sales assistant
Pharmacy technician	Phlebotomist	Psychotherapist
Reflexologist	Rehabilitation counsellor	Reiki practitioner
Respiratory scientist	Shiatsu therapist	Sleep technician
Social worker	Sonographer	Speech pathologist
Sterilisation technician	Therapy aide	Weight loss consultant
Western herbalist		

 Professions in the scope of the research study.

(AHMAC, 2013: 10, 59-60, 90-94).

The inclusion criteria for selecting professions for the study were pragmatic. The ‘registration status’ domain distinguished professions not registered at the conclusion of the two initial NRAS implementation tranches on 1 July 2012. The ‘self-regulation status’ domain identified whether a voluntary certification scheme was in place for the profession and if a representative professional body existed to invite interview participation. The ‘healthcare provider status’ and ‘access to government financial entitlements’ domains were established to improve the likelihood that government health policy actors were aware of and were more likely to have opinions about regulating these professions.

Appendix 4 sets out the eligibility criteria and indicators for assessment and the evaluation steps for selecting the healthcare professions included in the study. A summary of the eligibility criteria is presented in Table 4.2. It lists the professions excluded following the assessment.

Table 4.2: Assessment domains and criteria used for selection of health professions.

Domain	Eligibility criteria	Practitioners not meeting eligibility criteria (excluded from the study)	
1. Registration status	a. Unregistered profession as of 1 July 2012 and identified in the 2013 Options Report	None	
2. Self-regulation status	b. Voluntary occupational certification scheme in place	• Assistant in nursing • Bioresonance practitioner • Cardiac scientist/technician • Electroencephalographic technician • Hospital orderly	• Occupational health and safety adviser • Operating theatre technician • Optical mechanic • Pharmacy sales assistant • Pharmacy technician • Therapy aide • Weight loss consultant
3. Health care provider status	c. Primary care and/or hospital care and/or d. Allied health provider	• Anatomist/ physiologist • Audiometrist • Biomedical engineer • Dental assistant • Dental technician • Dialysis technician • Diversional therapist • Environmental health officer • Health information manager • Health practice manager • Health promotion officer • Hypnotherapist	• Lactation consultant • Medical laboratory scientist • Medical laboratory technician • Medical scientist • Optical dispenser • Orthotist • Phlebotomist • Prosthetist • Reflexologist • Rehabilitation counsellor • Reiki practitioner • Respiratory scientist • Shiatsu therapist • Sleep technologist
4. Government financial entitlements	e. Medicare rebatable and/or f. GST-free status and/or g. Workers' compensation payment (in at least one State/Territory)	• Anaesthetist technician • Aromatherapist • Art therapist • Ayurvedic practitioner • Complementary and alternative medicine practitioner • Dance therapist • Drama therapist	• Drug and alcohol counsellor • Family and marriage counsellor • Homeopath • Music therapist • Neurophysiology technician • Orthotic and prosthetic technician

Consumer utilisation of health services provided by non-registered professions and workforce data were used to contribute additional information to support and confirm decisions made regarding the inclusion of health professions (see Appendix 4).

Table 4.3 presents the fifteen professions meeting the study eligibility criteria.

Table 4.3: Health professions meeting the eligibility criteria for study inclusion.

Audiology	Clinical perfusion
Counselling	Dietetics
Exercise physiology	Massage therapy
Myotherapy	Naturopathy
Orthoptics	Paramedicine ²⁶
Psychotherapy	Social work
Sonography	Speech pathology
Western herbal medicine	

4.3 Methods of data generation, analysis, and interpretation

The qualitative multi-method design used in this investigation was conceptualised as four phases, defined by the analytic approach. The phases involved an analysis of two separate documentary sources of evidence, an analysis of stakeholder interviews, and a theoretical analysis and interpretation of the results of these analyses. Qualitative description was used to analyse documents for mapping the HPR field and stakeholder perspectives derived from document sources. Applied thematic analysis was used to analyse stakeholder documents and interviews. Bourdieusian concepts were used to analyse and interpret the results theoretically.

Table 4.4 sets out the four phases of the study design and the key activities undertaken in each phase.

²⁶ Paramedicine was included as a 'non-registered' profession since it was not registered on 1 July 2012, the date set for selecting non-registered professions examined in this research.

Table 4.4: The four phases of the study design.

Study phase	Key activities
1 Mapping the health practitioner regulation field	Map the health practitioner regulation field by detailing the following: • key events and decisions leading to and beyond the NRAS; • statutory and co-regulatory mechanisms for 15 non-registered health professions; • estimated number of non-registered practitioners; • estimated annual number of consumer consultations; and • estimated public funding received by non-registered practitioners.
2 Qualitative multi-method analysis of document sources	Descriptive analysis of document sources on positions held by stakeholders regarding HPR. Thematic analysis of document sources describing stakeholder reasons for supporting particular positions on HPR.
3 Qualitative analysis of stakeholder interviews	Thematic analysis of perspectives and experiences of HPR from interviewed: • consumer advocates; • government health policy actors; and • professional body representatives.
4 Theoretical analysis and interpretation	Bourdieuian analysis and interpretation of stakeholder perspectives of HPR relating to non-registered professions.

The first three study phases involved data collection corresponding to the method for studying a field outlined by Bourdieu (Bourdieu & Wacquant, 1992: 104-105), adapted by Neu and colleagues (2013: 6-7), and modified for the present research.

Table 4.5 sets out the three data collection phases, outlining the data sources, data generated, analysis methods, and timeframes from which data samples were drawn.

Table 4.5: Data sources and analysis approaches for data collection.

Data collection phase	1	2	3
Data source	Documents	Documents	Interviews
Data generated	Map of key decisions, events, regulation mechanisms, size, reach and funding relating to non-registered professions	Stakeholder positions and perspectives of HPR	Stakeholder perspectives and experiences of HPR
Data analysis methods	Descriptive analysis	Descriptive and applied thematic analysis	Applied thematic analysis
Data sampling period	1992–2025	2004–2022	March 2022 to October 2022

The first research phase was expected to generate information about the contextual arena of the study and the location of health professions therein. It supplied data to chart a timeline of regulatory activities over 34 years to 2025. The data collected also provided information for mapping non-registered professions and their representative bodies onto the HPR field. The study's second phase entailed collecting and analysing publicly accessible documentary sources to determine documented stakeholder perspectives regarding HPR. As the documents included in the present study were sourced from the public domain, they were expected to contain information regarding the formally expressed opinions of stakeholders about HPR. The third data collection phase used stakeholder interviews to gain a deeper insight into perspectives and experiences than what might be available in the documents. Using these data collection techniques, I aimed to develop an understanding of the competing accounts of stakeholders and their perspectives of reality regarding HPR for non-registered health professions.

The sequential study design enabled the results of one research phase to inform subsequent phase/s, although there was some overlap between the end of one phase and the beginning of the next. The study design with three data collection stages also facilitated data triangulation (Natow, 2020: 161, 166).

4.3.1 Research Phase 1: Document analysis – mapping the HPR field

According to Bourdieu in Bourdieu and Wacquant (1992), when studying the field:

one must analyze the position of the field vis-à-vis the field of power [and] map out the objective structure of the relations between the positions occupied by the agents or institutions who compete for the legitimate form of specific authority of which this field i[s] the site. (Bourdieu & Wacquant, 1992: 104-105)

Following Bourdieu's direction to map the field, the study's first phase involved understanding the social space known as 'health practitioner regulation'. Mapping was accomplished by purposeful collection of specific documents from the public domain, from which data for addressing the research objectives were extracted (Patton, 2015: 401). From this data, a timeline of events, policies, actions, and decisions related to HPR

was charted. The collected data also facilitated the placement of key social actors in the HPR field.

Data collection

Politico-historical documents were identified describing key events, recommendations, and decisions leading to the establishment of the NRAS, the major policy reforms for regulating specific health professions, and the key events and decisions relevant to non-registered health professions pre- and post-NRAS establishment. The information gathered included the decision-making processes and criteria for admitting new professions to the National Scheme. Documents dating from 1992 were collected since it was in that year that the Commonwealth *Mutual Recognition Act 1992* (Cth) was passed, allowing the movement of registered health practitioners across jurisdictional borders through an administration registration procedure (COAG 1992: 1).

Analysis of the key HPR literature made it possible to discern and describe the layout and boundaries of the HPR field before and after NRAS implementation, analyse the historical context of the National Scheme, determine the relationships between different regulatory schemes, map professions to schemes, and establish the correspondences between professions, regulatory schemes, and dominance of the field.

Documents were sourced from internet searches using search terms based on the knowledge and expertise of the supervisory team and targeted use of known government websites. In particular, the websites of the Council of Australian Governments (COAG) Health Council²⁷, Parliamentary Inquiries²⁸, Productivity

²⁷ This site was decommissioned after completing the initial document searches for this research from May to June 2021.

²⁸ The Parliamentary Inquiries website hosts current and completed Inquiries from Senate Standing Committees on Community Affairs. Documents hosted at this site include terms of reference, full texts of public submissions received by the Committee, reports of the Committee, and Government responses to Committee reports (Senate Standing Committees on Community Affairs, n.d.).

Commission²⁹, Australian Health Practitioner Regulation Agency (Ahpra³⁰), and Trove³¹ were searched. I searched for documents from the Council of Australian Governments, Australian Health Ministers' Advisory Council meetings, known landmark reports, other key documents known to the researcher and supervisory team, and general website searches. There were also serendipitous discoveries of relevant documents retrieved from the scholarly literature, other document searches, and citation tracking. Literature searches took place throughout the candidature, primarily from 15 May 2021 to 4 June 2021, 7 September 2021 to 27 October 2021, and 10 February 2022 to 18 March 2022. A summary of document sources for this research phase is presented in Appendix 5.

Documents collected include ministerial intergovernmental agreements, communiqués from meetings of health ministers, consultation papers, calls for submissions, reports resulting from commissioned inquiries, meeting minutes, and regulatory impact analyses/statements regarding the regulation of health workers. Documents were included if they contained information regarding decisions by government for establishing the NRAS, the professions included or excluded, decisions regarding other governance frameworks for health professions, and the criteria for assessing health professions for statutory registration.

To investigate the institutional linkages between professional bodies and government and non-government co-regulatory partner organisations, between 2023 and 2025, other data were collected from targeted searches of organisation websites, such as the Australian Taxation Office, Medicare Australia, and private health insurance providers. Data located from these searches were included if they provided specific information regarding GST-free status, government compensable schemes, and private health

²⁹ The Productivity Commission is an independent research and advisory body of the Australian Government providing advice to government on a range of economic, social, and environmental issues affecting the welfare of Australians (Productivity Commission, n.d.). The Commission was created by an Act of Parliament in 1998 (*Productivity Commission Act 1998* (Cth)). See: <https://www.pc.gov.au/about>.

³⁰ The Australian Health Practitioner Regulation Agency uses sentence case for its acronym. See: <https://www.ahpra.gov.au/About-Ahpra.aspx>.

³¹ Trove is an Australian Government online archival website hosting full-text documents, bibliographic data, digital images, and other data holdings no longer available on government websites. Trove hosts the archived records of the National Registration and Accreditation Scheme (AHMAC, 2008a). See: <https://trove.nla.gov.au/about>.

insurance rebates. Data were sourced from jurisdictional healthcare complaint commissions to determine the legislative and implementation status of the National Code of Conduct. Australian Census, the Australian Bureau of Statistics, and other government documents and websites were also searched for data to estimate the size of the non-registered workforce, the number of Australians consulting with non-registered practitioners, and the amount of public funding received by non-registered practitioners.

Collected documents and downloaded website pages were systematically titled, collated, and catalogued in readiness for data analysis. Documents were stored electronically on a laptop hard drive and backed up onto an external hard drive and a cloud storage facility.

Data analysis

Documents and web pages were analysed using the READ approach to policy research (Dalglish et al., 2020) and adapted for use in this analysis. The READ approach consists of readying materials by collating and organising documents, extracting the relevant data by reading documents to identify the information of interest, analysing the extracted information, and distilling or synthesising the results (Dalglish et al., 2020: 1426-1430). The READ approach provided a methodical, pragmatic, and rigorous method for collating, interrogating, and extracting data from relevant media. The approach ensured the required information was obtained to build a comprehensive map of the HPR field.

The data analysis procedure is set out in Textbox 4.1.

4.3.2 Research Phase 2: Document analysis – positions on and perspectives of HPR

The intent of this phase was to ascertain from publicly available documents stakeholder positions and perspectives on regulation for professions in the scope of the study.

Textbox 4.1: Data analysis procedure for mapping the field.

Step 1. Documents and web pages were read for information regarding the historical context of the NRAS, the NCC, co-regulatory arrangements, the profile of the non-registered workforce, and other background information (Dalglish et al., 2020: 1426-1427; Fischer et al., 2007: 411).

Step 2. Information regarding dates, decisions, resolutions, or recommendations was recorded in a data extraction table (Dalglish et al., 2020: 1429).

Step 3. Data were analysed to identify and establish a timeline of events and decisions. The data were used to map information regarding non-registered professions, and the document corpus was analysed to assess its completeness (Dalglish et al., 2020: 1429).

Step 4. The results of the analysis were synthesised and presented descriptively and narratively (Dalglish et al., 2020: 1430).

Data collection

Publicly accessible documents in which stakeholders offered opinions and perspectives regarding the regulation of 15 non-registered health professions were collected. Documents were included if they were dated between 2004 and 2022. The sampling commencement year is pertinent because, on 25 June 2004, COAG commissioned a report on health workforce issues (Productivity Commission, 2005: IV), precipitating a chain of events that led to the establishment of the NRAS commencing on 1 July 2010.

Document searches were conducted between 24 April 2021 and 13 August 2021. Additional website searches took place from 20 January 2022 to 13 February 2022. Documents retrieved during these periods were found through a systematic search of website repositories set out in Table 4.6. Documents were purposively collected and included if they reported an opinion regarding any type of HPR for the professions in scope. The aim of the search was to collect the totality of publicly available documents addressing the research objectives, enabling the reporting of frequency counts of categories and concepts generated from the analysis (Guest et al., 2012: 171).

Collected documents were systematically collated and catalogued using a file naming convention to identify the occupation, author (individual or organisation), document date or year, and document title. Documents were stored electronically on a laptop hard drive and backed up to an external hard drive and a cloud storage facility. A spreadsheet

summary of search dates, search terms, websites searched, and URLs of retrieved documents was recorded (see Appendix 6).

Table 4.6: Summary of search strategy for document analysis.

Websites searched	Search method	Search details
- Professional associations - Peak professional bodies - Voluntary registering organisations	- Websites were identified by searching for organisation names and acronyms - All organisation webpages were systematically reviewed for relevant documents/information - All links and attachments were accessed and searched for relevant documents/information - Organisation journals/magazine sites were searched using keywords 'regulation', 'registration', 'statutory', 'nras', 'ahpra'	Documents including: - submissions to government - strategic plans - reports - annual reports - policy documents - position statements - media releases - member communications
The Google search engine was used to identify documents not indexed against organisation websites but available online	- Name of the professional body and the terms 'position statement' and 'submission' - Name of the professional body with the terms 'regulation', 'registration', 'statutory', 'nras', 'ahpra'	- The first two web pages of retrievals were reviewed for relevant documents - The first web page of retrievals was reviewed for relevant documents
Key government websites, including: - COAG Health Council - Parliamentary Inquiries - Productivity Commission	All government inquiries and reviews known to the supervisory team relating to HPR were systematically searched for relevant documents, such as submissions to government	Documents were systematically reviewed and included if they referred to the regulation of any profession in scope

Data analysis

Retrieved documents were imported into a qualitative analysis software program (NVivo 12 Pro (QSR International, 2019)) commencing 4 July 2021. NVivo was used to encode the data into categories, generate concept groupings and sub-themes, arrange sub-themes into themes, and record frequency counts. An audit trail of coding category changes, category review dates, and resulting changes to the codebook was maintained. Memos were maintained throughout the analysis, including perceived patterns, insights,

discrepancies, and matters to follow up on with relevant parties during stakeholder interviews.

Prior argued that documents are more than “*containers of content*”; they function as “*active agents in episodes of interaction and schemes of social organization*” (2008: 824). Documents provide “*evidence of the ways in which individuals, groups, social settings, institutions and organizations represent and account for themselves*” (Coffey, 2014: 367). Far from being passive communication devices, documents can be considered “*act[s] of persuasion*”, serving to communicate particular perspectives of reality (Coffey, 2014: 372).

Alaszewski noted that content analysis may refer to all forms of textual analysis or more narrowly to identify specific information (2013: 76). He stated that content analysis involves the textual disassembly of documents to identify information of interest, followed by the reassembly of the parsed segments to create something new from the reconstructed data (2013: 78). The content analytic approach used to analyse stakeholder documents collected for this research was developed by Guest, MacQueen, and Namey, referred to as applied thematic analysis (2012). Applied thematic analysis uses a varied and pragmatic approach to qualitative analysis that is inductive, primarily descriptive, and exploratory. It promotes rigour and transparency in procedures and is ideally suited to identifying perceptions and/or experiences from interviews and documents. Applied thematic analysis may use qualitative and quantitative methods as complementary arms of a comprehensive analytic strategy (Guest et al., 2012: 4-9, 18).

Although there is controversy regarding the use of numbers in qualitative research (Hammersley, 1992: 159-160; Maxwell, 2010: 475; Miles & Huberman, 1994: 40), some researchers have argued their use adds depth to qualitative data analysis (Boyatzis, 1998: 129-132; Miles & Huberman, 1994: 40-41; Sandelowski, 2001: 231-232; Tashakkori & Teddlie, 1998: 126). The use of numbers in qualitative research aids the search for patterns in the dataset, enables the researcher to discern the preoccupations of authors, and helps to generate meaning (Miles & Huberman, 1994: 253; Morgan, 1993: 116-117; Sandelowski, 2001: 231-232). Using numbers in qualitative research can be justified depending on the sample size and composition of the study population

(Sandelowski, 2001: 231). The present study included all publicly available documents that were located in which the opinions of any person or organisation were reported regarding the regulation of 15 healthcare professions. Consequently, the analysis of documents in this research applied quantitative methods using frequency counts and percentage calculations to augment the qualitative analysis. The documents were also subjected to thematic analysis to identify patterns in the data from which overarching categories and themes were generated (Boyatzis, 1998: 3-4; Bryman, 2012: 580). This method was used due to the type of data collected, the aims and exploratory nature of the research, and the desire to comprehensively mine the collated documents for stakeholder attitudes and perspectives.

Textbox 4.2 sets out the analysis procedures for retrieved documents.

Document data analysis commenced before stakeholder interviews were conducted, allowing for the tailoring of appropriate questions for relevant stakeholders based on information gleaned from relevant documents. Coding was conducted between July 2021 and December 2021, February 2022 and June 2022, and was reviewed at intervals thereafter. The analysis was regularly shared with my supervisory team for review and feedback.

4.3.3 Research Phase 3: Key informant interviews – perspectives and experiences of HPR

While the perspectives presented in documents in the public domain provide one perspective of reality, they are created for a specific purpose (Arksey & Knight, 1999: 17). These perspectives may be self-censored, rhetorically controlled, or otherwise made fit for public consumption (Hodder, 1994: 394). Furthermore, publicly accessible documentary evidence is only provided by stakeholders and from websites, making the material available³². To deal with these potential limitations, documentary evidence was complemented by qualitative interviews (Baker, 2013: 309).

³² An example during the course of this research is the COAG Health Council website, which hosted information about HPR and the NRAS. The website was available at the time the first document searches were conducted for Phase 1 of the research between May 2021 and June 2021, but was decommissioned by the time the second search commenced in September 2021.

Textbox 4.2: Data analysis procedure for stakeholder document sources.

Step 1. Retrieved documents were systematically file-named and imported as PDF documents into the NVivo qualitative analysis software program.

Step 2. File classifications were assigned to documents according to profession, organisation, organisation type, and document type.

Step 3. Familiarisation entailed document skimming and superficial review.

Step 4. Coding entailed a keyword search of each document from which relevant text segments, sentences or paragraphs were inductively coded. Keyword search terms used were: 'accreditation', 'ahpra', 'certification', 'credential', 'national law', 'nras', 'register', 'registration', 'regulation', and 'statutory'.

Step 5. Coding involved iterative and cyclical rounds of reading and coding of relevant data. The following is a summary of the coding process applied:

- Inductive and descriptive codes were established (Boyatzis, 1998: 3-4) to maintain the codes as close as possible to the language in the documents (Braun & Clarke, 2022: 57).
- Data were assigned to as many discrete codes as were identified in text segments.
- Patterns and connections were identified (Saldaña, 2011: 104), and similar codes were grouped into categories and concepts.
- Frequency counts were generated by coding each instance of a concept irrespective of how often it was repeated in the document.
- Initial coding efforts followed the advice of Richards and Morse, *"if it moves, code it"* (2013: 162).
- Progressive reviews of the codes brought greater order to the dataset. Coding coherence was achieved by repeatedly reviewing codes and categories, including validating coded segments for internal consistency, recoding text segments, merging similar codes, and establishing sub-themes and themes from which a thematic hierarchy was established.
- Memoing of insights continued throughout the analysis (Saldaña, 2009: 32-34; 2011: 102).

Step 6. The document was removed from NVivo and the study where no relevant information was identified.

Sampling strategy

Purposive, stratified sampling was used to identify personnel from organisations and government departments for interviewing. The sampling strategy involved selecting the most appropriate stakeholder groups and prospective participants to meet the research objectives (Miles & Huberman, 1994: 27-28). From the scoping review (see Chapter 2, Section 2.5.3), the stakeholder cohorts for which little or no research has been conducted were consumer advocates, government health policy officers, and

professional body representatives. The sampling of participants from these three cohorts required different recruitment strategies.

Organisation and population sampling

Consumer advocates

These stakeholders were recruited via consumer advocacy organisations. National health-related consumer advocacy organisations were identified from internet searches and knowledge of these organisations within the supervisory team. All relevant consumer advocacy organisations found from website searches were invited to nominate a representative for an interview. Invitations were addressed to the Chief Executive Officer and emailed to addresses found on organisation websites.

Government health policy officers

The sampling strategy for policy officers was to interview one participant from the workforce branches of each state, territory, and Commonwealth departments of health, and national agency bodies with responsibility for assessing or operationalising HPR policy change. Purposive sampling was used to identify the most appropriate personnel from health departmental branches and agencies with knowledge about the research objectives (Low, 2013: 89). Invitations were emailed to the heads of departments of HPR branches or equivalently named departments or to the Chief Allied Health Officers in each jurisdiction.

Professional body representatives

The study was conducted sequentially, such that each phase commenced at or near the conclusion of the previous phase. This meant the list of prospective profession representatives to be interviewed was not finalised until the first phase of document analysis was completed, the regulatory context had been mapped, and I understood the range and location of players therein. Mapping the regulatory context revealed that the fifteen health professions were represented by 28 professional associations, five peak professional bodies, and four voluntary registering organisations. As there were likely to be approximately 20 consumer advocates and policy actors invited for interview, further screening of professional associations was necessary to reduce the number of interview

participants to a manageable level³³. The recruitment strategy was to interview personnel from approximately half the professional associations and most peak professional bodies and voluntary registering organisations. The procedure for selecting organisations for interview participation is detailed in the following two sections.

Recruitment of professional associations

Where only one association represented a profession, it was included in the recruitment schedule with no further assessment. Where two or more associations represented a profession, inclusion in the recruitment schedule was based on the number of members; the more association members, the greater the likelihood of inclusion. Membership numbers were ascertained from website searches, annual reports, or submissions sourced as part of the documentary evidence. If no membership data were found, the decision for inclusion/exclusion was based on the number of documents retrieved in the document search; the more documents retrieved, the greater the likelihood of association inclusion in the recruitment schedule, based on the assumption that these participants would have more perspectives and experiences regarding HPR to share in interviews. Following the assessment of professional associations, at least one association from each of the 15 professions was included for recruitment. Some professions had as many as four representative associations invited to nominate a representative for interview participation. Table 4.7 lists the professional associations included in the recruitment schedule, and Appendix 7 lists those excluded.

³³ This strategy did not alter the documentary sources included for document analysis. Irrespective of the stakeholder, all documents found in the public domain offering opinions regarding the regulation of the 15 professions in the scope of the research were included in the analysis.

Table 4.7: Professional bodies included in the recruitment schedule and the profession represented.

Organisation	Audiology	Clinical perfusion	Counselling	Dietetics	Exercise physiology	Massage therapy	Myotherapy	Naturopathy	Orthoptics	Paramedicine	Psychotherapy	Social work	Sonography	Speech pathology	Western herbal medicine	Comment
Peak professional bodies																
Allied Health Professions Australia (AHPA)	•	•	•	•	•		•		•		•	•		•		
Council of Ambulance Authorities (CAA)										•						CAA represents ambulance authorities (employers) in Australia, New Zealand, and Papua New Guinea. It does not represent paramedic members. CAA was included in the recruitment schedule after the Australasian College of Paramedicine declined to participate.
National Alliance of Self Regulating Health Professions (NASRHP)	•	•	•	•	•						•			•		
Voluntary registering organisations																
Australian Orthoptic Board (AOB)									•							
Australian Register of Naturopaths and Herbalists (ARONAH)								•							•	
Australian Sonographer Accreditation Registry (ASAR)													•			
Professional associations																
Audiology Australia (AA)	•															Member of AHPA, member of NASRHP
Australian and New Zealand College of Perfusionists (ANZCPerf)		•														Member of AHPA, member of NASRHP
Independent Audiologists Australia (IAA)	•															
Dietitians Australia (DA)				•												Member of AHPA, member of NASRHP
Exercise and Sports Science Australia (ESSA)					•											Member of AHPA, member of NASRHP
Australian Counselling Association (ACA)			•								•					Member of AHPA

Organisation	Audiology	Clinical perfusion	Counselling	Dietetics	Exercise physiology	Massage therapy	Myotherapy	Naturopathy	Orthoptics	Paramedicine	Psychotherapy	Social work	Sonography	Speech pathology	Western herbal medicine	Comment
Psychotherapy and Counselling Federation of Australia (PACFA)			•								•					Member of AHPA, member of NASRHP
Australian Natural Therapists Association (ANTA)			•			•	•	•							•	
Australian Traditional Medicine Society (ATMS)			•			•		•							•	
Association of Massage Therapists (AMT)						•										
Massage and Myotherapy Australia (MMA)						•	•									Member of AHPA
Myotherapy Association Australia (MAA)							•									Member of AHPA
Naturopaths and Herbalists Association of Australia (NHAA)								•							•	
Orthoptics Australia (OA)									•							Member of AHPA
Australasian College of Paramedicine (ACP)										•						
Australasian College of Paramedic Practitioners (ACPP)										•						Member of AHPA
Australian Association of Social Workers (AASW)												•				Member of AHPA
Australasian Sonographers Association (ASA)													•			Member of AHPA
Australasian Society of Ultrasound in Medicine (ASUM)													•			
Speech Pathology Australia (SPA)														•		Member of AHPA, member of NASRHP

Recruitment of peak professional bodies and voluntary registering organisations

Allied Health Professions Australia (AHPA) is the peak professional and advocacy body for allied health professional associations in Australia. Thirteen professional associations representing 13 professions included in this research are full or affiliate members of AHPA (AHPA, 2025b) (see Table 4.7 and Table 4.8). As a peak professional body for most professions in this research, AHPA was included in the interview recruitment schedule.

The National Alliance of Self Regulating Health Professions (NASRHP) is a non-statutory certifying body providing a quality framework of standards for the self-regulation and accreditation of member organisations (NASRHP, 2025). Six professional associations representing seven professions included in this research have full or provisional standards certification through NASRHP (see Table 4.7 and Table 4.8). As a professional standards-setting body for around half the professions examined in this research, NASRHP was included in the recruitment schedule.

All voluntary registering organisations operating independently of professional associations were included in the recruitment schedule. Three organisations accrediting four health professions met this criterion (see Table 4.8). The Australian Register of Counsellors and Psychotherapists does not operate independently of professional associations and was excluded from the study (see Appendix 7).

Table 4.8: Professions represented by peak professional and voluntary registering bodies.

AHPA	NASRHP	Voluntary registering bodies
• Audiology • Clinical perfusion • Counselling • Dietetics • Exercise physiology • Massage therapy • Myotherapy • Orthoptics • Paramedicine • Psychotherapy • Social work • Sonography • Speech pathology	• Audiology • Clinical perfusion • Counselling • Dietetics • Exercise physiology • Psychotherapy • Speech pathology	• Naturopathy • Orthoptics • Sonography • Western herbal medicine

Overall, twenty professional associations, three peak professional bodies, and three voluntary registering organisations were identified for interview recruitment. Email invitations were addressed to the Chief Executive Officer of the professional body using information found on organisation websites.

Data collection

Interviews added personal and experiential dimensions to the data obtained from the documents (Arksey & Knight, 1999: 2-4). Semi-structured interviews were conducted to elicit and explore informants' personal perspectives and experiences.

Some writers have contended that there are several advantages to the semi-structured interview compared to other approaches. First, this format is appropriate for drawing out relevant information to meet research objectives (Alvesson & Ashcraft, 2009: 69-70; Byrne, 2018: 220), which I considered was unachievable with the rigid format of a structured interview or the free-ranging format of an unstructured interview (Arksey & Knight, 1999: 4-9). Second, the semi-structured format enables the use of open-ended questions to pursue lines of inquiry specific to each informant and allows for variation in the order of questioning based on informant responses (Healey, 1991: 216-217). Third, semi-structured interviews give informants time and the latitude to provide extended responses in a free and open manner (Byrne, 2018: 220). Finally, although I acknowledge that comments in interviews, like documents, can be filtered or censored, semi-structured interviews allow for additional techniques, such as verbal and non-verbal probing, to elicit further information or steer the interview. Verbal probing facilitates elaboration if responses are unclear, limited, or evasive. It enables the querying of perceived discrepancies in informant accounts and can be used to overcome informant defence strategies and carefully crafted responses (Berry, 2002: 681). Non-verbal probing, such as silence, allows informants time to continue talking and the opportunity to disclose further insights and perspectives (Baker, 2013: 313; Berry, 2002: 681).

Before commencing each interview, informants were given a brief overview of the study and the format for the interview. They were given an opportunity to ask

questions before the interview began and the recording commenced. An interview guide was developed to cover the key areas of inquiry and was slightly modified for each stakeholder cohort. The guide included questions regarding the background of the informant and their role in the organisation, views regarding the IGA assessment criteria, opinions about perceived differences between registered and non-registered professions, international comparisons of professions, and views regarding potential harms of occupational practice. For professional bodies, additional questions were asked regarding the profession and its place in Australian health provision, previous actions taken (if any) in pursuit of statutory registration, barriers encountered and plans regarding regulation. See Appendix 8 for the interview guides used in this research.

In preparation for interviews, four pilot interviews were conducted between 15 February 2022 and 9 March 2022. Interview questions were slightly modified following these interviews. Responses from these interviews were not included in the data analysis.

During the interviews, I shared with informants a table of registered and non-registered health professionals, several of which were loosely matched to provide a focus for specific questions posed. This list is presented in Table 4.9 to give context for informant responses referring to professions on the 'left' or 'right'.

Interviews were approached as an interaction where both parties took an active role (Holstein & Gubrium, 2004: 140-143). The interview style varied in response to the informant being interviewed (Ball, 1994: 106). In general, a more facilitative questioning style was used with consumer advocates (Willig, 2001: 97), while a more probing style was employed with policy actors (Baker, 2013: 313, 315; Ball, 1994: 106). Interviews with profession representatives employed both interview styles depending on informant responses.

See Figure 4.2 for a model of the approach typically taken in stakeholder interviews.

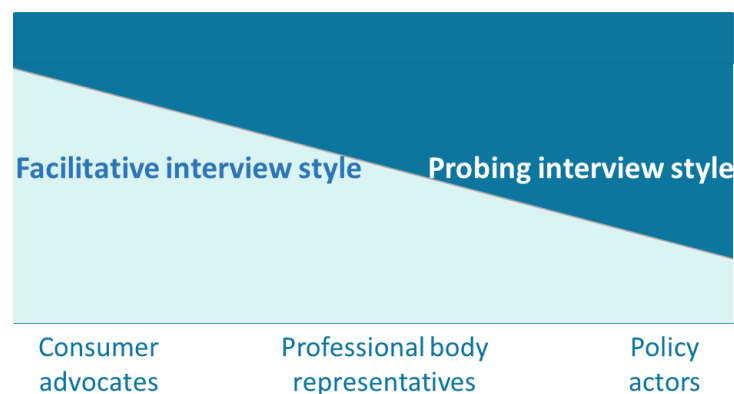
At the end of formal questioning, informants were given a further opportunity to ask questions or comment on any matters not covered during the interview. Often, this

led to further discussions and insights. In most cases, the audio recording continued until the interview was concluded. All informants were given the opportunity to review a transcript of their interview before analysis commenced.

Table 4.9: List of registered and non-registered practitioners presented to interview informants.

Registered practitioner	Non-registered practitioner
‘Matched’ practitioners	
Chiropractor Osteopath Physiotherapist	Massage therapist Myotherapist
Medical radiation practitioner	Sonographer
Podiatrist Occupational therapist	Audiologist Speech pathologist
Optometrist	Orthoptist
Chinese medicine practitioner	Dietitian Naturopath Western herbal medicine practitioner
Psychologist	Counsellor Psychotherapist
‘Unmatched’ practitioners	
Aboriginal and Torres Strait Islander health practitioner Dental practitioner Medical practitioner Midwife Nurse Pharmacist Paramedic (registered on 1 December 2018)	Clinical perfusionist Exercise physiologist Paramedic (registered on 1 December 2018) Social worker

Figure 4.2: Model of interview styles generally employed in stakeholder interviews.



Following each interview, recordings were stored in a university-secured, password-protected cloud storage facility. De-identified transcripts were stored electronically on a laptop hard drive and backed up onto an external hard drive and a cloud storage facility. An audit trail and spreadsheet summary of interview details were maintained, including organisations approached, the date the invitations were sent, follow-up dates, organisations declining an interview, information regarding interviewees, interview dates, and interview duration.

Data analysis

Bourdieu observed that language extends beyond mere communication. He described language as *“performative utterances”* (1991: 75, 111), a mechanism of power *“to make things with words”* (1989: 23), and a means by which symbolic violence is exercised (1991: 167). Bourdieu stated that *“relations of communication are always, inseparably, power relations, which, in form and content, depend on the material or symbolic power accumulated by the agents (or institutions)”* (Bourdieu, 1991: 167). In social policy, language is required for both agenda and problem setting; *“policy is text, bound by language”* (Beilharz, 1987: 390).

In the present study, the interview data were analysed using an inductive approach to applied thematic analysis (Guest et al., 2012: 4) and adapted for this research. The data analysis procedures are set out in Textbox 4.3.

Data familiarisation was accomplished by repeatedly listening to interview recordings while correcting, reading, and coding the transcripts. This familiarisation method of engaging both sight and hearing senses facilitated attentiveness to the features of informant discourses, the characteristics of speech and language, and the emphases, pauses, preoccupations, and omissions (Gay et al., 2006: 469; Mishler, 2003: 317-318). By taking this approach, I aimed to *“internalize”* the language and meaning of informant accounts to facilitate pattern identification and locate related threads within and between the transcripts (Gay et al., 2006: 469-470).

Textbox 4.3: Data analysis procedure for stakeholder interviews.

Step 1. Memoing: the analysis commenced with documenting field notes of reflections and insights following each interview, using prompt questions to guide note-taking (Saldaña, 2009: 32-34; 2011: 102). Memoing continued throughout the analysis.

Step 2. Preparing data files:

- Following each interview, recordings were uploaded to an artificial intelligence transcription software program (Otter.ai) to generate the initial transcriptions.
- Transcripts were corrected in Otter while replaying the recordings.
- Recordings were transcribed verbatim and edited for readability.
- During data correction, transcripts were de-identified by removing person and jurisdiction identifiers and were replaced with codes that preserved sufficient information for classification purposes³⁴.
- Non-verbal sounds such as laughter and other vocalisations were retained in the transcripts, and pauses in conversation of three seconds or longer were also retained, for example, [5 seconds].
- Corrected transcripts were downloaded from Otter and uploaded into NVivo as Microsoft Word files ready for coding.
- Recordings and transcripts were then permanently deleted from Otter.

Step 3. Data familiarisation: involved repeatedly listening to the recordings while closely reading the transcripts.

Step 4. Creating categories: using inductive coding to descriptively assign or code text segments to topic areas at the semantic level (Guest et al., 2012: 7; Saldaña, 2009: 70) in a manner Saldaña described as “*a method of discovery*” (2011: 95). Topic codes were defined and clustered into the most important categories (Guest et al., 2012: 52-53).

Step 5. Generating sub-themes and themes: the final analysis step took place after all transcripts had been coded. Categories were checked for internal consistency and recoded, combined, and refined (Guest et al., 2012: 52-53, 78). Categories were transformed into sub-themes and clustered into higher-order themes. Relistening to the recordings helped to confirm coding and deal with any other elements of the transcript not detected earlier.

(Adapted from Guest et al., 2012: 49-78).

When presenting the analysed data in the results sections of this thesis, quotations are italicised, presented verbatim, and placed in textboxes. Ellipses in square brackets, that is, [...], denote missing words, and added text is presented in square brackets, for instance, [registration]. Non-verbal sounds are retained in the quotations and placed

³⁴ Classification categories included the stakeholder cohort (consumer advocates, policy actors, and profession representatives) with additional descriptors in the case of professional bodies to identify the profession and the professional body represented.

in square brackets. Pauses of three seconds or longer in conversation are noted in square brackets. These speech characteristics and notations were aimed at maintaining fidelity to stakeholder accounts, animating stakeholder quotations, and facilitating comprehension of stakeholder perspectives and meanings.

Initial coding was conducted from 31 July 2022 to 29 October 2022. Further rounds of reviewing and relistening to the recordings and refining codes, categories, and themes occurred at periodic intervals until October 2023.

4.3.4 Research Phase 4: Theoretical analysis and interpretation of study results

According to Wolcott, transformation or *“doing something”* with qualitative data involves description, analysis, and interpretation (1994: 10). He stated that *“[t]heory can serve both analytically and interpretively”* in the transformation (1994: 43). Analytically, theory can contextualise and provide structure to the interpretation. Interpretively, theory can connect data to *“larger issues”* and provide *“explanatory power”* to the studied phenomenon (Wolcott, 1994: 34, 43).

In analysing primary data sources, writers have maintained that data analysis involves disassembling and decontextualising text from documents and transcripts into data segments, deciphering and parsing text segments into codes, and reassembling and recontextualising the data into categories expressing a concept, idea, or theme (Gay et al., 2006: 470-472; Tesch, 1990: 115-123). In contrast, data interpretation is the conceptual act of making clear, making sense (Taylor, 1979: 25), and making meaning (Gay et al., 2006: 467).

In this research, I performed a type of secondary analysis to transform the primary analysis of documentary and interview data results by using theory to re-analyse and recontextualise stakeholder perspectives and connect these to larger conceptual issues. In this thesis, I refer to this approach as theoretical analysis and interpretation of the study results. The approach was crucial because of a research goal to propose theoretical explanations and causal mechanisms for stakeholder perspectives of HPR in Australia as they relate to non-registered professions. The source data for the theoretical analysis and interpretation were the results from Phases 2 and 3 of the

research, analysis of stakeholder documents and interviews. The approach was informed by the critical realist meta-theory introduced in Chapter 3, Section 3.2.3. It drew on Bourdieusian theory presented in Section 3.3.4 to re-analyse the key themes and concepts from stakeholder data.

The approach involved an iterative dialogue between stakeholder perspectives and interpretations of reality, my interpretations of the perspectives and interpretations of stakeholders (Fielding, 2016: 157), and a dialogue with Bourdieu about these perspectives and interpretations. This recursive function was applied because “*we are dealing with interpretations and interpretations of interpretations*” (Rabinow & Sullivan, 1979: 6).

Smith maintained that interpretivists regard both the interpreter and the interpreted as being embedded in historical contexts such that:

no act of interpretation can take place from a neutral standpoint or aspire to an accuracy of depiction. Understanding cannot be a matter of the accurate representation of meaning, because meaning does not stand independent of and prior to the act of interpretation; on the contrary, meaning comes into being only as the result of a dialogical encounter between the interpreter and the interpreted. (Smith, 1993: 106)

The ‘dialogical encounter’ in this research involved establishing a dialogical bridge between stakeholder accounts and broader concepts (Guest et al., 2012: 75; Wolcott, 1994: 43). The broader concepts were found in Bourdieusian theory. An interpretive explanation was used to transform the data, concepts, and themes into a “*fully integrated explanation*” (Sandelowski & Barroso, 2003: 914) using the conceptual tools offered by Bourdieu. This integrated explanation entailed conceptual abstraction and applying Bourdieu’s concepts as a theoretical filter to explain, in Bourdieusian language, the perspectives and opinions of stakeholders.

Hodder observed that interpretation required the cognitive engagement of the researcher to draw general understandings of written and spoken language through evaluative techniques (1994: 398). Interpretation is the process of moving beyond the codes, categories, and themes to achieve what Rogers and Willig described as an “*amplification of meaning, an exploration and clarification of the many strands of*

meaning which constitute the phenomenon of interest" (2017: 10). In this study, theoretical analysis and interpretation required the evaluative techniques of looking for patterns, similarities and differences in the data (Hodder, 1994: 399). It involved detecting concordances, connections, and correspondences between the various stakeholder accounts and between stakeholder accounts and Bourdieusian theoretical concepts. This method was used to amplify and accentuate the meaning of stakeholder perspectives and provide a language to communicate this meaning in light of the Bourdieusian concepts they aligned with.

From a critical research perspective, interpretation seeks to "*critique or make transparent [...] false consciousness and ideological distortion*" (Smith, 1993: 106). Critical realists aim to identify these distortions through the subjective participant interpretations of reality. These notions are consistent with the Bourdieusian concept of misrecognition. As a researcher using the conceptual tools set out by Bourdieu and taking a critical realist stance to theoretically analyse and interpret the results, I understood that interview informants and document authors would be subject to misrecognition and ideological distortion in interpreting reality. These subjective interpretations required a translator to achieve understanding and provide explanations. As the translator, I was cognisant of the need to acknowledge that my interpretations of the data may have also been subject to misrecognition and ideological distortion.

Different interpretations of written and spoken language are unavoidable, but the number of possible interpretations or constructions is not limitless (Rabinow & Sullivan, 1979: 12; Ricoeur, 1973: 108). Furthermore, not all interpretations are equally plausible (Ricoeur, 1973: 108). My overriding aim in theoretically analysing and interpreting the study results was to use "*insight and judgement*" (Rabinow & Sullivan, 1979: 7), or what critical realists refer to as "*judgemental rationality*" (Archer et al., 2016: 6; Bhaskar, 1986: 24) to develop a better understanding of and insight into the underlying meaning of the data than that provided by the manifest content of the perspectives offered by informants and authors (Rabinow & Sullivan, 1979: 12).

Judgemental rationality was also used to propose causal mechanisms and offer plausible explanations for stakeholder perspectives.

The primary analysis presented in this research is grounded in the collected data by including typical, conflicting, and contrasting quotations from stakeholder interviews and documents in a way that is transparent and defensible. When re-presented as a theoretical analysis and interpretation of results, I offer a recontextualised and reintegrated set of findings that transform and transcend the data.

4.4 Research quality and validity

4.4.1 Researcher position

I am a relative novice in the field of HPR. My induction into this field of inquiry commenced with my doctoral research. I have no background in government policy analysis, although I have experience in corporate policy and workforce development, having worked in the corporate sector for over three decades. I have been trained in facilitation skills and interviewing techniques and have been employed as a workshop and focus group facilitator on a broad range of projects conducted in the corporate business sector.

Over ten years ago, I completed my studies in naturopathy and Western herbal medicine and was in clinical practice for several years. I am a current member of the Naturopaths and Herbalists Association of Australia (NHAA). This association has long supported registration for naturopaths and Western herbalists, two professions examined in this research. In the first year of my doctoral candidature, I nominated and was elected as Board Director of NHAA, an appointment for which no remuneration was paid. I stepped down from the role at the end of my two-year term in October 2022. I am a registered member of the voluntary registering organisation, the Australian Register of Naturopaths and Herbalists (ARONAH), which also supports statutory registration for naturopaths and Western herbalists. In November 2023, I nominated and was elected as Board Director of ARONAH, a currently held appointment for which no remuneration is paid. The NHAA and ARONAH were included in the interview recruitment schedule for this study. These memberships and

appointments have implications for research validity because of the potential for researcher bias (Lincoln & Guba, 1985: 174). The threats to research validity were addressed by employing the measures detailed below.

4.4.2 Research rigour

There is no critical research that is wholly objective since it is inherently based on researcher values and beliefs (Willis, 2007: 86). Conducting the research within a critical realist paradigm meant accepting that:

human observers of the social world cannot conduct research from a neutral position. This means that the social, cultural, demographic and intellectual background, [...] influences the way that an observer describes and interprets the social world. Any attempt to understand the social world is conceptually mediated and theory-laden. (Blaikie & Priest, 2017: 177)

Being cognisant of these potential biases and threats to the research made me acutely aware that my interpretations of the results would be shaped by my background, values, beliefs, and attitudes (Hill, 1984: 66-70). I approached this research from an axiological position of fairness and equity, a belief that all health professions have a role in contributing to the health and well-being of individuals and communities. No single health profession is more or less important, each contributing in its own unique way. I tend to sit on the side of the oppressed and seek to redress disempowerment and disenfranchisement (Hart, 2018: 127).

As a researcher, I have a responsibility to act ethically and in a morally, socially, and politically responsible manner (Bhaskar, 1986: 24-25). Although my findings may be presented in a way that may be uncomfortable for some, I resolved to hold a mirror to the social interpretations of reality. My purpose was to present findings and interpretations in a way that is transparently linked and justified through the data presented. My commitment was to produce knowledge that, at its core, seeks the most appropriate HPR settings for the inherent risks of occupational practice for the non-registered professions examined in this study and the broader healthcare sector.

To facilitate this aim, measures were taken to promote rigorous, credible, and trustworthy research that optimised data integrity and minimised potential bias. These measures were:

- Acknowledging the existence of bias associated with:
 - my social and personal background and how these may have influenced the research conduct, analysis, interpretations, claims, and conclusions (Bourdieu & Wacquant, 1992: 39; Creswell & Miller, 2000: 127);
 - my position in the academic field as a researcher aiming to bring original knowledge to the discipline (Bourdieu & Wacquant, 1992: 39); and
 - projecting my interests onto the research (Ribeiro & Miraldi, 2022: 122-123).
- Use of reflexivity and journalling to explore and remain vigilant to potential biases, such as my personal beliefs about the research and the opinions of various stakeholders (Ahern, 1999: 408; Saunders et al., 2019: 131).
- Maintaining an audit trail of methodological actions and decisions (Guest et al., 2012: 93-94; Lincoln & Guba, 1985: 319-320).
- Systematic, transparent, and replicable methods consisting of meticulous organisation, identification, and cataloguing of document files and interview transcripts (Guest et al., 2012: 85, 93-94), along with detailed field notes following interviews and memoing throughout data collection and analysis research phases (Saldaña, 2009: 32-34; 2011: 102).
- Regular debriefings with my supervisory team and reviews of informant interview transcripts, documents, coding, categorisation, and theme generation.
- Use of rich and representative quotations that ground the interpretations in the stakeholder data and demonstrate congruence between stakeholder accounts and the results, interpretations, and conclusions (Denzin, 1989: 83ff; Slevin & Sines, 1999: passim).
- Inclusion of atypical and negative cases (Sandelowski, 1986: 35).

- Triangulation of different data sources, use of multiple methods, and inclusion of multiple stakeholder cohorts and organisations to optimise research integrity and validity (Denzin, 1978: 294-295).

4.4.3 Triangulation

Triangulation involves actions taken by researchers to overcome the “*biases that stem from single methodologies*” (Denzin, 1978: 294). Denzin argued that using different data sources, multiple methods, and organisational analyses are three types of triangulation that can introduce greater research rigour (1978: 291-302). In this study, I used two data sources (documents and interviews) to examine the same phenomenon. Multiple methods were used: qualitative analyses, simple quantitative analyses, descriptive analyses, thematic analyses, and theoretical analysis and interpretation. Three stakeholder perspectives were investigated: consumer advocates, government health policy actors, and professional body representatives. Moreover, data were sampled from an extended period, 1992 to 2025, to support data triangulation (Natow, 2020: 161).

4.4.4 Ethical considerations and procedures

Approval to conduct stakeholder interviews was obtained from the University of Technology Sydney Human Research Ethics Committee (UTS HREC REF NO. ETH20-5684) and amendment approvals (ETH22-6976 and ETH22-7324). In addition, site-specific approvals were obtained to interview informants from the South Australian Department for Health and Wellbeing (2022/SSA00151) and the Tasmanian Department of Health (2022/SSA00151 and SSA494 Site Authorisation).

No authorisations were required to conduct document analysis using public domain documentary evidence.

4.5 Power balance

Interviews with consumer advocates, policy actors, and profession representatives raise issues regarding the distribution of power between the researcher and study informants. Kvale argued that qualitative interviews are arenas of asymmetrical power

comparable to a hierarchical relationship in which the interviewer typically “rules” the interview (2006: 484). In this role, the interviewer initiates and defines the interview, poses questions, probes for answers, and closes the interview (Kvale, 2006: 484).

Ball contended that interviewing political “*elites*” was an extension of the state’s “*play of power*”, particularly when interviewing on issues of public interest (1994: 113). He recommended that elite interviews be viewed as sites of struggle with complex dynamics involving “*dominance/resistance and chaos/freedom*” (1994: 113). Another perspective was offered by Duke, who observed that in elite interviews, power is a complex dynamic operating in different directions, shifting and changing depending on the situation and participants, their status and professional affiliations (2002: 52).

These perspectives suggest interviews may be considered Bourdieusian fields comprising two or more players. The unspoken negotiation of power in an interview is part of the interviewee/interviewer relationship. It draws on Bourdieusian concepts such as the habitus of the parties involved in the interview, the doxa or belief systems of the parties, the types and quantities of capital possessed, such as qualifications and institutional status and power, and contests for control of the interview ‘field’. The situation is more complex for doctoral candidates, who generally occupy a position of low status relative to power and insignificant academic credentials compared with academic researchers (Duke, 2002: 52).

The power dynamics in the interviews conducted for the present investigation were a complex arrangement akin to Duke’s observations of elite interviews. Power may have been unevenly distributed in favour of informants, particularly in the case of policy actors. In some interviews, informants were evasive, some actors declined to answer some questions, and in one or two cases, there was mild hostility from informants. On the other hand, I have over 30 years of experience working in the corporate sector, and the behaviour of some informants was not entirely foreign. I felt a sense of collegiality in many interviews, particularly in interviews with consumer advocates and profession representatives. It is difficult to say with certainty what direction power was tilted in the interviews, but overall, I would conclude it was evenly balanced and collegial in most cases.

4.6 Chapter summary

This chapter has presented the research design used to examine the HPR field in Australia and the perspectives and experiences of healthcare stakeholders regarding the regulation of non-registered health professions. The research strategy, methods, and procedures used to collect, analyse, and interpret data in the four research phases were established to thoroughly investigate the research topic and meet the research objectives. By combining data sources, data collection methods, and data analysis techniques, the research methods were designed to maximise rigour and quality and minimise researcher bias and other threats to the research conduct.

I now introduce Phase 1 of the research study in which the first of the results chapters is presented. Chapter 5 provides a descriptive analysis of the HPR field in which I detail the regulatory policy and institutional history, contexts, and frameworks for the occupational regulation of health professions, introduce the registration decision-making criteria and processes, and provide a comprehensive mapping of the HPR field for 15 non-registered health professions in Australia.

Research Phase 1

THE REGULATORY FIELD

In Chapter 3, I introduced the theoretical concepts of Pierre Bourdieu as a framework for analysing and interpreting stakeholder perspectives of health practitioner regulation (HPR). In Chapter 4, I outlined a method for mapping the field as a prerequisite for understanding the location of players and the types of capital resources possessed by field occupants.

This chapter presents the first results chapter that maps the HPR field. It sets out the results of an analysis of 107 publicly available documents and outlines the politico-institutional context for the data presented in subsequent chapters. Surveying the regulatory field establishes the policy, regulatory, and institutional contexts that apply to HPR in Australia, the key players and entities involved in their regulation, and the location of non-registered professions in the field relative to other registered and non-registered professions. This assists in understanding the matrix of regulatory measures governing non-registered professions in the health system and the potential power dynamics between field players.

The chapter is organised into four sections. The first introduces the key social actors and entities involved in HPR. It gives an overview of their role and function to enable an appreciation of government and non-government decision-makers, decision-making bodies, and other statutory and non-statutory regulation arrangements. The second section is a descriptive analysis of the historical, legislative and policy context of the National Registration and Accreditation Scheme (NRAS). As the statutory occupational licensing tool for regulating certain health practitioners in Australia, it is helpful to have an appreciation of the history and timeline of key events and decisions that led to the NRAS and the inclusion of nearly 600,000 health practitioners in 14 professions between 2010 and 2012 under statutory registration (Ahpra, 2013: 9). These same events and decisions excluded an unknown number of practitioners in the

15 professions examined in this study. The third section of the chapter surveys the institutional contexts that, directly or indirectly, regulate and assure the quality of non-registered health practitioners. The final section provides an overview of the professions in scope in terms of estimates of the size of the non-registered workforce, their reach into the Australian community, and the amount of public funding their practitioners receive. A discussion of the results from mapping the field concludes the chapter.

Chapter 5

MAPPING THE HEALTH PRACTITIONER REGULATION FIELD IN AUSTRALIA

5.1 Key players in health practitioner regulation

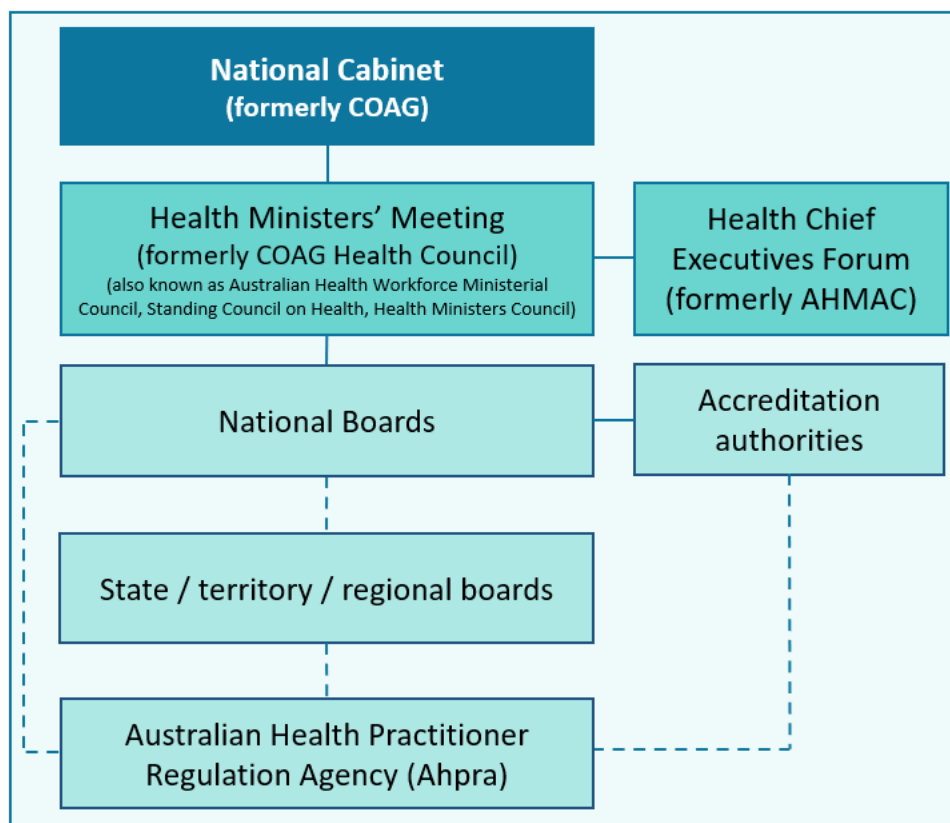
Several government bodies are involved in decision-making for the registration of health professions. Numerous government and non-government bodies also perform regulatory functions for non-registered health practitioners. This section identifies these entities in the period leading up to and at the time of implementation of the NRAS between 2010 and 2012. The section overviews their key responsibilities and describes their role in regulating health practitioners. The section is organised according to the statutory and non-statutory entities impacting HPR for registered and non-registered practitioners.

5.1.1 Statutory governance arrangements underpinning the National Scheme

Figure 5.1 presents the governance arrangements underpinning the NRAS as of 1 July 2012, including entities with statutory responsibility for the NRAS. Each has decision-making or operational responsibilities in HPR. Brief descriptions of these entities are presented in this section.

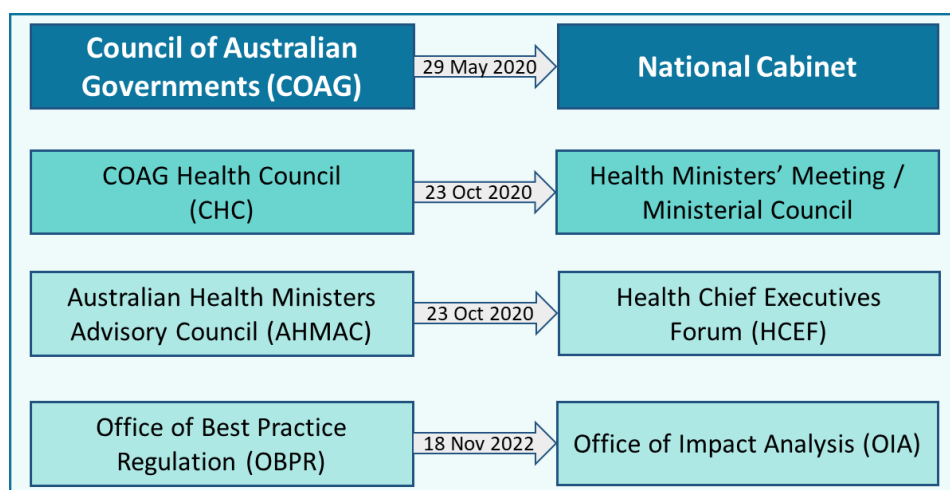
In 2020, the Australian Government renamed several government bodies associated with HPR. These changes are set out in Figure 5.2. The current government bodies have a similar composition of members to previous entities, and the roles and functions of these bodies are largely the same as previous entities. In this chapter, the nomenclature used when referring to these entities is the same as that applicable at the time the decisions were taken.

Figure 5.1: Governance arrangements underpinning the National Scheme.



(Adapted from AHMAC, 2018b: 5).

Figure 5.2: Name changes of government bodies and date of change.



National Cabinet/Council of Australian Governments

Now known as National Cabinet, the Council of Australian Governments (COAG) was established in 1992 as Australia's peak federal/state/territory intergovernmental forum. National Cabinet is a cross-jurisdictional council that functions to manage matters of national significance or that require coordinated action by all Australian governments across a range of departmental portfolios, including health. Its members are the prime minister, state premiers, territory first ministers, and the president of the Australian Local Government Association (COAG, 2012).

Health Minister's Meeting/COAG Health Council

The Health Minister's Meeting (HMM), comprising Commonwealth and state/territory health ministers, provides leadership and facilitates joint decision-making on health issues of national importance and governance on issues endorsed in national agreements. This includes decisions on legal and regulatory matters relating to the *National Law* (DOHAC, 2025a). When the HMM exercises functions under the *National Law*, including reforms and amendments to the Law, such as registering additional professions, it sits as the Ministerial Council. The Ministerial Council has certain statutory functions under the *National Law*, including appointing members to the NRAS National Boards³⁵, issuing policy directions, guidance and directives, and publishing reports relevant to the National Scheme (Ahpra, 2023b).

Health Chief Executives Forum/Australian Health Ministers' Advisory Council

The Health Chief Executives Forum (HCEF) is the advisory and support body of the HMM. It comprises the chief executive officers of the Commonwealth/state/territory health departments. This body advises on strategic issues to deliver key agreed national priorities, oversees public health protection policy, and operates as a national forum for planning and innovation to deliver health services more efficiently (DOHAC, 2024a).

³⁵ Appointments to National Boards are prescribed in the *National Law* whereby at least half, but not more than two-thirds of National Board members must be practitioner members and the remaining members are appointed as community members (Ahpra, 2011: 8).

Australian Health Practitioner Regulation Agency

The Australian Health Practitioner Regulation Agency (Ahpra³⁶) is the statutory health practitioner regulation body. It was established on 6 October 2009 to administer the NRAS, provide operational and administrative support to the National Boards, and implement reforms to the *National Law* agreed to by the Ministerial Council (*Health Practitioner Regulation National Law Act 2009* (Qld): 48-50). Ahpra's regulatory functions include:

- providing policy advice on standards and codes;
- managing registration and renewal processes for local and overseas practitioners and student registrations;
- managing complaints about registered practitioners, except in New South Wales and Queensland, where only referred complaints are handled;
- monitoring and auditing practitioners for compliance with requirements;
- working with course accreditation authorities to ensure graduating students are suitably qualified and skilled to apply for registration;
- together with the national boards, ensuring that only health practitioners with the skills and qualifications are registered to practise; and
- maintaining a public register of registered practitioners.

(Ahpra, 2023a).

National Boards

The National Boards were established under the *National Law* for registered health professions, with Board members appointed by the Ministerial Council. Boards are responsible for registering health practitioners who meet the required registration standards, investigating and managing complaints about health practitioners, developing standards, codes, and guidelines, and setting registration fees (Senate Finance and Public Administration Reference Committee, 2011: 9).

³⁶ The Australian Health Practitioner Regulation Agency uses sentence case for its acronym. See Ahpra website: <https://www.ahpra.gov.au/About-Ahpra.aspx>.

Office of Impact Analysis/Office of Best Practice Regulation

The Office of Impact Analysis (OIA) (formerly the Office of Best Practice Regulation (OBPR³⁷)) is located in the Commonwealth Department of the Prime Minister and Cabinet. The OIA is charged with ensuring government policy and decisions are supported by the best possible evidence and analysis. The Office has been operating since 2007, working with government departments and agencies to produce assessments on complex policy issues and proposed changes to regulation (DPMC, n.d.).

The guidelines under which OBPR/OIA operated until June 2023 required an impact analysis to be conducted and a regulation impact statement (RIS) to be documented for any changes to regulation, including to the *National Law* and proposed inclusion of further professions in the National Scheme. The RIS was required to establish a case for action, identify a range of viable policy options, and assess the benefits and costs of each option (DPMC, 2021: 9). The Ministerial Council was required to abide by the principles of best practice regulation, including that: legislation would not be the default option; the option offering the greatest net benefit was to be recommended; stakeholders were to be consulted on the options; and information relating to the options and decisions was to be published (DPMC, 2021: 7). A RIS was assessed as non-compliant if any part of the analysis was unsatisfactory or inaccurate. If assessed as non-compliant, policy officers were nevertheless able to take the RIS to health ministers, and the OBPR/OIA would then publish the non-compliant RIS on its website together with its assessment (DPMC, 2021: 8, 11, 33).

5.1.2 Statutory codes and bodies regulating health practitioners

Two related statutory arrangements that aim to safeguard the public serve to oversee non-registered health practitioners. These arrangements are known as health complaints entities and the National Code of Conduct (NCC).

³⁷ On 18 November 2022, the OBPR was renamed to the Office of Impact Analysis with no change in function or scope at that time (DPMC, n.d.).

Health complaints entities

Each Australian jurisdiction has a statutory body that accepts and investigates complaints about the quality of healthcare services. Collectively known as health complaints entities (HCEs), these were established as part of the *Medicare Agreements Act 1992* (Cth), which mandated the jurisdictional establishment of health complaints bodies independent of government (*Medicare Agreements Act 1992* (Cth): Section 6, 26 (3)-(6); Morris et al., 2018: 223).

The primary objective of HCEs is to manage complaints by receiving, assessing, investigating, and resolving consumer complaints (*Health Practitioner Regulation National Law Act 2009* (Qld): 31-32). A practitioner who is the subject of a complaint is given the opportunity to respond, but under the terms of the legislation, participation in complaint resolution is voluntary, and practitioners may choose not to respond or participate (Morris et al., 2018: 229). A second objective of HCEs is to facilitate healthcare quality improvement and safety by analysing complaints data (see, for instance, NSW HCCC, 2024: 6). Collection and analysis of complaints data has been described as having great potential to prevent patient harm, improve healthcare safety and quality (Bismark & Studdert, 2010: 15), avert problems before reaching the complaint stage, and harness complaints data for practitioner education purposes (Morris et al., 2018: 231).

In the case of registered professions, the *National Law* provides for any state/territory HCE to be a “co-regulatory authority” with the National Boards (*Health Practitioner Regulation National Law Act 2009* (Qld): 30, 51). Under these arrangements, the jurisdictional HCE manages the handling and resolution of the complaint brought against a registered practitioner. Outcomes are reported to the relevant Ahpra National Board, particularly if action is required to place conditions on a practitioner’s registration or to remove a practitioner’s name from the national register. To date, two states have declared themselves co-regulatory jurisdictions, New South Wales and Queensland (AHMAC, 2018b: 11-12).

National Code of Conduct

The NCC for healthcare workers is part of an intergovernmental agreement providing a policy framework that guides states and territories in enacting local NCC legislation. Even though the NCC is known as the 'National' Code of Conduct, it is legislated separately in each state/territory and implemented differently according to jurisdictional requirements.

The NCC is a negative licensing arrangement under which a provider may enter practice without a licence, irrespective of training or qualifications. The NCC sets out a range of minimum professional standards of conduct and practice that must be observed, including that practitioners must not provide health services outside their training and experience, must not financially exploit clients, must not engage in sexual misconduct, and must maintain appropriate professional indemnity insurance (CHC, 2015d: 17-18). Once legislated and implemented, state and territory legislation giving effect to the NCC extends the powers of jurisdictional health complaints entities to sanction practitioners in cases of serious breaches of professional standards, including prohibiting a provider from practising. As part of the NCC policy framework, Health Ministers also agreed to a nationally accessible register of prohibition orders and provision for mutual recognition of these orders across jurisdictions where the Code has been implemented (CHC, 2015d: 8). The COAG Health Council agreed to the NCC on 17 April 2015. The NCC was designed to cover health practitioners not registered under the NRAS, deregistered practitioners, and NRAS-registered health practitioners providing health services unrelated to their registration.

5.1.3 Non-statutory health practitioner regulation bodies

Non-statutory bodies also provide regulatory oversight of non-registered health professions. These bodies fall into three categories: professional associations, peak professional bodies, and voluntary registering organisations. Each has a different purpose and function.

Professional associations

Professional associations commonly state on their websites that they function to maintain professional standards, advocate for the profession, and improve the health and well-being of Australians. The governance and professional development responsibilities assumed by the associations include some or all the following activities: setting training and education standards for membership; accrediting courses and training programs; establishing professional codes of conduct; defining professional indemnity insurance requirements; accepting and resolving consumer complaints; hosting conferences; delivering training and other continuing professional development programs; and conducting criminal history checks. Where more than one professional body represents a profession, each has standards and requirements distinct from other associations.

Peak professional bodies

Five peak bodies were identified in this research study: Allied Health Professions Australia (AHPA); Australian Naturopathic Council (ANC); Council of Ambulance Authorities (CAA); National Alliance of Self Regulating Health Professions (NASRHP); and Psychotherapy and Counselling Federation of Australia (PACFA). These professional bodies represent professional associations (AHPA, ANC, NASRHP, PACFA), educators (ANC), employers (CAA), and practitioners (PACFA).

AHPA is a membership body for professional associations representing allied health professions. Its website states AHPA is:

the national voice for allied health professions. AHPA provides national policy and advocacy leadership to optimise the role of allied health professionals in the Australian healthcare system [...] represents and advocates for the role of allied health professionals in health, aged care, disability, education and all systems where allied health services have a role. (AHPA, 2025a)

An allied health profession:

- has a direct patient care role and may have application to broader public health outcomes;

- has a national professional organisation with a code of ethics/conduct and clearly defined membership requirements;
- is training in university health sciences courses (not medical, dental or nursing) at AQF Level 7 or higher³⁸, accredited by their relevant national accreditation body;
- has clearly articulated national entry-level competency standards and assessment procedures;
- has a defined core scope of practice;
- has robust and enforceable regulatory mechanisms; and
- practices within an evidence-based paradigm.

(AHPA, 2025c).

The ANC is a membership body for professional associations representing naturopathy and education providers of naturopathic courses. The ANC's website indicates its purpose is to present a united body that represents Australian naturopathic practitioners in relation to lobbying, statutory registration, and policy formation and interpretation. The ANC fosters communication and resource-sharing between Australian naturopathic stakeholders to advance the profession. Eligibility for membership with the ANC is based on membership of the World Naturopathic Federation (ANC, 2025).

The CAA is the peak body for the Australian, New Zealand and Papua New Guinea ambulance sectors. It aims to provide ambulance service CEOs the opportunity to discuss issues, learnings and achievements in the pre-hospital industry. The three pillars of CAA's strategic plan are providing a unified voice for the ambulance sector, building strong knowledge and information-sharing relationships, and creating learning and development programs to maintain world-class education and training (CAA, 2025).

NASRHP is an independent body providing a quality framework for self-regulating professions to set uniform standards. Professional bodies wishing to join NASRHP must

³⁸ AQF refers to the Australian Qualifications Framework, a national policy guide for qualifications in the Australian education and training system. AQF level 7 is classified as a bachelor's degree. See: <https://www.aqf.edu.au/framework/aqf-qualifications>.

apply and meet benchmark standards for the regulation and accreditation of practitioners. There are eleven items in the NASRHP standards: scope of practice; code of ethics/practice and/or professional conduct; complaints procedures; competency standards; course accreditation; continuing professional development; English language requirements; mandatory declarations; professional indemnity insurance; practitioner certification requirements; and recency and resumption of practice requirements. The NASRHP website states that the standards facilitate national consistency in quality and support for self-regulating health professionals and satisfy national and jurisdictional regulatory requirements, including the NCC for healthcare workers (NASRHP, 2025).

PACFA is a leading national peak body for the counselling and psychotherapy professions. It was established in 1998 to provide a unifying self-regulation function for the professions (Schofield, 2008: 1). PACFA is both a professional association membership body with eight current association members (PACFA, n.d.) and a practitioner membership association with over 9,600 members (PACFA, 2024: 7).

Voluntary registering organisations

Four voluntary registering organisations have been identified: the Australian Orthoptic Board, the Australian Register of Counsellors and Psychotherapists, the Australian Register of Naturopaths and Herbalists, and the Australian Sonographers Accreditation Registry. Each has specific membership requirements, and each states its functions include operating as a registration body to regulate the professions represented, maintaining a register of qualified professionals, and investigating complaints brought against registrants.

Table 5.1 sets out the professional associations, peak bodies, and registering organisations for the 15 health professions in this research. All professions have at least one professional association, ten are represented by more than one association, and eight professions are represented by three or more professional associations. Six professions have a voluntary registering body (counselling, naturopathy, orthoptics, psychotherapy, sonography, and Western herbal medicine (WHM)).

Table 5.1: Representative arrangements for non-registered professions included in the research.

Profession	Professional body	Professional association	Peak professional body	Registering organisation	AHPA member	NASRHP member
Allied Health	Allied Health Professions Australia (AHPA)		•			
	National Alliance of Self Regulating Health Professions (NASRHP)		•			
Audiology	Audiology Australia (AA)	•			•	•
	Australian College of Audiology (ACAud)	•				
	Independent Audiologists Australia (IAA)	•				
Clinical Perfusion	Australian and New Zealand College of Perfusionists (ANZCPerf)	•			•	•
	Australasian Society of Cardio-Vascular Perfusionists (ASCVP)	•				
Counselling	Australian Register of Counsellors & Psychotherapists (ARCAP)			•		
	Australian Counsellors Association (ACA)	•			•	
	Australian Community Counselling Association (ACCA)	•				
	Australian Natural Therapists Association (ANTA)	•				
	Australian Traditional Medicine Society (ATMS)	•				
	Christian Counsellors Association Australia (CCAA)	•				
	Psychotherapy & Counselling Federation of Australia (PACFA)	•	•		•	•
Dietetics	Dietitians Australia (DA)	•			•	•
Exercise physiology	Exercise and Sports Science Australia (ESSA)	•			•	•
Massage Therapy	Association of Massage Therapists (AMT)	•				
	Australian Natural Therapists Association (ANTA)	•				
	Australian Traditional Medicine Society (ATMS)	•				
	Massage and Myotherapy Australia (MMA)	•			•	
Myotherapy	Australian Natural Therapists Association (ANTA)	•			•	
	Massage and Myotherapy Australia (MMA)	•			•	
	Myotherapy Association Australia (MAA)	•			•	
Naturopathy	Australian Naturopathic Council (ANC)		•			
	Australian Register of Naturopaths and Herbalists (ARONAH)			•		
	Australian Naturopathic Practitioners Association (ANPA)	•				

Profession	Professional body	Professional association	Peak professional body	Registering organisation	AHPA member	NASRHP member
	Australian Natural Therapists Association (ANTA)	•				
	Australian Traditional Medicine Society (ATMS)	•				
	Complementary Medicine Association (CMA)	•				
	Naturopaths and Herbalists Association of Australia (NHAA)	•				
Orthoptics	Australian Orthoptic Board (AOB)			•		
	Orthoptics Australia (OA)	•			•	
Paramedicine ³⁹	Council of Ambulance Authorities (CAA)					
	Australasian College of Paramedic Practitioners (ACPP)	•			•	
	Australasian College of Paramedicine (ACP)	•				
	Paramedics Australasia (PA)	•				
Psychotherapy	Australian Register of Counsellors & Psychotherapists (ARCAP)			•		
	Australian Counselling Association (ACA)	•				
	Psychotherapy & Counselling Federation of Australia (PACFA)	•	•		•	•
Social work	Australian Association of Social Workers (AASW)	•			•	
Sonography	Australian Sonographers Accreditation Registry (ASAR)			•		
	Australasian Sonographers Association (ASA)	•			•	
	Australian Society of Medical Imaging and Radiation Therapy (ASMIRT)	•			•	
	Australasian Society for Ultrasound in Medicine (ASUM)	•				
Speech pathology	Speech Pathology Australia (SPA)	•			•	•
Western herbal medicine	Australian Register of Naturopaths and Herbalists (ARONAH)			•		
	Australian Natural Therapists Association (ANTA)	•				
	Australian Traditional Medicine Society (ATMS)	•				
	Complementary Medicine Association (CMA)	•				
	Naturopaths and Herbalists Association of Australia (NHAA)	•				

³⁹ Paramedicine was included as a 'non-registered' profession since it was not registered on 1 July 2012, the date set for selecting non-registered professions examined in this research.

The table shows that all professions in scope have at least one professional association with membership in AHPA and/or NASRHP, apart from naturopathy and WHM.

Findings from the mapping review identified 28 professional associations, five peak professional bodies, and four registering organisations representing 15 professions.

5.2 Policy and regulatory contexts for Health Practitioner Regulation

5.2.1 The Australian Constitution and Health Practitioner Regulation

The *Commonwealth of Australia Constitution Act 1900* established a federated system of government in which legislative powers are distributed between the Commonwealth (national) Government and the state/territory (sub-national) governments. Under the Constitution, both levels of government are responsible for different components of the healthcare system (Duckett & Willcox, 2015: 124). Section 51 of the Constitution specifies areas of governance over which the Commonwealth has authority and responsibility, known as specific heads of power. Importantly, components not included in Section 51, termed residual powers, fall to the state/territory governments, including the regulation of health practitioners. Therefore, the Australian Constitution has invested the states and territories with powers to regulate health practitioners (AHWMC, 2011: 3).

Until 2010, each Australian jurisdiction enacted laws under which various health professions were regulated. What resulted was a patchwork of arrangements marked by variation in health professions subject to registration, where practitioners were required to register in every state and territory requiring registration for that profession, except for podiatrists practising in the Northern Territory who were required to be registered in any state/territory to qualify for practice in the Territory. There were a myriad of laws, organisations, and entities involved in registering practitioners and accrediting education programs for each profession, except for two jurisdictions that had introduced multi-profession registration Acts: the Australian Capital Territory (*Health Professionals Act 2004* (ACT)) and Victoria (*Health Professions Registration Act 2005* (Vic)). The result was national fragmentation of functions, ineffective coordination,

rigid regulation arrangements, and inefficient funding and payment arrangements for health services (Productivity Commission, 2005: xix)

Appendix 9 presents a table of events and policy decisions leading to the *Health Practitioner Regulation National Law Act 2009* (Qld) and the implementation of NRAS on 1 July 2010. The information in the table extends beyond 2010 to summarise the events related to HPR for non-registered health professions following this period to bring the information up to the present day. What is described in the following sections are the key events documented in Appendix 9 with specific reference to how these contributed to the current HPR arrangements for registered and non-registered professions. These key events are mapped in a summarised timeline in Figure 5.3. Also described in this section are the actions taken by some professional bodies to strengthen their self-regulation arrangements in direct response to their non-inclusion in the NRAS.

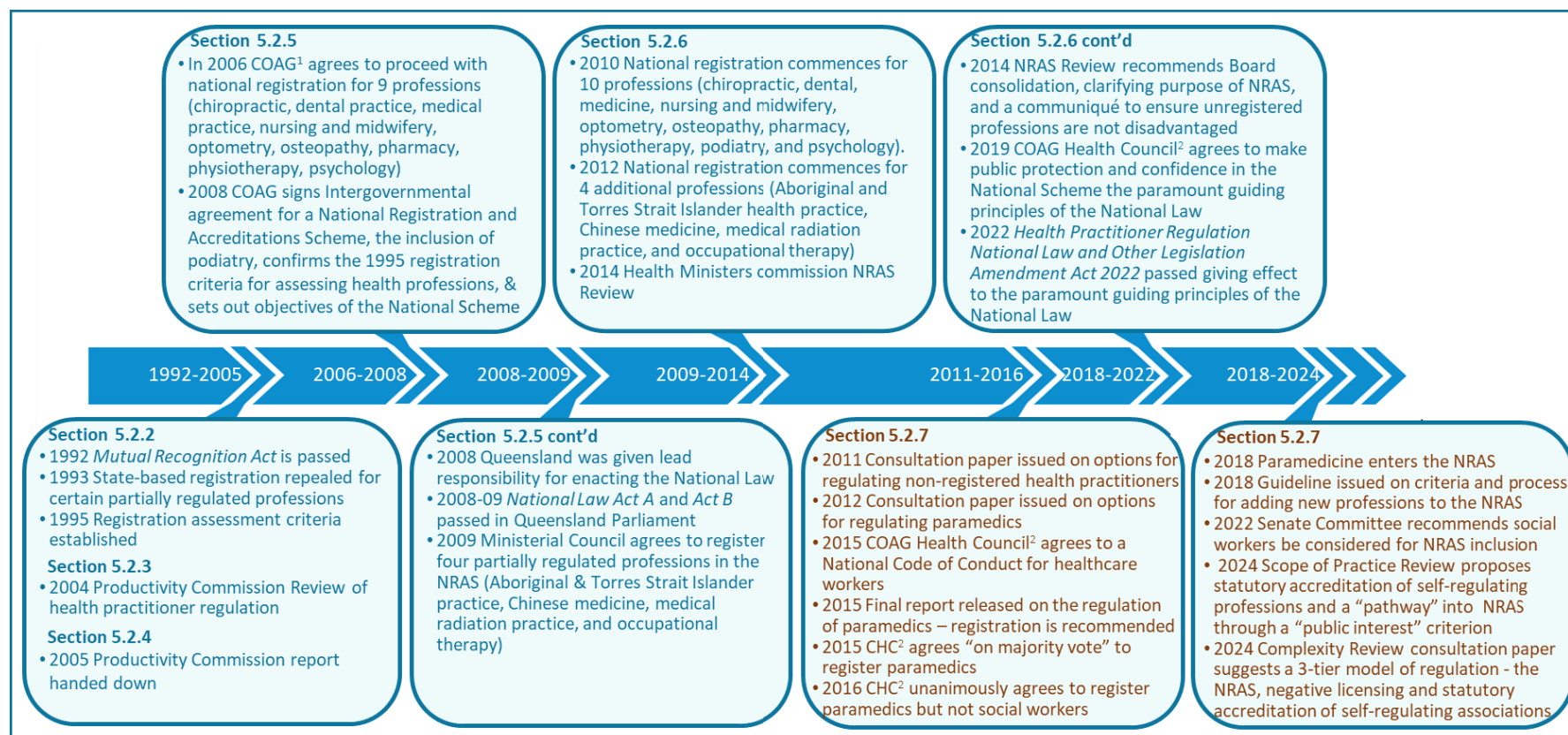
5.2.2 Setting the ground rules – mutual recognition legislation 1992

The *Mutual Recognition Act 1992* (Cth) (MRA) was a law passed by the Commonwealth Government and subsequently adopted and applied as separate laws in each state/territory. The legislation allowed for the mutual recognition of professional qualifications in all states and territories. It granted a practitioner registered in one jurisdiction automatic entitlement for registration in others. The legislation facilitated the movement of registered health practitioners across jurisdictional boundaries by only requiring practitioners to administratively register in each state/territory they wished to practise (COAG, 1992: 1; Vic DOHS, 2003: 11)⁴⁰. Importantly, the MRA prompted an intergovernmental policy review between the states, territories, and the Commonwealth to determine which professions should be registered in all jurisdictions⁴¹.

⁴⁰ Registration under these arrangements did not require practitioners to undergo a full assessment, the assumption being that this assessment had occurred in the primary jurisdiction in which the practitioner was registered.

⁴¹ The intergovernmental policy review prompted by the *Mutual Recognition Act 1992* (Cth) led to all State, Territory and Commonwealth Governments signing, in 1995, the criteria and process for regulatory assessment of health professions for statutory registration. This was the first time all governments had come together to agree on a national regulatory policy for the occupational regulation of health professions.

Figure 5.3: Summary of key events and decisions in health practitioner regulation 1992–2024.



Section numbers correspond to the sections in this chapter.

Blue text (Sections 5.2.2 to 5.2.6) corresponds to events and decisions relating to NRAS and registered professions.

Brown text (Section 5.2.7) corresponds to events and decisions relating to non-registered professions.

Notes:

1. COAG (Council of Australian Governments) is now known as National Cabinet.

2. CHC (COAG Health Council) is now known as the Health Ministers’ Meeting.

During 1992, AHMAC worked towards implementing the MRA by agreeing on the professions that should be registered in all states and territories and establishing a process for assessing unregulated and “*partially regulated*”⁴² health professions for registration (Vic DOHS, 2003: 12). In 1993, following recommendations by the AHMAC Working Group, registration legislation was repealed for dietitians in Victoria (*Health and Community Services (Further Amendment) Act 1993* (Vic): 2237) and dietitians, naturopaths, social workers, and speech pathologists in the Northern Territory (*Allied Professionals Registration Amendment Act 1993*, (NT): 2-3). Despite these recommendations, some jurisdictions, such as Queensland, did not repeal legislation for partially registered professions, including occupational therapy and speech pathology (Vic DOHS, 2003: 12).

During 1993–1994, the AHMAC Working Group recommended a set of criteria and processes for assessing unregulated health professions for registration. AHMAC accepted these recommendations in April 1995 (Vic DOHS, 2003: 12). The following assessment criteria were established for considering a health profession for registration:

- **Criterion 1:** Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another ministry?
- **Criterion 2:** Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
- **Criterion 3:** Do existing regulatory or other mechanisms fail to address health and safety issues?
- **Criterion 4:** Is regulation possible to implement for the occupation in question?
- **Criterion 5:** Is regulation practical to implement for the occupation in question?
- **Criterion 6:** Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

(COAG, 2008a: 23-24).

⁴² Partially regulated professions refer to professions registered in one or more but not all Australian states and territories.

5.2.3 Genesis of a national law – Productivity Commission Review

In 2004, the HPR field in Australia presented a fertile territory for change. Despite the passage of the MRA, there were growing concerns regarding state-based occupational licensing schemes. Concerns included ongoing issues with practitioner mobility, inconsistent legislation and administration of regulation schemes across jurisdictions, uncertainty over the transparency and accountability of regulation mechanisms based on professional peer review, the need for a more effective regulatory mechanism to protect the public, and the need for a system that allowed for greater flexibility and responsiveness of the health workforce (Carlton, 2006: 23-31).

In June 2004, COAG commissioned a whole-of-government review by the Productivity Commission⁴³ on issues relating to health workforce supply and demand over the following ten years (Productivity Commission, 2005: IV). The scope of the review was the entire health workforce, including allied and complementary health workers (Productivity Commission, 2005: V, 335). It encompassed the regulatory, institutional, structural, educational, workforce distribution, service demand, and strategic components of health professions and healthcare provision (Productivity Commission, 2005: V-VII). The catalyst for the review was the anticipated health workforce shortages Australia was facing and a substantial increase in health service demand (Productivity Commission, 2005: XVI-XVIII).

One of the Commission's more noteworthy observations relating to the current research study was that although the overall health workforce grew by more than 11 per cent in the six years to 2001, growth in the allied health and complementary medicine sectors grew by over 25 per cent (Productivity Commission, 2005: 10). It is also noteworthy that while consumer use was growing, a proportion of these professions were regulated outside of formalised government HPR structures.

⁴³ The Productivity Commission is a Commonwealth Government advisory body providing independent research and advice on a range of economic, social, and environmental issues affecting the welfare of Australians (Productivity Commission, n.d.).

5.2.4 Paving the way for a national registration scheme for health professionals

In its final report handed down on 22 December 2005, recommending a suite of reforms addressing health workforce planning, education, and regulation, the Productivity Commission emphasised several obstacles to “*sustainable and responsive workforce arrangements*” (Productivity Commission, 2005: XIX). Impediments included the involvement of both Commonwealth and state/territory levels of government in various aspects of health workforce regulation, resulting in a complex arrangement of more than 90 registration boards and over 20 government bodies overseeing healthcare professions, unclear accountabilities, ineffective coordination, inflexible regulatory practices that were subject to capture by professional groups, increased costs, unsuitable funding arrangements, and health workforces resistant to change (Productivity Commission, 2005: 26-31). Two of the Commission’s recommendations were the statutory establishment of a single national registration board for health professionals and a single national accreditation board for health professional education and training (Productivity Commission, 2005: XXXIX-XL).

The Productivity Commission report also considered the potential inclusion of additional professions in the recommended scheme. The Commission stated that a national approach to health workforce registration would:

provide objective evaluation of what additional professional or sub-professional registration is warranted, taking into account alternatives to formal registration, such as strengthened credentialing and delegation processes. (Productivity Commission, 2005: XXV)

The Commission’s recommendation for a single national registration board for health professionals included that this board:

should be given authority to determine which professions to register and which specialities to recognise. Initially, however, the new board should cover, at a minimum, all professions which currently require registration across the eight jurisdictions. (Productivity Commission, 2005: 145)

As part of the present study, this was a critical recommendation left unactioned when the National Scheme was established, with separate registration boards for each profession (COAG, 2008a: 2, 14).

The effect of the Productivity Commission review was unprecedented in Australian HPR, setting in motion a series of events that culminated in the establishment under state and territory government statutes of what became known as the National Registration and Accreditation Scheme (NRAS) and the registration of 14 health professions nationally between 2010 and 2012.

5.2.5 The road to registration – agreement for a single national registration scheme

On 14 July 2006, following the release of the Productivity Commission report, COAG agreed to establish:

*a single national registration scheme for health professionals, beginning with the nine professions currently registered in all jurisdictions [...and] a single national accreditation scheme for health education and training.*⁴⁴ (COAG, 2008a: 1-2)

From its outset, COAG “envisaged that other health professions would be added over time” (COAG, 2008a: 22). This expectation was reported in a published article the year NRAS commenced operations (Freckelton, 2010: 210).

On 26 March 2008, COAG signed an Intergovernmental Agreement (IGA) to implement the NRAS by 1 July 2010 (COAG, 2008a: 2). Several clauses of the IGA are relevant to this research. First, the 1995 IGA assessment criteria for assessing health professions for registration were confirmed (COAG, 2008a: 23-24). Second, the IGA included a clause stating that:

In addition to being able to demonstrate that they meet the relevant criteria, those professions seeking inclusion in the scheme will also be required to develop their own nationally-consistent registration proposal for consideration by the Ministerial Council. (COAG, 2008a: 22)

Third, the IGA announced the inclusion of podiatry in the National Scheme as a special case profession because it was registered in all but one jurisdiction, the Northern Territory, due to insufficient numbers of practitioners to make registration viable in the jurisdiction (COAG, 2008a: 22). This brought the total number of professions to be

⁴⁴ The nine professions registered in all jurisdictions were chiropractic, dental (including dentists, dental hygienists, dental prosthetists, and dental therapists), medicine, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, and psychology.

registered to ten. Finally, the IGA set out the objectives of the National Scheme, which were to:

- protect the public by ensuring that suitably trained, qualified, competent and ethical practitioners are registered to practise;
- facilitate workforce mobility across Australia;
- promote high-quality education and training, and facilitate the assessment of overseas-trained practitioners;
- have regard to the public interest in promoting access to health services; and
- enable the continuous development of a flexible, responsive and sustainable Australian health workforce and promote innovation in education and service delivery.

(COAG, 2008a: 3).

During 2008 and 2009, a series of public forums were held and calls for submissions were issued relating to operational aspects of the National Scheme (AHMAC, 2008b). This included a request for submissions regarding the regulation arrangements for the “*partially regulated*” professions (AHMAC, 2008b). The partially regulated professions under consideration were Aboriginal and Torres Strait Islander health practice, Chinese medicine, dental technician, medical radiation practice, occupational therapy, optical dispensing, and speech pathology.

At the Ministerial Council of 8 May 2009, Health Ministers agreed to add three further professions to the National Scheme from 1 July 2012: Aboriginal and Torres Strait Islander health practice, Chinese medicine, and medical radiation practice (AHWMC, 2009: 2). Three months later, on 27 August 2009, Ministers announced the inclusion of occupational therapy in the NRAS (OTBOQ, 2011: 9). These decisions excluded speech pathology which the Ministerial Council considered posed insufficient risk to the public to warrant registration, given their low complaint rate, the adequacy of existing regulation mechanisms, and the high registration costs relative to the number of practitioners (AHMAC, 2009: 48-49). The cost ratio identified for speech pathology was 1:4, compared with 1:3 for Aboriginal and Torres Strait Islander health practice, 1:3 for

Chinese medicine, and 1:3 for occupational therapy⁴⁵, all of which were identified for registration (AHMAC, 2009: 154-155).

At the same Ministerial Council meeting of 8 May 2009, several key features of the NRAS were agreed. These included mandatory criminal history and identity checks for applicants, independent course accreditation mechanisms, annual continuing professional development requirements, mandatory reporting of notifiable conduct that placed the public at risk of harm, and mandatory registration of students at a designated point during their program of study (AHWMC, 2009: 1-3). At later meetings of the Council, additional features of the Scheme were agreed upon, including the need for registrants to hold professional indemnity insurance and meet English language and recency of practice requirements (Ahpra, 2011: 7).

The *National Law* is legislated and implemented by each state and territory. Under the IGA, Queensland is the host jurisdiction for the legislation giving effect to the Scheme and was given lead responsibility to enact the primary legislation to establish the *National Law* (COAG, 2008a: 4). Other jurisdictions either passed corresponding legislation or legislation applying the Queensland Law (AHWMC, 2011: 4, 6). The *National Law* was introduced in two stages. The administrative arrangements for the National Scheme (*Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (Qld)) received Royal Assent on 25 November 2008 to establish the structure of the NRAS and the administration agency (Ahpra) to support the Scheme (AHWMC, 2011: 5). The following year, on 3 November 2009, Queensland received Royal Assent for the adoption of the *National Law (Health Practitioner Regulation National Law Act 2009* (Qld)).

⁴⁵ A cost ratio was established for these professions in the regulation impact statement as part of the assessment of partially regulated professions. The regulation impact statement noted: “*In the absence of information on absolute costs, the relative overall cost to each of the partially regulated professions associated with regulation has been calculated by way of a ratio which looks at the impact/cost of registration on the professions by comparing the number of professionals currently registered in the profession as against the number of professionals who would need to be registered if the profession were included in the Scheme. For example, the number of regulated Chinese medical practitioners [in Victoria] is 970 and the total number of Chinese medical practitioners is approximately 3000, producing a cost indicator ratio of 1:3.*” (AHMAC, 2009: 35). The closer the ratio is to 1:1, the more favourable (lower) the cost ratio to proceed with registration.

The *National Law* made provisions for establishing the NRAS National Boards, registering practitioners, and accrediting training and education. The Law also made provisions for inclusion in the National Scheme of the four partially registered professions (*Health Practitioner Regulation National Law Act 2009* (Qld): 207). For the *National Law* to be amended, change proposals must be approved by the Ministerial Council and passed by the Queensland Parliament (and other state and territory parliaments where required).

Before establishing the NRAS, eighteen health professions were registered in at least one Australian jurisdiction. Fourteen were nationally registered as of 1 July 2012. Table 5.2 sets out the professions registered by jurisdiction before NRAS and the professions registered nationally following the implementation of the Scheme⁴⁶. Currently, sixteen health professions are registered under the *National Law* (Ahpra, 2020: 14)⁴⁷.

5.2.6 Commencement of the National Scheme

On 1 July 2010, the NRAS commenced operations for ten professions in all jurisdictions except Western Australia, which began on 18 October 2010 (AHWMC, 2011: 7). The delay in that jurisdiction was due to the Western Australian Parliament's scrutiny of the *Health Practitioner Regulation National Law* (WA) Bill 2010, resulting in several amendments during Parliamentary debates (AHWMC, 2011: 6). Two years later, on 1 July 2012, registration commenced for four additional professions.

Section 7 of the IGA gave the Australian Health Workforce Ministerial Council the responsibility for initiating an independent review of the NRAS after three years of operation (COAG, 2008a: 6). Health Ministers commissioned a review of the National Scheme in April 2014 (Standing Council on Health, 2014: 3-4), with the final report released in December 2014 (AHMAC, 2014b). The review recommended, *inter alia*, consolidating nine “low-regulatory-workload” National Boards and “that health

⁴⁶ Nursing and midwifery were declared separate professions as part of reforms leading to amendments to the *National Law* passed in 2017 (*Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017* (Qld): 68). This separation brought the number of registered health professions to fifteen.

⁴⁷ The sixteenth profession, paramedicine, was registered under the NRAS on 1 December 2018. This came after 1 July 2012, the date set for selecting non-registered professions examined in this research.

professionals not included in the National Scheme should not be excluded or disadvantaged professionally” (AHMAC, 2014b: 6).

Table 5.2: Registered professions prior to and following the establishment of NRAS.

Jurisdiction	Health professions registered prior to 2010 by jurisdiction								Professions registered under the NRAS
	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	
Profession									
Aboriginal health work ^a			•						•
Chinese medicine							•		•
Chiropractic	•	•	•	•	•	•	•	•	•
Dental practice	•	•	•	•	•	•	•	•	•
Dental prosthetist	•	•		•	• ^b	•	• ^b	•	
Dental technician	•	•		•			• ^b		
Medicine	•	•	•	•	•	•	•	•	•
Nursing and midwifery	•	•	•	•	•	•	•	•	•
Occupational Therapy			•	•	•			•	•
Optical dispensing					•			•	
Optometry	•	•	•	•	•	•	•	•	•
Osteopathy	• ^c	• ^c	• ^c	•	• ^c	• ^c	•	•	•
Pharmacy	•	•	•	•	•	•	•	•	•
Physiotherapy	•	•	•	•	•	•	•	•	•
Podiatry	•	•		•	•	•	•	•	•
Psychology	•	•	•	•	•	•	•	•	•
Radiography	d	d	d	•	d	•	•	d	•
Speech pathology				•					

Notes:

- Profession was renamed to Aboriginal and Torres Strait Islander health practice following national registration.
- Registered by the dental boards in the jurisdiction.
- Registered with chiropractic in the ACT, NT, SA, and Tas.
- No practitioner registration was in force; the jurisdiction only required licences to operate specific radiation equipment.

(Adapted from Productivity Commission, 2005: 359-360).

In August 2015, Health Ministers deferred all decisions regarding consolidating National Boards pending advice from AHMAC (CHC, 2015c: 2). Amendments were subsequently made to the *National Law* to give health ministers powers to make structural changes to National Boards (*Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017* (Qld): 10-11). To date, health ministers have not exercised these powers. At the same meeting in August 2015, Ministers agreed to issue a communiqué

to clarify the intent of the National Scheme and propose a process for non-registered professions to raise concerns about disadvantages resulting from NRAS exclusion (CHC, 2015c: 3). Three years later, a communiqué was issued regarding the purpose of the NRAS (CHC, 2018). No further information has been found regarding a process for non-registered professions to raise issues regarding perceived disadvantages.

At the COAG Health Council meeting of 31 October to 1 November 2019, Health Ministers agreed to amend the *National Law* to make public protection and confidence in the National Scheme the paramount guiding principle. Ministers also resolved to issue a policy direction to Ahpra and the National Boards to consult with patient safety and healthcare consumer bodies regarding new and revised registration standards, codes, and guidelines (CHC, 2019: 2). On 13 October 2022, legislation was passed giving effect to the agreed amendments to the guiding principle of the *National Law (Health Practitioner Regulation National Law and Other Legislation Amendment Act 2022 (Qld): 34-35)*.

5.2.7 Non-registered health professions

In February 2011, in response to concerns raised by several jurisdictions regarding public protection for consumers of non-registered health services, AHMAC issued a consultation paper on options for the regulation of more than 60 non-registered health professions (the Options Report) (AHMAC, 2011b). The consultation paper noted:

Of particular concern are the small number of practitioners who engage in serious misconduct that would suggest they are not 'fit and proper' to provide health services. In such cases, the conduct may be so serious that, if the practitioner had been registered, the conduct would have resulted in cancellation of their registration and removal of their right to practise. Sometimes the practitioner has committed offences under a number of different laws, repeatedly and over an extended period. (AHMAC, 2011b: 1)

Two years later, after extensive consultation, AHMAC delivered its report, in which a:

National Code of Conduct with enforcement powers for breach of the Code is considered likely to deliver the greatest net public benefit to the community [...] because it is the least cost option while effective in reducing harm and achieving the objective of protecting the public. (AHMAC, 2013: 7)

The Ministerial Council accepted the recommendation in August 2013. In April 2015, the COAG Health Council agreed to the terms of the NCC for healthcare workers, with legislation to be enacted in each state and territory except for New South Wales and South Australia, which had the required legislation in place (CHC, 2015b).

During this period, several representative bodies of non-registered professions set about developing additional self-regulation mechanisms due to the establishment of NRAS. The first was the NASRHP, which was formed in 2007 after the publication of the 2006 Productivity Commission Report on Australia's Health Workforce, as an informal group of eight self-regulating professional associations (Oke, 2013). Members of NASRHP at the time were associations representing audiology, diabetes education, clinical perfusion, orthotics and prosthetics, sonography, dietetics, exercise and sports physiology, and speech pathology. In 2011, in response to the *"reluctance to extend the newly operating National Registration and Accreditation Scheme (NRAS) to incorporate further professions"*, NASRHP embarked on the development of an *"evidence-based framework of minimum standards of practice to be enforced"* for member organisations and their practitioners (Oke, 2013). These were introduced in 2014/15.

Like associations that evolved from within occupational groups, NASRHP developed from within a group of professions. The professional body has not been externally established or defined by a government or other independent body. As such, the nature of professional politics is inevitably at play, which may partly explain the number and types of professions that have and have not achieved NASRHP certification (see Table 5.1).

In 2012, NASRHP submitted a proposal to government for statutory regulation of the newly established body for consideration. In the proposal, Ahpra was designated as the regulatory authority for all health practitioners under one of three schemes, each of which was to be recognised in the *National Law*: the NRAS for high-risk professions, a statutory Health Professions Panel for professions identified as being of *"medium risk of harm"* to consumers, and a statutory negative licensing scheme for remaining health professions (NASRHP, 2012: 9). To date, no correspondence has been found regarding a government response to the proposal. However, a recent government-commissioned

review into the complexity of the NRAS has proposed a three-tiered model of HPR similar to that recommended by NASRHP in 2012 (Dawson, 2024: 88).

In 2011, the professional associations PACFA and ACA announced a collaboration to establish a national register of counsellors and psychotherapists known as the Australian Register of Counsellors and Psychotherapists (ARCAP). The register was established in response to the federal government's desire for a unified register to "*progress the recognition of counsellors and psychotherapists*" and provide a single, searchable platform for the general public (CCAA, 2022). According to ARCAP, the aim of the register is:

to provide greater protection for the public through professional consensus about required standards of training and practice. The self-regulation process must encompass the whole field in order to achieve unification. (ARCAP, 2011: 2)

Also, during this period, ARONAH, a voluntary registering body for naturopaths and Western herbalists, was established, with the register open for membership in June 2013. In a 2014 submission on the alignment of qualifications to the Australian Qualifications Framework, ARONAH declared it was established due to:

the gap in public protection caused by delays in the development of statutory registration of these professions, delays brought about by the move from individual state-based registration to the national registration and accreditation scheme [...] Despite numerous formal government assessments indicating the requirement for statutory regulation [...] these professions do not currently fall under this scheme. (ARONAH, 2014: 3)

At an intergovernmental level, a consultation paper was issued in July 2012 on options for regulating paramedics (AHMAC, 2012). This followed a request two years earlier by the Australian Health Workforce Ministerial Council for advice on a proposal to include paramedics in the NRAS (AHMAC, 2012: 3; AHWMC, 2010: 3). Issues identified in the consultation paper include diversity in the scope of paramedicine practice due to the array of employers and employment arrangements, variability in education standards, the absence of mechanisms preventing unfit paramedics from moving between employers and jurisdictions to continue working, and a lack of standardised complaints and clinical incident data collection and reporting (AHMAC, 2012: 27). The review of paramedicine was the first formal profession-specific assessment for registration using

the IGA criteria since the commencement of the NRAS. Paramedicine was also the first profession nationally assessed that had not been registered in any Australian jurisdiction. The final report on options for the regulation of paramedicine was released in September 2015. It recommended the inclusion of paramedicine in the National Scheme as this was *“likely to deliver the greatest net public benefit to the community compared with all other options”* (AHMAC, 2015: 12). On 6 November 2015:

on a majority vote, the [COAG Health Council] meeting agreed to move towards a national registration of paramedics [...] with only those jurisdictions that wish to register paramedics adopting the necessary amendments. (CHC, 2015a: 2)

This decision is noteworthy because it disregarded the requirements of the 2008 Intergovernmental Agreement that *“decisions relating to this [national] scheme will be by consensus”*, and in the event a decision was not unanimous, a transparent review be undertaken to facilitate reaching an agreement (COAG, 2008a: 5). The decision by Health Ministers established an ‘opt-in’ provision, contrary to the 2008 IGA, that *“If the amendment is passed through the Queensland Parliament, legislation of [all remaining states and territories] will incorporate the changes”* (COAG, 2008a: 8). The following year, at the COAG Health Council meeting on 7 October 2016, Health Ministers issued a communiqué stating all Ministers agreed to include paramedicine in the NRAS. The communiqué included a statement that *“[w]ith the agreement of Ministers that paramedics will be registered in all jurisdictions, it was noted that the draft amendment bill will not require the inclusion of an opt-in mechanism”* (CHC, 2016: 5).

At the same meeting, Ministers referred to an earlier meeting where the proposal to include social workers in the NRAS was discussed and *“[a]fter considering further advice, Ministers have now decided not to include the social work profession in the National Scheme”* (CHC, 2016: 2). Despite this decision, the South Australian Health Minister, who had proposed the national registration of social workers to the Ministerial Council, pressed ahead with registration of the profession at the state level. The Social Workers Registration Bill was introduced to the South Australian Parliament on 5 September 2018 (*Social Workers Registration Bill 2018* (SA)) and was passed into law in December 2021. To date, social work is the only health profession registered under statute outside

the *National Law*. It is important to note that this decision is also contrary to the 2008 IGA for cross-jurisdictional consensus in registering a health profession nationally.

At the time of the paramedicine review, all proposals regarding national regulation were subjected to a regulation impact assessment process and were expected to meet best practice regulation guidelines as determined by the OBPR (COAG, 2007: 8-9). Following the review of the paramedicine RIS, the OBPR reported on 18 March 2016:

*On 6 November 2015, the COAG Health Council agreed to regulate **paramedics under the National Registration and Accreditation Scheme**. [...] An adequate Regulation Impact Statement (RIS) was not prepared to inform the decision by the COAG Health Council. Consequently, the OBPR has assessed the COAG Health Council decision of 6 November as being non-compliant with the COAG best practice regulation requirements. (DPMC, 2016)*

In effect, this announcement states that Health Ministers proceeded with registration for paramedicine even though, according to the OBPR, the RIS did not meet best practice guidelines. It indicates that even though there are processes in place to assess professions for registration, health ministers are not bound by OBPR findings. Ministers may still exercise discretion to make decisions contrary to the advice of departmental staff and ignore the 'rules' when considered necessary. On 1 December 2018, paramedicine was admitted to the National Scheme (Ahpra and Paramedicine Board, 2018).

Also in 2018, a guideline was issued reaffirming the IGA criteria for assessing a health profession for registration and setting out a process for adding new professions to the National Scheme (AHMAC, 2018a). For the first time, an avenue to pursue registration for aspiring non-registered health professions had been explicitly and formally opened. This guideline came ten years following the IGA, which stated further professions would be added to the NRAS over time (COAG, 2008a: 22) and four years after the independent review of the NRAS recommended greater clarity on the "*threshold measures for entry to the National Scheme to applicant professions*" (AHMAC, 2014b: 27).

In April 2022, a Senate Community Affairs References Committee delivered a report commissioned a year earlier on the administration of registration and notifications, that is, complaints, by Ahpra and related entities under the *National Law* (Senate Community

Affairs References Committee, 2022). The Committee was established due to persistent issues, including *“delays, disappointment, confusion and stress”* associated with administering the National Scheme’s regulatory processes and outcomes (Senate Community Affairs References Committee, 2022: 2). The Committee noted, *inter alia*, *“there is a substantial case for regulation of currently unregulated professions including social workers”* and recommended the Ministerial Council consider whether social workers should be included in the NRAS (Senate Community Affairs References Committee, 2022: xiii). To date, no further information has been found regarding this recommendation.

On 28 April 2023, National Cabinet (formerly COAG) agreed to changes to impact analysis requirements whereby a RIS is no longer to be mandatorily finalised with the OIA (formerly OBPR) unless requested by the relevant decision makers (health ministers in the case of HPR matters). Under the change, the OIA provides independent advice on the adequacy of a RIS prepared for public consultation and decision-making only when requested by decision-makers (DPMC, 2023).

Also in April 2023, National Cabinet commissioned a ‘Scope of Practice Review’ to explore the benefits, risks, barriers and enablers associated with health practitioners working to their full scope of practice (DOHAC, 2024d: 4). In October 2024, the review recommended possible mechanisms to strengthen and standardise the regulation of self-regulated professions. Recommendations included establishing a *“pathway into the NRAS by introducing an additional criterion, such as a ‘public interest’ criterion”* and statutory accreditation of certain professional bodies to ensure *“consistent, quality self-regulation functions for professions which are not nationally registered in the NRAS”* (Cormack, 2024: 123). Self-regulated professions proposed by the review as a starting point for consideration of these options were:

- audiology;
- dietetics;
- counselling;
- exercise physiology;

- social work;
- sonography (cardiac and medical); and
- speech pathology.

(Cormack, 2024: 129).

At the Health Ministers' Meeting on 13 December 2023, Ministers agreed to prepare a Decision RIS to consider options for the regulation of audiology, including the option of registration under the NRAS (Queensland Government, 2024a: 3). In July 2024, the RIS for the registration of audiology was finalised and assessed as compliant by the OIA. On 16 August 2024, the Ministerial Council agreed "*in-principle*" to include audiology in the NRAS pending further work to inform a final decision, including targeted consultations with stakeholders to consider issues relating to costs, implementation, risks, and impacts on First Nations communities (Queensland Government, 2024b: 3).

On 29 May 2024, Health Ministers commissioned an independent review of the regulatory complexity of the NRAS (the Complexity Review). The review aims were to identify areas of unproductive and unnecessary complexity in health practitioner regulation, propose reforms to enable the National Scheme to work, and ensure the National Scheme remains 'fit for purpose' and meets community expectations (DOHAC, 2024b). As part of the review, a consultation paper issued on 12 September 2024 included a proposal for a new "*co-regulatory pathway*" in addition to registration under the NRAS and the negative licensing arrangement of the NCC. Under the co-regulatory pathway, it was proposed that Ahpra accredits professional membership bodies to establish and maintain statutory registers of practitioners who may voluntarily sign up to the register (Dawson, 2024: 88-89). There were no non-registered professions suggested for taking in this co-regulatory pathway.

5.2.8 Regulatory stewardship

In 2020, the Australian Government published a *Health Regulatory Policy Framework*, in which it commits to working with the states and territories to achieve national outcomes that ensure regulation remains fit for purpose (DOHAC, 2020: 10). The framework sets out seven guiding principles of health policy regulation that guide decisions and

behaviours, and views government as stewards of Australia's regulatory systems (DOHAC, 2020: 20). The seven Australian guiding principles of regulatory stewardship in health policy are:

- We will value regulation as an asset that protects the health and safety of Australians.
- We will take into account the regulatory impact of our decision and minimise regulatory costs.
- We will effectively engage with our stakeholders.
- We will adopt a best practice approach to the compliance and enforcement of our regulation.
- We will build our regulatory capability.
- We will ensure good governance.
- We will regularly monitor and review our regulation to ensure it remains fit-for-purpose.

(DOHAC, 2020: 20)

5.3 Institutional contexts for regulating non-registered health practitioners

Non-registered professions are subject to a range of Commonwealth and state/territory statutory laws and non-statutory requirements established by government departments, agencies, and civil institutions. These laws and requirements act as regulatory mechanisms either directly or indirectly. The mechanisms exert their influence on practitioners in one of two ways. The first is via the statutory powers of regulators to apply sanctions to practitioners not meeting legislative requirements. The second is from the benefits and entitlements available to non-registered practitioners or consumers of their health services from government and non-government organisations, which entail practitioners meeting specific requirements such as membership of an approved professional body. These arrangements, in effect, establish co-regulatory partnerships between institutions and the professional bodies they authorise to 'credential' practitioners on their behalf (AHMAC, 2018a: 11-12). Examples of co-regulatory partnerships include arrangements with governments or private health

insurers for rebates available to consumers consulting with practitioners of certain non-registered professions who are members of a credentialed professional body.

This section examines these statutory and non-statutory arrangements as they apply to the 15 health professions in this study. It provides an overview of a range of regulatory mechanisms practitioners are subject to. The section is organised into two parts. The first presents the regulation arrangements imposed by statutory regulators. The second sets out the co-regulation arrangements between professional bodies and national-level government and non-government institutions, together with the requirements set by these institutions.

The primary aim of this section on institutional mapping is to demonstrate the range of regulatory arrangements non-registered practitioners are subject to. It identifies where non-registered professions are situated in the health system, how deeply embedded they are in the network of government and non-government schemes, and the co-regulatory relationships and partnerships professional bodies have with national institutions.

In addition to the national mechanisms mapped in this section, a series of state- and territory-based government institutions having no direct responsibility for regulating non-registered practitioners authorise certain professional bodies to credential member practitioners for benefits paid by the institutions. These benefits include payment for the treatment of consumers under jurisdiction-based workers' compensation and traffic accident insurance programs. This research will not examine these state/territory authorities due to the substantial variation in the eligibility criteria applied by jurisdictional schemes⁴⁸.

⁴⁸ An example of the variation in jurisdictional payment of benefits for one non-registered profession, naturopathy, is provided in Appendix 10, showing the institutional recognition for one government scheme, workers' compensation (Carlton et al., 2025: 233).

5.3.1 Statutory regulators

This section examines the legislation enacted for two statutory mechanisms: State and Territory health complaints entities (HCEs) and the NCC for healthcare workers. Regulation effected through the HCEs and NCC is part of a suite of mechanisms for non-registered and registered professions that aim to ensure practitioners abide by ethical standards and, if breached, provide for appropriate action to be taken. Both mechanisms operate to protect patients because they include all health providers, accept complaints lodged by any individual, and give statutory powers to health complaints commissioners for complaints handling.

State and Territory health complaints entities

Section 5.1.2 summarised the role of the state/territory health complaints entities (HCEs) in receiving and investigating complaints about health services, including health practitioners. Table 5.3 presents further details of the HCEs in Australia, the year of establishment, portfolio responsibilities, and the breadth of complaints reporting. Across the jurisdictions, there are slight variations in complaint lodgement requirements and considerable heterogeneity in complaints data reported. The New South Wales Health Care Complaints Commission provides the most comprehensive reporting. The Commission reports annually on:

- disaggregated complaints data for registered and most non-registered professions, except for five professions included in this study: clinical perfusion, exercise physiology, myotherapy, orthoptics, and WHM;
- analysis of the types of complaints for each reported profession, for example, treatment, professional conduct, communication, and medication;
- information on the outcome of the assessment, for example, complaint discontinued, local resolution, and investigation; and
- the outcome of the investigation, for example, referred to Director Proceedings, no further action, and referred to Council.

(NSW HCCC, 2024: 100, 106, 134-135, 140, 142, 146-147).

The Queensland and South Australian HCE's report disaggregated complaints for each registered profession and aggregated complaints data for non-registered professions as a single category (SA HCSCC, 2024: 4, 31-32; Qld OHO, 2024: 4, 14, 17-20, 28, 33-34). Victoria reports on complaints for eight of 16 registered professions and for two non-registered professions included in this study: massage therapy and diet/nutrition services. Other information reported by the Victorian Health Complaints Commission includes complaints against health practitioners aggregated under umbrella categories, such as allied health, complementary and alternative health, mental health, and physical therapy services (Vic HCC, 2024: 18, 21). Western Australia reports percentage complaints against several but not all registered professions and aggregated percentage of complaints brought against allied health practitioners as a single category (WA HDSCO, 2024: 26). The Australian Capital Territory and Tasmania report on the number of complaints for several but not all registered professions, and do not report on complaints brought against non-registered practitioners (ACT HRC, 2024: 32; Tas HCC, 2024: 15). The Northern Territory does not report complaints data in their annual reports or on its website for registered or non-registered professions (NT HCSCC, 2023).

The Complexity Review consultation paper, issued in September 2024, reported differences in the operational features of jurisdictional HCEs and inconsistencies in the powers held by HCEs across jurisdictions (Dawson, 2024: 80-81). The mapping of statutory regulators for non-registered professions set out in Table 5.3 presents some of these differences, such as variations in complaint lodgement requirements and complaints reporting processes.

National code of conduct (NCC)

The NCC for healthcare workers was described in Section 1.7.4 of Chapter 1 and Section 5.1.2 of this chapter as a negative licensing arrangement under which no licence or permit is required to enter practice as a health provider irrespective of training or qualifications, but serious breaches of statutory standards may result in the provider being prohibited from practice (COAG, 2015d: 17; Carlton et al., 2024: 40). Consequently, the NCC facilitates action against offending practitioners once harm has occurred and a complaint has been lodged.

Table 5.3: Health complaints entities, commencement year, portfolio responsibilities, and reporting.

State/ Territory	Health complaints entity	Year established	Portfolio responsibility	Annual reporting of complaints data disaggregated by profession
Australian Capital Territory	Office of the Commissioner for Health Complaints	1993	Public and private health services provided in hospital and general practice by registered and non-registered providers.	✓ for some registered professions ✗ for non-registered professions
New South Wales	Health Care Complaints Commission	1993	Public and private health services provided in hospital, general practice, medical centres, and imaging and radiation services by registered and non-registered providers. Prior to 1993, the Commission was known as the Health Complaints Unit (NSW Joint Committee, 2010: vi).	✓ for registered professions ✓ for most non-registered professions
Tasmania	Health Complaints Commissioner Tasmania	1995	Public and private health services provided in hospital and community health services by registered and non-registered health service providers.	✓ for some registered professions ✗ for non-registered professions
Western Australia	Health and Disability Services Complaints Office	1995	Public and private hospitals and health centres provided by registered and non-registered health providers.	✓ for some registered professions ✗ for non-registered professions
Northern Territory	Health and Community Services Complaints Commission	1998	Registered and non-registered health service providers or service provider organisations, such as a general practice clinic or the Department of Health.	✗
South Australia	Health and Community Services Complaints Commissioner	2004	All health and community services, hospitals and health centres provided by registered and non-registered providers.	✓ for registered professions ✗ for non-registered professions
Queensland	Office of the Health Ombudsman	2013	Any health service, health service provider, or health support service. In 1991, the Office of the Health Rights Commissioner was established to provide for independent review and conciliation of healthcare complaints (<i>Health Rights Commission Act 1991</i> (Qld)). It was replaced by the Office of the Health Ombudsman in 2013.	✓ for registered professions ✗ for non-registered professions
Victoria	Health Complaints Commissioner	2016	Public and private health services provided in hospitals, clinics and community health services by registered and non-registered health providers, or anyone holding health records, including schools, gyms, and other non-health service providers.	✓ for registered professions ✓ for two non-registered professions

The NCC was agreed to by the Ministerial Council in April 2015, at which time:

Ministers agreed to use their best endeavours to give effect to the National Code and code-regulation regime, noting that those jurisdictions with existing schemes will consider adjustments to their codes and arrangements to achieve national consistency. (CHC, 2015b: 1)

Table 5.4 reviews the status of NCC legislation and implementation in the states and territories. It identifies the jurisdictions that have enacted the legislation and the date of implementation. The table shows that New South Wales and South Australia had relevant legislation before Health Ministers agreed to the NCC policy. Both jurisdictions have updated their legislation to conform to NCC requirements. Legislation giving effect to the NCC has not yet been passed in the Northern Territory. Tasmania has passed legislation but has not yet implemented the NCC. The four remaining jurisdictions enacted and implemented the NCC over nine years following Ministerial agreement in April 2015. While the intent of the NCC was to build consistency in complaints handling and practitioner accountability for non-registered professions, federalism has allowed variation in implementation to creep into jurisdictional legislation.

Although two jurisdictions have not yet enacted or implemented the NCC and their HCEs do not have the accompanying powers, health complaints commissioners in these jurisdictions nevertheless have the authority to investigate and adjudicate on complaints against non-registered practitioners. The powers they lack relate to imposing interim or permanent prohibition orders or other sanctions against non-registered providers for breaching the Code, monitoring compliance with prohibition orders, information sharing, and appeal mechanisms.

Concerns regarding the NCC were described in the Final Report on options for the regulation of unregistered health practitioners. Concerns raised in submissions include the reactive nature of negative licensing and the absence of probity checking and minimum qualification standards for practice entry (AHMAC, 2013: 41). These and other deficiencies have previously been documented in the literature (Wardle, 2014: 364, 365, 371).

Table 5.4: Jurisdiction and year the National Code of Conduct was legislated and adopted.

State/Territory	Date legislation passed	Date code in force	Details
New South Wales	✓ 26 November 2006 ⁴⁹	✓ August 2008	New South Wales legislation for the Code of Conduct was passed as the <i>Health Legislation Amendment (Unregistered Health Practitioners) Act 2006</i> and updated as the Public Health Regulation 2022 to conform to the NCC policy requirements.
South Australia	✓ 17 March 2011 ⁵⁰	✓ 14 March 2013	The SA Code was legislated as the <i>Health and Community Services Complaints (Miscellaneous) Amendment Act 2011</i> . It was updated as the Health and Community Services Complaints Regulations 2019 to conform to the NCC policy requirements.
Queensland	✓ 1 July 2014 ⁵¹	✓ 1 October 2015	The Queensland NCC was implemented as the <i>National Code of Conduct for Health Care Workers (Qld)</i> .
Victoria	✓ 1 February 2017	✓ 1 February 2017	The Victorian Parliament passed legislation to implement the NCC under the <i>Health Complaints Act 2016</i> . It was updated in 2023 as the <i>Health Complaints Act 2016</i> .
Western Australia	✓ 28 October 2022	✓ 7 July 2023	The Western Australian Parliament passed legislation to implement the NCC under the <i>Health and Disability Services (Complaints) Amendment Act 2022</i> .
Australian Capital Territory	✓ 30 March 2023	✓ 8 January 2024	The ACT Parliament passed legislation to implement the NCC under the Human Rights Commission Amendment Bill 2023.
Tasmania	✓ 15 October 2018	✗	The Tasmanian Parliament passed legislation to implement the NCC under the <i>Health Complaint Amendment (Code of Conduct) Act 2018</i> . Tasmania is yet to implement the Code.
Northern Territory	✗	✗	The Northern Territory Government issued a Consultation paper for the National Code of Conduct in 2018 but has yet to enact the Code.

⁴⁹ The New South Wales legislation predates the establishment of the National Code of Conduct national policy agreed to by AHMAC on 17 April 2015.

⁵⁰ The South Australian legislation predates the establishment of the National Code of Conduct national policy agreed to by AHMAC on 17 April 2015.

⁵¹ The Queensland Health Ombudsman Act established a Health Ombudsman providing similar powers to those applying in NSW and South Australia. The Queensland scheme does not require a Code of Conduct to be made by regulation in order for the Health Ombudsman to investigate an unregistered health practitioner and impose an interim prohibition order (CHC, 2015d: 20).

5.3.2 National co-regulation arrangements

There are several co-regulation arrangements in place for non-registered professions. While co-regulatory models in other professional sectors have advanced and matured to the point of having specific statutory bodies act as formal co-regulatory partners (such as the Professional Standards Councils, 2024), co-regulation arrangements for non-registered health professions are almost all informal and indirect, exerting their influence on practitioners as a by-product rather than a core regulatory function. These informal arrangements involve several government departments and non-government organisations providing financial entitlements or other benefits to non-registered practitioners or consumers of their services. Their regulatory function is exercised when the department or institution determines eligibility for recognition or payment based on practitioner membership of a professional body having co-regulatory arrangements with the institution.

These institutions delegate to professional bodies the task of assessing the eligibility of practitioners for entitlements and benefits. Through this mechanism, institutions are endorsing the status of professional bodies to act on their behalf. The COAG Health Council described these arrangements in regulating practitioners as follows:

a partnership between government and the [...professional] certifying body, and the benefits that flow to practitioners from certification act as incentives for practitioners to submit to and comply with the self-regulatory standards.
(AHMAC, 2018a: 11-12)

The following section maps the co-regulation partnerships between professional bodies of non-registered professions and six government and five private institutions. These are:

- Government departments/authorities:
 - Australian Taxation Office (ATO);
 - Medicare Australia (Medicare);
 - National Disability Insurance Scheme (NDIS);
 - Department of Veterans' Affairs (DVA);
 - Comcare; and
 - Department of Home Affairs.

- Private health insurance (PHI) providers:
 - Bupa;
 - Medibank;
 - HBF;
 - HCF; and
 - NIB.

Government institutions

Table 5.5 charts the credentialling requirements applied to providers under co-regulatory arrangements with government departments and other government authorities. It identifies the professional bodies delegated by government institutions to assess member practitioners for access to government entitlements.

Australian Taxation Office (ATO)

Among other functions, the ATO is charged with administering Australia's Goods and Services Tax (GST), which applies a 10% tax across most industry sectors. Some services, including certain medical, health, and care services, are exempt from GST, resulting in a lower fee being paid by consumers. This exemption can attract consumers to these health services. Health practitioners offering these services gain an economic advantage through increased clientele. A health service is GST-free if it is a listed health service performed by a recognised health professional. All NRAS registered practitioners are recognised health professionals eligible to provide GST-free services. Non-registered practitioners are eligible to provide GST-free services if they are members of a professional association that has nationally uniform membership requirements (ATO, 2024). The ATO recognises multiple professional bodies for the same profession if they meet this requirement.

Table 5.6 sets out the professions eligible to offer consumers GST-free health services. Practitioners in ten of the 15 health professions included in this research are eligible. Ineligible professions are counselling, massage therapy, myotherapy, orthoptics, and psychotherapy.

Table 5.5: Professional associations recognised for government benefits to consumers/practitioners.

Profession	Goods and Services Tax exempt ⁵²	Medicare rebates	Department of Veterans' Affairs	National Disability Insurance Scheme	Comcare	Department of Home Affairs, Skilled Migration Assessing Authority
Audiology	✓	✓ AA, ACAud	✓ Eligible with Medicare no.	✓	✓	✗
Clinical perfusion ⁵³	✓	✗	✗	✗	✗	✗
Counselling	✗	✗	✗	✗	✓	✗
Dietetics	✓	✓ DA	✓ Eligible with Medicare no.	✓	✗	✓ DA
Exercise physiology	✓	✓ ESSA	✓ Eligible with Medicare no.	✓	✓	✗
Massage	✗	✗	✗	✗	✓	✗
Myotherapy	✗	✗	✗	✗	✗	✗
Naturopathy	✓	✗	✗	✗	✗	✗
Orthoptics	✗	✓ AOB, OA	✓ Eligible with Medicare no.	✓	✗	✗
Paramedicine	✓	✗	✓	✗	✗	✗

⁵² Non-registered professions are eligible to provide GST-free services if they are considered a recognised health professional, that is, if they are a member of a professional association related to the listed health service and have nationally uniform membership requirements (ATO, 2024).

⁵³ Medicare benefits are not payable for clinical perfusion unless performed by a medical practitioner (DOHAC, 2024f). The clinical perfusion profession in the scope of this study did not include medical practitioners performing perfusion but, rather, clinical perfusionists operating outside of the medical profession.

Profession	Goods and Services Tax exempt ⁵²	Medicare rebates	Department of Veterans' Affairs	National Disability Insurance Scheme	Comcare	Department of Home Affairs, Skilled Migration Assessing Authority
Psychotherapy	✗	✗	✗	✗	✗	✗
Social work	✓	✓ AASW	✓ Eligible with Medicare no.	✓	✓	✓ AASW
Sonography	✓	✓ ASAR, on referral from a medical doctor	✗	✗	✓	✗
Speech pathology	✓	✓ SPA	✓ Eligible with Medicare no.	✓	✓	✓ SPA
Western herbal medicine	✓	✗	✗	✗	✗	✗

Legend: **AA**: Audiology Australia; **AASW**: Australian Association of Social Workers; **ACAud**: Australian College of Audiology; **AOB**: Australian Orthoptic Board; **ASAR**: Australian Sonographer Accreditation Registry; **DA**: Dietitians Australia; **ESSA**: Exercise and Sports Science Australia; **OA**: Orthoptics Australia; **SPA**: Speech Pathology Australia.

⁵² Non-registered professions are eligible to provide GST-free services if they are considered a recognised health professional, that is, if they are a member of a professional association related to the listed health service and have nationally uniform membership requirements (ATO, 2024).

Medicare Australia

Medicare is Australia's universal healthcare system that provides consumers with free or subsidised health services. Medicare rebates refunded to consumers for allied health services are generally 85% of the government-set schedule fee. The Medicare Benefits Schedule lists the Medicare services subsidised by the Australian Government. Eligibility for subsidised services by health practitioners is determined based on criteria set out in the *Health Insurance Act 1973* (Cth) (Services Australia, 2024). Health services provided by all but two registered professions, Chinese medicine and paramedicine, are covered by Medicare. Non-registered practitioners identified as eligible for Medicare must be members of specific professional associations, as set out in Table 5.6. Practitioners in seven professions included in this research are eligible to apply for a Medicare provider number. The eight professions ineligible for Medicare are clinical perfusion, counselling, massage therapy, myotherapy, naturopathy, paramedicine, psychotherapy, and WHM.

Table 5.6 presents the eligibility criteria applied by Medicare for relevant non-registered professions. Of note, five of the seven Medicare-eligible professions each have a single representative professional association⁵⁴. Seven of the eight Medicare-ineligible professions have between three and six representative associations⁵⁵.

Department of Veterans' Affairs (DVA)

DVA is an Australian Government department that provides support, including healthcare support, to war veterans, their dependents, and surviving spouses. Assessment as a DVA provider is automatically granted to practitioners with a Medicare provider number. Other assessment criteria are applied to practitioners without a Medicare provider number, and practitioner applicants must contact DVA to determine their eligibility (DVA, 2023). Practitioners in seven professions are eligible for DVA

⁵⁴ The Medicare-eligible professions with a single representative professional association are: dietetics, exercise physiology, orthoptics, social work and speech pathology. Audiology (AA, ACAud, and IAA) and sonography (ASA, ASMIRT, and ASUM) each have three representative professional associations.

⁵⁵ The seven Medicare-ineligible professions with three or more representative professional associations are: counselling, massage therapy, myotherapy, naturopathy, paramedicine, psychotherapy, and Western herbal medicine. The eighth Medicare-ineligible profession with a single professional association is clinical perfusion (ANZCP).

provider status. The eight ineligible professions are clinical perfusion, counselling, massage therapy, myotherapy, naturopathy, psychotherapy, sonography, and WHM.

Table 5.6: Eligibility criteria for Medicare-eligible non-registered professions.

Profession	Eligibility criteria
Audiology	The provider must be either: • an accredited audiologist with Audiology Australia (AA); or • a full/ordinary member or fellow audiologist of the Australian College of Audiology (ACAud) with a certificate of recognition of competency as a hearing and diagnostic rehabilitation specialist.
Dietetics	The provider must be a current Accredited Practising Dietitian with certification from Dietitians Australia (DA).
Exercise physiology	The provider must be a current Accredited Exercise Physiologist with certification from Exercise and Sports Science Australia (ESSA).
Orthoptics	The provider must hold current registration with the Australian Orthoptic Board (AOB), have a Certificate of Currency, and be a member of Orthoptics Australia (OA).
Social work	For mental health services, the provider must be a member of the Australian Association of Social Workers (AASW) and be either: • certified by AASW as meeting the standards for mental health set out in Practice Standards for Mental Health Social Workers 2014; or • certified by AASW before 1 July 2018 without later revocation, as meeting the standards for mental health set out in Practice Standards for Mental Health Social Workers.
Sonography	The provider performing medical ultrasound examinations on behalf of an eligible health practitioner (such as a medical doctor) must be: • suitably qualified; • involved in a relevant and appropriate Continuing Professional Development program; and • registered on the Australian Register of Accredited Sonographers (ASAR).
Speech pathology	The provider must be a certified practising member of Speech Pathology Australia (SPA). Other types of SPA memberships are not eligible for Medicare.

National Disability Insurance Scheme (NDIS)

The NDIS is an Australian Government scheme that provides funding to Australians aged between 9 and 65 who live with a disability. The scheme aims to promote greater independence, access to new skills, jobs, or volunteering in the community, and improved quality of life. Services funded by the NDIS relevant to this research are therapeutic supports and assistance to an NDIS participant by skilled personnel for required aids and equipment, including assessment, set up, and training. Health-related supports are available for conditions such as dysphagia, diabetes, incontinence, and epilepsy. Six non-registered health professions are recognised by the NDIS: audiology, dietetics, exercise physiology, orthoptics, social work, and speech pathology. The range

of health services, though, is not well-defined and considerable discretion exists for other practitioners to be assessed and approved on a “case-by-case” basis to provide services to a participant (NDIS, 2018: 2). Professions not currently included in the scheme are clinical perfusion, counselling, massage therapy, myotherapy, naturopathy, paramedicine, psychotherapy, sonography, and WHM, although the services of these practitioners may be covered if deemed appropriate to the NDIS participant’s care.

Comcare

Comcare is the national authority for work health and safety and workers’ compensation for employees of Commonwealth Government agencies and authorities, and companies with majority Commonwealth ownership⁵⁶. Comcare is charged with minimising the impact of workplace harm, improving recovery at work and return to work, and promoting the health benefits of good work. It is a government regulator, insurer, claims manager, and scheme administrator. Allied health professionals providing services under the *Safety, Rehabilitation and Compensation Act 1988* (Cth) must have the appropriate qualifications, skills and experience to provide those services. Practitioners listed as providers with Comcare are not required to hold membership in a professional body. The Authority’s website states:

Comcare strongly recommends that employees engage an allied health provider with relevant membership to an appropriate professional body. By choosing a provider with a membership to a professional body, the employee and Comcare can be confident that the provider has the training and competencies to deliver high quality, individualised services. (Comcare, 2023)

Seven non-registered professions are eligible to apply for provider status with Comcare. Professions not currently included in the scheme are clinical perfusion, dietetics, myotherapy, naturopathy, orthoptics, paramedicine, psychotherapy, and WHM.

⁵⁶ The majority of employees in Australia are covered under state and territory workers’ compensation schemes. These have not been included in this analysis. The institutional recognition of state/territory workers’ compensation schemes has been identified for one non-registered profession (naturopathy) in a report by Carlton et al. (2025: 233). That review of compensation schemes showed that, similar to the institutional arrangements identified in this chapter, there is significant variation in the recognition of naturopathy across jurisdictions for workers’ compensation payments and considerable discretion in reimbursement to workers for services provided by naturopaths. See: Appendix 10 for workers’ compensation arrangements for naturopathy in Australia.

Department of Home Affairs, Skilled Migration Program

The Commonwealth Department of Home Affairs oversees a Skilled Migration Program to attract migrants who contribute to the economy and provide skills and labour for occupations experiencing workforce shortages in Australia. Potential migrants are assessed to ensure they meet the skills criteria for entry to Australia under the program. Skills assessments are issued by relevant skills assessing authorities. A skills-assessing authority is an organisation delegated by the Department to assess practitioners to ensure their skills meet the required standards to work in the relevant occupation. The Department has delegated three professional associations to act as assessing authorities for non-registered professions, the Australian Association of Social Workers, Dietitians Australia, and Speech Pathology Australia.

Private health insurance

There are more than 30 private health insurers in Australia providing insurance coverage for healthcare services not covered by Medicare (ACCC, n.d.). For this study, the five largest insurers by market share (Donato & Onur, 2018: 15) were mapped to determine their co-regulation arrangements with professional bodies to pay rebates to private health insurance policyholders. The five largest private health insurers in 2017, covering an estimated 13 million Australians, are presented in Table 5.7.

Table 5.7: The five largest private health insurers in Australia by market share.

Private health insurer	Market share in 2017
Bupa	27%
Medibank Private	27%
HCF	11%
HBF	7%
NIB	7%

(Donato & Onur, 2018: 15).

Table 5.8 charts the non-registered professions against insurers, the professional bodies recognised for rebatable payments to policyholders, and the eligibility criteria applied. Most professions are recognised by at least one private health insurer, and most insurers use Medicare status to determine rebate eligibility, HCF being the only exception. For

providers without Medicare numbers, most insurers assess eligibility through membership of a professional body, except for NIB, which assesses providers 'case by case'. Most rebates paid by insurers to consumers of health services offered by these professions are provided under 'extras' cover rather than core hospital insurance cover.

The part played by private health insurance in regulating non-registered practitioners and ensuring they meet specific standards lies in its ability to attract practitioner membership to professional bodies having co-regulation arrangements with insurers. Professions ineligible for private health insurance rebates have no such incentives encouraging practitioners to join a professional body.

On 1 April 2019, following a government-commissioned review of natural therapies in which no clear evidence demonstrating the efficacy of certain natural therapies was found, 16 therapies, including naturopathy and WHM, were excluded from the definition of private health insurance general treatment (DOHAC, 2019a). This exclusion removed private health insurance provisions to offer policyholders rebates for these therapies. Prior to the review, co-regulation arrangements were in place with professional associations representing naturopathy and WHM, similar to other professions receiving private health insurance rebates. The quasi-regulatory function of private health insurance rebates and the perceived effect of their removal on consumer safety has been noted by professional bodies because of the implications for professional and educational standards (ANC, 2020; NHAA, 2020). One professional association stated that consumers are more at risk from "*fake naturopaths*" because of the removal of rebates in 2019 (NHAA, 2020).

On 7 April 2019, six days after the exclusion of natural therapies from the definition of private health insurance general treatment, the Health Minister commissioned an updated review to:

assess additional available evidence for natural therapies, undertake public consultation and provide advice to Government on whether certain natural therapies should be eligible for subsidy through the private health insurance rebate. (DOHAC, 2019b)

Table 5.8: Professional associations recognised by private health insurers.

Profession	Private health insurer				
	Bupa	HBF	HCF	Medibank Private	NIB
Audiology	✓ Eligible with Medicare	✗	✓	✓ Eligible with Medicare	✓ Eligible with Medicare
Clinical perfusion	✗	✗	✗	✗	✗
Counselling	✓ Association membership	✗	✓ With HCF-approved counselling	✓ ACA, ATMS, PACFA	✗
Dietetics	✓ Eligible with Medicare	✓ Eligible with Medicare	✓	✓ Eligible with Medicare	✓ Eligible with Medicare
Exercise physiology	✓ Eligible with Medicare	✓ Eligible with Medicare	✓ As part of a group Health Management Program	✓ Eligible with Medicare	✓ Eligible with Medicare
Massage therapy (remedial massage therapy)	✓ Association membership	✓ AMT, ANPA, ANTA, ATMS, MAA, MMA	✓ AMT, ANTA, ATMS, MMA	✓ AMT, ANTA, ATMS, MAA, MMA	✓ On a provider case-by-case basis
Myotherapy	✓ Association membership	✓ AMT, ANTA, MAA, MMA	✓ AMT, ANTA, ATMS, MMA	✓ AMT, ANTA, ATMS, MAA, MMA	✓ On a provider case-by-case basis
Naturopathy	✗	✗	✗	✗	✗
Orthoptics	✗	✓	✓ AOB	✓ Depends on cover	✓ Eligible with Medicare
Paramedicine	✓	✓	✓	✓	✓
Psychotherapy	✗	✗	✗	✗	✗

Profession	Private health insurer				
	Bupa	HBF	HCF	Medibank Private	NIB
Social work	✓ Eligible with Medicare & is an accredited mental health social worker	✗	✓ Accredited mental health social worker	✓ Mental health social worker AASW	✓ Eligible with Medicare
Sonography ⁵⁷	✗	✗	✗	✗	✗
Speech pathology	✓ Eligible with Medicare	✓ Eligible with Medicare	✓	✓ Eligible with Medicare	✓ Eligible with Medicare
Western herbal medicine	✗	✗	✗	✗	✗

Legend: **AASW**: Australian Association of Social Workers; **ACA**: Australian Counselling Association; **AMT**: Association of Massage Therapists; **ANPA**: Australian Naturopathic Practitioners Association; **ANTA**: Australian Natural Therapists Association; **AOB**: Australian Orthoptic Board; **ATMS**: Australian Traditional Medicine Society; **MAA**: Myotherapy Association of Australia; **MMA**: Massage and Myotherapy Australia; **PACFA**: Psychotherapy and Counselling Federation of Australia.

⁵⁷ By law, private health insurance does not offer coverage for out-of-hospital medical services, including out-of-hospital diagnostic imaging such as ultrasounds, provided by sonographers (DOHAC, 2022a).

On 27 March 2025, the review findings were released, in which the re-inclusion of seven natural therapies, including naturopathy and WHM, as eligible providers for private health insurance benefits was recommended (DOHAC, 2025b)⁵⁸. On 14 April 2025, the recommendation was accepted by the Minister for Health and Aged Care as the review *“was satisfied there was enough evidence these therapies are effective to allow them to return to being supported by private health insurance”* (Butler, 2025).

5.3.3 Other institutional recognition

Not all forms of government and non-government recognition attract financial benefits. Table 5.9 presents two institutions that apply other forms of recognition to non-registered professions.

The first is governments’ acknowledgement of occupations as allied health professions for professional associations holding membership with Allied Health Professions Australia (AHPA). While no formal government definition or designation of allied health exists, governments recognise AHPA member associations for consultation purposes. AHPA membership includes all but two non-registered professions examined in this research, naturopathy and WHM.

The second form of recognition is the Occupation Standard Classification for Australia (OSCA), a skill-based classification scheme categorising occupations in the Australian labour market. The classification specifies occupations for which statistical occupational data are collected, published, and analysed (ABS, 2024). OSCA has classified all non-registered professions except one examined in this research, myotherapy.

⁵⁸ The five other health practices recommended for re-inclusion as eligible providers for private health insurance benefits were Alexander Technique, shiatsu, Tai Chi, Pilates, and yoga.

Table 5.9: Institutions recognising non-registered professions as allied health and occupations.

Profession	Government acceptance of professions as allied health if the professional body is a member of AHPA	Classified as an occupation in OSCA
Audiology	✓ AA	✓ Skill level 1
Clinical perfusion	✓ ANZCPerf	✓ Skill level 2
Counselling	✓ ACA, PACFA	✓ Skill level 1
Dietetics	✓ DA	✓ Skill level 1
Exercise physiology	✓ ESSA	✓ Skill level 1
Massage	✓ AMT. MAA, MMA	✓ Skill level 2
Myotherapy	✓ AMT. MAA, MMA	✗
Naturopathy	✗	✓ Skill level 1
Orthoptics	✓ OA	✓ Skill level 1
Paramedicine	✓ ACPP	✓ Skill level 2
Psychotherapy	✓ ACA, PACFA	✓ Skill level 1
Social work	✓ AASW	✓ Skill level 1
Sonography	✓ ASMIRT	✓ Skill level 1
Speech pathology	✓ SPA	✓ Skill level 1
Western herbal medicine	✗	✓ Skill level 4

Legend: **AA**: Audiology Australia; **AASW**: Australian Association of Social Workers; **ACA**: Australian Counselling Association; **ACPP**: Australasian College of Paramedic Practitioners; **AMT**: Association of Massage Therapists; **ANZCPerf**: Australia and New Zealand College of Perfusionists; **ASMIRT**: Australian Society of Medical Imaging and Radiation Therapy; **DA**: Dietitians Australia; **ESSA**: Exercise and Sports Science Australia; **MAA**: Myotherapy Association of Australia; **MMA**: Massage and Myotherapy Australia; **OA**: Orthoptics Australia; **PACFA**: Psychotherapy and Counselling Federation of Australia; **SPA**: Speech Pathology Australia.

OSCA: Occupation Standard Classification for Australia skill levels:

1. Health professional with a bachelor's degree or higher qualification.
2. Health technicians and support workers with an associate degree, advanced diploma or diploma.
3. Health workers with an AQF Certificate IV or Certificate III.
4. Community and personal service workers with Certificate II or III.

(ABS, 2024).

5.4 Mapping the non-registered healthcare workforce

5.4.1 Size of the workforce

Unlike registered professions, there are no data repositories to accurately identify the size of the non-registered workforce. This was the subject of a Commonwealth Government review on gaps in data sources for the allied health sector. The review noted the lack of formal credentialling of non-registered allied health professions and the paucity of available data, such as the number of practitioners, where they work, and how they work (DOHAC, 2022b: 2, 6). The voluntary nature of association membership adds to the unreliability of any data sources. Even when association membership numbers are publicly available, and not all are, they are likely inaccurate because practitioners are not required to hold professional membership in order to practise. In addition, it is difficult to determine the extent of practitioner membership of multiple professional associations, which adds to the unreliability of any data sources.

The number of non-registered practitioners examined in this study was estimated by sourcing data from the last Australian Census held in August 2021 (ABS, 2021a, 2021b)⁵⁹. As census data can be inaccurate, the number of registered practitioners in several allied health professions from the 2021 Census was compared with the data on statutory registrants for those professions from the 2020–2021 Ahpra Annual Report (Ahpra, 2021a). The percentage rate of difference between the two sets of figures was calculated. The Census workforce data was between 22.4% and 95.8% lower than the Ahpra Annual Report registrant data (see Table 5.10).

The median percentage difference (31.9%) and upper percentage difference (95.8%) were used to estimate the number of non-registered practitioners based on available Census data. The estimated workforce size for non-registered professions is presented in Table 5.11. Five non-registered professions could not be located in the Census data,

⁵⁹ The Australian Census is a survey conducted by the Australian Government every five years of every person and household in Australia. The survey includes questions relating to information on the economic, social, and cultural make-up of Australians, including the characteristics of age, country of birth, religion, ancestry, language used at home, work, and education. The last Census was conducted on 10 August 2021 (ABS, 2021a). De-identified data from the Australian Census are publicly available for research purposes (ABS, 2021b).

clinical perfusion, exercise physiology, myotherapy, psychotherapy, and WHM. The estimated number of exercise physiologists was sourced from the 2020–2021 Annual Report of the professional association (ESSA, 2021: 9). The remaining professions for which no Census data were available do not publish their membership numbers or have multiple representative professional bodies, making any available membership data likely inaccurate.

Table 5.10: Workforce numbers for registered allied health professions from Census data and the Ahpra Annual Report, and calculated rate of difference.

Profession	Census August 2021	Ahpra Annual Report 2020–2021	Rate of Difference %
Acupuncturist and Traditional Chinese Medicine Practitioner	2,484	4,863	95.8 [■]
Chiropractor	4,409	5,968	35.4
Medical Diagnostic Radiographer	12,740	17,844	40.1
Occupational Therapist	19,429	25,632	31.9 [#]
Optometrist	5,213	6,288	20.6
Osteopath	2,276	2,951	29.7
Paramedic	15,678	21,492	37.1
Physiotherapist	28,913	37,650	30.2
Podiatrist	4,723	5,783	22.4

■ Upper rate of difference; # Median rate of difference.

The accuracy of the estimates was assessed by using paramedicine as a test case. The number of paramedics sourced from the 2021 Census data (15,678), when increased by the median percentage rate of difference (31.9%), resulted in an estimated 20,679 paramedics. When increased by the upper percentage difference (95.8%), the number of paramedics is 30,698. The 2020–2021 Ahpra Annual Report shows there were 21,492 registered paramedics at the end of June 2021 (Ahpra, 2021a: 35). This suggests the median percentage difference potentially provides a more accurate estimate of the number of non-registered practitioners. The percentage rates of difference were applied across the non-registered professions for which Census data are available. The resulting data indicate that the estimated size of the non-registered workforce for the 15 professions included in this research represents a substantial number of practitioners

(between 160,000 and 240,000). Together with data presented earlier in the chapter regarding the accelerated growth of more than 25% in the allied and complementary health workforce sectors compared to 11% in the overall health workforce (Productivity Commission, 2005: 10), this represents a considerable number of health practitioners providing health services to Australian consumers, subject to voluntary certification mechanisms and inconsistent co-regulation arrangements.

Table 5.11: Estimated number of practitioners in specified non-registered professions.

Profession	Census data August 2021 No. practitioners	Estimated no. based on median % difference (+ 31.9%)	Estimated no. based on upper % difference (+ 95.8%)
Audiology	2,651	3,497	5,191
Clinical perfusion	Not available		
Counselling	23,675	31,227	46,356
Dietetics	5,447	7,185	10,665
Exercise physiology	Not available	7,059*	7,059*
Massage therapy	15,329	20,219	30,014
Myotherapy	Not available		
Naturopathy	2,438	3,216	4,774
Orthoptics	1,069	1,410	2,093
Paramedicine	15,678	20,679	30,698
Psychotherapy	Not available		
Social work	33,934	44,759	66,443
Sonography	6,009	7,926	11,766
Speech pathology	10,961	14,458	21,462
Western herbal medicine	Not available		
Total	117,191	161,635	236,521

* Sourced from ESSA Annual Report 2021 (ESSA, 2021: 9).

5.4.2 Consumer consultations

The number of consumers consulting with non-registered professions was estimated from the Australian Bureau of Statistics National Health Survey 2014–2015 (ABS, 2017). Consumer consultation data were available for eight of the fifteen health professions. The available data show that these professions, comprising half the occupations under study, consulted with an estimated 2.4 million consumers in 2014–2015 (see Table 5.12) or around 10% of the Australian population. In the three years up to 2014–2015, there

was an increase in consumer consultations of over 50%. Social workers almost doubled the number of consumers consulted during the same period.

Table 5.12: Consumer consultations with non-registered practitioners.

Profession	ABS Health Survey 2011–2012 No. of persons	ABS Health Survey 2014–2015 No. of persons	Increase in the 3 years to 2014–2015
Audiology	264,000	246,100	-6.8%
Clinical perfusion	Not available	Not available	Not available
Counselling	234,500	359,400	53.3%
Dietetics	324,600	566,000	74.4%
Exercise physiology	Not available	Not available	Not available
Massage therapy	Not available	Not available	Not available
Myotherapy	Not available	Not available	Not available
Naturopathy	366,300	400,100	9.2%
Orthoptics	Not available	Not available	Not available
Paramedicine	Not available	Not available	Not available
Psychotherapy	Not available	Not available	Not available
Social worker	135,900	255,900	88.3%
Sonography	Not available	273,400	Not available
Speech Pathology	152,700	207,900	36.1%
Western herbal medicine	86,400	97,000	12.3%
Total	1,564,400	2,405,800	53.8%

(ABS, 2017).

5.4.3 Public spending

Public spending on health services provided by non-registered professions is difficult to source. Data for a few non-registered professions is available from Medicare, the Department of Veterans' Affairs, and the National Disability Insurance Scheme. These data are incomplete and only include spending on certain clinical services. For example, the data do not include public spending on the education of non-registered practitioners or the out-of-pocket expenses incurred by consumers for services not covered by Medicare.

The available data on public expenditure are set out in Table 5.13.

Table 5.13: Public spending on specified non-registered professions.

Profession	Medicare spend 2019 AUD\$	DVA spend 2019–2020 AUD\$	NDIS spend 2022–2023 AUD\$	Total spend AUD\$
Audiology	195,497	Not available	300,000	495,497
Counselling	Not funded	Not available	26,900,000	26,900,000
Dietetics	24,369,620	10,000	15,900,000	40,279,620
Exercise physiology	19,003,806	60,000,000	64,900,000	143,903,806
Orthoptists	Not funded	Not available	600,000	600,000
Social work	Not available	Not available	11,400,000	11,400,000
Speech pathology	8,717,766	Not available	135,400,000	144,117,766
Total AUD\$	52,286,689	60,010,000	255,400,000	367,696,689

Legend: **DVA**: Department of Veterans' Affairs; **NDIS**: National Disability Insurance Scheme.

(DVA, 2021: 8; AIHW, 2022; NDIA, 2023: 44).

5.4.4 Registered professions nationally and internationally

In Chapter 1, Section 1.6, a table comparing the registration status of health professions in four anglophone countries was presented. This table is presented again in Table 5.14.

Like jurisdictionally registered professions prior to 2010 (see Table 5.2), there are inconsistencies in the regulation arrangements for health professions in different countries. Notably, all but three non-registered professions examined in this research are registered in at least one comparable overseas jurisdiction, the exceptions being clinical perfusion, exercise physiology, and WHM. Such differences prompt questions regarding possible factors that may account for the variation, which this research aims to explore in the Australian setting.

Table 5.14: Regulation status of selected health practitioners in selected countries.

Health practitioner	Australia	Canada ^a	Aotearoa/ New Zealand	United Kingdom
Indigenous health practitioners	• ^b			
Art therapists				•
Acupuncturists	•	• (ABOQ)		c
Audiologists		• (ABOQ)		c
Chinese medicine practitioners	•	• (BO)	•	
Chiropractors	•	• (ABOQ)	•	•
Clinical perfusionists			d	c
Counsellors				c
Dental practitioners	• ^e	• (ABOQ)	•	•
Dietitians		• (ABOQ)	•	•
Exercise physiologists				c
Massage therapists		• (BO)		c
Myotherapists				
Medical imaging/radiation practitioners	•	• (AOQ)	•	•
Medical laboratory scientists, anaesthetic technicians		• (AOQ)	•	
Medical practitioners	•	• (ABOQ)	•	•
Midwives	•	• (ABOQ)	•	•
Naturopaths		• (ABO)		c
Nurses	•	• (ABOQ)	•	•
Occupational therapists	•	• (ABOQ)	•	•
Optometrists	•	• (ABOQ)	•	•
Orthoptists				•
Osteopaths	•		•	•
Paramedics	•	• (ABOQ)	•	•
Pharmacists	•	• (ABOQ)	•	•
Physiotherapists	•	• (ABOQ)	•	•
Podiatrists	•	• (ABOQ)	•	•
Psychologists	•	• (ABOQ)	•	•
Psychotherapists		• (OQ)	•	c
Social workers		• (ABOQ)	• ^f	•
Sonographers		• (OQ)	•	c
Speech pathologists		• (ABOQ)		•
Western herbal medicine practitioners				

Practitioners in the scope of the research study.

Notes:

- a. Registered in Alberta (A), British Columbia (B), Ontario (O), Quebec (Q) (the four largest provinces by population).
- b. In Australia, these practitioners are known as Aboriginal and Torres Strait Islander health practitioners.
- c. A government-accredited register is in place for this profession, which practitioners may voluntarily join if they meet requirements. Exercise physiologists are listed under the Healthcare Science register. Sonographers are listed under the Clinical Technology register.
- d. Preparation of a registration regulation impact statement for Cabinet agreement is underway (NZ MOH, 2023a).
- e. Includes dentists, dental specialists, dental hygienists, dental prosthetists, and dental and oral health therapists.
- f. Registered under the Ministry of Social Development and not under the health portfolio (NZ MOH, 2023b).

(Ahpra, 2024a; Health Canada, 2021–2024; NZ MOH, 2023b; UK PSA, 2024a; UK PSA, 2024b).

5.5 Summary of institutional mapping

The institutions charted in this chapter show considerable variation in regulation arrangements and a complex array of statutory and non-statutory governance mechanisms for non-registered health professions, including various institutions involved in co-regulation arrangements with relevant professional bodies. However, only one mechanism covers every non-registered profession, the health complaints entities, two of which have limited powers to act because jurisdictions have yet to implement the NCC. Even in jurisdictions where the NCC has been introduced, there are differences in how the Code has been implemented. The varied approaches taken by jurisdictions and the delayed action to enact and enforce the NCC by most Australian states and territories suggest that jurisdictional autonomy dominates over patient safety. This has led to prolonged delays in implementing the NCC and its complete absence in two jurisdictions despite a decade-old report detailing serious issues relating to certain non-registered practitioner groups. The most egregious issues documented are sexual misconduct, financially exploitative conduct, misleading and deceptive conduct, and failing to refer, resulting in delayed diagnosis or treatment and sometimes death (AHMAC, 2013: 31-32). The implementation delay of the NCC may be an example of a “regulatory practice gap”, a term used by a WHO Technical Expert Group to describe the difference between regulatory policy and regulation in practice (WHO, 2024: 26).

Despite all jurisdictions having HCEs in place, these entities are considered to have several weaknesses. These weaknesses persist even though some disadvantages are overcome with the powers granted by the NCC, such as the power to issue prohibition orders and share this information with other jurisdictions under mutual recognition laws. The documented weaknesses of HCEs include a predominant reliance on complaint lodgement and hence are mainly reactive organisations, no proactive assessment of practitioner training or fitness to practice before practice entry, voluntary participation of non-registered practitioners in complaint investigations, where sanctions are imposed, such as the need for practitioners to change policies or processes, most HCEs are powerless to enforce compliance, and although Complaint Commissioners can refer cases for court action, this is uncommon (Morris et al., 2018:

229, 231, 236). Furthermore, most HCEs do not report complaint data for all health professions, as shown in Table 5.3, which hampers complaint analysis and quality improvement efforts.

In contrast to the slow pace of NCC implementation, the NRAS was legislated and implemented for registered professions in all eight jurisdictions over three years between 2009 and 2012, with the years 2006 to 2012 devoted to developing, enacting and implementing the requirements of the legislation. NRAS implementation was partly facilitated by the establishment of a single agency (Ahpra) to operationalise jurisdictional NRAS legislation and the national approach taken. While agreement was reached to pass nationally consistent NRAS legislation enacted through corresponding “*adoption*” legislation in each Australian jurisdiction (AHWMC, 2011: 4, 6), both the passage and implementation of NCC legislation were left to each jurisdiction. This difference between the NRAS and NCC resulted in protracted implementation timelines for the NCC, potentially because of distributed responsibilities across jurisdictional HCEs. Moreover, consumers in two jurisdictions are denied the protection of laws ten years on from ministerial agreement to the NCC. Table 5.15 presents a consolidated map summarising the extent of institutional coverage for non-registered professions and their representative bodies. The institutional mapping presented in this chapter shows that government institutions recognise different professions and professional bodies for the purpose of offering entitlements to practitioners or consumers of their services. The ATO, Medicare, NDIS, DVA, and Comcare recognise some but not all professions for payment of government entitlements. This analysis finds that four professions: audiology, exercise physiology, social work, and speech pathology, are recognised by all five government institutions reviewed in this chapter and have more extensive co-regulation coverage than other professions mapped. Dietetics is recognised by four of the five government institutions reviewed, orthoptics and sonography are recognised by three, and paramedicine is recognised by two. Myotherapy and psychotherapy are not recognised by any government institution reviewed in this analysis. Clinical perfusion, counselling, massage therapy, naturopathy, and WHM are each recognised by one institution, primarily to determine eligibility for GST-free health services.

Table 5.15: Consolidated map of institutional recognition for non-registered professions.

Non-registered professions																		
Statutory mechanisms					Co-regulation and other recognition mechanisms													
State/Territory	Health complaints entity in place	NCC legislation passed	NCC legislation is in force	Complaints disaggregated by non-registered profession	Professions	ATO GST-free	Medicare	NDIS	DVA	Comcare	Assessing authority for skilled migration	Medibank	Bupa	HCF	NIB	HBF	Allied health	OSCA
New South Wales	✓	✓	✓	✓ for most professions	Audiology	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✗	✓	✓
					Clinical perfusion	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✓
South Australia	✓	✓	✓	✗	Counselling	✗	✗	✗	✗	✓	✗	✓	✓	✓	✗	✗	✓	✓
					Dietetics	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Queensland	✓	✓	✓	✗	Exercise physiology	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
					Massage	✗	✗	✗	✗	✓	✗	✓	✓	✓	✓	✓	✓	✓
Victoria	✓	✓	✓	✓ for two professions	Myotherapy	✗	✗	✗	✗	✗	✗	✓	✓	✓	✓	✓	✓	✗
					Naturopathy	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓
Western Australia	✓	✓	✓	✗	Orthoptics	✗	✓	✓	✓	✗	✗	✓	✗	✓	✓	✓	✓	✓
					Paramedicine	✓	✗	✗	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓
Australian Capital Territory	✓	✓	✓	✗	Psychotherapy	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✓
					Social work	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tasmania	✓	✓	✗	✗	Sonography	✓	✓	✗	✗	✓	✗	✗	✗	✗	✗	✗	✓	✓
					Speech pathology	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓
Northern Territory	✓	✗	✗	✗	Western herbal medicine	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓

The variation in eligibility requirements across the institutions and professions analysed presents a regulatory farrago marked by gaps and discontinuities. Sometimes, this complexity also exists for registered professions. For example, Chinese medicine practitioners, despite being registered, are required to hold membership of a recognised professional association for patients to claim some private health insurance rebates (Bupa, n.d.; HBF, 2024; HCF, 2023; Medibank, 2024; NIB, 2024). Also, while Chinese medicine practitioners enjoy GST-free status (ATO, 2024), their patients do not receive Medicare rebates (DOHAC, 2024c), adding to the complexity.

The more co-regulatory partnerships between institutions and professional bodies of non-registered professions, the stronger the co-regulation overlay. Some professions have more extensive coverage with more institutional co-regulatory arrangements that collectively apply stronger regulation to members because of greater incentives for practitioners to join an association to reap the benefits of membership. Professions with substantial co-regulatory partnerships may be considered to offer greater protections to consumers because of these incentives. Some institutions stipulate that associations meet specific professional and ethical requirements, which is an indirect mechanism for setting and enforcing standards. Professions with fewer institutional partnerships, that is, are recognised by few or no institutions, offer practitioners less incentive to join an association. These practitioners may not be subject to professional entry, practice, and ongoing development standards. This results in weaker regulation arrangements to quality assure practitioners. Weaker regulation means consumers may have less protection from these practitioners, potentially rendering consumers more vulnerable to the treatment provided.

Extensive institutional co-regulation arrangements are an indicator of the acceptance and acknowledgement of non-registered professions in the health system. They indicate the professional recognition and approval bestowed upon these professions by being granted, in most cases, recognition by state institutions with all the rewards and prestige these bring. These partnerships may be viewed as a proxy for how well-established professions are in the Australian healthcare system and, therefore, the influence they may exert on the system. They are forms of social capital possessed by practitioners and

their representative bodies due to their recognition alongside registered professions, most of which hold provider status with many of the same institutions.

Fewer institutional linkages, on the other hand, deny practitioners the opportunity to build their social capital and elevate their status. Professions with the least co-regulation arrangements may find themselves vulnerable to further politicisation because of their marginalisation, which makes further co-regulation more difficult. Marginalisation can be viewed as a product of the marginalised status of particular professions and can encourage the very factors that lead to a marginalised status. The direct and indirect co-regulation partnerships are important considerations since elevating the standing of some professions over others may go on to shape or influence government and departmental policy officer perspectives on HPR policy. How well-embedded professions are in the health system may also dictate broader health system policy changes, such as which professions to consult and include in scope expansion opportunities or other health system reforms.

Strong co-regulation partnerships may also attract economic capital to practitioners. Practitioners of non-registered professions with extensive institutional arrangements have a greater capacity to attract consumers and accumulate economic capital through increased funding subsidies, incentivising consumer patronage and expanded employment prospects from being a recognised provider. Greater economic capital allows professions to compete for a more dominant position in the regulatory field relative to their current position. By contrast, practitioners of professions with few or no institutional linkages have reduced earning potential and accumulate less economic capital, conditions that may tether them to their current position in the regulatory field.

Professions with more co-regulation partnerships may also enjoy increased cultural capital because of the credentialling applied by institutions. Some institutions apply more stringent requirements than others. These range from Comcare, which “*strongly recommends*” providers hold relevant membership of an appropriate professional body, to the ATO, which requires a practitioner to be a member of an association with nationally uniform requirements, through to Medicare, which applies the most stringent provider requirements by stipulating which association/s a practitioner must be a

member of. Eligibility requirements for other government institutions, such as the NDIS, are unknown, and eligibility for some non-registration professions is conducted “*case by case*”. DVA is the only institution that automatically grants provider access to practitioners with a Medicare provider number. This means DVA has based its decisions regarding practitioner eligibility for payment of entitlements on professions having a formal recognition pathway identified in the legislation underpinning Medicare.

Adopting Medicare for benefit eligibility by four out of five private health insurers and by DVA represents the most stringent criteria analysed in this study. Stronger eligibility requirements stipulated by Medicare potentially enhance protections for consumers. Much like NRAS registration, using Medicare as the default eligibility criterion by private health insurers and DVA, in addition to eligibility for available government rebates, potentially elevates Medicare to the level of symbolic capital. Just as NRAS registration appears to be a passport to almost all government entitlements, possessing a Medicare provider number may be perceived as a passport for accessing a range of capital assets available to particular non-registered professions. The economic capital from Medicare flows from government-funded financial entitlements and employment opportunities. Its cultural capital stems from holding a consultation-rebatable status symbol, and the social capital of Medicare derives from joining the most elite health professions in which practitioners possess a Medicare provider number.

The mapping analysis shows that generally speaking, professions with the least government and institutional co-regulatory arrangements (counselling, massage therapy/myotherapy, and naturopathy are prime examples) have a greater number of professional associations (n=6, n=4, n=5, respectively) (see Table 4.7, Table 5.1, and Appendix 7 for further details). Conversely, professions with strong co-regulation partnerships, such as audiology, dietetics, social work, and speech pathology, each have a single representative professional association. This finding suggests that weak co-regulation arrangements may encourage the proliferation of professional associations, further weakening regulation efforts because of a lack of agreement between professional bodies.

Implicit in the above arguments are two assumptions. The first is that co-regulation leads to higher professional standards. The second is that practitioners are incentivised to join an association and subject themselves to professional association standards in order to access the economic, cultural, and social capital deriving from association membership. However, these assumptions have not been tested or measured in this study or other studies and remain hypotheses until further investigation establishes the validity of the assumptions. It is also acknowledged that co-regulation partnerships provide no guarantee that practitioners will join a professional association and submit to the required professional standards and rules of the association. Indeed, optional membership of a professional representative body is the very nature of self-regulation in Australia.

Following the enactment of the *National Law*, some professional associations formed the credentialling body, NASRHP⁶⁰, or joined the allied health peak body, AHPA⁶⁰. The profession-specific registering bodies ARCAP and ARONAH⁶⁰ were also established following the implementation of the National Registration and Accreditation Scheme (NRAS). Collectively, these peak professional bodies and registering organisations incorporate almost every professional group included in this research. By joining or establishing peak organisations and registering bodies, professional groups have endeavoured to build additional economic, cultural, and social capital to reposition the profession, carve out a more favourable position in the regulatory field, and progress their professional agendas.

5.6 Chapter summary

The mapping review presented in this chapter shows that non-registered professions are a mixed group of mostly heterogeneous healthcare cadres. Some professions, such as dietetics and speech pathology, appear assimilated into the health system and, therefore, depend on government integration and funding. At the other end of the continuum, some professions, such as WHM practitioners and naturopaths, appear

⁶⁰ **AHPA:** Allied Health Professions Australia; **ARCAP:** Australian Register of Counsellors and Psychotherapists; **ARONAH:** Australian Register of Naturopaths and Herbalists; **NASRHP:** National Alliance of Self Regulating Health Professions.

excluded from most health system funding. Even though some non-registered professions have similar scopes of practice, such as massage therapy and myotherapy or counselling and psychotherapy, and the same representative bodies, there is little this group has in common other than that they are self-regulating. The extent of integration and funding of these professions may affect their passage through the HPR field and their success in achieving their regulation goals.

Mapping the HPR field shows that the non-registered health professions identified for inclusion in this research hold different positions in the regulatory field. Even though none of the professions have found a place in the NRAS field, some have secured a place in other legislative and institutional arenas in the healthcare system. The recognition resulting from these field positions bestows benefits such as financial rewards, status, and integration with other healthcare professions and providers.

In this Chapter, I have presented a summary of key events and decisions relating to HPR for registered and non-registered health professions. I have mapped the field according to the statutory governing mechanisms for non-registered professions, their institutional recognition, and their positions in the field relative to other professions.

I now present Phase 2 of the research, an analysis of stakeholder perspectives of occupational regulation for non-registered professions derived from document sources. This is the subject of the next two chapters.

Research Phase 2

DESCRIPTIVE AND QUALITATIVE ANALYSIS OF DOCUMENT SOURCES

The previous chapter presented a summary of the health practitioner regulation (HPR) field in Australia in which policy decisions and events leading up to and beyond the implementation of the *National Law* were charted, health professions were mapped against government and non-government rebate schemes, and actions taken by professional bodies were presented to identify responses to policy events.

Chapter 6 is the first of two, presenting the results of a descriptive and thematic analysis of document sources on healthcare stakeholder perspectives of HPR. Chapter 6 details the results of an applied thematic analysis, consisting of three sections. The first sets out the results of an analysis of stakeholder positions on preferred types of regulation. It addresses the research objective of identifying the publicly documented positions of stakeholders on HPR for the professions examined. The second section presents a descriptive analysis of stakeholder perspectives regarding preferred regulation models. The final section of the chapter explores stakeholder perspectives, addressing the Intergovernmental Agreement (IGA) assessment criteria and the criterion-centred discourses used to support stakeholder positions on HPR. The results presented in the latter two sections of the chapter address the research objective of describing stakeholder perspectives of HPR as articulated in document sources. They answer the contextual question of what attitudes stakeholders have to HPR.

The results reported in Chapter 6 are a prelude to the findings from a detailed applied thematic analysis of documentary sources that follows in Chapter 7. In Chapter 7, the themes generated from a thematic analysis are presented. They provide a deeper exploration of stakeholder perspectives of HPR that address the research objective of describing the reasons given by stakeholders for supporting publicly documented positions on HPR. They answer the diagnostic question of why stakeholders hold particular positions and perspectives on regulation.

Chapter 6

DOCUMENTED STAKEHOLDER POSITIONS ON REGULATION Descriptive analysis of document sources

6.1 Introduction

The document searches yielded 741 documents from the websites of professional bodies, government departments and agencies, Trove repositories, and Google searches (see Section 4.3.2 for further information on the search methods). Retrieved documents were catalogued and coded. Following successive rounds of coding review, 181 documents were removed from the analysis due to no relevant content. After finalising the coding, 560 documents were considered eligible for inclusion in the analysis.

Figure 6.1 presents the document selection process and reasons for exclusion.

Appendix 6 includes all data sources from which documents were retrieved.

Before coding the document corpus, the texts were categorised according to four classifications: the type of document retrieved, the profession under consideration, and authorship of the document by organisation and organisation type.

Table 6.1 sets out the classification of documents according to document type, profession, and organisation type in descending order of frequency.

Table 6.2 presents a count of documents in descending order of frequency categorised by organisation.

An additional category was assigned to the documents to specify the documented positions on regulation. Nine regulation categories were identified in the dataset:

- support for registration;
- support for co-regulation and registration;
- support for self-regulation and registration;
- support for self-regulation;

- support for self-regulation and co-regulation;
- support for co-regulation;
- not supportive of registration;
- unclear or ambiguous position on regulation; and
- position on regulation not stated.

Figure 6.1: Selection process for document sources.

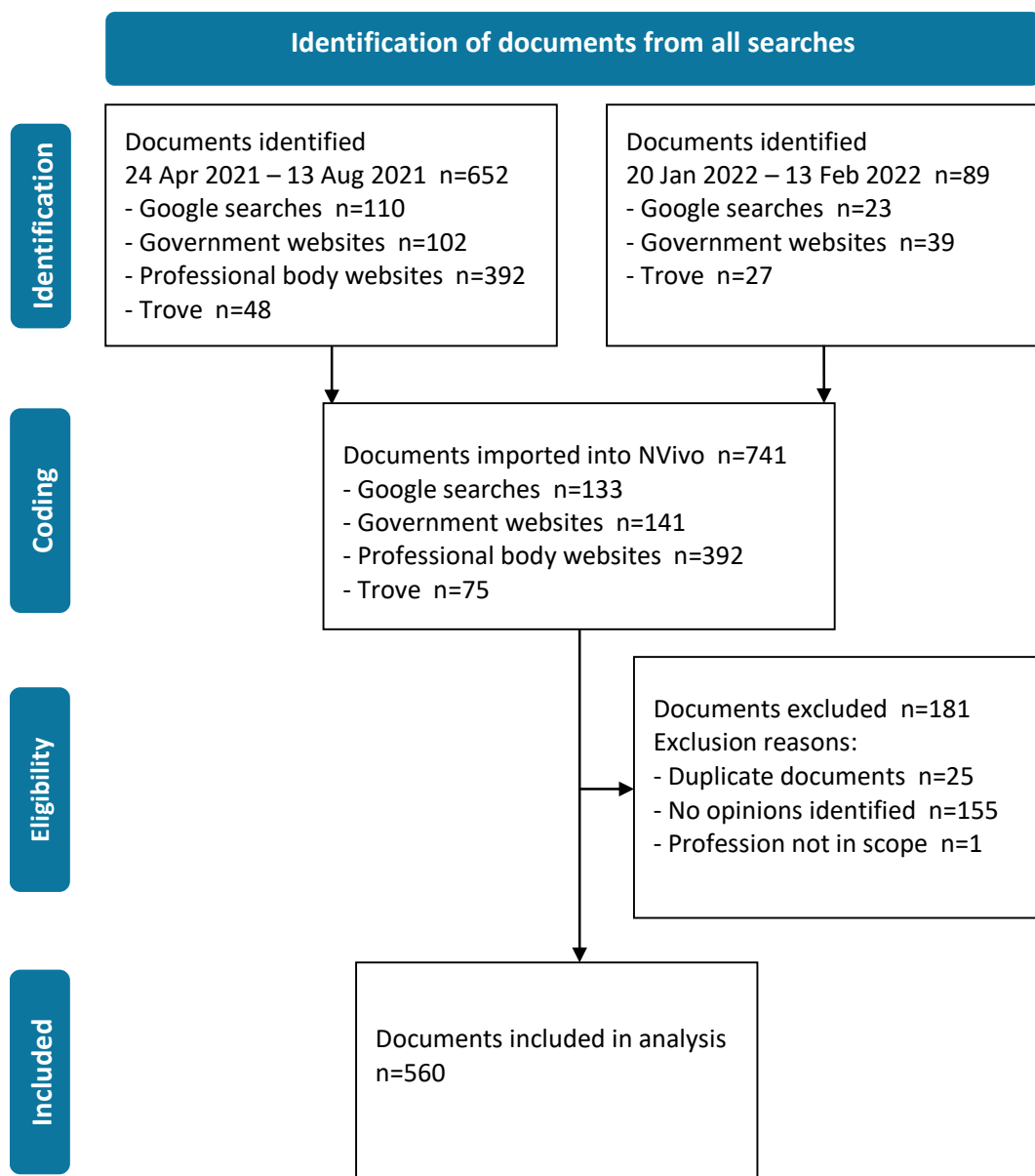


Table 6.1: Documents classified by document type, profession, and organisation type.*From highest to lowest frequency*

Document type	No. documents retrieved	%
Submissions to government	312	55.7
General communications ⁶¹	102	18.2
Annual reports	59	10.6
Position statements	24	4.3
Media releases	22	3.9
Codes/Standards/Guidelines	17	3.0
Strategic plans	17	3.0
Reports	4	0.7
Policy statements	3	0.6
Total	560	100
Profession	No. documents retrieved	%
Naturopathy	85	15.2
Western herbal medicine	72	12.8
Massage therapy	53	9.5
Sonography	46	8.2
Social work	44	7.9
Counselling	39	7.0
Speech pathology	30	5.3
Audiology	29	5.2
Myotherapy	28	5.0
Paramedicine ⁶²	28	5.0
Psychotherapy	28	5.0
Dietetics	23	4.1
Exercise physiology	21	3.8
Allied health ⁶³	18	3.2
Clinical perfusion	8	1.4
Orthoptics	8	1.4
Total	560	100
Organisation type	No. documents retrieved	%
Professional associations	446	79.6
Registering organisation	41	7.3
Peak professional bodies ⁶⁴	30	5.4
Other organisations	18	3.2
Contributions from individuals	16	2.9
Government departments/agencies	6	1.1
Consumer advocacy bodies	3	0.5
Total	560	100

⁶¹ General communications include member communications, news updates, fact sheets, and FAQs.

⁶² Paramedicine was included as a 'non-registered' profession since it was not registered on 1 July 2012, the date set for selecting non-registered professions examined in this research.

⁶³ Documents categorised as allied health were written on behalf of the non-registered allied health sector as a whole. These documents have been reported in the results chapters of this thesis as advocating perspectives on behalf of allied health, rather than specific non-registered professions.

⁶⁴ Peak professional bodies are not practitioner membership bodies. They generally fall into one of two categories: membership bodies for professional associations advocating on behalf of the profession or standard-setting bodies to which associations apply for accreditation of the association's standards.

Table 6.2: Documents categorised by organisation.

From highest to lowest frequency.

Organisation	No.	Organisation	No.
Australian Natural Therapists Association	52	Australian Naturopathic Practitioners Association	7
Naturopaths and Herbalists Association of Australia	44	Australian and New Zealand College of Perfusionists	6
Australian Association of Social Workers	42	Complementary Medicine Association	6
Psychotherapy and Counselling Association of Australia	32	Government department/ agency	6
Australian Traditional Medicine Society	31	National Alliance of Self Regulating Health Professions	6
Australasian Sonographers Association	30	Orthoptics Australia	6
Australian Register of Naturopaths and Herbalists	28	Australian Naturopathic Council	5
Massage and Myotherapy Australia	28	Massage Association of Australia	5
Speech Pathology Australia	26	Paramedics Australasia	4
Dietitians Australia	22	Australian College of Audiology	3
Association of Massage Therapists	21	Australian Sonographer Accreditation Registry	3
Exercise and Sports Science Australia	20	Consumer advocacy bodies	3
Other organisations	18	Australasian College of Paramedicine	2
Australian Counselling Association	17	Australian College of Ambulance Professionals	2
Independent Audiologists Australia	17	Australian Orthoptic Board	2
Individual submissions	16	Australasian Society of Cardio-Vascular Perfusionists	2
Allied Health Professions Australia	10	Australian Community Counselling Association	1
Australasian Society for Ultrasound in Medicine	10	Australian Society of Medical Imaging and Radiation Therapy	1
Audiology Australia	8	Christian Counsellors Association of Australia	1
Australian Register of Counsellors and Psychotherapists	8	National Council of Ambulance Unions	1
Council of Ambulance Authorities	8	Total	560

6.2 Overview of the document corpus

Appendix 11 presents the complete list of documents meeting the inclusion criteria for document analysis, with classification attributes, position on regulation, and identification code applied to documents.

Over half of all retrieved documents were responses to government calls for submissions, Government Inquiries, and Royal Commissions. More than one in five documents were general communication pieces and media releases/reports. The combined number of position statements, strategic plans, codes/standards/guidelines, reports, and policy statements represented fewer than 12% of located documents.

Most professional bodies represented a single health profession and discussed regulation matters concerning one professional group. Where a professional body represented two or more professional groups examined in this research and addressed regulation issues relevant to each profession, these were analysed and reported separately for the respective professions. A small proportion of documents referred to and advocated for regulation relating to 'allied health', which is reported in this chapter as a single professional group.

One-third of the 15 included health professions (massage therapy, naturopathy, social work, sonography, and Western herbal medicine (WHM)) accounted for just over half the dataset. Most documents were authored by professional bodies, and fewer than one in fourteen were contributed by individuals, consumer bodies, government organisations, and organisations outside the 15 professions examined. These 'other' organisations are the Australian General Practitioner Network, Complementary Medicines Australia, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal Flying Doctor Service, and the Southern School of Natural Therapies. Government departments and agencies represented a small part of the dataset (n=6), and less than 1% of documents were from consumer advocacy bodies. There were also 16 documents from individuals not affiliated with any organisation commenting on regulation issues relating to specific professions.

6.3 Stakeholder positions on health practitioner regulation

Table 6.3 presents the classification of documents by profession and identified positions on regulation. Registration was the preferred regulation model in more than half of all documents. Around one in seven documents was identified as supporting self-regulation, and a few documents were found to support co-regulation. Around one-quarter of documents were identified where no position on regulation could be discerned or the position was unclear/ambiguous. A few sources documented a lack of support for registration. Almost one in 20 documents advocated for dual regulation preferences, such as co-regulation and registration, described in some documents as short- and long-term regulation goals.

Consistent with the dataset findings, almost half the documents from professional bodies were found to support registration and a minority preferred self-regulation. Nearly all documents from consumer bodies, individuals, governments, and other organisations advocated for registration for the professions concerned, and none explicitly supported self-regulation.

Documents produced for audiology, naturopathy, paramedicine, social work, sonography, and WHM more frequently expressed a preference for registration than other forms of regulation and compared with other professions. Documents produced for counselling, exercise physiology, massage therapy, and psychotherapy more often declared support for self-regulation or favoured dual self-regulation/co-regulation than other forms of regulation and compared with other professions. Documents from professional associations representing dietetics and massage therapy were more frequently found to be unclear/ambiguous in their regulation preferences, or a position on regulation could not be discerned.

Professions more frequently found to favour types of regulation other than registration tended to have more documents where regulation preferences could not be identified or were unclear/ambiguous compared with professions preferencing registration.

Table 6.4 sets out stakeholder positions on regulation categorised by organisation. Each dot (•) in the table represents one document included in the analysis. The sections that

follow explore the positions on regulation documented by stakeholders. They include the documented perspectives of professional body representatives taking a consistent position on regulation across time and those whose positions varied between documents. Also presented is documented commentary regarding unclear/ambiguous positions on regulation. Additionally, the perspectives of document authors from professions with single or multiple representative bodies are reviewed. An examination of the perceptions of consumer and government sources, other organisations, and individuals completes the presentation of results in this first section of the chapter.

Table 6.3: Documents categorised by profession and position on regulation.

Profession	Registration	Co-regulation	Co-regulation & registration	Self-regulation & registration	Self-regulation	Self-regulation & co-regulation	Not supportive of registration	Unclear/ambiguous	Not stated	Total
Allied health	1	4			3			2	8	18
Audiology	18		1		3				7	29
Clinical perfusion	3							1	4	8
Counselling	4	1		4	17			4	9	39
Dietetics	2	1			1			6	13	23
Exercise physiology		1		1	12			2	5	21
Massage therapy	8				4	15	1	13	12	53
Myotherapy	8				7	4		2	7	28
Naturopathy	69				4		2	4	6	85
Orthoptics									8	8
Paramedicine	26						1		1	28
Psychotherapy		1		4	17			3	3	28
Social work	42								2	44
Sonography	37							1	8	46
Speech pathology	14	4			7				5	30
Western herbal medicine	56				4		2	4	6	72
Total	288	12	1	9	79	19	6	42	104	560
%	51.4	2.1	0.2	1.6	14.1	3.4	1.1	7.5	18.6	100

Table 6.4: Documents categorised by organisation and position on regulation.

Each dot (•) represents one document.

Profession	Organisation	Registration	Co-regulation	Co-regulation & registration	Self-regulation & registration	Self-regulation	Self-regulation & co-regulation	Not supportive of registration	Unclear/ambiguous	Not stated	Total
Allied health	Allied Health Professions Australia (AHPA)		••						••	••••• •	10
	National Alliance of Self Regulating Health Professions (NASRHP)		••			•••				•	6
	Consumer advocacy body (Consumer Health Forum of Australia)	•								•	2
Audiology	Audiology Australia (AA)			•		•				••••• •	8
	Australian College of Audiology (ACAud)					••				•	3
	Independent Audiologists Australia (IAA)	•••••••• ••••••••									17
	Consumer advocacy body (Parents of Deaf Children and Aussie Deaf Kids)	•									1
Clinical perfusion	Australian and New Zealand College of Perfusionists (ANZCPerf)	•							•	••••	6
	Australasian Society of Cardio-Vascular Perfusionists (ASCVP)	••									2

Profession	Organisation	Registration	Co-regulation	Co-regulation & registration	Self-regulation & registration	Self-regulation	Self-regulation & co-regulation	Not supportive of registration	Unclear/ambiguous	Not stated	Total
Counselling	Australian Counselling Association (ACA)		•		••	•••			•	••	9
	Australian Community Counsellors Association (ACCA)	•									1
	Australian Natural Therapists Association (ANTA)	•••							•	••	6
	Australian Register of Counsellors and Psychotherapists (ARCAP)					••				••	4
	Australian Traditional Medicine Society (ATMS)									••	2
	Christian Counsellors Association Australia (CCAA)									•	1
	Psychotherapy and Counselling Federation of Australia (PACFA)				••	•••••••• ••••			••		16
Dietetics	Dietitians Australia (DA)	•	•			•			••••••	•••••• •••••• ••••	22
	Other (Australian GP Network)	•									1

Profession	Organisation	Registration	Co-regulation	Co-regulation & registration	Self-regulation & registration	Self-regulation	Self-regulation & co-regulation	Not supportive of registration	Unclear/ambiguous	Not stated	Total
Exercise physiology	Exercise and Sports Science Australia (ESSA)		•			•••••••• ••••			••	•••••	20
	Government department/agency				•						1
Massage therapy	Association of Massage Therapists (AMT)						•••••••••• •		•••••••• •	•	21
	Australian Natural Therapists Association (ANTA)	••••••••							•	••	11
	Australian Traditional Medicine Society (ATMS)							•		••••	5
	Massage & Myotherapy Australia (MMA)					••••	••••		•••	•••••	16
Myotherapy	Australian Natural Therapists Association (ANTA)	••••••••							•	••	11
	Massage & Myotherapy Australia (MMA)					••••	••••		•	•••	12
	Myotherapy Association Australia (MAA)					•••				••	5
Naturopathy	Australian Naturopathic Council (ANC)	•••••									5
	Australian Naturopathic Practitioners Association (ANPA)	••••••••									7
	Australian Natural Therapists Association (ANTA)	••••••••							•	••	12

Profession	Organisation	Registration	Co-regulation	Co-regulation & registration	Self-regulation & registration	Self-regulation	Self-regulation & co-regulation	Not supportive of registration	Unclear/ambiguous	Not stated	Total
	Australian Register of Naturopaths and Herbalists (ARONAH)	•••••••• •••••									14
	Australian Traditional Medicine Society (ATMS)					••••		••	••	••••	12
	Complementary Medicine Association (CMA)	•••									3
	Naturopaths and Herbalists Association of Australia (NHAA)	•••••••• •••••••• ••••									22
	Individual	•••••									5
	Other organisations (Complementary Healthcare Council of Australia, Complementary Medicines Australia, Naturopaths for Registration, Southern School of Natural Therapies)	••••							•		5
Orthoptics	Australian Orthoptic Board (AOB)									••	2
	Orthoptics Australia (OA)									••••• •	6

Profession	Organisation	Registration	Co-regulation	Co-regulation & registration	Self-regulation & registration	Self-regulation	Self-regulation & co-regulation	Not supportive of registration	Unclear/ambiguous	Not stated	Total
Paramedicine	Australian College of Ambulance Professionals (ACAP)	••									2
	Australasian College of Paramedicine (ACP)	••									2
	Council of Ambulance Authorities (CAA)	••••••								•	8
	Paramedics Australasia (PA)	••••									4
	National Council of Ambulance Unions (NCAU)	•									1
	Government department/agency	•						•			2
	Individual	•••••									5
	Other organisations (Ambulance Employees Australia, Australian Medical Association, Australian Paramedics Association Qld, Royal Flying Doctor Service)	••••									4
Psychotherapy	Australian Counselling Association (ACA)		•		••	•••			•	•	8
	Australian Register of Counsellors and Psychotherapists (ARCAP)					••				••	4
	Psychotherapy and Counselling Federation of Australia (PACFA)				••	•••••••• ••••			••		16

Profession	Organisation	Registration	Co-regulation	Co-regulation & registration	Self-regulation & registration	Self-regulation	Self-regulation & co-regulation	Not supportive of registration	Unclear/ambiguous	Not stated	Total
Social work	Australian Association of Social Workers (AASW)	●●●●●●●● ●●●●●●●● ●●●●●●●● ●●●●								●●	42
	Individual	●									1
	Other organisation (Australian GP Network)	●									1
Sonography	Australian Sonographers Accreditation Registry (ASAR)									●●●	3
	Australasian Sonographers Association (ASA)	●●●●●●●● ●●●●●●●● ●●●●●●●●								●●●	30
	Australian Society of Medical Imaging and Radiation Therapy (ASMIRT)	●									1
	Australasian Society for Ultrasound in Medicine (ASUM)	●●●●●●●●								●	10
	Individual									●	1
	Other (Royal Australian and New Zealand College of Obstetricians and Gynaecologists)								●		1
Speech pathology	Speech Pathology Australia (SPA)	●●●●●●●● ●	●●●●			●●●●●●●●				●●●●	26
	Government department/agency	●●●									3

Profession	Organisation	Registration	Co-regulation	Co-regulation & registration	Self-regulation & registration	Self-regulation	Self-regulation & co-regulation	Not supportive of registration	Unclear/ambiguous	Not stated	Total
	Other (Australian GP Network)	•									1
Western herbal medicine	Australian Natural Therapists Association (ANTA)	••••••••							•	••	12
	Australian Register of Naturopaths and Herbalists (ARONAH)	•••••••• •••••									14
	Australian Traditional Medicine Society (ATMS)					••••		••	••	••••	12
	Complementary Medicine Association (CMA)	•••									3
	Naturopaths and Herbalists Association of Australia (NHAA)	•••••••• •••••••• ••••									22
	Individual	••••									4
	Other organisations (Complementary Healthcare Council of Australia, Complementary Medicines Australia, Naturopaths for Registration, Southern School of Natural Therapies)	••••								•	5
Total %		288 51.4	12 2.1	1 0.2	9 1.6	79 14.1	19 3.4	6 1.1	42 7.5	104 18.6	560 100

6.3.1 Stakeholders taking a consistent position or dual positions on regulation

Stakeholders from eleven professional bodies were identified as maintaining a consistent position on HPR in documents retrieved over the data sampling period. These organisations were:

- AASW (representing social work);
- AMT (massage therapy);
- ANC, ANPA, ANTA, ARONAH, and NHAA (naturopathy, WHM);
- ANTA (counselling, massage therapy, myotherapy);
- ASA, ASUM (sonography);
- CAA (paramedicine); and
- IAA (audiology)⁶⁵.

Except for AMT⁶⁵, these organisations were found to support registration in retrieved documents.

CAA supports the concept of national registration of paramedics under the Australian Health Practitioner Registration Authority.
(PARA_CAA_2016_Doc6: 2)

The association with the most retrieved documents consistently supporting registration was AASW⁶⁵, with 42 retrieved documents over a 17-year period.

The AASW has pursued statutory registration of social work in Australia since 1968 [...] The AASW therefore recommends the statutory [registration] of social work through licensing.
(SOCWK_AASW_2005_Doc1: 5, 7)

⁶⁵ **AASW**: Australian Association of Social Workers; **AMT**: Association of Massage Therapists; **ANC**: Australian Naturopathic Council; **ANPA**: Australian Naturopathic Practitioners Association; **ANTA**: Australian Natural Therapists Association; **ARONAH**: Australian Register of Naturopaths and Herbalists; **ASA**: Australasian Sonographers Association; **ASUM**: Australasian Society for Ultrasound in Medicine; **CAA**: Council of Ambulance Authorities; **IAA**: Independent Audiologists Australia; **NHAA**: Naturopaths and Herbalists Association of Australia.

The AASW shares the same core objective as the NRAS (to keep the public safe from harm) and therefore continues to actively campaign for the inclusion of the social work profession under the NRAS. (SOCWK_AASW_2021_Doc34)

Appendix 12 presents a summary of retrieved documents from the AASW⁶⁶ showing consistency in the stance taken on HPR over time.

The exception to the consistent support for registration was the massage association, AMT⁶⁶, which consistently supported a dual self-regulation and co-regulation model in documents where a position on regulation was evident. In the following passage, the association seeks stronger self-regulation, which has the force of government “*statute*” and additional protections to enshrine the association’s standards in law.

AMT would like to see AHMAC further explore opportunities for strengthened self-regulation and co-regulation through recognition of benchmark professional standards in statute as a further mechanism to enhance public protection. (MASS_AMT_2014_Doc10: 3)

Nine other professional bodies were found to document two or more positions on regulation, though not consistently throughout the suite of documents retrieved for the organisation. These organisations were:

- AA (representing audiology);
- ACA and PACFA (counselling and psychotherapy);
- ATMS (counselling, massage therapy, naturopathy, WHM);
- DA (dietetics);
- ESSA (exercise physiology);
- MMA (massage and myotherapy);⁶⁶

⁶⁶ **AA:** Audiology Australia; **AASW:** Australian Association of Social Workers; **ACA:** Australian Counselling Association; **AMT:** Association of Massage Therapists; **ATMS:** Australian Traditional Medicine Society; **DA:** Dietitians Australia; **ESSA:** Exercise and Sports Science Australia; **MMA:** Massage and Myotherapy Australia; **PACFA:** Psychotherapy and Counselling Federation of Australia.

- NASRHP (audiology, clinical perfusion, counselling, dietetics, exercise physiology, psychotherapy, speech pathology); and
- SPA (speech pathology).⁶⁷

A few of these professional bodies were identified as supporting regulation models positioned around self-regulation and/or co-regulation at different time points, for example, NASRHP, ESSA, and MMA⁶⁷.

A key priority [...] includes improving the professional standing of massage therapists and the sector through higher education, improved standards of practice, clinical research and robust self-regulation.
(MASS_MMA_2016_Doc16: 11)

[O]ngoing research is required to provide the evidence and quality assurance benchmarks for strong self- or co-regulation and health policy-making specific to our profession. (MASS_MMA_2020_Doc9: 17)

Some professional bodies, such as ACA, MMA, and NASRHP⁶⁷, appeared to indicate time-specific stances on regulation. Earlier documents from the organisation were identified as supporting one type of regulation, while more recent documents appeared to support another. For example, documents produced before 2015 by NASRHP⁶⁷ (representing allied health member associations) were found to support co-regulation, while later documents favoured self-regulation. Another example is that documents produced by MMA⁶⁷ (massage and myotherapy) up until 2016 supported self-regulation, while later documents supported self-regulation and co-regulation. This suggests that the positions of these organisations on regulation evolved over time. The change may have been influenced by observations of how the statutory scheme was operating for registered professions or the impact the registration scheme was considered to have on non-registered professions. For other organisations, positions varied on regulation, with no discernible pattern.

⁶⁷ **ACA:** Australian Counselling Association; **ATMS:** Australian Traditional Medicine Society; **ESSA:** Exercise and Sports Science Australia; **MMA:** Massage and Myotherapy Australia; **NASRHP:** National Alliance of Self Regulating Health Professions; **SPA:** Speech Pathology Australia.

6.3.2 Positions on regulation not stated or unclear/ambiguous

One in four documents was found where authors discussed certain aspects of HPR, but a position on regulation was not evident (n=104) or unclear/ambiguous (n=42). Documents from AHPA (representing allied health professional associations), AMT (massage), ANZCPerf (clinical perfusion), ATMS (counselling, massage therapy, naturopathy, WHM), DA (dietetics), MMA (massage and myotherapy), and OA (orthoptics)⁶⁸ tended to be overly represented in these categories as a proportion of the total number of documents located for the organisation.

6.3.3 Positions on regulation – professions with single and multiple representation

Two-thirds of the 15 included professions were represented by more than one association. Several professions were represented by more than five professional bodies. For example, at the time document searches were performed, counselling was found to be represented by at least six professional associations and one registering body. It might be assumed that professions with a single representative body would demonstrate greater consistency of opinion regarding HPR, while multi-association professions would demonstrate greater variation. This is not borne out by the data, however.

Five of the 15 professions were represented by one professional association. Only one of these associations (AASW⁶⁸, representing social work) showed a consistent stance on regulation. In contrast, despite being the sole representative association for their profession, three associations (DA, dietetics; ESSA, exercise physiology; and SPA, speech pathology⁶⁸) demonstrated varied opinions on regulation over time. The fifth association (OA⁶⁸, orthoptics) was identified as not stating an opinion in the six documents located.

⁶⁸ **AASW**: Australian Association of Social Workers; **AHPA**: Allied Health Professions Australia; **AMT**: Association of Massage Therapists; **ANZCPerf**: Australian and New Zealand College of Perfusionists; **ATMS**: Australian Traditional Medicine Society; **DA**: Dietitians Australia; **ESSA**: Exercise and Sports Science Australia; **MMA**: Massage and Myotherapy Australia; **OA**: Orthoptics Australia; **SPA**: Speech Pathology Australia.

For document sources produced by multiple professional bodies representing a single profession, some, such as those representing paramedicine and sonography, documented consistent positions across associations and time periods where a position on regulation could be identified. For other professions with multiple representation, varied opinions and positions on regulation were found. For instance, three audiology associations supported three different regulatory models from 2013 to 2021, and four counselling associations supported four distinct types of regulation over a 14-year period to 2021. In some professions, the differences in views between associations revealed marked divisions. For example, naturopathy is represented by five associations, all but one of which consistently supported registration in the documents located.

6.3.4 Positions on regulation – consumer bodies, government, and individuals

Documents from consumer advocacy groups (n=3) focused on the allied health professions as a whole and audiology, while government departments/agencies submitted documents on behalf of exercise physiology (n=1), paramedicine (n=2), and speech pathology (n=3). Seven professions, dietetics, naturopathy, paramedicine, social work, sonography, speech pathology, and WHM, were the target of documented contributions from organisations outside the 15 professions included in this research (n=16 documents). Naturopathy and paramedicine each had five contributions from individuals. Individuals also submitted documents on behalf of WHM (n=4), social work (n=1), and sonography (n=1).

In contrast to the often diverse views of professional bodies, the opinions of consumer groups, government departments, other organisations, and individuals demonstrated consistency in the stances taken on HPR. These stakeholders were found to prefer registration, except for one state government department, NSW Health, which did not support registration for paramedics. This was in direct contrast to the Victorian Government Department of Health and Human Services, which supported registration for paramedicine.

In determining whether or not registration should proceed, it is necessary to consider both the benefits and the costs, and whether the benefits outweigh the costs. In NSW, where there is already a high level of regulation of paramedics, many of the benefits of national registration have already been achieved through other regulatory mechanisms. (PARA_NSWHealth_2016_Doc1: 9)

The Victorian Government strongly supports the national registration of paramedics as part of the National Scheme. (PARA_VicDHHS_Undated_Doc1: 5)

6.3.5 Member views of health practitioner regulation

Several professional bodies commented on the views of their membership regarding regulation. This was limited to associations supporting registration, and the comments centred on the support for registration among members ascertained from survey data.

A recent survey of audiologists found that 97% of audiologists indicated that they supported mandatory registration. (AUDIO_IAA_2019_Doc16: 14)

An on-line survey conducted by PA in 2012 found exceptionally strong support for registration from both practitioners and students, with overall support for NRAS registration being 86.8% from 3841 respondents. (PARA_INDIVIDUAL_2016_Doc1: 14)

6.4 Stakeholder perspectives of health practitioner regulation

6.4.1 Perspectives of registration

There was considerable commentary in the documents regarding the suitability of different types of regulatory governance for health professions. Generally, statements of support for registration were explicit, unequivocal, and brief. The stance taken on regulation was typically found on the document's first page, leaving the reader in no doubt about the position taken by the author/s. Often, positions on regulation were accompanied by statements urging government action.

Independent Audiologists Australia Inc [...] calls on government to open mandatory national registration to audiologists with a professional board established under the Australian Health Practitioner Regulation Agency. (AUDIO_IAA_2016_Doc7: 1)

Irrespective of the type of document produced, some registration proponents took every opportunity to press for registration. This was frequently evident even when the purpose of the document was unrelated to regulation. For instance, 102 documents were identified as general communication pieces. Of these, 78 were from organisations supporting registration, and most of these (n=68) indicated that registration was preferred even though some of the documents were unrelated to regulation, for example, 'About us' communications.

Professional bodies supporting registration frequently commented on the “*limitations*” or “*failures*” of other forms of regulation, such as the lack of coverage of all practitioners. Failures were considered to affect a range of stakeholders, most notably patients.

The AASW notes the failure of existing self-regulatory mechanism to protect the public interest and the consumers of health social work services, with a number of social workers currently ineligible for membership of the AASW that, however, continue to practice as social workers. (SOCWK_AASW_2005_Doc2: 7-8)

Existing governance and regulatory mechanisms fail to provide the public with satisfactory assurance that speech pathologists deliver consistently safe and high quality health care services. Although the speech pathology profession has done a great deal in recent years to introduce measures to optimise public health and safety, the absence of a unifying framework, that is universally applicable for all practitioners, means that these efforts are fragmented, fail to provide comprehensive coverage, and lack appropriate powers to provide effective public protection. (SPPATH_SPA_2008_Doc3: 6)

Professional bodies supporting regulation models other than registration also commented on the same ‘limitations’ of self-regulation, such as the lack of coverage of all practitioners of a profession.

The limitations to self-regulation are acknowledged: Self-regulation cannot reach those Counsellors and Psychotherapists who do not belong to a relevant professional association.
(COUNS_PACFA_2011_Doc6: 4)

Few documents were found to explicitly express a lack of support for registration. Five of the six documents offering such opinions originated from one professional association, ATMS, representing naturopathy and WHM.

ATMS is of the view that government registration for natural medicine practitioners of naturopathy [...] and medical herbalism is neither justified nor achievable. (WHM_ATMS_2017_Doc10: 1)

6.4.2 Perspectives of self-regulation

Proponents of self-regulation declared their support by identifying its suitability for the profession, acknowledging the adequacy of current regulatory settings, or indicating support for existing arrangements. Document authors were sometimes direct in communicating the stance taken and at other times were less than direct. A few document authors indicated that existing regulatory mechanisms made registration unnecessary.

We feel the steps in place are adequate to ensure ethical conduct amongst members and disagree with statement[s] suggesting the requirement for further regulation. (AUDIO_ACAud_2019_Doc2: 1)

ARCAP advocates for handling complaints against counsellors and psychotherapists using existing procedures. However, ARCAP prefers Option 2: Strengthen self-regulation – A Voluntary Code of Practice, because this option provides greater opportunities to build on current self-regulation mechanisms. (COUNS_ARCAP_2011_Doc1: 8)

Stakeholders frequently provided reasons for maintaining existing regulation arrangements. These included the view that practitioners posed a low risk of harm or that registration costs were prohibitive. Some associations argued their position by drawing on the perceived support of the state to affirm the safety of the profession. This

was considered an endorsement of existing governance arrangements and the inappropriateness of registration. Training and evidence were sometimes used to reinforce the adequacy of existing regulation mechanisms.

[G]overnment considers that the profession [of exercise physiology] as a whole is not considered risky enough to the public to require inclusion in the NRAS, and that ESSA provides sufficient self-regulation. (EXEPHY_ESSA_2021_Doc16: 2)

6.4.3 Perspectives of co-regulation

The few stakeholder documents found to support co-regulation tended to use terms such as “authorised” or “recognised” self-regulation to describe a co-regulatory partnership with government. By doing so, document authors were seeking to endow self-regulation with statutory power. By becoming an “authorised” self-regulating profession, state power would be partially transferred to the profession itself.

If authorised self-regulation is introduced, the Australian community could be assured that more than 30,000 allied health practitioners, not currently regulated through AHPRA [...] were fit to practice and deliver quality allied health services. Allied Health Professions Australia [...] will keep advocating for authorised self-regulation to minimize adverse events impacting on health consumers. (ALLH_AHPA_2013_Doc2: 4-5)

Co-regulation, however, had several detractors, chief among them the professional bodies advocating for registration. A few detractors commented that although co-regulation offered some protections, it was insufficient for consumers of health services. Others viewed co-regulation as disjointed, costly, and inadequate to minimise practice risks.

A level of protection from exploitation in this way is extended to Medicare, Hearing Services Program Voucher Scheme, Department of Veterans Affairs and Workcover programs. These all require professional membership to peak associations [...but] unqualified persons [...] will nonetheless be able to practise relatively unabated, putting individuals at risk. (AUDIO_IAA_2019_Doc16: 5, 6)

Co-regulation is widely accepted as being more expensive than a coordinated single regulatory entity in its administration [...] While [...] the provision of ultrasound services are controlled through the Australian Government's DIAS and the MBS, this regulation does not extend to 'fitness to practise' requirements. (SONO_ASA_2014_Doc5: 4)

6.4.4 Perspectives of dual regulation arrangements

Five professional body representatives supported dual regulation arrangements, more often coupling self-regulation with co-regulation, but also self-regulation and registration, and in one instance, co-regulation and registration. When combining self-regulation with other regulation types, stakeholders generally appealed for an enhanced type of self-regulation, frequently described as “strong” or “strengthened” self-regulation. The form such strengthened self-regulation should take was not evident in all documents expressing these views. Some associations proposed a type of self-regulation with statutory measures such as protection of title or a statutory code of conduct in what would commonly be understood as a co-regulatory partnership with government, without labelling it as such. Stakeholders favouring dual regulation models sometimes expressed the desire to implement the proposal as a permanent regulatory mechanism and, at other times, expressed the preference as a short-term expediency measure ahead of a longer-term aspiration.

[ACA] supports the development of a best practice model for self-regulation [...] as a transitional step towards a preferred position of a national statutory regulatory system. (COUNS_ACA_2008_Doc1: 41)

AMT further believes that the current self-regulatory mechanisms in place for massage therapists should be strengthened [...] through] protection of the title Massage Therapist and barriers to entry [...] and] establishment of a register. (MASS_AMT_Undated_Doc21)

6.4.5 Perspectives of negative licensing and the National Code of Conduct

Views regarding the National Code of Conduct (NCC) for non-registered health professions were divided between proponents (n=49 documents) and detractors (n=65).

Some professional bodies considered the additional protections afforded by the NCC adequately protected consumers from errant practitioners, while others did not. Supporting perspectives were that the NCC possessed statutory powers, could issue prohibition orders against practitioners, and encompassed all health workers irrespective of registration status. These views were typically identified in documents where stakeholders supported types of regulation other than registration. In a few documents, the NCC was seen as a form of co-regulation with government.

[E]ven without statutory registration there is a relatively informal scene of co-regulation [...] with negative licensing from the states and territories, they can actually prohibit a practitioner from practicing for a finite or an indefinite period. (WHM_ATMS_2018_Doc11)

Most document sources supporting registration also gave qualified support for the NCC as an interim measure. These stakeholders described the NCC as the minimum requirement to enhance patient protection. Other sources supported the introduction of the NCC for some professions but considered it unsuitable for others.

While the authors support the introduction of a National Code of Conduct for lower risk and lower acuity functions that may be the realm of some other unregistered health workers, they do not support a code-based reactive model of regulation for paramedics. (PARA_INDIVIDUAL_2016_Doc1: 15)

A few professional associations considered the NCC too little, too late, and too limited. These stakeholders viewed the NCC as reactive, restricted to jurisdictions in which it was implemented, dealt with only the most egregious of failures, and did not deliver improved professional standards, title protection, or enforceable entry barriers.

Standing Council on Health announced a proposal for a National Code of Conduct for unregistered health professionals as an alternative to registration [...]. The AASW opposes this measure as providing only an 'ambulance at the bottom of the cliff'. (SOCWK_AASW_2013_Doc7: 4)

The proposed National Code of Conduct still to be activated, is reactive rather than proactive. (PERF_ANZCPerf_2014_Doc1: 1)

6.4.6 Perspectives of regulation for position not stated or unclear/ambiguous

As discussed in Section 6.3.2, for around one in four documents (n=146), either no stance on regulation could be identified or the stance was unclear/ambiguous. Massage therapy (n=25) and dietetics (n=19) dominated these categories, accounting for almost one-third of this dataset.

At times, vague terms, such as “*regulatory reform*” and “*appropriate authorities*”, were used to describe preferences. Such language was used even though most documents in these categories were produced after the implementation of the NRAS, and standard registration terminology was in use. The obscure language made comprehending the author’s intentions difficult, requiring their classification into the unclear/ambiguous category. What is apparent from some documented accounts is the desire for “*recognition*”, although how such recognition would be conferred was unclear.

PACFA is lobbying for recognition of counselling and psychotherapy by federal and state governments. The aims of our lobbying efforts are to: Gain recognition of counsellors and psychotherapists as an important part of Australia’s mental health workforce [...] Obtain recognition by other government departments and agencies. (COUNS_PACFA_2021_Doc14: 1)

Recognition in policy and regulatory reform would ensure that only those therapists with the appropriate end-of-life and palliative care training who can meet the professional standards as defined in the Certification Program would do much to protect end users and ensure a high quality of massage care. (MASS_MMA_2017_Doc6: 7)

6.5 Stakeholder assessments against the Intergovernmental Agreement assessment criteria

Almost one-third of the documents (n=170) addressed one or more items of the Intergovernmental Agreement (IGA) assessment criteria. The criterion attracting the greatest number of contributions in stakeholder documents was Criterion 2, which

considers the risks of practitioner harm to consumers. This was followed by Criterion 3, which considers the adequacy of existing mechanisms to address health and safety issues, and Criterion 6, which evaluates the benefits of regulation to the public against the potential negative impacts.

Table 6.5 sets out the frequency counts of documents found to comment on the assessment criteria. Stakeholders supporting registration tended to comment on more of the assessment criteria than organisations supporting other regulation models. For example, the AASW⁶⁹ was identified as supporting registration. Seventeen documents from this association addressed at least one assessment criterion, predominantly the risks posed by social work practice, and the association addressed all six criteria across the 17 documents. Similar profiles of attending to more of the assessment criteria by organisations supporting registration were evident for associations such as ANTA, ASA, and NHAA⁶⁹. In contrast, PACFA⁶⁹ was found to support self-regulation in most retrieved documents. Of the 18 documents by PACFA addressing the assessment criteria, most reinforced the safety of practice as part of the risk criterion, a few documents emphasised the adequacy of existing mechanisms, but no commentary was evident for other criteria. Other professional bodies supporting self-regulation and emphasising safety factors were ACA, ARCAP, ATMS, DA, and ESSA⁶⁹, although in some instances, there were few documents to determine this with certainty.

Of the six government submissions in the document corpus, one addressed all six criteria (on behalf of speech pathology), two considered the benefits/negative impacts of registration (on behalf of paramedicine and speech pathology), and one addressed the risks of harm (on behalf of paramedicine). Individuals and other organisations also commented on the criteria, principally on the risks of specific practices and, to a lesser extent, the benefits of registration over the negative impacts. None of the three documents from consumer bodies were found to comment on the assessment criteria.

⁶⁹ **AASW**: Australian Association of Social Workers; **ACA**: Australian Counselling Association; **ANTA**: Australian Natural Therapists Association; **ARCAP**: Australian Register of Counsellors and Psychotherapists; **ASA**: Australasian Sonographers Association; **ATMS**: Australian Traditional Medicine Society; **DA**: Dietitians Australia; **ESSA**: Exercise and Sports Science Australia; **NHAA**: Naturopaths and Herbalists Association of Australia; **PACFA**: Psychotherapy and Counselling Federation of Australia.

Table 6.5: Documents addressing assessment criteria categorised by profession and organisation.

Each dot (•) represents one document.

Profession	Organisation	1. Is it appropriate for Health Ministers to exercise responsibility for the profession?	2. Do the activities of the profession pose a significant risk of harm?		3. Do existing regulatory mechanisms fail to address health and safety issues?	4. Is regulation possible to implement for the profession?		5. Is regulation practical to implement for the profession?	6. Do the benefits to the public clearly outweigh the potential negative impacts?	Total
			Yes	No		Yes	Profession is well defined			
Allied health	Allied Health Professions Australia (AHPA)			••			•			3
	National Alliance of Self Regulating Professions (NASRHP)				•					1
Audiology	Audiology Australia (AA)									0
	Australia College of Audiology (ACAud)			•						1
	Independent Audiologists Australia (IAA)		••		••••••••				•	8
Clinical perfusion	Australian and New Zealand College of Perfusionists (ANZCPerf)		•						•	1
	Australasian Society of Cardio-Vascular Perfusionists (ASCVP)		•							1
Counselling	Australian Christian Counselling Association (CCAA)									0
	Australian Counselling Association (ACA)			••						2
	Australian Natural Therapists Association (ANTA)	•	•							2
	Australian Register of Counsellors and Psychotherapists (ARCAP)			••						2

Profession	Organisation	1. Is it appropriate for Health Ministers to exercise responsibility for the profession?	2. Do the activities of the profession pose a significant risk of harm?		3. Do existing regulatory mechanisms fail to address health and safety issues?	4. Is regulation possible to implement for the profession?		5. Is regulation practical to implement for the profession?	6. Do the benefits to the public clearly outweigh the potential negative impacts?	Total
			Yes	No		Yes	Profession is well defined			
	Christian Counsellors Association of Australia (CCAA)									0
	Psychotherapy and Counselling Association of Australia (PACFA)			•••••	•••					9
Dietetics	Dietitians Australia (DA)			•						1
Exercise physiology	Exercise and Sports Science Australia (ESSA)			••						2
Massage therapy	Australian Natural Therapists Association (ANTA)	••	••		•	•	•	•	•	2
	Australian Traditional Medicine Society (ATMS)		•							1
	Association of Massage Therapists (AMT)		•••		•					3
	Massage & Myotherapy Australia (MMA)		•							1
	Massage Association of Australia (MAA)									0
Myotherapy	Australian Natural Therapists Association (ANTA)	••	•		•	•	•	•	•	2

Profession	Organisation	1. Is it appropriate for Health Ministers to exercise responsibility for the profession?	2. Do the activities of the profession pose a significant risk of harm?		3. Do existing regulatory mechanisms fail to address health and safety issues?	4. Is regulation possible to implement for the profession?		5. Is regulation practical to implement for the profession?	6. Do the benefits to the public clearly outweigh the potential negative impacts?	Total
			Yes	No		Yes	Profession is well defined			
	Massage & Myotherapy Australia (MMA)		•							1
	Massage Association of Australia (MAA)									0
Naturopathy	Australian Natural Therapists Association (ANTA)	••	•••		•	•	•	•	•	3
	Australian Naturopathic Council (ANC)		•						•	1
	Australian Naturopathic Practitioners Association (ANPA)		••••			•				4
	Australian Register of Naturopaths and Herbalists (ARONAH)		••••• •		•••	•				10
	Australian Traditional Medicine Society (ATMS)		•••••						••	7
	Naturopaths and Herbalists Association of Australia (NHAA)	••	•••••		••••	••••		••	•••	7
	Complementary Medicine Association (CMA)									0
	Individuals	••	••••		••	••	•	••	••	4
	Other organisations	•	••		•	•	•	•	•	2
Orthoptics	Australian Orthoptic Board (AOB)									0
	Orthoptics Australia (OA)									0

Profession	Organisation	1. Is it appropriate for Health Ministers to exercise responsibility for the profession?	2. Do the activities of the profession pose a significant risk of harm?		3. Do existing regulatory mechanisms fail to address health and safety issues?	4. Is regulation possible to implement for the profession?		5. Is regulation practical to implement for the profession?	6. Do the benefits to the public clearly outweigh the potential negative impacts?	Total
			Yes	No		Yes	Profession is well defined			
Paramedicine	Paramedics Australasia (PA)		••							2
	Australasian College of Paramedicine (ACP)		••						•	2
	Australian College of Ambulance Professionals (ACAP)									0
	Council of Ambulance Authorities (CAA)		•							1
	National Council of Ambulance Unions (NCAU)		•							1
	Individuals		••••						•	4
	Government		•							1
	Other organisations		•						•	1
Psychotherapy	Australian Counselling Association (ACA)			••						2
	Australian Register of Counsellors and Psychotherapists (ARCAP)			••						2
	Psychotherapy and Counselling Association of Australia (PACFA)			••••••	•••					9
Social work	Australian Association of Social Workers (AASW)	••	•••••• •••••• ••		••••	••	••	•	••••	17
Sono-graphy	Australasian Society for Ultrasound in Medicine (ASUM)		•••							3

Profession	Organisation	1. Is it appropriate for Health Ministers to exercise responsibility for the profession?	2. Do the activities of the profession pose a significant risk of harm?		3. Do existing regulatory mechanisms fail to address health and safety issues?	4. Is regulation possible to implement for the profession?		5. Is regulation practical to implement for the profession?	6. Do the benefits to the public clearly outweigh the potential negative impacts?	Total
			Yes	No		Yes	Profession is well defined			
	Australian Society of Medical Imaging and Radiation Therapy (ASMIRT)									0
	Australasian Sonographers Association (ASA)		••••• ••••		••			••••	••••	11
	Australian Sonographer Accreditation Registry (ASAR)									0
Speech pathology	Speech Pathology Australia (SPA)	•	••••	•	••	••	•	••	•••	4
	Government	•			•	•		•	••	2
Western herbal medicine	Australian Natural Therapists Association (ANTA)	••	•••		•	•	•	•	•	3
	Australian Register of Naturopaths and Herbalists (ARONAH)		••••• •		•••	•				10
	Australian Traditional Medicine Society (ATMS)		•••••						••	7
	Complementary Medicine Association (CMA)									0
	Naturopaths and Herbalists Association of Australia (NHAA)	••	•••••		••••	••••		••	•••	7
	Individuals	••	••••		••	••	•	••	•	4
	Other organisations	•	••		•	•	•	•	•	2

6.5.1 Criterion 1. Is it appropriate for Health Ministers to exercise responsibility for regulating the profession in question, or does the profession more appropriately fall within the domain of another Ministry?

Documents from seven stakeholders addressed this criterion. Professional associations, other organisations, individuals, and government bodies documented that the profession was a health service and sat within the health portfolio. No stakeholder contested this criterion. To support arguments for this criterion, some stakeholders commented on the primary care role of the profession, the populations served, and the role of the profession in caring for the health and well-being of Australians.

Although the type of therapies, substances and health philosophy applied in Nat/WHM/NM may be different from orthodox medicine, the focus is upon clients' health and it is appropriate that Health Ministers consider regulation of these professions.
(NAT_ANTA_2016_Doc4: 5)

6.5.2 Criterion 2. Do the activities of the profession pose a significant risk of harm to the health and safety of the public?

Nearly two-thirds of document authors from every stakeholder cohort except consumer bodies addressed this criterion. Of the 142 documents where authors commented on risk, two-thirds dealt with the potential for harm, and almost all of these called for registration to minimise the claimed risks. The remaining one-third of documents addressing risk included commentary on the perceived safety of professional practice, which was considered to obviate the need for registration.

Several stakeholders compared the risks of their profession to those of registered occupations to support their views that registration was necessary. Others detailed a typology of risks, such as economic risks or adverse events related to practice. The risks of a profession and the risky situations and practices of some practitioners, including performing medical procedures, were also commented on. Some authors presented complaints data and outcomes of criminal court cases to support risk claims. Also identified were the power and information asymmetries between practitioners and patients, perceived to amplify the risks associated with some professions.

Audiologists pose no less risk to the public than do their registered counterparts in optometry, occupational therapy, physiotherapy, psychology. (AUDIO_IAA_2016_Doc7: 3)

Paramedics are often required to provide clinical care that is similar to or the same as those performed by a range of other registered health care professionals including nurses and medical practitioners. (PARA_CAA_2016_Doc6: 5)

[T]he level of trust and power invested in social workers combined with the vulnerability of their client group puts the social work profession in a high risk category for harm. (SOCWK_AASW_2011_Doc5: 5)

Not all professional bodies viewed professional practice as sufficiently risky to justify registration. Some acknowledged that an element of risk was ever-present in health settings and emphasised the criterion's qualifier of 'significant' risk. At times, claims of non-significant risk were supported by factors such as practitioner qualifications, which, stakeholders argued, removed the need for registration. Several associations emphasised their self-regulation mechanisms, such as codes and standards, that were perceived to manage known risks. Others commented on the low rate of consumer complaints, some using data from health complaints commissions to support claims. In opposition to associations claiming to be of high risk, several professional bodies contrasted the minor risks of the profession with the high risks of registered practitioners. Rather than commenting on risk directly, a few associations drew on the support of the state to affirm the safety of the profession.

Audiologists [...] are not presently required to be registered with the Australian Health Practitioner Regulation Agency framework as their professions are deemed to be of low risk to public safety. (AUDIO_ACAud_2019_Doc1: 18)

The counselling profession is one of a large number of health professions that are considered safe to be self-regulating [...] The reported incidence of complaints against Counsellors in Australia is low. (COUNS_ACA_2021_Doc8: 8)

6.5.3 Criterion 3. Do existing regulatory or other mechanisms fail to address health and safety issues?

Around one-quarter of organisations described the limitations of self-regulation, principally due to the perceived inadequacy of existing arrangements in safeguarding consumers. Many authors from all stakeholder cohorts, other than consumer bodies, documented comments on the ineffectiveness of self-regulation. The failure was considered to be due to the voluntary nature of association membership and the multiple associations representing certain professions. These authors commented that under existing arrangements, associations could not reach or provide oversight of all practitioners of a profession, could not control entry to practice, enforce professional standards or practitioner accountability, or effectively manage complaints. These stakeholders called for registration to overcome the “*limitations*” of self-regulation.

Existing mechanisms to address [...] public health and safety in relation to the speech pathology practice are fragmented, fail to provide universal coverage and lack appropriate powers for effectively protecting the public. (SPPATH_SPA_2008_Doc3: 22)

[A]ssociations are suggesting co-regulatory or self-regulatory arrangements. There are serious weaknesses with these alternatives. Success of co-regulation or self-regulation is contingent upon a single national professional association. This is not the current situation for WHM or Naturopathy and is unlikely to ever be so [...] and therefore self-regulation is impossible. (WHM_NHAA_2013_Doc12: 7)

Some association stakeholders contradicted these views, contending that self-regulation adequately protected consumers. In a few instances, the contrary opinions came from different associations representing the same professions as those arguing the limitations of self-regulation. Stakeholders supporting existing regulation arrangements perceived practitioners were governed by high standards, practice entry and membership were well-controlled, and existing complaint mechanisms were robust.

Given [...] the effectiveness of the existing regulatory and self-regulatory mechanisms in place, it is difficult to argue there is a need for further regulation by government. (PSYC_ARCAP_2011_Doc1: 5, 6)

[W]e support the current status quo. Where as a professional association we have a code of conduct, we have a complaints mechanism. We have the capacity within our constitution to expel members. (NAT_ATMS_2018_Doc11: 6)

In one document, an author commented on the limitations of self-regulation in reaching all practitioners of the profession. They indicated that complaints were effectively managed but suggested this was not the case for all complaints. Despite the documented limitations of self-regulation and the acknowledged inability to adequately deal with all complaints against practitioners, the stakeholder nonetheless supported existing mechanisms for complaints handling and advocated for no change to regulatory settings.

As self-regulation already provides effective processes for handling complaints relating to Counsellors and Psychotherapists, self-regulation should continue to fulfil these important functions. [...] The limitations to self-regulation are acknowledged: Self-regulation cannot reach those Counsellors and Psychotherapists who do not belong to a relevant professional association. [...] Self-regulation provides effective complaints handling processes for the vast majority of complaints which are minor in nature. PACFA and its Member Associations should continue to handle complaints using existing procedures. (COUNS_PACFA_2011_Doc6: 2, 4, 13)

6.5.4 Criterion 4. Is regulation possible to implement for the profession in question?

A few association stakeholders, registering bodies, individuals, and government sources reported on the feasibility of establishing registration for the professions. Arguments supporting feasibility claims included comparisons with similar registered professions, the purported existence of a distinct body of knowledge, well-defined professional boundaries, and the profession's history in Australian healthcare. Some document authors compared the profession to international jurisdictions, which they contended attested to the feasibility of registration. Some emphasised what were perceived as official endorsements by government and non-government institutions to support feasibility claims.

RMM⁷⁰ is at its best a well-defined profession [...] Many other institutions and bodies such as health funds and professional indemnity insurers are prepared to regulate or endorse the practice of RMM. This suggests that there is a secure basis to implement regulation. (MYOTH_ANTA_2018_Doc10: 33)

Regulation of speech pathologists in Australia is possible - with the previous existence of the Speech Pathology Board of Queensland providing operational evidence of this possibility. Speech pathologists in the UK, USA, Canada and Ireland work within a similar scope of practice, and [...] are recognised and protected against through [...] statutory registration. (SPPATH_SPA_2014_Doc6: 18)

6.5.5 Criterion 5. Is regulation practical to implement for the profession in question?

In addressing this criterion, a few individuals, government sources, and professional association authors referred to the preparedness of specific professions for registration. Other authors documented the practical challenges of registration while providing national and international precedents, demonstrating that any difficulties could be surmounted. A few stakeholders commented that strong practitioner support would overcome opposition or obstacles to registration.

Statutory registration has been practically implemented for TCM practitioners in Australia, for Naturopaths in Canada and the USA, and for herbalists in New Zealand, providing good evidence that regulation is practical to implement. (WHM_NAT4REG_2008_Doc1: 13)

National regulation is a goal towards which social workers have advocated for a long time. The profession is ready and has the capacity to embrace the National Registration and Accreditation Scheme and abide by the processes of Australian Health Practitioner Regulation Agency. (SOCWK_AASW_2011_Doc5: 6)

⁷⁰ RMM: Remedial massage and myotherapy.

6.5.6 Criterion 6. Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

This criterion attracted comments from one-quarter of organisations and was the third most frequently commented-on criterion. The predominant view of professional associations, peak bodies, individuals, and governments was that the numerous benefits of registration outweighed the negative impacts. All but one professional association addressing this criterion documented lists of benefits and, less frequently, the costs. The benefits to the public were regarded as fostering consumer confidence and improving public safety, enhancing complaints handling and raising standards, promoting collaboration, and reducing administration. The negative impacts of registration were primarily described as the administrative burdens of the Scheme and costs to practitioners, patients, education providers, and government. To allay concerns regarding cost to practitioners, some associations quantified the likely number of registrants, claiming that the large workforce size would minimise costs to individual practitioners. One association stakeholder commented on the negative impacts of registration on practitioners but nevertheless considered registration the most appropriate model of regulation for the profession. Another association supporting self-regulation maintained that the benefits of registration did not outweigh the costs.

ANZCP believes the benefits to public safety of the national registration and accreditation components, far outweigh any ongoing administrative and interjurisdiction matters.

(PARA_ANZCPara_2016_Doc2: 13)

As professional membership of the AASW already demonstrates, with approximately 8,000 voluntary members currently, registration of the social work profession is financially viable and sustainable.

(SOCWK_AASW_2014_Doc16: 8)

[T]he other implications in terms of cost-benefit of having [to] set up registration boards, the red tape and bureaucratic involvement in maintaining those, the costs and so forth don't make it worthwhile.

(WHM_ATMS_2018_Doc11: 8)

6.6 Chapter summary

A large body of documents was located offering opinions regarding the regulation of the 15 health professions included in this research. Most documents were authored by professional bodies, and fewer than 10% of documents were contributed by consumers, governments, other organisations, and individuals.

The document corpus presenting positions on regulation demonstrated substantial support for registration from professional bodies, some of which maintained a consistent stance on regulation for periods of up to 17 years. Other professional groups varied their position on regulation over time. The only organisations supporting self-regulation and/or co-regulation in a sizeable minority of documents were professional bodies. Almost all documents produced by individuals, governments, and organisations outside the 15 health professions supported registration. One association and one government source expressly disavowed support for registration in retrieved documents. Reasons for supporting registration centred on the purported risks of practice, limitations and failures of self-regulation, and the assumed benefits accruing from registration compared with negative impacts. Documents from organisations supporting self-regulation focused on the claimed safety of the profession, the established and adequate standards, codes, and complaints mechanisms in place, and the unnecessary costs and administrative burdens of registration.

The descriptive findings were a rich source of information regarding the stance of stakeholders on preferred regulation mechanisms, opinions regarding the regulatory frameworks, and perceptions regarding the IGA assessment criteria. These perspectives are of interest to this research because they describe the positions of stakeholders on regulation. However, the perspectives reviewed in this chapter reveal only one aspect of attitudes described in the document corpus. A second chapter of the story lies in a deeper exploration of stakeholder perspectives regarding HPR. For this phase of the research study, documents were subjected to further analysis to understand the underlying motivations and reasons offered by stakeholders for held positions. The next chapter presents the results of this analysis.

Chapter 7

DOCUMENTED STAKEHOLDER PERSPECTIVES OF REGULATION Thematic analysis of document sources

7.1 Introduction

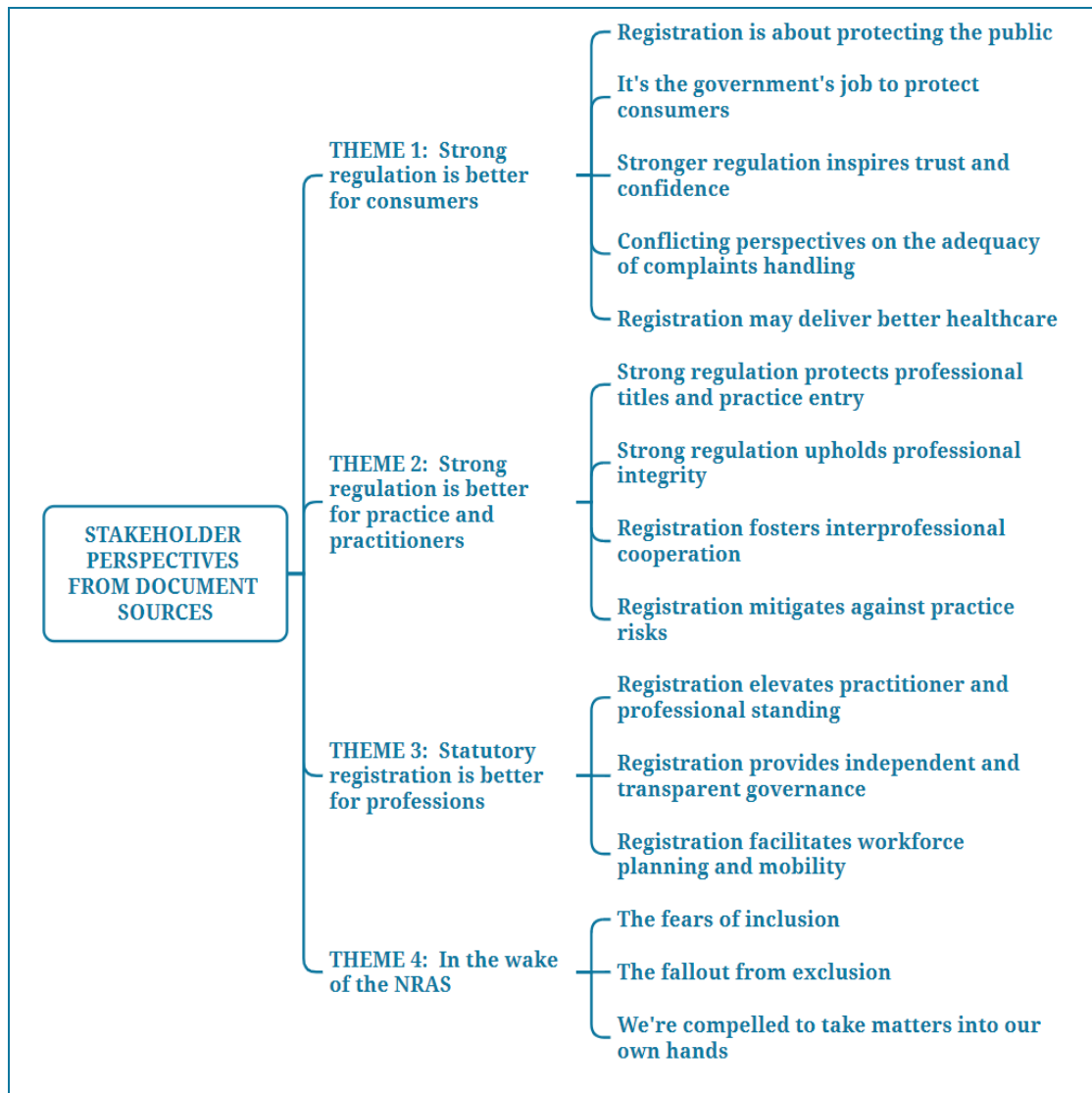
The previous chapter presented the results of a document analysis to identify stakeholder stated positions on health practitioner regulation (HPR). Perspectives of document authors in the cohorts of consumer advocacy bodies, individuals, government departments/agencies, and professional bodies were used to address the research objective of describing the publicly documented positions on occupational regulation. Using the same document dataset, this chapter presents an examination of stakeholder motivations. The chapter addresses the research objective of describing stakeholder perspectives regarding HPR. It sets out to understand why stakeholders hold certain positions on occupational regulation and details the reasons offered to support held positions.

Coding and analysis of documents identified four higher-order themes and 15 sub-themes from 424 of the 560 documents found to offer comments in support of stated positions.

The themes and sub-themes generated from the analysis are set out in Figure 7.1. Comments captured by the themes were identified in documents from every stakeholder cohort. Across the dataset, more statements were identified for the theme relating to 'Stronger regulation is better for consumers' than other themes, accounting for two-thirds of coded documents.

Comments describing the type of regulation considered better for practitioners and professional practice were identified in over half of the coded documents, and a similar proportion described the implications of inclusion or exclusion from the National Registration and Accreditation Scheme (NRAS). Fewer than one-third of documents included statements that registration was better for the professions.

Figure 7.1: Themes and sub-themes generated from document sources.



Some organisations were found to comment more frequently on certain types of regulation, while others commented to a lesser degree or not at all. Most statements in all thematic categories were identified in documents from stakeholders supporting registration. For instance, the Australian Association of Social Workers supported registration in all retrieved documents. Of 34 documents thematically coded, 29 included statements that registration was better for consumers, 29 that registration made for better practice and practitioners, 13 included comments that registration was better for the profession, and 17 contained statements describing the effects of NRAS exclusion on the profession.

Similar patterns of emphasis on consumer and profession-related concerns were evident in documented statements from other organisations supporting registration, such as ANTA, ARONAH, ASA, ASUM, and NHAA⁷¹. In contrast, Massage and Myotherapy Australia was identified as supporting self-regulation or the dual position of self-regulation and co-regulation. Of 23 thematically coded documents from the association, five included statements regarding the effect of regulation on consumers, three documents commented on how regulation would impact practice and practitioners, and 20 documents contained statements describing the effects of NRAS exclusion on the profession. This indicates the association's more selective emphasis on particular concerns, notably the effects of NRAS exclusion. This pattern of reasons offered for supporting regulation models other than registration is also evident in almost all documents retrieved from professional bodies such as AHPA, DA, and ESSA⁷¹.

The following sections present the themes and sub-themes generated from the analysis of documented statements indicating stakeholder reasons for supporting particular types of regulation.

Table 7.1 presents the frequency counts of documents coded to the higher-order themes. The table is categorised by profession and organisation. Each dot (•) in the table represents one document included in the analysis.

⁷¹ **AHPA:** Allied Health Professions Australia; **ANTA:** Australian Natural Therapists Association; **ARONAH:** Australian Register of Naturopaths and Herbalists; **ASA:** Australasian Sonographers Association; **ASUM:** Australasian Society for Ultrasound in Medicine; **DA:** Dietitians Australia; **ESSA:** Exercise and Sports Science Australia; **NHAA:** Naturopaths and Herbalists Association of Australia.

Table 7.1: Document frequency counts for themes by profession and organisation.

Each dot (•) represents one document.

Profession	Organisation	STAKEHOLDER PERSPECTIVES OF HEALTH PRACTITIONER REGULATION				
		1. Strong regulation is better for consumers	2. Strong regulation is better for practice and practitioners	3. Statutory registration is better for the profession	4. In the wake of the NRAS	Total
Allied health	Allied Health Professions Australia (AHPA)	••••		••	•••••••	8
	National Alliance of Self Regulating Health Professions (NASRHP)	••••	••	•	•••••	5
Audiology	Audiology Australia (AA)	•	•		•	2
	Australia College of Audiology (ACAud)	••				2
	Independent Audiologists Australia (IAA)	•••••••••	••••••••••	••••••••••	•••••	15
Clinical perfusion	Australian and New Zealand College of Perfusionists (ANZCPerf)	•		••	•••	5
	Australasian Society of Cardio-Vascular Perfusionists (ASCVP)	••	•	•	•	2
Counselling and psychotherapy	Australian Counselling Association (ACA)	•	•	•	•	14
	Australian Community Counselling Association (ACCA)	••••••		•••	•••••••	1
	Australian Register of Counsellors and Psychotherapists (ARCAP)	••••	••		•••	6
	Christian Counsellors Association of Australia (CCAA)				•	1
	Psychotherapy and Counselling Association of Australia (PACFA)	•••••••••••••• ••	••••••••••	••••	•••••••••••••• ••••	29
Dietetics	Dietitians Australia (DA)		••		••••••••••	14
Exercise physiology	Exercise and Sports Science Australia (ESSA)	••••	••		••••••••	9

Profession	Organisation	STAKEHOLDER PERSPECTIVES OF HEALTH PRACTITIONER REGULATION				
		1. Strong regulation is better for consumers	2. Strong regulation is better for practice and practitioners	3. Statutory registration is better for the profession	4. In the wake of the NRAS	Total
Massage & myotherapy	Association of Massage Therapists (AMT)	●●●●●●●●	●●●●●●		●●●●●●●● ●●●●●●	18
	Massage and Myotherapy Australia (MMA)	●●●●●	●●●		●●●●●●●●●● ●●●●●●●●	23
	Myotherapy Association of Australia (MAA)				●	1
Massage, myotherapy, naturopathy, WHM	Australian Natural Therapists Association (ANTA)	●●●●●●●● ●●●●●●●●	●●●●●●●● ●●●●●●●●	●●●●●●●●●●	●●●●●●●● ●●●●●●●●	30
	Australian Traditional Medicine Society (ATMS)	●●●●●●●● ●●●●●●	●●●●●		●●●●●●●●●●	19
Naturopathy, Western herbal medicine	Australian Naturopathic Council (ANC)	●●●	●●		●●	3
	Australian Naturopathic Practitioners Association (ANPA)	●●●●●	●●●●●	●●●	●	6
	Australian Register of Naturopaths and Herbalists (ARONAH)	●●●●●●●●●● ●●●●●●●●●●	●●●●●●●●●● ●●●●●●●●●●	●●●●●●●● ●●●●●	●●●●●●●● ●●●●●●●●	27
	Complementary Healthcare Council of Australia (CHCA)	●●●●●	●●●●●		●●	4
	Complementary Medicine Association (CMAss)	●	●●●	●●●	●●	5
	Complementary Medicines Australia (CMAust)	●●		●	●●	2
	Naturopaths and Herbalists Association of Australia (NHAA)	●●●●●●●●●●●● ●●●●●●●●●●●●	●●●●●●●●●●●● ●●●●●●●●●●●●	●●●●●●●●● ●●●●●●●●	●●●●●●●●●● ●●●●●●●●●●	36
Orthoptics	Australian Orthoptic Board (AOB)				●●	2
	Orthoptics Australia (OA)				●●	2

Profession	Organisation	STAKEHOLDER PERSPECTIVES OF HEALTH PRACTITIONER REGULATION				
		1. Strong regulation is better for consumers	2. Strong regulation is better for practice and practitioners	3. Statutory registration is better for the profession	4. In the wake of the NRAS	Total
Paramedicine ⁷²	Paramedics Australia (PA)	••	•••	••	•	3
	Australasian College of Paramedicine (ACP)	••	••	••		2
	Australian College of Ambulance Professionals (ACAP)			•		1
	Council of Ambulance Authorities (CAA)	•	••	•••		3
	National Council of Ambulance Unions (NCAU)	•	•	•		1
Social work	Australian Association of Social Workers (AASW)	•••••••••• ••••••••••	•••••••••• ••••••••••	••••••••	•••••••• ••••••••	34
Sonography	Australasian Society for Ultrasound in Medicine (ASUM)	••••••	•••••	•		9
	Australian Society of Medical Imaging and Radiation Therapy (ASMIRT)		•			1
	Australasian Sonographers Association (ASA)	•••••••• ••••••••	•••••••• ••••••••	••••••••	••••••••••	23
	Australian Sonographer Accreditation Registry (ASAR)		•		•	2
Speech pathology	Speech Pathology Australia (SPA)	•••••••• ••••••••	••••••••	•••••	••••••••••	20
Other	Consumer bodies	••	••	•	•	3
	Individuals	••••••••••	••••••~••••••	••••••~••••••	••••••••	15
	Government Departments	•••••	•••••	••	••	5
	Other organisations	••••~•••••	••••~•••••	••••~•••••	••••~•••••	14
Total		285	247	133	253	427

WHM: Western herbal medicine.

⁷² Paramedicine was included as a 'non-registered' profession since it was not registered on 1 July 2012, the date set for selecting non-registered professions examined in this research.

7.2 Theme 1. Strong regulation is better for consumers

Two-thirds of documents included statements describing the type of regulation perceived to be better for consumers. Documented comments from over three-quarters of organisations representing all stakeholder cohorts related to regulation frameworks that were considered to protect consumers, foster trust and confidence, and ensure complaints were well-managed. A smaller proportion of documents included statements regarding potential improvements to the health system if registration were granted to a particular profession. Several authors offered comments regarding the responsibility of governments to protect consumers through appropriate regulation. These sub-themes are presented in Figure 7.2.

Figure 7.2: Theme 1. Strong regulation is better for consumers.



Table 7.2 presents the frequency counts of sub-themes for Theme 1 categorised by profession and organisation.

Table 7.2: Document frequency counts for Theme 1 by profession and organisation.

Each dot (•) represents one document.

Profession	Organisation	THEME 1. STRONG REGULATION IS BETTER FOR CONSUMERS					
		1.1. Registration is about public protection	1.2. It's the government's job to protect consumers	1.3. Stronger regulation inspires trust and confidence	1.4. Conflicting perspectives on the adequacy of complaints handling	1.5. Registration may deliver better healthcare	Total
Allied health	Allied Health Professions Australia (AHPA)	•••	•		••		4
	National Alliance of Self Regulating Health Professions (NASRHP)	••	•	••	••••		4
Audiology	Audiology Australia (AA)	•					1
	Australia College of Audiology (ACAud)	•			•		2
	Independent Audiologists Australia (IAA)	••••••	•	••••••••	•••••••		10
Clinical perfusion	Australian and New Zealand College of Perfusionists (ANZCPerf)	•	•				1
	Australasian Society of Cardio-Vascular Perfusionists (ASCVP)	•	•				2
Counselling and psychotherapy	Australian Counselling Association (ACA)				•		6
	Australian Community Counselling Association (ACCA)	••••			••		1
	Australian Register of Counsellors and Psychotherapists (ARCAP)	••••	•		••		4
	Christian Counsellors Association of Australia (CCAA)						0
	Psychotherapy and Counselling Association of Australia (PACFA)	••••••••••			•••••••		19

Profession	Organisation	THEME 1. STRONG REGULATION IS BETTER FOR CONSUMERS					
		1.1. Registration is about public protection	1.2. It's the government's job to protect consumers	1.3. Stronger regulation inspires trust and confidence	1.4. Conflicting perspectives on the adequacy of complaints handling	1.5. Registration may deliver better healthcare	Total
Dietetics	Dietitians Australia (DA)						0
Exercise physiology	Exercise and Sports Science Australia (ESSA)	...			..		4
Massage & myotherapy	Association of Massage Therapists (AMT)	...		.....	...		11
	Massage and Myotherapy Australia (MMA)	...			....		5
	Myotherapy Association of Australia (MAA)						0
Massage, myotherapy, naturopathy, WHM	Australian Natural Therapists Association (ANTA)	..... ....	.	.....	..... ..	.....	19
	Australian Traditional Medicine Society (ATMS)	..... .			.....		16
Naturopathy, Western herbal medicine	Australian Naturopathic Council (ANC)	...	...		.	.	3
	Australian Naturopathic Practitioners Association (ANPA)	....	...		.....		5
	Australian Register of Naturopaths and Herbalists (ARONAH)	..... .....	..... .....	.....	.....	.	23

Profession	Organisation	THEME 1. STRONG REGULATION IS BETTER FOR CONSUMERS					
		1.1. Registration is about public protection	1.2. It's the government's job to protect consumers	1.3. Stronger regulation inspires trust and confidence	1.4. Conflicting perspectives on the adequacy of complaints handling	1.5. Registration may deliver better healthcare	Total
	Complementary Healthcare Council of Australia (CHCA)	•••	•	•		••••	4
	Complementary Medicine Association (CMAss)	•					1
	Complementary Medicines Australia (CMAust)	••	••			••	2
	Naturopaths and Herbalists Association of Australia (NHAA)	•••••••••• ••••••••••	••••••••••	•••••••••• ••••••••••	•••••••••• •••••	••••••••••	30
Orthoptics	Australian Orthoptic Board (AOB)						0
	Orthoptics Australia (OA)						0
Paramedicine ⁷³	Paramedics Australia (PA)	••		•	•		2
	Australasian College of Paramedicine (ACP)	••	•	•	••	•	2
	Australian College of Ambulance Professionals (ACAP)						0
	Council of Ambulance Authorities (CAA)	•		•			1
	National Council of Ambulance Unions (NCAU)	•			•		1

⁷³ Paramedicine was included as a 'non-registered' profession since it was not registered on 1 July 2012, the date set for selecting non-registered professions examined in this research.

Profession	Organisation	THEME 1. STRONG REGULATION IS BETTER FOR CONSUMERS					
		1.1. Registration is about public protection	1.2. It's the government's job to protect consumers	1.3. Stronger regulation inspires trust and confidence	1.4. Conflicting perspectives on the adequacy of complaints handling	1.5. Registration may deliver better healthcare	Total
Social work	Australian Association of Social Workers (AASW)	•••••••••• ••••••••••	•••••	•••••••••• •	•••••••••• ••	••••	29
Sonography	Australasian Society for Ultrasound in Medicine (ASUM)	•••••		••		•	7
	Australian Society of Medical Imaging and Radiation Therapy (ASMIRT)						0
	Australasian Sonographers Association (ASA)	•••••••••• ••	•••••••	•••••••	••••••••••	•	17
	Australian Sonographer Accreditation Registry (ASAR)						0
Speech pathology	Speech Pathology Australia (SPA)	•••••		••	••	•••••••••• ••••	18
Other	Consumer bodies			••			2
	Individuals	••••••••••	•••••	••••••••••	••••••~•••••	••••••••••	14
	Government Departments	••		••	••••		5
	Other organisations	••••••~•••••	•••	••	•••	••••	10
Total		209	72	103	137	57	285

WHM: Western herbal medicine.

In documents analysed, all stakeholders commenting on registration referred to the public protection objectives of the *National Law*. However, opinions were polarised on whether registration was necessary to protect consumers of certain professions. To illustrate, compare the two statements below from associations representing the same professions, both of which acknowledged the public protection principles of registration. One association contended its practitioners posed a “*very small*” risk to patients compared to registered practitioners, making registration unnecessary. The other claimed existing self-regulatory arrangements were “*untenable*” due to the perceived patient exposure to unacceptable risks.

[Registration is] *principally for the benefit of the public. To minimise the risk to the public of adverse drug reactions or fraud, or some other malevolent activities so that the public are protected. [...] Now, yes there are occasionally mishaps and occasionally deaths related to work done by natural medicine practitioners, who may or may not be in an association. But if we compare this to the type of serious risk involved in conventional Western medicine, or other allied health, the risk is very small.* (WHM_ATMS_2018_Doc11: 7-8)

Anybody with or without training or just the desire may call themselves a herbalist or naturopath and begin to practice. The NHAA believes this is an untenable position which leaves the public at risk from poor diagnosis, treatment and downright fraud. [...] The NHAA has supported a form of statutory regulation for Herbalists and Naturopaths since the 1920s. This position is still held by the association because we believe this form of regulation offers the public the best form of protection from the untrained, poorly trained or bogus practitioners. (WHM_NHAA_Undated_Doc21: 1, 2)

Stakeholders preferencing registration more often contended that registration was better for consumers. Those favouring other regulation models or those not supporting registration commented less frequently on the effects of regulation on consumers or remained silent on the topic. The few documents from other stakeholders supporting registration, such as consumer advocates, individuals, governments, and other organisations, often included statements about how regulation would affect consumers.

The propensity of stakeholders to offer more or fewer comments regarding how regulation affected consumers may reflect a desire by these organisations to advance a particular argument regarding preferred types of regulation.

7.2.1 Registration is about protecting the public

Nearly half the document dataset included statements from three-quarters of organisations and most stakeholder cohorts on the need for appropriate regulation to safeguard consumers. The reasons offered for these views were similar, even though the preferred types of regulation differed. Authors from most professional bodies argued they were unable to protect patients under self-regulation. These sources expressed the need to maintain patient safety when consumers consulted non-registered professionals.

In general, only stakeholders advocating for change to existing regulatory settings commented on patient safety issues to support their regulation arguments. This suggests that stakeholders preferring the regulatory status quo saw little or no need to express views about patient safety. Although not all stakeholders commenting on patient safety agreed on a single regulatory mechanism to achieve the necessary consumer protections, most used the patient safety trope to urge government action regarding regulation according to their preferred model. A few authors described the safety profile of the profession to affirm their self-regulating status. No documents were found denying the need for patient protection through regulation.

Although many documented statements promoted the idea that registration protected the public, a small proportion of association stakeholders perceived other regulatory measures, such as co-regulation or “*strengthened*” self-regulation, also enhanced patient safeguards. The accounts below, principally from professional bodies, express the need to protect the public. The last excerpt is one of two documents from government departments/agencies commenting on patient protection.

Support for co-regulation:

Any model developed for the self-regulated professions must address the obvious gaps in the current regulatory system [...] Of most importance is the need for improved consumer protection.
(ALLH_NASRHP_2012_Doc1: 11)

Support for registration:

Having considered the regulatory frameworks that will ensure the safety of the Australian public and realise optimum benefits in the public interest, the authors strongly recommend that all paramedics nationally be regulated under the National Statutory Registration & Accreditation Scheme. (PARA_INDIVIDUAL_2016_Doc1: 4)

Inclusion of paramedics in the National Scheme will bring a range of benefits [...] and] safeguard[s] the public from impaired or poorly performing paramedics. (PARA_VicDHHS_Undated_Doc1: 6)

7.2.2 It's the government's job to protect consumers

Fewer than one in five documents from more than one-third of organisations commented on the responsibilities of governments in protecting consumers. The role of government was questioned and criticised by many stakeholders. Document accounts referred to the inaction and failure of governments to protect consumers and the “*abdication*” of responsibility to consumers of non-registered health services.

Stakeholders commented on the perceived disregard of self-regulating professions by governments and the subsequent adverse impacts on consumer safety. According to some document authors, by governments disclaiming their responsibility for regulating non-registered professions, the burden of protecting consumers fell to the professional bodies and their reliance on informal co-regulation governance arrangements. Several stakeholders suggested that while they were willing to accept responsibility for regulating the profession, the lack of statutory authority thwarted their ability to do so effectively. This was a strong reason offered by document authors to support statutory forms of regulation, particularly registration.

The reluctance to consider extending the highest possible regulatory safeguards to vulnerable social work consumers such as is available under NRAS represents a significant abdication of responsibility on the part of governments. (SOCWK_AASW_2013_Doc13: 21)

We practice self-regulation but are frustrated with the lack of support [from] Governments to endorse this approach for public safety. Hence we are prepared to form an alliance with other self-regulating health professionals to promote safety in training and qualifications of our commitment to public safety. (PERF_ANZCPerf_2014_Doc1: 1-2)

In the face of inaction on the part of various governments to regulate Naturopathy (and Western Herbal Medicine), the private health insurers have assumed the pseudo-regulatory role [...] which has acted as a steadying influence on the profession. (NAT_NHAA_2018_Doc18: 1)

7.2.3 Stronger regulation inspires trust and confidence

Found in one-quarter of the document dataset, around half of all organisations from all stakeholder cohorts commented on the need for statutory mechanisms to foster consumer trust, promote public confidence, or meet patient expectations for appropriately regulated health practitioners. Often, these opinions were expressed as the need for consumers to be informed of provider credentials, to have confidence in the integrity and reputation of the profession and its practitioners, or for practitioners to be subject to regulation standards equivalent to registered professions. A few association authors perceived that gaining the trust and confidence of consumers was essential to establish an effective therapeutic relationship.

Almost all statements encompassed by this theme were documented by stakeholders supporting registration, although a few preferred co-regulation. Irrespective of the preferred regulation model, all who commented sought to address issues of professional trust and confidence. No documents supporting self-regulation were identified as commenting on this theme.

Practitioner regulation promotes public trust and consumer confidence in the service quality of their provider and the healthcare system.

(ALLH_NASRHP_2012_Doc1: 9)

A statutory model of regulation will [...] provide members of the public with greater confidence that a person using the title 'social worker' is qualified and conforms to ethical practice.

(SOCWK_AASW_2014_Doc14: 3)

The public must have confidence that when someone calls themselves a naturopath, that the education and licensing requirements exist that not only protect the public but maintain the integrity of our ethical practitioners. (WHM_ARONAH_2018_Doc11: 2)

These statements imply that stakeholders considered their practitioners may not be as trusted as they would like, potentially due to their self-regulating status. The authors implied consumers had less confidence in non-registered practitioners and that self-regulation compromised consumer trust in non-registered professions. To remedy the situation, many sources proposed that action by the state was necessary.

Preservation of trust is the starting point in securing the highest quality healthcare system for the Australian public. Professional regulation sustains the justified confidence of health consumers in the safety and effectiveness of clinical practice. [...] This is why a national statutory registration and accreditation scheme can best serve the public's safety and health interests. (SPPATH_SPA_2008_Doc3: 9)

7.2.4 Conflicting perspectives on the adequacy of complaints handling

There were diverse views regarding the adequacy of complaints handling under self-regulation. Views were expressed in around one-third of coded documents by nearly two-thirds of organisations from all stakeholder cohorts except consumer bodies. A small proportion of documents were found where association authors preferencing self-regulation commented on the adequacy of complaints processes or measures taken to improve complaints handling. The statements emphasise that consumer complaints were well-managed and met association objectives of assuring the professional conduct

of practitioners. These stakeholders commented or suggested that no additional regulatory measures were required. In one instance, statements about improved complaints mechanisms were partly in response to media comments that additional regulatory measures were warranted.

There have been some recent media comments around the need for further regulation. [...] Over the last 12 months ACAud have taken on board criticisms both factual and perceived [...] To further ensure consumer confidence an independent complaints and ethics committee was recently established enabling consumers direct contact with the committee [...] We feel the steps in place [for complaints handling] are adequate to ensure ethical conduct amongst members and disagree with statement[s] suggesting the requirement for further regulation. (AUDIO_ACAud_2019_Doc2: 1)

As self-regulation already provides effective processes for handling complaints relating to Counsellors and Psychotherapists, self-regulation should [...] continue to fulfil these important functions. (COUNS_PACFA_2011_Doc5 :2)

A contrary view from most professional body stakeholders, individuals, and government sources was that complaints handling was ineffective. These authors argued this was a valid reason for supporting registration or co-regulation. The views were given despite many stakeholders acknowledging the introduction of the National Code of Conduct (NCC) in some jurisdictions to enhance statutory complaints processes. Complaints handling under the NCC and self-regulation were viewed as reactive, fragmented, prone to subjectivity and conflict of interest by professional bodies, limited in reach and types of complaints investigated, dispersed across multiple entry points leading to consumer confusion, and ineffective in sanctioning practitioners.

Several stakeholders in professions with multiple representative associations were particularly critical of the numerous entry points for lodging complaints and the lack of transparency in managing consumer grievances. These representatives suggested they could not maintain patient safety because of inadequacies in existing complaints procedures. They implied their attempts to manage or resolve consumer complaints

effectively were stymied due to dispersed responsibilities, siloed information repositories, and a lack of centralised and coordinated control.

[C]omplaints handling for sonographers is currently inconsistent, fragmented and ineffectual [...] the complaint is insufficiently investigated, and the situation becomes a criminal prosecution to be resolved. (SONO_ASA_2020_Doc18: 2)

There are currently multiple channels for complaints management [that] vary in quality and ease of access. This confusing situation which has arisen out of self-regulation would benefit from a single complaints mechanism. (WHM_INDIVIDUAL_2009_Doc2: 22)

While AAMT have the support of its members to manage ethical complaints, it has no legal jurisdiction and limited investigative powers [...] We are simply asking for help to strengthen our ability to [...] identify, monitor, and manage high risk and problematic individuals. (MASS_MMA_2016_Doc3: 8)

Another perceived inadequacy of self-regulation was identified in a submission by a state government complaints body supporting the registration of speech pathologists. The stakeholder claimed that the powers granted under the NRAS for complaints handling, including the potential for deregistration, led to greater practitioner participation in complaints resolution processes compared to the limited powers available to authorities dealing with practitioners in self-regulating professions. The stakeholder suggested that effective management of consumer complaints relies on registration that encourages greater practitioner engagement.

Where a complaint is made against a registered provider, we find that providers are keen to cooperate with our process [...] They do this for many reasons, including their Registration [...] Where complaints involve an unregistered health occupation, however, cooperation with our process is dependent only on the willingness of the providers themselves to want to seek resolution with the consumer. There are no professional repercussions, nor incentives, for a practitioner to engage in a dialogue with a consumer. (SPPATH_OHR_WA_2008_Doc1: 1, 2)

7.2.5 Registration may deliver better healthcare

This sub-theme was identified in around one in ten documents from one-quarter of professional and individual stakeholders, all favouring registration. A few sources documented expectations that registration would lead to health service and system-wide improvements. Improvements included healthcare quality and effectiveness and greater consumer access to a range of practitioner services, particularly for consumers in rural and remote areas. Stakeholders proposed that these benefits delivered at the patient level would reduce healthcare costs and drive improved outcomes at a health system level. They suggested non-registered professions should be more involved in providing healthcare and could be, if registered. These sources inferred their practitioners had more to offer the health system, but the absence of registration and a lower professional profile was limiting their potential to positively contribute to consumer health and wellbeing.

National statutory registration will assist with the mobility and flexibility of the workforce [...] to help meet health workforce needs [...] and] provide more accessible healthcare for the public which in turn can improve health outcomes and again lower both economic and human costs. (PARA_INDIVIDUAL_2012_Doc3: 14)

*Regulation of health professions can [...] establish public trust in the **sustainability of their national health and hospitals system.***
(SPPATH_SPA_2008_Doc3: 9)

A well-regulated naturopathic and Western herbalism workforce could present an untapped resource of skilled professionals who could contribute to the healthcare crisis experienced in rural and urban Australia, particularly the poor availability of primary healthcare.
(WHM_NAT4REG_2008_Doc1: 16)

Protecting patients, considered a government responsibility by stakeholders, fostering consumer trust and confidence, ensuring effective complaints handling, and improving health services were viewed by most stakeholder organisations as important reasons for supporting certain types of regulation. Most stakeholders across the document corpus contended that registration best delivered these outcomes for consumers. Registration

was also identified as most frequently providing the necessary regulatory framework for a well-managed practitioner regulation system. Stakeholders supporting co-regulation were found to comment less frequently on the impact of regulation on consumers. Those supporting self-regulation commented the least, potentially due to satisfaction with current regulation arrangements.

7.3 Theme 2. Strong regulation is better for practice and practitioners

More than half of the thematically coded documents contained statements detailing how occupational regulation contributed to improving the quality and safety of practitioners and professional practice. Three-quarters of organisations representing all stakeholder cohorts argued for an occupational regulation mechanism that protected professional titles, assured workforce competency, controlled practice entry to those meeting required standards, upheld practitioner integrity, facilitated interprofessional collaboration, or mitigated against risks of occupational practice.

In identified documents, there was less commentary about improving the quality and safety of practitioners and practice from sources supporting self-regulation and co-regulation in comparison to the comments from those supporting registration. For instance, Audiology Australia, which was identified as supporting self-regulation and co-regulation, offered opinions on maintaining or improving practitioner or practice safety and quality in one of eight documents located by the association. By contrast, Independent Audiologists Australia commented on the need for registration to assure practitioner quality and safety in 13 of 17 documents retrieved. Another example is that five of 31 documents by the Australian Traditional Medicine Society included comments on the safety and competence of practitioners under self-regulation or supported current qualification standards. On the other hand, the Naturopaths and Herbalists Association of Australia called for registration to raise the quality of the workforce, control practice entry, improve collaboration, and effectively manage practice risks in 34 of 44 documents found for the association.

Figure 7.3 presents the four sub-themes generated for this theme.

Figure 7.3: Theme 2. Strong regulation is better for practice and practitioners.



Table 7.3 presents the frequency counts for Theme 2 categorised by profession and organisation.

Table 7.3: Document frequency counts for Theme 2 by profession and organisation.

Each dot (•) represents one document.

Profession	Organisation	THEME 2. STRONG REGULATION IS BETTER FOR PRACTICE AND PRACTITIONERS				
		2.1. Strong regulation protects professional titles & practice entry	2.2. Strong regulation upholds professional integrity	2.3. Registration fosters interprofessional cooperation	2.4. Registration mitigates against practice risks	Total
Allied health	Allied Health Professions Australia (AHPA)					0
	National Alliance of Self Regulating Health Professions (NASRHP)		••			2
Audiology	Audiology Australia (AA)		•			1
	Australia College of Audiology (ACAud)					0
	Independent Audiologists Australia (IAA)	••••••••	••••••••	••	•••	13
Clinical perfusion	Australian and New Zealand College of Perfusionists (ANZCP)					0
	Australasian Society of Cardio-Vascular Perfusionists (ASCVP)	•	•			1
Counselling and psychotherapy	Australian Counselling Association (ACA)		•			3
	Australian Community Counselling Association (ACCA)	•••	•			1
	Australian Register of Counsellors and Psychotherapists (ARCAP)	••				2
	Christian Counsellors Association of Australia (CCAA)					0
	Psychotherapy and Counselling Association of Australia (PACFA)	••••	••••••••			11
Dietetics	Dietitians Australia (DA)	•	•			2
Exercise physiology	Exercise and Sports Science Australia (ESSA)	•	••			2

Profession	Organisation	THEME 2. STRONG REGULATION IS BETTER FOR PRACTICE AND PRACTITIONERS				
		2.1. Strong regulation protects professional titles & practice entry	2.2. Strong regulation upholds professional integrity	2.3. Registration fosters interprofessional cooperation	2.4. Registration mitigates against practice risks	Total
Massage & myotherapy	Association of Massage Therapists (AMT)	●●●●●●	●●			7
	Massage and Myotherapy Australia (MMA)		●●●			3
	Myotherapy Association of Australia (MAA)					0
Massage, myotherapy, naturopathy, WHM	Australian Natural Therapists Association (ANTA)	●●●●●●●●	●●●●●●●●●● ●●●●●	●●●●	●●	20
	Australian Traditional Medicine Society (ATMS)	●●	●●●●●			5
Naturopathy, Western herbal medicine	Australian Naturopathic Council (ANC)	●●	●●			2
	Australian Naturopathic Practitioners Association (ANPA)	●●●	●●●●●			5
	Australian Register of Naturopaths and Herbalists (ARONAH)	●●●●●●●●●● ●●●●●●●●	●●●●●●●●●● ●●●●●●●●●●	●●●●	●●●●●●	27
	Complementary Healthcare Council of Australia (CHCA)	●●●●	●●●			4
	Complementary Medicine Association (CMAss)	●●	●			3
	Complementary Medicines Australia (CMAust)					0
	Naturopaths and Herbalists Association of Australia (NHAA)	●●●●●●●●●● ●●●●●●●●●● ●●●●●	●●●●●●●●●● ●●●●●●●●●● ●●●●●	●●●●●●●●●● ●●●●●	●●●●●●	34
Orthoptics	Australian Orthoptic Board (AOB)					0
	Orthoptics Australia (OA)					0

Profession	Organisation	THEME 2. STRONG REGULATION IS BETTER FOR PRACTICE AND PRACTITIONERS				
		2.1. Strong regulation protects professional titles & practice entry	2.2. Strong regulation upholds professional integrity	2.3. Registration fosters interprofessional cooperation	2.4. Registration mitigates against practice risks	Total
Paramedicine	Paramedics Australia (PA)	••	••		•••	3
	Australasian College of Paramedicine (ACP)	••	••		••	2
	Australian College of Ambulance Professionals (ACAP)					0
	Council of Ambulance Authorities (CAA)	••	•			2
	National Council of Ambulance Unions (NCAU)	•	•		•	1
Social work	Australian Association of Social Workers (AASW)	•••••••••• •	•••••••••• •••		••••••••	29
Sonography	Australasian Society for Ultrasound in Medicine (ASUM)	•••	••••		•	5
	Australian Society of Medical Imaging and Radiation Therapy (ASMIRT)	•				1
	Australasian Sonographers Association (ASA)	••••••••••	•••••••••• ••		•••••	16
	Australian Sonographer Accreditation Registry (ASAR)	•	•			1
Speech pathology	Speech Pathology Australia (SPA)	••••	••••••••		••	9
Other	Consumer bodies	••	••		•	2
	Individuals	••••••••••	•••••••••• ••	•••••	•••••	14
	Government Departments	•••	•••••		•	5
	Other organisations	••••	••••••••	•••••	••	9
Total		174	211	38	50	247

WHM: Western herbal medicine.

7.3.1 Strong regulation protects professional titles and practice entry

There was substantial commentary by three-quarters of organisation authors in all stakeholder categories about distinguishing credentialled practitioners from bogus providers. Expressed in around four in ten documents, this requirement was more often described as a need to ensure only appropriately qualified practitioners could enter practice.

Many statements by document authors conveyed the need for registration or co-regulation to enforce barriers to practice entry, protect occupational titles, mandate probity checks, establish practitioner registers, and remove bogus providers from practice. Of particular concern was that consumers and other parties had no means of distinguishing qualified and competent practitioners from unqualified or incompetent persons. Document authors considered unqualified and incompetent individuals brought the profession into disrepute.

Most stakeholders commenting on this topic argued that, without statutory mechanisms, consumers may incorrectly assume practitioners were appropriately trained. Without enforceable barriers to practice, profession sources suggested consumers were prey to unqualified, underqualified, unscrupulous, or rogue individuals. These stakeholders contended that other healthcare providers may be unaware of which practitioners they should refer patients to. They suggested there was little state support for the governance role they had assumed on behalf of the profession, yet they were powerless to enforce effective deterrents and penalties when necessary.

A statutory model of regulation will provide a legally enforceable set of probity, qualification and practice standards for entry into the profession. (SOCWK_AASW_Undated_Doc41: 2)

Having paramedics [...] as a part of a national regulatory scheme will both lessen the risk of the existence of rogue or unscrupulous practitioners and the risk of harm being done to the professions reputation as eminently trustworthy. (PARA_INDIVIDUAL_2016_Doc5: 22)

There is no barrier to practice, legal or otherwise, to stop untrained, poorly trained, unethical or criminal persons from setting up and providing naturopathic and herbal medicine services.
(WHM_NAT4REG_2008_Doc1: 6)

While the need for entry barriers was primarily identified by stakeholders supporting registration, one of several exceptions is presented in the following excerpt, where the case is made that self-regulation is inadequate. The proposed solution is statutory entry barriers while seeking to maintain self-regulation.

AMT believes that additional measures such as [...] barriers to entry are required [...] AMT supports the idea of extending AHPRA's current functions to encompass a regulatory framework for unregistered health practitioners. This would allow for greater consistency in the monitoring of all health services, regardless of whether the service is being provided by a registered or self-regulating practitioner.
(MASS_AMT_2011_Doc5 : 3)

Restricting practice entry is a form of occupational gatekeeping. Throughout the suite of documents, authors commented on the need for mechanisms that could be regarded as professional gatekeeping. They frequently argued that these mechanisms were only possible through registration. One of the most commonly cited mechanisms through which stakeholders argued entry to practice could be controlled was the legal protection of occupational titles.

Title protection was frequently identified by professional bodies preferencing registration and by a few profession stakeholders seeking co-regulation. Protection of title was alluded to as an essential professional asset that marked occupational boundaries and was tied to professional identity. Many stakeholders commented that “anyone” could lay claim to occupational titles, suggesting current regulatory mechanisms permitted the unrestricted use of professional titles. They alluded to the idea that a lack of statutory title protection denied associations professional agency. The following excerpts speak of divested autonomy and powerlessness over a profession in the face of providers intent on assuming professional titles irrespective of training or

competency. For associations to gain control of the profession, stakeholders proposed registration or co-regulation.

Anyone can call themselves an audiologist in Australia [...] There is no protection of title for audiology. (AUDIO_IAA_2019_Doc16: 3, 6)

[T]he absence of protection of title means the community is not able to ascertain what qualifications or standards someone with the title of social worker actually has. (SOCWK_AASW_2013_Doc13: 11)

With a few exceptions, the single biggest factor that exacerbates the risk of harm [...] is the lack of any control of persons claiming to be a practitioner [...] no law prevents any one, regardless of training or character, from calling themselves a herbalist or naturopath. (WHM_NHAA_2011_Doc9: 10)

Document authors maintained that a centralised, statutory, publicly accessible register was a powerful regulatory tool for identifying credentialed practitioners. They argued that without a statutory public register, there was no way of knowing who was suitably qualified to practise. This suggests stakeholders perceived they had little control over who could legitimately enter practice without a public listing of bona fide practitioners. The authors inferred this reflected poorly on the profession because it exposed consumers to unacceptable risks and deprived patients and health practitioners of mechanisms to undertake practitioner validation checks.

There is no registration system – there needs to be. (AUDIO_CONSUMER_2017_Doc1: 10)

The protection of the consumers is best attained through the development of a register of practitioners, based upon specified standards of practitioner probity and professional practice, education and training. (MYOTH_ANTA_2018_Doc10: 20)

Through a national register: Only people who meet approved and nationally consistent educational and practitioner standards would be able to call themselves a paramedic. (PARA_PA_2016_Doc2: 5)

Mandatory probity checking was another mechanism identified by profession stakeholders as an essential occupational screening tool for new registrants. The primary type of probity assessment described by stakeholders was criminal history checks, although some also identified self-declaration obligations.

CHF [...] anticipates that consumers would expect the legislation to require criminal history checks on all new applicants, with a discretionary power for boards to require checks at annual renewals and self-declaration obligations. (ALLH_CONSUMER_2008_Doc1: 3)

Measures that would help to provide an improved level of protection for the public include [making] probity or other checks a condition of both initial and continuing practice (e.g. checks of criminal history). (PARA_PA_2014_Doc1: 6)

[P]eople unfit to practice have been able to gain professional association membership. Failure of self-regulation to ensure adequate probity checking suggests that fitness to practice should be a statutory requirement. (NAT_ARONAH_2011_Doc2: 33-34)

Documented accounts regarding pre-entry and ongoing criminal checks, practitioner declarations, and unfit providers suggest professional bodies were doubtful about their ability to assure the quality of the workforce because self-regulation provided no enforced practitioner entry screening mechanisms. Statutory measures, on the other hand, were seen to offer the necessary practitioner checks to ameliorate the concerns of many stakeholders.

As well as ensuring adequate mechanisms to control practice entry, a sizeable minority of document authors commented on the need to remove from practice unqualified, unethical, rogue, or unscrupulous providers and limit the co-option of occupational titles. Using statutory mechanisms to remove bogus providers was considered to go beyond ridding the professions of unqualified and incompetent providers to include removing persons holding out and limiting co-option of occupational practice. There was substantial commentary from professional bodies and individuals regarding the issue of persons holding out as qualified practitioners, the unfettered freedom of providers to

lay claim to a profession, and the requirement to limit these practices through statutory measures. These concerns were identified in more than one-fifth of documents in which situations were described where deregistered providers from related or unrelated occupations were perceived to appropriate the titles and practices of non-registered professions. The extent of such practices was not identified but was suggested to be an ever-present threat to the professions.

[U]ntil there is protection of the title "Massage Therapist", the public will remain at risk from rogue and untrained practitioners of massage. (MASS_AMT_2014_Doc10: 3)

[I]f a psychologist was struck off by the Psychology Board for an incident of misconduct [...] such a person could identify as a social worker, and be spared of any accountability or regulation [...] the AASW is continually made aware of instances where the social work title is misrepresented. (SOCWK_AASW_2014_Doc15: 7, 9)

ARONAH is aware of several practitioners calling themselves naturopaths who have co-opted the term to continue practising after being deregistered in their original professions (or voluntarily removing themselves from the register before action could commence). (NAT_ARONAH_2011_Doc2: 16)

7.3.2 Strong regulation upholds professional integrity

All stakeholder cohorts and three-quarters of organisations documented statements in nearly half of the coded dataset describing the adequacy or inadequacy of regulation mechanisms to maintain practitioner quality. While a few authors commented on the adequacy of self-regulation for assuring the quality of practitioners, most described the current regulatory settings as inadequate. Several also documented the perceived attributes of registration that assured practitioner competency. According to these stakeholders, the identified attributes were not considered possible under other governance arrangements. Uncontrolled use of occupational titles, varied practitioner capabilities, increased diversity of practice requirements, and expanding scopes of occupational practice were identified as important factors informing stakeholder views on statutory forms of regulation.

Many stakeholders emphasised the difficulties in vouching for the qualifications and competence of practitioners and adequately monitoring all providers of a profession. For a few stakeholders, it was a matter of trust between patients and providers that practitioners were suitably trained and qualified to enter and continue practising. Without statutory mechanisms, most professional bodies considered practitioner credentialling became their responsibility on behalf of consumers. Yet, it was commonly argued that such credentialling was not possible in a self-regulating environment. Many professional body sources suggested that the limitations imposed by self-regulation meant they lacked the means to appropriately monitor practitioner competence, enforce consumer protections, and avert potential patient exploitation and abuse. According to most stakeholders, the objectives of assuring a qualified, ethical, and high-quality workforce were essential to professional practice and achieving these objectives was founded upon registration.

[T]he public is entitled to protection from incompetent and/or unprofessional conduct. (SOCWK_AASW_2005_Doc1: 6-7)

[Under Ahpra] the safety of the public is protected by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered. (PARA_CAA_2016_Doc6 : 5)

It is the profession's responsibility to ensure our practitioners are well-educated, ethical, safe and effective. The [...] best way to achieve this is with statutory registration. (NAT_NHAA_2006_Doc1: 10)

The National Scheme [...] acts as a community recognised 'signpost' that health practitioners in this country are suitably trained, qualified and monitored to provide safe and high quality healthcare. (SPPATH_SPA_2014_Doc6: 3)

Almost one-quarter of professional body sources commented on the need for mandatory professional standards to maintain appropriate practitioner qualifications and competence. Most of these stakeholders claimed this could only be achieved through statutory means. In a minority of documents, authors expressed a commitment

to high-quality training and education standards, practice and course accreditation standards, codes of conduct, and ongoing professional development requirements. Stakeholder reservations concerning current regulation arrangements included the perceived unacceptable variation in standards across jurisdictions and, in the case of multiple professional bodies representing a profession, across associations. Many profession stakeholders documented the ineffectiveness of voluntary standards under self-regulation. Some maintained that other countries better managed standard-setting for the profession through regulation and commented on the poor management of professional standards for non-registered practitioners in Australia. To overcome the identified deficiencies, registration or co-regulation was viewed as providing the necessary stimulus and framework to establish minimum, mandatory, nationally uniform training, education, and ongoing practice standards.

There is no single or legislatively enforceable practice, clinical or competency standards for audiologists and audiometrists - there should be. (AUDIO_CONSUMER_2017_Doc1: 11)

The current lack of nationally consistent, legally enforceable qualifications and standards for the paramedic profession leaves individual employers to bear the costs of determining the suitability of persons to be employed as paramedics. (PARA_VicDHHS_Undated_Doc1: 6)

Professional regulation under the [NRAS] is the aspiration. This will mean an enforced national minimum standard of education for the profession. (NAT_ANPA_2021_Doc7: 1)

A few profession stakeholders described the difficulties in establishing or maintaining consistent standards. These sources suggested that attempts to develop educational standards were stymied due to voluntary mechanisms that failed to provide associations with the necessary authority to enforce the standards.

Attempts to determine appropriate minimum educational standards are unlikely to succeed without the support of a regulatory system that can mandate those minimum requirements. (WHM_NAT4REG_2008_Doc1: 15)

Currently, different industry member associations have different standards in relation to the educational requirements for their members and accreditation of courses [...] Educational standards across the sector vary significantly, resulting in confusion amongst practitioners and a lack of consistency. (COUNS_ACCA_2014_Doc1: 4)

Although few stakeholders supported other types of regulation to establish professional standards, one appealed for co-regulation to provide the statutory standards perceived as necessary.

These current arrangements run contrary to public expectation that a formal regulation structure exists which provides recognition of qualifications, minimum entry standards, assurance of practice standards, a code of conduct and ethics, and a single avenue for complaints [...] The national law [should] be amended to include a description of self-regulating health professions for inclusion under the NRAS. (ALLH_NASRHP_2014_Doc2: 2, 3)

Several authors argued that oversight of providers only included practitioners within their ambit, and any standards set by the association did not cover all individuals professing to practice. Voluntary membership was considered a professional threat because it hampered the ability of associations to set and enforce profession-wide codes and standards or impose sanctions on culpable practitioners.

Whilst a voluntary board can set standards and publicise breaches - it cannot impose fines or remove practitioners from practice. Moreover, it is still voluntary, and only has jurisdiction over those who actually choose to register [with the association]. (NAT_INDIVIDUAL_2010_Doc4: 2)

Profession stakeholders were particularly concerned about their inability to control practitioner movements between associations when such action was prompted by a patient complaint or threat of disciplinary action. As well as posing a perceived threat to the profession, stakeholders inferred that voluntary membership also threatened the integrity and viability of the association itself. For a few stakeholders, the solution was

registration, while others maintained that self-regulation was appropriate with additional supporting statutory mechanisms.

[M]assage therapists who have been sanctioned by one disciplinary authority, body or association can currently move seamlessly between jurisdictions and/or organisations and continue to practice without interruption. (MASS_AMT_2011_Doc5: 8)

[S]ome social workers who are AASW members will deliberately terminate their membership when a complaint is made to avoid having to be investigated. Members subject to a complaint can leave the Association or let their membership lapse in order to avoid investigation. (SOCWK_AASW_2011_Doc5: 18)

In a related issue, profession stakeholders frequently described practitioner accountability as another mechanism to maintain practitioner quality and professional integrity. These sources claimed that registration was required to ensure practitioners were held accountable for their practice. If practitioners erred in clinical practice, appropriate sanctions were considered necessary. According to many stakeholders, holding practitioners accountable under self-regulatory governance was unachievable because associations lacked appropriate, enforceable, disciplinary avenues. Common difficulties identified by authors were voluntary association membership and the multiplicity of associations for several professions, which meant practitioners who had transgressed could readily move between associations or relinquish membership entirely and continue practising. Stakeholders suggested they lacked the power and authority to keep practitioners accountable, rendering sanctions and disciplinary actions unenforceable. Document authors contended that statutory measures, in contrast, either through registration or co-regulation, would hold practitioners accountable using enforceable sanctions and disciplinary measures.

[T]he only effective means of protecting the public from harm is by holding all social workers accountable through National Statutory Registration and Accreditation. (SOCWK_AASW_2013_Doc8: 5)

*[P]ractitioners need to be held to account for the services they provide
[...] Statutory registration and regulation does this.*
(SPPATH_OHR_WA_2008_Doc1: 1)

*[S]tatutory regulation would permit by statute under the National Law
access to an objective transparent and accountable system for
managing complaints and professional misconduct [...] with statutory
backing for determinations made including fines, conditions of
practice, further education, suspension and exclusion.*
(WHM_ANTA_2016_Doc4: 35)

7.3.3 Registration fosters interprofessional cooperation

A minority of profession and individual stakeholders, in a little over one in ten organisations, contended that registration would foster greater interprofessional collaboration and cooperation, cross-referrals, and integration into the healthcare system. Stakeholders commented that healthcare providers such as GPs would more confidently collaborate with and refer to registered health practitioners because of greater assurances of professional standards and practitioner quality. By fostering interprofessional cooperation and communication through registration, document authors anticipated greater integration into mainstream healthcare to address gaps in and improve the quality and safety of healthcare.

*It is important for GPs that, referrals to their allied-health colleagues are
made in the confidence that patients will receive professional care and
service. A national scheme can afford GPs greater confidence in the
competency of other occupations when referring patients.*
(DIET_AUSTGPNETWORK_2008_Doc1: 1)

*[S]tatutory registration will build stronger working relationships
between Herbalists, naturopaths and other healthcare professions.
Other healthcare professionals will be able to confidently refer to
Herbalists knowing statutory registration standards are consistent with
other registered health professionals.* (WHM_NHAA_2008_Doc5: 9)

7.3.4 Registration mitigates against practice risks

Authors from around one-third of organisations in more than one in ten documents representing all stakeholder cohorts commented that registration was required to ensure appropriate practitioner proficiency. Adequate practitioner proficiency was perceived as necessary to manage the claimed risks of occupational practice that heightened patient exposure to potential harm in the hands of less competent individuals. Many document authors viewed existing practice scopes as sufficiently risky to warrant registration. The dynamic nature of health practices and primary care settings, and working in high-risk environments, such as solo practices or working in isolation with no supervision and little opportunity for collegial collaboration, were all topics on which stakeholders commented.

The risks to clients [...] are compounded in private practice environments, where social workers are not necessarily subject to the normal standards of formal supervision, organisational practices and peer engagement. (SOCWK_AASW_2011_Doc5: 13)

What often sets paramedic practice apart is that risks are magnified in the out of hospital environment (PARA_NCAU_2016_Doc1: 9).

The scope of practitioners is one factor that will exacerbate or ameliorate the risk of unregistered practitioner groups. For example, practitioner groups with a greater primary care role such as naturopaths and Western herbalists will have increased risk via acts of omission (for example failure to appropriately refer serious cases). (WHM_ARONAH_2011_Doc2: 14).

Other stakeholders commented that professions were subject to ever-expanding scopes of occupational practice, technological advancements, and occupational evolution and progression, often from external demands and expectations. Sources argued that the increased practice complexity and greater diagnostic and decision-making responsibilities required statutory regulatory oversight. These stakeholders maintained that only registration would provide the regulatory framework to mitigate against the perceived risks. They implied that although the expansion of practice scopes and the

growing complexity of practice requirements were inevitable, they placed ever-increasing demands on practitioners and heightened risks posed by professional practice. Document authors commented or suggested their practitioners were capable of responding to these demands but could not rise to their potential without the structural and legislative registration framework to manage them effectively. Stakeholders also inferred that a lack of government support to meet these externally driven demands left professional associations with the responsibility for navigating the path between practice complexity and patient safety.

These developments have resulted in significant changes in the nature and scope of the role and responsibilities of the profession, the conditions under which work is performed, and the expectations that other professionals and members of the public have of speech pathologists. [...] The profession recognises that if the continued evolution of its role does not occur in a systematic and structured way, in close relationship with other health practitioners, the opportunities for positive gains for healthcare will not be realised and the potential for harm may in fact be significantly increased. [...] in the absence of effective registration, accreditation, and credentialing processes it is unlikely that these opportunities can be realised safely or with the confidence of other professionals and the public.
(SPPATH_SPA_2008_Doc3: 21-22)

According to most stakeholders, statutory measures to control practice entry, raise professional standards, assure practitioner competency, hold practitioners accountable, foster interprofessional cooperation, mitigate against the risks of practice, and manage the scopes of occupational practice were part of a suite of essential regulatory tools ensuring healthcare was provided by ethical and competent practitioners held to high professional standards.

7.4 Theme 3. Statutory registration is better for professions

Just under one-third of coded documents included comments on the benefits or advantages of registration to the professions. Often phrased in aspirational discourse, the comments were identified in documents from all stakeholder cohorts and over half

of organisations. Apart from a few exceptions, stakeholders claimed that only through registration would the identified advantages be realised. These advantages included elevating professional standing, fostering respect for the profession, providing independent and transparent governance of professions, improving workforce planning capability, and facilitating workforce mobility. In a few documents, authors acknowledged several benefits of registration but pointed out that these were not the Scheme's intended purpose.

Figure 7.4 presents the three sub-themes generated for this theme.

Figure 7.4: Theme 3. Statutory registration is better for professions.



Table 7.4 presents the frequency counts for Theme 3 categorised by profession and organisation.

Table 7.4: Document frequency counts for Theme 3 by profession and organisation.

Each dot (•) represents one document.

Profession	Organisation	THEME 3. REGISTRATION IS BETTER FOR PROFESSIONS			
		3.1. Registration elevates professional and practitioner standing	3.2. Registration provides independent and transparent governance	3.3. Registration facilitates workforce planning and mobility	Total
Allied health	Allied Health Professions Australia (AHPA)	••			2
	National Alliance of Self Regulating Health Professions (NASRHP)			•	1
Audiology	Audiology Australia (AA)				0
	Australia College of Audiology (ACAud)				0
	Independent Audiologists Australia (IAA)	•••••••	••••••••••		13
Clinical perfusion	Australian and New Zealand College of Perfusionists (ANZCPerf)	••			2
	Australasian Society of Cardio-Vascular Perfusionists (ASCVP)	•			1
Counselling and psychotherapy	Australian Counselling Association (ACA)	•			0
	Australian Community Counselling Association (ACCA)				1
	Australian Register of Counsellors and Psychotherapists (ARCAP)				0
	Christian Counsellors Association of Australia (CCAA)				0
	Psychotherapy and Counselling Association of Australia (PACFA)	••••			4
Dietetics	Dietitians Australia (DA)				0
Exercise physiology	Exercise and Sports Science Australia (ESSA)				0

Profession	Organisation	THEME 3. REGISTRATION IS BETTER FOR PROFESSIONS			
		3.1. Registration elevates professional and practitioner standing	3.2. Registration provides independent and transparent governance	3.3. Registration facilitates workforce planning and mobility	Total
Massage & myotherapy	Association of Massage Therapists (AMT)				0
	Massage and Myotherapy Australia (MMA)				0
	Myotherapy Association of Australia (MAA)				0
Massage, myotherapy, naturopathy, WHM	Australian Natural Therapists Association (ANTA)	••••••••	•••••	••	12
	Australian Traditional Medicine Society (ATMS)				0
Naturopathy, Western herbal medicine	Australian Naturopathic Council (ANC)				0
	Australian Naturopathic Practitioners Association (ANPA)	•	••		3
	Australian Register of Naturopaths and Herbalists (ARONAH)	••••	•••••••••• •		13
	Complementary Healthcare Council of Australia (CHCA)				0
	Complementary Medicine Association (CMAss)	••	•		3
	Complementary Medicines Australia (CMAust)			•	1
	Naturopaths and Herbalists Association of Australia (NHAA)	••••••••••	••••••••••	•••••••	18
Orthoptics	Australian Orthoptic Board (AOB)				0
	Orthoptics Australia (OA)				0

Profession	Organisation	THEME 3. REGISTRATION IS BETTER FOR PROFESSIONS			
		3.1. Registration elevates professional and practitioner standing	3.2. Registration provides independent and transparent governance	3.3. Registration facilitates workforce planning and mobility	Total
Paramedicine	Paramedics Australia (PA)		••	••	2
	Australasian College of Paramedicine (ACP)		•	••	2
	Australian College of Ambulance Professionals (ACAP)			•	1
	Council of Ambulance Authorities (CAA)	•		•••	3
	National Council of Ambulance Unions (NCAU)		•	•	1
Social work	Australian Association of Social Workers (AASW)	•••••	•••••	•••••	10
Sonography	Australasian Society for Ultrasound in Medicine (ASUM)			•	1
	Australian Society of Medical Imaging and Radiation Therapy (ASMIRT)				0
	Australasian Sonographers Association (ASA)	•••••••	•	•	9
	Australian Sonographer Accreditation Registry (ASAR)				0
Speech pathology	Speech Pathology Australia (SPA)	•••	••	•••	5
Other	Consumer bodies		•		1
	Individuals	••••	•••••••••• •	••••	14
	Government Departments	•	•	••	2
	Other organisations	••	••••	••••••	8
Total		67	76	42	133

WHM: Western herbal medicine.

7.4.1 Registration elevates practitioner and professional standing

Commentary from well over one-third of organisations in around one in six documents and from all stakeholder cohorts except consumer bodies referred to the professional advantages achieved through registration. Rhetorical devices frequently employed to describe the prestige afforded by registration included terms such as “*recognition*”, “*official*”, and “*sanctioned*”. Document authors most often associated registration with recognition, and professional self-worth was described as being reliant on state ‘recognition’. Comments documented by sources suggested that, for healthcare providers, gaining acceptance and acknowledgement equal to registered professions was a strong motive for supporting registration. This implies that a lack of professional acknowledgement due to the absence of registration impacted stakeholder perceptions of professional self-esteem and self-regard. For a few stakeholders, the exigency of ‘recognition’ under state authority was essentially a desire to establish professional credibility, legitimacy, and respect.

[R]egistration is recognised as conferring status and legitimacy on an occupational group because it is seen publicly as a state sanctioning or affirming of its professionalism. (PARA_INDIVIDUAL_2016_Doc5: 20)

Inclusion in NRAS will mean that professionally qualified social workers will [...have] recognition as NRAS registered practitioners. (SOCWK_AASW_2012_Doc6: 6)

A key focus for the Australian and New Zealand College of Perfusionists is to help its members obtain official recognition (course accreditation and regulation). (PERF_ANZCPerf_2021_Doc3:1)

Many naturopaths believe that the answer to our eternal quest for legitimacy, or at least for greater respect of our profession [...], hinges on the attainment of statutory registration. (NAT_ARONAH_2018_Doc12: 1)

A minority of document authors were critical of the claimed professional advantages of registration. They contended that registration was not established to provide status, credibility, or any other form of prestige, suggesting that registration through NRAS had

been co-opted for a purpose never intended. The comments inferred that the status conferred on registered practitioners by NRAS had led to a diminution of the status of non-registered professions.

AHPA notes that the National Scheme was designed to fulfill four key objectives, not to provide status and credibility to practitioner groups. (ALLH_AHPA_2014_Doc3: 2)

PACFA is concerned that statutory registration with AHPRA [...] has become a status symbol. (PSYC_PACFA_2014_Doc9: 5)

[T]he national scheme was not established to provide credibility to any particular health profession. (SPPATH_SPA_2014_Doc6: 20)

7.4.2 Registration provides independent and transparent governance

Well over one-third of documents from well over one-third of organisations in all stakeholder cohorts documented concerns with self-regulation mechanisms relating to conflicts of interest, regulatory independence and transparency, separation of powers, and lack of consumer representation in professional governance.

Stakeholders argued that self-regulation was subject to conflicts of interest at the individual and organisational levels. Employers and practitioners, professional associations, educational institutions, businesses, and commercial operators were all considered prone to conflicts of interest and, according to sources, demonstrated how existing self-regulation mechanisms failed to protect consumers from the effects of such conflicts. Stakeholders suggested that governance bodies entrusted with overseeing health professions should do so in a way that served the public interest rather than the interests of the professions or their own. All sources who commented on perceived conflicts identified registration as a means by which the conflicts could be minimised and managed.

The types of conflicts of interest stakeholders commented on were, at times, occupation-specific, for example, the potential for business and commercial conflicts associated with selling hearing aids. At other times, the perceived conflicts were

applicable more broadly, such as employers conflicted by the need to sanction employees on the one hand and, on the other, maintain their business reputation.

Audiology now faces influences from industry that are parallel to relationships between medicine and the pharmaceutical industry, but to date has escaped external regulatory structures.

(AUDIO_IAA_2016_Doc7: 3)

Statutory registration includes an independent complaints mechanism. In the present self-regulated environment, complaints handling is not independent and can be biased. (NAT_ANPA_2013_Doc1: 19)

Employers are faced with an inevitable conflict of interest when seeking to protect their own reputation, their financial position and their workforce. (PARA_INDIVIDUAL_2012_Doc3: 5)

Practitioners were also described as being prone to conflict of interest influences. For example, the independence of judgements made by audiologists selling hearing aids was queried, and the potential conflict of naturopaths prescribing and dispensing products was highlighted.

In the absence of external regulation or mandatory statutory registration [...] sales targets and commissions paid to audiologists for device fitting are commonplace. (AUDIO_IAA_2016_Doc8: 6)

It is estimated that 78% of naturopaths sell pre-prepared products directly to patients. This demonstrates a clear potential for conflict of interest. (NAT_INDIVIDUAL_2009_Doc2: 8)

Of all the groups subject to potential conflicts, professional associations were the target of most stakeholder comments, documented at around double the rate of other groups. The conflict of associations was described as the tension between protecting their membership revenues and professional scopes while attempting to uphold education standards and protect consumers by sanctioning culpable practitioners. Conflicts were also perceived for associations accrediting lower qualifying awards and accepting graduates from these educational institutions to boost membership. Profession

stakeholders maintained that independence and transparency by an impartial authority accountable to the public were essential to regulate health practitioners effectively. The independence promoted by stakeholders was a separation of regulatory oversight for managing course and qualification accreditation, complaints investigations, practitioner disciplining, and reporting to the public. They contended these responsibilities should be separated from professional associations, education providers, and, in some cases, governments.

Studies of professional regulation inside and outside of healthcare have consistently raised the tendency of self-regulating professions to protect their scope of practice as a means of benefiting their members. The self-regulatory model thus suffers from perceptions of self-interest, conflict of interest, lack of accountability and lack of community (citizen) engagement. (PARA_INDIVIDUAL_2016_Doc1: 6)

Under a statutory registration system, education standards will be determined at arm's length from professional associations [...] This will also prevent any conflict of interest that arises. (NAT_NHAA_2013_Doc12: 8)

Market pressures to attract membership by professional associations may result in lower standards and differences in standards. (MASS_ANTA_2018_Doc10: 15)

Several stakeholders considered existing regulatory arrangements unacceptable because associations investigated consumer complaints against their members and accredited courses against which they assessed prospective members. The statements suggested that practitioner regulation should not be left in the hands of the association because their independence regarding complaint matters and accreditation standards could not be assured. A few stakeholders proposed that the independence of governance arrangements could be strengthened through consumer representation on self-regulating boards and a separate occupational standard-setting body. They argued this promoted confidence in governance measures and ensured the needs of patients and consumers were considered.

The public interest in the fairness and transparency of the regulatory process thus demands that there be meaningful lay representation. (PARA_INDIVIDUAL_2016_Doc1: 10)

Consumer involvement in setting professional standards is an important step towards enhancing confidence in all professions, including self-regulating professions. (SOCWK_AASW_2015_Doc17: 6)

Co-regulation would not resolve the issue of lack of transparency in a disciplinary system administered by a professional association, even if accredited. [...] professional associations have failed to develop transparent and open disciplinary systems to date. (NAT_ARONAH_2011_Doc2: 23)

Stakeholders included statements that independent, transparent regulatory governance was required to ensure impartial review mechanisms and publicly available reporting. Through these measures, consumer safeguards would be enhanced, and the profession would be strengthened. The breadth of comments highlighted the widespread concerns regarding conflicts of interest in a number of professional sectors. The doubts about the adequacy of self-regulation were used to support arguments regarding the need for a state regulator to provide professional governance separate from and independent of associations, employers, education providers, and commercial operators.

The current [...] regulatory mechanisms do not protect the public [because t]here will remain a clear lack of transparent public reporting on matters of grave misconduct. (PARA_ACP_2012_Doc1: 29)

[E]ffective regulation and public confidence is gained by having regulatory functions carried out by bodies that are wholly separate from the professional associations or service providers. (PARA_INDIVIDUAL_2016_Doc5: 25-26)

7.4.3 Registration facilitates workforce planning and mobility

In fewer than one in ten documents, stakeholders from over one-third of organisations in all stakeholder cohorts except consumer bodies commented on the importance of

collecting accurate and comprehensive data for workforce profiling and planning purposes. The collection of these data was argued to be impossible under self-regulation. Most stakeholders maintained that registration would facilitate more effective workforce utilisation and mobility, particularly in areas of need. According to these stakeholders, attempting to harness the potential of the workforce under self-regulation was futile due to the voluntary nature of association membership and incomplete or duplicated information on practitioner demographics and location.

As data was only collectible from association members, workforce planning was regarded as especially challenging for professions with multiple representative bodies where members were spread across different associations. Document authors commented that voluntary membership and multiple associations leading to inaccurate workforce data created difficulties for workforce planning and development. Inaccurate workforce data was claimed to stymie government objectives of creating a flexible, responsive, and sustainable national workforce. Most stakeholders raising this issue perceived the annual, routinised collection of workforce data during the re-registration process was another reason for supporting registration. The advantages of registration for workforce data collection and planning were also acknowledged by a few stakeholders supporting co-regulation, although they fell short of supporting registration as a regulation mechanism to enable workforce data capture. One source commented that registration and statutory co-regulation could achieve similar data collection outcomes.

The national regulation of the social work profession would also increase the mobility of social workers across Australia, and develop the capability of this key allied health profession in delivering advanced services to clients. (SOCWK_AASW_2011_Doc5: 6)

National statutory registration of paramedics could facilitate a greater utilisation of the paramedic workforce in geographical areas that are under-resourced in regards to traditional healthcare providers (doctors and nurses). (PARA_ANZCPara_2016_Doc2: 7)

Mandatory registration of speech pathologists through the NRAS would be one way of determining the total number of speech pathologists working in Australia. Equally, government recognition of nationally standardised self-regulation across the professions that are currently not covered by NRAS could achieve a similar level of data collection. (SPPATH_SPA_2014_Doc5: 84)

7.5 Theme 4. In the wake of the NRAS

Comments noted in around one-third of documents from fewer than two-thirds of organisations in all stakeholder cohorts detailed the consequences of NRAS establishment for professions and practitioners. These consequences fell into two broad categories, those anticipated to result from including non-registered professions in the NRAS and those considered to result from their exclusion. Concerns over potential inclusion were described by sources preferencing all types of regulation. These concerns centred on registration costs and the consequent effects on practitioners and consumers to whom it was assumed costs would be passed. There was also uncertainty and apprehension regarding the effects of registration on education providers.

The documented comments on the consequences of exclusion from the NRAS were three times greater than those documenting concerns regarding inclusion. The comments regarding exclusion from NRAS were predominantly found in documents from stakeholders supporting registration. Stakeholders referred to the “disadvantages” experienced by non-registered practitioners and the “fragmented” regulation arrangements in the absence of registration. They used the perceived implications of NRAS inclusion and exclusion as grounds for supporting particular preferences for regulation. Several professional body sources commented that, in the absence of registration or co-regulation, the disadvantages experienced by their practitioners prompted their organisation to strengthen their self-regulation arrangements.

Figure 7.5 presents the three sub-themes generated for this theme.

Figure 7.5: Theme 4. In the wake of the NRAS.

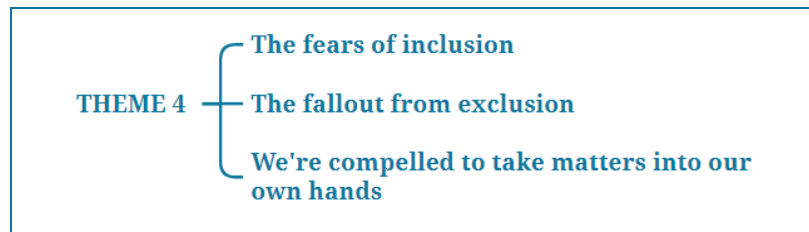


Table 7.5 presents the frequency counts for Theme 4 categorised by profession and organisation.

Table 7.5: Document frequency counts for Theme 4 by profession and organisation.

Each dot (•) represents one document.

Profession	Organisation	THEME 4. IN THE WAKE OF THE NRAS			
		4.1. The fears of inclusion	4.2. The fallout from exclusion	4.3. We're compelled to take matters into our own hands	Total
Allied health	Allied Health Professions Australia (AHPA)		•••••	•••	7
	National Alliance of Self Regulating Health Professions (NASRHP)		•••	•••••	5
Audiology	Audiology Australia (AA)			•	1
	Australia College of Audiology (ACAud)				0
	Independent Audiologists Australia (IAA)	•	••••	••	5
Clinical perfusion	Australian and New Zealand College of Perfusionists (ANZCPerf)		•	•••	3
	Australasian Society of Cardio-Vascular Perfusionists (ASCVP)				1
Counselling and psychotherapy	Australian Counselling Association (ACA)	•	•	•	7
	Australian Community Counselling Association (ACCA)		••	•••••••	1
	Australian Register of Counsellors and Psychotherapists (ARCAP)		•	•••	3
	Christian Counsellors Association of Australia (CCAA)			•	1
	Psychotherapy and Counselling Association of Australia (PACFA)	••••••	•••••••••	••••••••	21
Dietetics	Dietitians Australia (DA)	••	••••••••••	••	13
Exercise physiology	Exercise and Sports Science Australia (ESSA)	•••	••	•••••••	9

Profession	Organisation	THEME 4. IN THE WAKE OF THE NRAS			
		4.1. The fears of inclusion	4.2. The fallout from exclusion	4.3. We're compelled to take matters into our own hands	Total
Massage & myotherapy	Association of Massage Therapists (AMT)			●●●●●●●●●● ●●●●	17
	Massage and Myotherapy Australia (MMA)	●●	●●	●●●●●●●●●● ●●●●●●	20
	Myotherapy Association of Australia (MAA)		●		1
Massage, myotherapy, WHM, naturopathy	Australian Natural Therapists Association (ANTA)	●●●●●●●	●●●●●●●●●● ●●	●●●●●	19
	Australian Traditional Medicine Society (ATMS)	●●●●●●●	●	●●	10
Naturopathy, Western herbal medicine	Australian Naturopathic Council (ANC)	●		●●	2
	Australian Naturopathic Practitioners Association (ANPA)	●			1
	Australian Register of Naturopaths and Herbalists (ARONAH)	●●●●	●●●●●	●●●●●●●●●● ●●	16
	Complementary Healthcare Council of Australia (CHCA)		●●		2
	Complementary Medicine Association (CMAss)			●●	2
	Complementary Medicines Australia (CMAust)		●●		2
	Naturopaths and Herbalists Association of Australia (NHAA)	●●●●●●●●●● ●●	●●●●●	●●●●●●●●	20
Orthoptics	Australian Orthoptic Board (AOB)			●●	2
	Orthoptics Australia (OA)			●●	2

Profession	Organisation	THEME 4. IN THE WAKE OF THE NRAS			
		4.1. The fears of inclusion	4.2. The fallout from exclusion	4.3. We're compelled to take matters into our own hands	Total
Paramedicine	Paramedics Australia (PA)			•	1
	Australasian College of Paramedicine (ACP)				0
	Australian College of Ambulance Professionals (ACAP)				0
	Council of Ambulance Authorities (CAA)				0
	National Council of Ambulance Unions (NCAU)				0
Social work	Australian Association of Social Workers (AASW)	••••••••	••••••••	••••••	17
Sonography	Australasian Society for Ultrasound in Medicine (ASUM)				0
	Australian Society of Medical Imaging and Radiation Therapy (ASMIRT)				0
	Australasian Sonographers Association (ASA)	••••••	••••••	•••••	11
	Australian Sonographer Accreditation Registry (ASAR)			•	1
Speech pathology	Speech Pathology Australia (SPA)	•••	•	••••••••••	12
Other	Consumer bodies		•		1
	Individuals	••	••••••••	••	8
	Government Departments	••		••	2
	Other organisations	••	••••	•	7
Total		74	101	145	253

WHM: Western herbal medicine.

7.5.1 The fears of inclusion

Concerns over the potential inclusion of professions in the NRAS were expressed by professional bodies, individuals, and governments in around one in six documents from fewer than half of organisations. Costs associated with registration and the claimed consequences of those costs dominated these concerns. Profession stakeholders expressed apprehension that the costs expected to arise from registration would impact practitioners, patients, and education providers. At times, costs were coupled with the increased administration associated with registration. This perspective was expressed by sources who suggested that registration was in excess of regulation needs for the profession. For these stakeholders, registration was considered unnecessarily burdensome and costly for associations regarded as having adequate self-regulatory arrangements in place.

Registration will increase the annual costs that a practitioner will have to pay for the privilege of being able to provide those services to the public. (WHM_ATMS_2017_Doc10: 2)

Statutory registration will necessitate a higher level of bureaucratic intervention in a practice to ensure full compliance with statutory registration obligations. (NAT_ATMS_2020_Doc12: 1)

The ACCA is also mindful of the tight fiscal challenges faced by all levels of Government at this time and would like to discuss other cost-effective models of regulation, that would both recognise and raise the profile of this highly qualified, experienced and innovative practitioner group, as well as provide assurances to the public, government, business and not-for-profit sectors. (COUNS_ACCA_2014_Doc1)

A few stakeholders documented concerns that registration and the need to raise education standards might threaten the viability of education providers and potentially deter future practitioners from entering the profession.

There is no valid evidence that the regulators are interested in registering natural medicine practitioners in a climate where there is a lack of political support. The only driver to this change is the AQF level. [...] the cost for colleges to apply to have the AQF7 qualifications added to their scope is prohibitive but the cost to potential new entrants into our industry is restrictive. Our research advises that it is likely to be on average an additional cost of above \$40,000-\$55,000 for a student to undertake study at the degree level.
(WHM_ATMS_2014_Doc8: 3, 4)

Other stakeholders considered the costs associated with registration acceptable for the perceived benefits gained. These authors conceded the potential for registration to increase costs to education providers, students, and practitioners, which might be passed onto consumers or threaten the livelihoods of practitioners. Nonetheless, they supported registration for the presumed benefits to consumers and the profession. In a small number of documents, stakeholders commented that even though registration incurred additional costs, professional bodies were willing to support registration, even at the association's expense, to ensure consumer protection.

The potential negative effects of regulation [...include] loss of livelihood to some practitioners who may be refused statutory registration [...] On balance, the advantages of regulation far outweigh remaining with the status quo as the benefits of public protection and higher standards within the profession auger well for the benefits to public health in Australia. (NAT_NHAA_2008_Doc5: 10)

The potential increase in fees for practitioners (including registration costs and in addition, membership of professional associations) may mean higher fees charged to consumers. [...] Statutory regulation may increase costs for some educational institutions to upgrade courses which may result in higher fees for students.
(MYOTH_ANTA_2018_Doc10: 39)

Surveys of AASW members show overwhelming support for statutory regulation, including a willingness to contribute to the cost. [...] registration may discourage social workers from paying an additional fee to join a professional association. However, the AASW favours public interest over self-interest and considers that uniform, national statutory registration is the best way to ensure the health and safety of the public. (SOCWK_AASW_2011_Doc5: 23, 24)

To argue that registration was viable for the profession, one stakeholder estimated registration costs to practitioners based on membership numbers and benchmarked those costs against registered professions.

There are a minimum of 22,000 Social Workers practicing in Australia today. Based on the fees of like professions, we estimate the income from this group of health professionals at \$6,600,000 per annum (based on a statutory registration fee of \$300). This could self-fund a statutory registration board and associated systems. (SOCWK_AASW_2013_Doc9: 7)

Other document authors used costs incurred by associations in regulating non-registered professions and the subsequent savings to governments as a rationale for maintaining self-regulation or arguing for co-regulation. Those stakeholders promoting co-regulation suggested that existing arrangements were or could be adequate with a government mandate through a co-regulation partnership.

Self-regulation is provided at no cost to government or to the community. (PSYC_PACFA_2014_Doc9: 2)

DAA has effectively administered this national system at nil cost to the tax payer and could continue to do so if the government chose to make such national accreditation compulsory for practitioners. (DIET_DA_2005_Doc1: 11)

Several sources suggested that the perceived reluctance of governments to register further professions was due to cost issues.

A significant amount of government funding is required to investigate options, write and enact legislation, establish and maintain registration boards. [...Unless] risk is identified, governments will not commit resources to registration for these occupations.
(NAT_ATMS_2017_Doc10: 1, 2)

Some authors commented on mechanisms they claimed would reduce government costs relating to registration. One source repeated an earlier government review recommendation for a multi-profession board under the NRAS to minimise government registration costs while allowing for the inclusion of more professions in the Scheme. This same stakeholder made a point of reinforcing patient safety priorities over costs.

We believe that proposed changes to the governance structure of the National Scheme for professions that have low regulatory workloads - provides an opportunity to increase the breadth of coverage to include further professions whilst at the same time still extracting significant cost efficiencies [...] We understand a need for economic considerations and fiscal responsibility of the scheme but this should not come at the expense of protecting patient health and safety.
(SPPATH_SPA_2014_Doc6: 3, 7).

Overall, comments were identified from a broad range of stakeholders supporting different regulation models. In documenting concerns, those supporting self-regulation described the costs and other burdens of registration while rarely acknowledging any benefits. They emphasised the detrimental effects of registration on practitioners, students, and education providers, suggesting these were too high a price to pay for the profession. Supporters of registration documented many of the same fears as those supporting self-regulation. They described the potential consequences of registration while documenting the benefits in consumer protection that were considered to predominate over cost issues.

7.5.2 The fallout from exclusion

The claimed disadvantages of exclusion from the NRAS generated more commentary than the documented fears of inclusion. Statements about the negative consequences of NRAS exclusion were identified in around one-quarter of documents from more than

half of organisations representing all stakeholder cohorts except governments. The disadvantages of exclusion noted by document authors fell into three main categories: the documented discrimination against non-registered practitioners and professions due to NRAS, the claimed complexity of regulation for non-registered professions, and the purported entrenchment of so-called “*healthcare hierarchies*”.

Although acknowledged as unintended, the discrimination asserted by profession stakeholders was claimed to originate from government departments, agencies, and private companies. Discrimination due to NRAS exclusion was described as persistent and widespread. The documented disadvantages include ineligibility for postgraduate programs, scholarships, employment opportunities, private health insurance rebates, government projects, research grants, and other funding allowances. Stakeholders claimed the disadvantages commenced shortly after the introduction of the NRAS. The disadvantages were used by professional bodies to advocate for registration or co-regulation. They urged governments to issue public statements to reinforce the purpose of the NRAS rather than it being used as a vehicle for discrimination.

There are serious unintended consequences of the scheme and simply claiming that wasn't the intention does not remedy the situation. Healthcare professionals are being excluded from employment, positions on boards and access to grants and scholarships for further education. (ALLH_AHPA_2014_Doc3: 2)

PACFA has been advised by [the private health insurance company] HCF that counsellors and psychotherapists will not be considered for recognition by them because we are not regulated by the Australian Health Practitioner Regulation Agency. (PSYC_PACFA_2015_Doc10: 12)

Along with the presumed exclusion from job and funding opportunities, several authors documented a belief that registered professions were viewed more favourably than non-registered professions. These stakeholders contended that self-regulation was perceived as substandard, and their credibility as professional associations was being subverted. They suggested that non-registered professions were being discredited and

that the legitimacy of their members as health professionals was being devalued. They inferred that not only did governments offer little support for their self-regulation efforts, but since the commencement of the NRAS, had paid them even less attention, allowing discrimination and prejudice against non-registered professions to flourish.

Since the introduction of NRAS however this record of quality self-regulation has been undermined by the perception that the professions registered under the Australian Health Practitioner Regulation Agency (AHPRA) are somehow better, safer, more credible, and more respectable. (DIET_DAA_2014_Doc10: 3)

AHPA continues to have strong concerns about the use of Australian Health Practitioner Regulation Agency (AHPRA) registration as a shorthand for identifying health professionals. This was evident throughout the initial pandemic response where various initiatives were made available to AHPRA-registered professionals. (ALLH_AHPA_2020_Doc10: 7)

By raising doubts about the credibility and legitimacy of non-registered professions, some profession stakeholders contended the NRAS had established a “*tiered regulatory system*” that created an occupational divide between quality-assured registered professions and ‘others’. These stakeholders implied that non-registered professions were considered inferior or lower-class health professions. They argued that NRAS had reinforced the occupational hierarchies perceived to exist in the health system and unintentionally undermined public confidence in non-registered practitioners. The documented statements suggested that decision-making by professional bodies regarding a preferred type of regulation was an attempt to elevate their position in the healthcare division of labour and re-establish their role as legitimate healthcare practitioners.

The confined application of the NRAS has resulted in the evolution of a two tier regulatory system (NRAS regulated VS self-regulated) with a number of unintended consequences. (SONO_ASA_2014_Doc5: 2)

There is also the misconception that health professionals who fall under NRAS are the only quality healthcare professionals. This falsely implies that health professionals who fall outside of NRAS do not have the same level of recognition of qualifications, minimum entry standards, assurance of practice standards, or a code of conduct and ethics. (EXEPHY_ESSA_2014_Doc5: 1)

One stakeholder objected to the professional “*tiering*” perceived to result from NRAS but supported another form of stratification by petitioning the state for a statutory form of regulation based on evidence. In the proposed framework, professions perceived as “*evidence-based*” would be partitioned from those viewed as “*non evidence-based*”. Professions regarded as non-evidence-based were not identified in the documents.

Unfortunately the National Scheme has created a two-tier regulatory system [...]. It is important that all evidence-based health professions are recognised equally by government and public, whether registered or self-regulated. (ALLH_AHPA_2014_Doc3: 2)

This perspective suggests a desire to promote certain professions into the statutory class and establish a clear separation from professions considered ‘inferior’ by some stakeholders using evidence-based rather than risk-based criteria. In this framing, three tiers of regulation were proposed by the stakeholder. The first is high-risk health professions regulated under NRAS. The second is medium-risk “*evidence-based*” professions regulated by governments as “*authorised*”, and the final category is “*non evidence-based practitioners*” who, irrespective of risk, are monitored via negative licensing. In essence, this proposal relocates the statutory demarcation to another point on the continuum of regulation. Using the idiom of evidence, such boundary work is apparent in the following excerpt, in which the stakeholder attempts to limit which professionals are designated as health practitioners. While some document authors claimed the NRAS entrenched healthcare hierarchies, some concerns appeared to be more about disassociating from certain ‘undesirable’ or ‘non-credible’ professions.

A clear definition of 'health practitioner' under the 'authorised self-regulation' model will mark a boundary between evidenced-based health practitioners and unregulated health workers.
(ALLH_NASRHP_2012_Doc1: 3)

Being classified as a non-registered profession was suggested by one stakeholder to devalue their profession and was reason enough to seek recognition through registration. According to this source, registration through the NRAS would mean paramedicine would be associating with the more deserving registered professions and would, at the same time, disassociate paramedicine from non-registered occupations that were implied to be unworthy of registration status. Like the previous excerpt regarding evidence-based professions, for this stakeholder, the list of professions to be disassociated from appears limited to particular non-registered occupations.

Registration recognises the status of paramedics as being equal to those of other registered health practitioners. [...] Without registration, paramedics remain categorised with the following non-exhaustive list of nonregistered health practitioners:- art therapists, aromatherapists, assistants in nursing, audiologists and audiometrists, Ayurvedic medicine practitioners, bioresonance practitioners, clinical perfusionists, complementary and alternative medical practitioners, dental assistants, herbalists, homeopaths, hypnotherapists, massage therapists, music, dance and drama therapists, naturopaths, optical dispensers, pharmacy assistants, phlebotomists, reflexologists, reiki practitioners and shiatsu therapists. (PARA_INDIVIDUAL_2016_Doc5: 20)

Professional body sources argued that NRAS had introduced greater complexity and fragmentation to HPR. A sizeable minority of stakeholders supporting registration and co-regulation viewed the NRAS as yet another regulatory system to navigate in addition to other schemes in place, with their array of voluntary and statutory governance mechanisms. The claimed complexity was often proffered as a reason for supporting their favoured regulation model. These stakeholders suggested they were frustrated by the layers of regulatory complexity they had to contend with, none of which were considered to provide coverage similar to their preferred regulation mechanism.

The National Code adds to the complexity and confusion around the varied arrangements in place for sonographer complaints.

(SONO_ASA_2021_Doc29: 6)

The practice of Nat/WHM/NM is framed by a myriad of incoherent complex and confusing legislation and regulations at both State and Federal levels. These legislative and regulatory measures are based upon different policy imperatives [...] it is not easy to point to [a] clear regulatory structure for the practice. (WHM_ANTA_2017_Doc5: 20)

7.5.3 We're compelled to take matters into our own hands

Many stakeholders regarded the existing regulatory measures for non-registered professions as complex. They also viewed them as inadequate. Three-quarters of organisations in stakeholder cohorts other than consumer advocates described actions taken to strengthen self-regulation or suggested alternative regulation and certification mechanisms. Document authors used these actions and recommendations to reinforce their support for their preferred type of regulation mechanism.

In the absence of registration, several professional bodies claimed they set about strengthening self-regulation arrangements to raise professional standards and maintain practitioner competency while continuing to advocate for registration or co-regulation. A few sources stated or suggested they felt compelled to take responsibility for strengthening self-regulation measures due to a lack of government action to persistent petitioning for registration or co-regulation. The actions of these stakeholders were taken to bridge the identified gaps in regulatory coverage. The short-term measures described by associations to improve self-regulation were initiated to fill a perceived void that many professional bodies claimed should be filled by statutory mechanisms. Actions taken by professional bodies were sometimes presented as a direct response to NRAS exclusion and sometimes cast as interim or transitional arrangements while waiting for governments to act.

In the absence of statutory registration many allied health professional associations have taken responsibility for setting and enforcing standards, quality, accreditation and disciplinary measures.

(ALLH_NASRHP_2012_Doc1: 6)

Australian Counselling Association (ACA) supports the development of a best practice model for self-regulation [...] as a transitional step towards a preferred position of a national statutory regulatory system.

(PSYC_ACA_2008_Doc2: 8)

In lieu of statutory registration for naturopaths and WHM practitioners in Australia, an independent self-regulatory body was established by the profession in 2010 which mirrors the standards upheld by currently registered professions. (NAT_ANC_2020_Doc1: 2)

The reference to standards that “mirror” NRAS was a refrain often repeated in stakeholder documents. By claiming to reproduce NRAS standards, professional bodies were potentially aiming to impress upon the reader the high professional standards they aspired to and endeavoured to implement for the profession. Terms of comparison to NRAS included “modelled”, “mirrors”, “same as”/“similar to”, or performing “similar/equivalent functions”. The impression given by these comments is of professional bodies striving to advance the profession by establishing standards and processes exemplifying those of the NRAS. This type of equivalence discourse was identified in stakeholder documents, irrespective of the kind of regulation supported and was frequently contextualised with a statement supporting the preferred regulation model.

NASRHP standards have been closely modelled on AHPRA standards.
(ALLH_NASRHP_2017_Doc4: 1)

The Constitution of ARONAH requires it to mirror the standards of the NRAS administered by the Australian Health Practitioner Regulation Agency (AHPRA) and the National Law which guides the national registration process. Despite numerous formal government assessments indicating the requirement for statutory regulation of naturopathy and Western herbal medicine, these professions do not currently fall under this scheme. (WHM_ARONAH_2014_Doc4)

The Accredited Practising Dietitian credentialing program [...] sets rigorous standards, often exceeding the standards set by the Australian Health Practitioner Regulation Agency. (DIET_DA_2021_Doc20: 5)

A few professional bodies offered insights into the possible motivations for aligning voluntary standards to those set by the NRAS.

[A]n independent self-regulatory body was established by the profession in 2010 which mirrors the standards upheld by currently registered professions - the Australian Register of Naturopaths and Herbalists (ARONAH). ARONAH was created to prepare the professions of naturopathy and WHM for statutory registration and is active in petitioning the federal and state governments of Australia to include naturopathy and WHM as AHPRA-registered professions. (NAT_ANC_2020_Doc1: 2)

Hence, some professional bodies considered establishing professional standards modelled on NRAS standards as the pathway to registration.

7.6 Chapter summary

The thematic analysis of documents found that most of the commentary regarding regulation was offered by sources supporting registration, and less commentary came from stakeholders supporting co-regulation and self-regulation. There were exceptions, such as the Association of Massage Therapists, which was ‘vocal’ in documenting the need for statutory protection of title, entry barriers, and criminal probity checks within a self-regulating framework. Most stakeholders considered statutory measures essential to promote trust and confidence in non-registered professions, ensure complaints were adequately managed and potentially deliver better healthcare. While most document authors agreed on the principle of protecting consumers of non-registered health services, there were mixed views about how this was best achieved. There was more commentary from stakeholders supporting statutory measures than those supporting self-regulation. This may be due to the little perceived need by self-regulation proponents to mount arguments when there was no foreseeable likelihood

of change to the regulatory status quo. Those supporting statutory mechanisms, especially registration, commented on shouldering the responsibility for safeguarding consumers, partly because governments were regarded as having abandoned them.

Registration was considered to protect professional titles and practice entry, raise professional standing and the quality of practitioners, foster collaboration with other providers, and guard against increasing risks of occupational practice. Co-regulation was also identified as providing some of these benefits, particularly title protection. The ability to develop better workforce planning models and mechanisms was only identified by stakeholders preferring registration, as was the need for independence and transparency of regulatory governance of health professions.

For professional body sources supporting self-regulation, there were fears over the prospect of being included in the NRAS, primarily because of cost issues and the loss of livelihood of practitioners and education providers. NRAS exclusion was the greater concern for other profession stakeholders because it meant more than exclusion from a registration scheme. Being excluded from NRAS meant preclusion from a range of financial, educational, and occupational opportunities, being considered less credible, less safe, and less respectable, and being viewed as a 'second-rate' profession.

To overcome the negative consequences of exclusion, many professional bodies felt compelled to take action to improve and strengthen voluntary self-regulation measures and mechanisms. The professional aspirations for taking these actions were not the same for all professional bodies. For some, there was a need to gain credibility and greater integration through registration. For others, these same attributes were sought through statutory co-regulation. These actions were sometimes cast as interim measures, measures taken in readiness for registration, necessary measures to uphold high standards, and frequently, measures aligned with NRAS standards. While stakeholders considered these measures necessary, they were primarily taken due to the perceived inaction by governments and with a firm view that the responsibility for HPR rested with the state.

This chapter completes the presentation of results from Phase 2 of the research. The next three chapters comprise Phase 3, in which the results of interviews with healthcare stakeholders are presented. The first of these chapters features findings from interviews with consumer advocates.

Research Phase 3

QUALITATIVE ANALYSIS OF STAKEHOLDER INTERVIEWS

In the two previous chapters, I presented findings from an applied thematic analysis of 560 publicly available documents. I identified considerable support for statutory registration from most organisations and individuals. There were lower levels of support for co-regulation and self-regulation. Many respondents described the perceived limitations of self-regulation. In contrast, those supporting self-regulation tended to emphasise the low risks of occupational practice and cautioned against over-regulation for the profession.

I now present the results of Phase 3 of the research, in which interviews were conducted with participants from three stakeholder cohorts, consumer advocates, government health policy actors, and professional body representatives. This first section outlines the participant selection procedures, followed by a summary of the interview schedule and format. Findings from the interviews with stakeholders are then presented in the following three chapters, one chapter for each stakeholder cohort.

Between 15 March 2022 and 27 September 2022, 48 interview invitations were issued to prospective participants, and 42 were accepted. From 22 March 2022 to 24 October 2022, 42 semi-structured interviews were completed with 46 participants. Five consumer advocates agreed to be interviewed, twelve interviews were conducted with fifteen policy actors, and 24 interviews were completed with 26 professional body representatives.

Interviews were held with policy actors in every Australian state and territory health department and from the Commonwealth Department of Health. Interviews were also held with informants from the Australian Health Practitioner Regulation Agency

(Ahpra⁷⁴) and the Office of Best Practice Regulation⁷⁵ (OBPR). At least one professional body respondent was interviewed from 14 of the 15 professions examined in the research.

Table 8.1 summarises the information on invitations issued, accepted, and declined, interviews scheduled and completed, and the number of interview participants. The table also presents the duration range and median duration of the interviews for each stakeholder cohort, the number of interview hours, and the number of transcribed pages generated from the interviews.

Table 8.1: Summary of the stakeholder interview schedule.

Organisation	Invitations issued	Interviews scheduled	Interviews completed	Number of interviewees	Interview duration range hrs:mins (median duration)	Comment
Consumer advocacy organisations	9	5	5	5	0:30 - 1:43 (1:11)	Declined to participate: • Australian Research Alliance for Children and Youth. • Chronic Illness Alliance. • Council on the Ageing. • National Aboriginal Community Controlled Health Organisation.
Government departments/ agencies	13	13	12	15	0:48 - 2:42 (1:39)	• One participant withdrew from the study during the interview.
Peak professional and voluntary registering organisations	6	6	6	6	1:11 - 1:36 (1:22)	
Professional associations	20	18	18	20	0:59 - 2:11 (1:34)	Declined to participate: • Australasian College of Paramedicine. • Dietitians Australia.
Total interviews	48	42	41	46	0:30 - 2:42 (1:33)	
Total interview time: 63 hours 31 minutes Total transcribed pages: 1198						

⁷⁴ The Australian Health Practitioner Regulation Agency uses sentence case for its acronym. See: <https://www.ahpra.gov.au/About-Ahpra.aspx>.

⁷⁵ The Office of Best Practice Regulation has since been renamed to the Office of Impact Analysis.

Five interviews were conducted, in which two participants were present at the request of the nominated interviewee, two with profession representatives and three with policy actors from government departments/agencies. An additional interview with a policy actor included an observer who did not take part in the interview. Apart from one interview, which was conducted by telephone, interviews were held via videoconference (Zoom Video Communications Inc.) and were audio recorded with participant consent. One consumer advocate advised that they would allocate 30 minutes to the interview. One policy actor withdrew from the interview at the 46-minute mark. The policy actor requested that their responses not be included in the research and that the audio recording be deleted. These requests were accommodated. Three participants, two profession representatives and a policy actor, requested a copy of the transcript to review. One of the profession representatives returned the transcript with changes and redactions. The remaining two did not return the transcript or respond to reminder emails regarding the transcript.

The next chapter presents the results of interviews with consumer advocates about their views on the regulation of non-registered health professions.

Chapter 8

NO PLACE IN THE FIELD Perspectives of consumer advocates

8.1 Introduction

Semi-structured interviews with five consumer advocates were conducted between 27 April 2022 and 24 October 2022. The advocacy bodies that nominated a representative for interview were:

- Australian Patients Association;
- Consumers Health Forum of Australia;
- Federation of Ethnic Communities Council of Australia;
- Public Health Association of Australia⁷⁶; and
- Services for Australian Rural and Remote Allied Health.

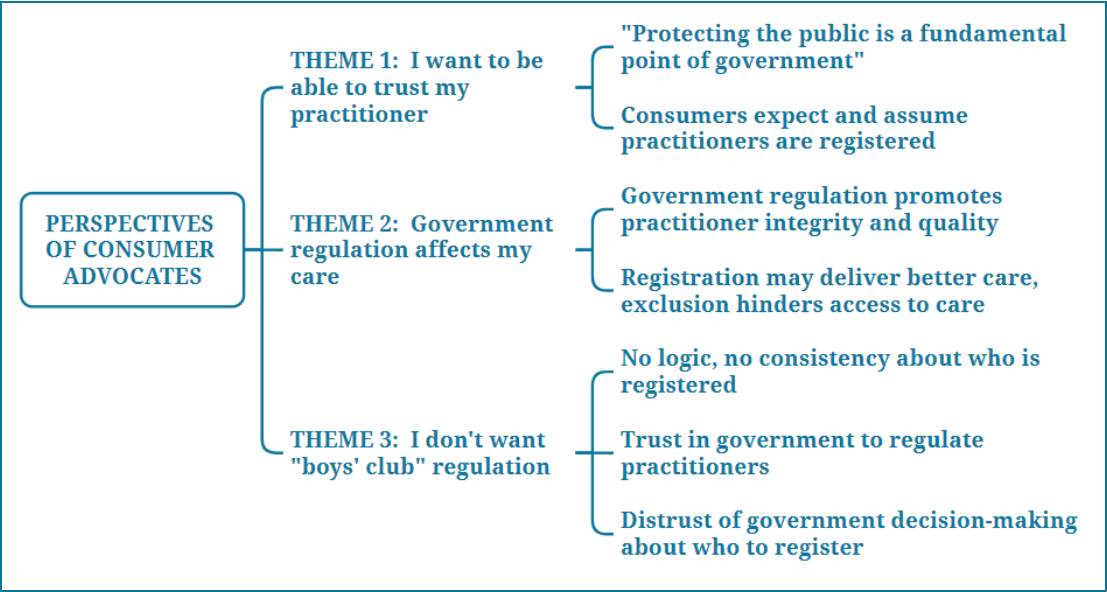
The views of consumer advocates regarding key aspects of health practitioner regulation (HPR) were broadly consistent. Advocates expressed the view that trust in health practitioners was essential to consumers. They stated a belief that consumers assumed practitioners were already subject to statutory quality assurance mechanisms and considered governments were best placed to provide such assurances. Registration was said by advocates to uphold the integrity of health practitioners, promote confidence in the probity of providers, and deliver better quality healthcare. Exclusion from registration was considered to hinder access to care. There was considerable disagreement with governments regarding professions not subject to registration, and little agreement between advocates on which health professions should be registered.

⁷⁶ The Public Health Association of Australia (PHAA) is the peak body for public health in Australia. The PHAA advocates for the health and well-being of all Australians by aiming to shape policies that help people at the national, state/territory, and local levels. While the association has more than 2,000 individual members representing over 40 professional groups, it does not represent a single profession. Instead, it represents individuals and organisations interested in promoting public health. As such, the PHAA was considered a consumer advocacy body for the purposes of this research. See: <https://www.phaa.net.au/Web/Web/About/About.aspx>.

Consumer advocates declared their trust in governments to regulate health practitioners appropriately but expressed distrust of governments maintaining the public interest when deciding which practitioners to register.

Following coding and analysis of interview transcripts, three themes and seven sub-themes were identified from the data. These are set out in Figure 8.1.

Figure 8.1: Themes and sub-themes generated from interviews with consumer advocates.



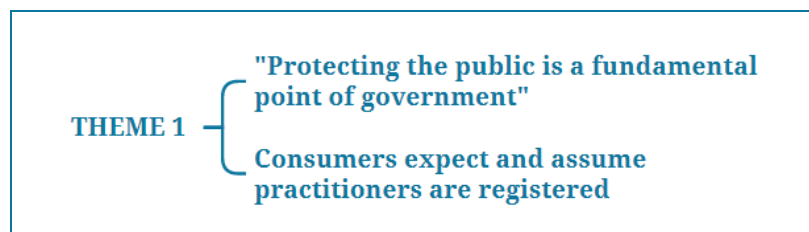
8.2 Theme 1. I want to be able to trust my practitioner

A common perspective among consumer advocates was the expectation that consumers should be able to trust their health practitioner, with most advocates stating that one way of building trust was through government or statutory registration. Advocates remarked that consumers assumed a government authority had assessed health practitioners as qualified and competent. They voiced concerns about “*dodgy practitioners*” being able to offer a health service with no government-authorised credentials behind them. Advocates spoke of the vulnerability of consumers without statutory protections and the onus of responsibility this placed on consumers to assess practitioner bona fides. They often contrasted the reluctance of governments to register practitioners with the perceived readiness to issue government licences to providers in other industry sectors. According to all advocates, the job of governments was to

provide protections against bogus or unqualified providers and ensure the reputability of practitioners to enter and conduct practice.

Figure 8.2 presents the sub-themes generated for this theme.

Figure 8.2: Theme 1. I want to be able to trust my practitioner



8.2.1 “Protecting the public is a fundamental point of government”

Almost all consumer advocates maintained that statutory registration protects consumers, and the absence of registration renders patients vulnerable to ‘charlatans’. They claimed too many professions were in the non-registered category, leaving it to consumers to assess practitioner bona fides. Non-registered practitioners were of concern to advocates because of consumer reliance on the advice given by these providers. Sometimes, advocates commented on the need for further action, suggesting government action, to protect consumers by ensuring statutory registration covered the right healthcare professionals. Under a self-regulatory regime, consumers were said to assume the risks of treatment from non-registered providers and the responsibility for assessing practitioner quality, rather than governments accepting the responsibility for public protection.

There are many, and probably too many, in that [non-registered] category [...] and essentially, it becomes caveat emptor for the public who use or draw upon advice from those professionals. [...] here's a clear level of inconsistency and some concerns about the extent to which the [NRAS] regulatory framework doesn't cover a range of health professionals upon whom people might rely, or have expectations that they are indeed registered. So, I think there's more work to be done to ensure the regulatory framework is thorough and provides better protection for consumers. (CA3)

Advocates spoke of the “duty” or “point” of governments, which they perceived as safeguarding consumers. Protecting consumers by ensuring health services were offered by registered practitioners was described by one advocate as a matter of “common sense”. They suggested that consumer protection was the minimum the public should expect from governments.

Regulating and ensuring protections for the public is like a fundamental point of government. (CA2)

What's the duty of care of government? [...] just [a] common sense, community quality care and protection viewpoint. (CA1)

In discussing the merits of registration, advocates responded to claims regarding the costs of registering smaller professions by pointing out the purpose of registration, which they identified as consumer protection. The quotation below impresses upon the reader that a vulnerable person is at the end of a practitioner’s treatment. The advocate inferred that consumer safety should be prioritised over other matters, such as the number of practitioners in a profession. The advocate emphasised the consumer as a person and rationalised that, despite being few in number, the impact of a “dodgy” practitioner on even a single consumer could be severe.

It's a concern that the government is going, Oh, we want to save money on regulating and protecting the public from potentially dodgy practitioners. Just because there's not a lot of them is like, for the one person to the handful of people who go to a dodgy person and get something going wrong, it means a lot to them, it's going to be a big concern for them that something went wrong. (CA2)

8.2.2 Consumers expect and assume practitioners are registered

All advocates stressed that consumers assumed and expected practitioners to be competent, accredited to a professional standard, and credentialled to hold a professional title. Some raised concerns about consumers assuming non-registered health professionals were regulated by governments. The comments implied consumers

might entrust their healthcare to practitioners, little knowing the provider may have no relevant qualifications.

There would be an expectation, particularly amongst the clients, users, patients [...] would have an expectation of a minimum standard of training and qualifications and competence. (CA3)

Yes, they do expect that they've got qualifications, and they can use that name. (CA5)

Advocates expressed the need for practitioners to be authorised to practise and hold a title. They suggested that government credentialling permitting the use of a professional title should be applied to registered and non-registered practitioners alike. They indicated that providers should not be allowed to practise without proper government authorisation.

People won't realise that. The public, they will just see this is a professional medical person and presume they are all regulated and registered to the same high quality and standard. (CA2)

A few consumer advocates compared non-registered and registered professions to emphasise appropriate regulatory oversight by governments. They expressed doubts about the ability of consumers to differentiate between qualified and unqualified providers and the dangers of making assumptions about the qualifications of non-registered practitioners. Some advocates gave examples of non-registered professions to illustrate the need for competent and ethical practitioners. They alluded to the need to register some non-registered practices so consumers would be adequately protected against false claims made by providers. One advocate suggested that by not taking responsibility for registering non-registered health professions, governments were permitting the unrestricted, unregulated activity of non-registered providers.

If you're a practising doctor, or a Chinese medicine therapist or an optometrist, you of course, have done qualifications and met requirements and been endorsed by regulatory bodies that you are competent and skilled to do the health service that you are professing to offer [...] and people would be mystified, confused, sceptical that that's not the case [...] If they're selling me this medicine, then obviously this medicine is proven to do the thing they're telling me. It would make no sense for them to be allowed to lie to me. (CA2)

8.3 Theme 2. Government regulation affects my care

There were many comments from consumer advocates about how regulation affects patient care, and most advocates identified the potential for higher-quality care under registration. Advocates frequently spoke of the need for a government body to ensure practitioners were qualified and competent. They commented on how the absence of registration affected consumers. One advocate said that the lack of registration created obstacles to multidisciplinary care because registered practitioners may be reluctant to refer consumers to non-registered practitioners. Some advocates stated these perceptions may arise from what they viewed as inter-professional rivalry between registered and non-registered professions. Another effect of the absence of registration was considered to be the partitioning of health professionals into different classes. This was suggested to dissuade some consumers from seeking healthcare from non-registered practitioners because of assumptions about lower-quality care.

Figure 8.3 presents the sub-themes generated for this theme.

Figure 8.3: Theme 2. Government regulation affects my care.



8.3.1 Government regulation promotes practitioner integrity and quality

All consumer advocates considered the role of governments in monitoring health professionals. They stated that the role of governments was to oversee practitioners, ensure appropriate care was provided, assess compliance with practice requirements, and establish adequate complaints mechanisms. Advocates were concerned about the risks of unscrupulous providers of non-registered health services. They considered part of the job of governments was ensuring “quacks”, “cowboys”, “shysters”, and “dodgy practitioners” were removed from practice.

If they're really interested in quality, to make sure that anyone who is purporting to be a health or other therapies sort of practitioner isn't just a shyster and isn't putting people at risk. (CA1)

[Patients expect] there's some sort of body that is monitoring their performance or misperformance [...] They do expect the cowboys would be cut out of the system. (CA5)

Advocates commented on the need for a “regulatory body” or “Ahpra registration” to set standards and requirements for non-registered practitioners. Having a government body overseeing practitioners was considered to instil consumer confidence, while the absence of a government regulatory body was said to raise doubts about the competence of health service providers. Advocates suggested that non-registered practitioners might not engender consumer confidence because consumers may not consider them competent or as competent as registered practitioners.

Essentially [statutory registration] sets a regulatory framework around health professionals where there's a certain standard of education competency [that] must be met [...] there's a certain, at least, level of confidence that the individuals who are Ahpra registered have had to go through an agreed set of processes in terms of both education and training and presumably reached an agreed level of competence. (CA3)

Advocacy stakeholders indicated that governments should accredit practitioners to ensure they were well qualified and competent to provide a health service. They frequently remarked that registration would give assurances about the quality and competence of practitioners because government oversight ensured standards of practitioner competency would be met. Advocates contended practitioners should be held accountable for their practice and they expected misconduct cases would lead to appropriate practitioner sanctions. They viewed registration as a vehicle for promoting practitioner accountability and stated that only a government authority could ensure this. Comments suggested that advocates were dubious about the ability of professional associations to adequately regulate practitioners and were uncertain about provider qualifications and competence when credentialled by those associations. They implied professional bodies may be unable to hold practitioners accountable or apply appropriate sanctions when necessary.

The risk always in the non-registered occupations is for quackery, for people setting themselves up as experts and without being held to account as to on what basis they're doing what they're doing. (CA4)

And so there's this view that like, Oh, if this person is telling me that they are a counsellor, then, of course, there's some sort of a health process body, regulation they've gone through and training that they've done to show that and do that and become qualified and accredited. [...] And if there's problems, then there is a mechanism for [...practitioners] to be penalised and forced to improve and things like that, there's government regulation involved. (CA2)

And there'll be consequences if they perform poorly, or act poorly [...] they do expect compliance [...] and they think there's accountability. (CA5)

Although all advocates identified the need for governments to safeguard consumers by regulating practitioners, one participant went further and placed the onus of responsibility on governments for any failures in consumer protection at the hands of non-registered practitioners. According to the advocate, self-regulation mechanisms failing to protect consumers were seen as a failure of government, thereby inferring that

self-regulating professional bodies were not responsible for any harm caused to consumers by practitioners.

If these [self] regulatory and other mechanisms aren't protecting everyone in those things, then that's their [the government's] failing, not the professions. (CA1)

Advocates viewed registration as an authorising licence and a necessary warrant for health practitioners. To illustrate the perceived need for the licensing of health practitioners, some advocates compared the absence of a practice licence for non-registered practitioners with the readiness of governments to license individuals in other industry sectors. Some advocates appeared surprised to learn that not all health practitioners were registered, a few suggesting that government attitudes towards non-registered health practitioners were less stringent than the licensing requirements for plumbers, electricians, and school bus drivers.

It's funny, isn't it, because you've got to be a licensed plumber or licensed electrician. [...] We issue fishing licences. (CA4)

You won't let a bus driver drive a bus with kids on it unless they have this card [...] So why would you let someone hang a shingle to do that [health practice] without some form of.... (CA1)

8.3.2 Registration may deliver better care, exclusion hinders access to care

Although there was agreement among consumer advocates that government regulation provided assurances about practitioner quality, there was no consistent view on whether registration delivered better quality healthcare. Most considered that fewer controls placed upon non-registered practitioners increased the likelihood of lower-quality care and raised the risk of harm. Registered professions, on the other hand, were described as having rigorous entry requirements, including mechanisms for corrective action when problems arose, compared with the perceived lower requirements for non-registered professions. Advocates commented that the “*higher bars*” for entry to registered professions raised the overall standards of practitioners.

By the nature of the registration, those professions are more likely to be high quality and safe for people [...] because there are higher bars to achieve in order to get the thing [...], whereas for the non-registered occupations, while they might have mechanisms there, the lower barrier of entry, and the less rigorous and less systematic mechanisms to identify and correct problems means that, inevitably there will be a lower standard of quality and a lower level of safety, maybe not an unacceptably low in terms of an absolute sense, but relatively low compared to the registered ones. (CA2)

A different view offered by an advocate was that the quality of care provided by non-registered and registered practitioners was comparable. This appeared to contradict earlier comments by the advocate regarding licensed school bus drivers and the failure of governments if self-regulating mechanisms inadequately protected consumers.

I think, from my own personal perspective, and I think from a reasonably informed one that understands government, having worked in it, I think the quality of care that I would get as a result of seeing a professional from a self-regulated profession as on that list would be likely to be as good as one from a regulated profession. (CA1)

Advocacy stakeholders speculated on the potential impact of the absence of registration on professional relationships. They claimed that the registration status of practitioners might affect inter-professional practice and potentially disincentivise collaborative care. They said that some registered practitioners might be unwilling to collaborate with non-registered practitioners and commented on the potential effect this would have on consumer care, such as longer wait times for patient treatment and increased costs of care from registered practitioners.

Several reasons were given for the apparent reluctance of registered practitioners to collaborate with non-registered providers. These included possible liability issues for registered practitioners, the need for the referrer to maintain their reputation, which was potentially compromised if they referred patients to a non-registered provider, and the preference to refer to registered practitioners because of perceived higher qualifications held, suggesting this would mean better quality practitioners.

One advocate said that some non-registered practitioners had stated they had been “cut off” from providing services to consumers, presumably because they were not registered. The advocate commented on the contribution non-registered practitioners could make despite not being as highly qualified as registered practitioners.

At present, [GPs] don't, as a rule, recommend to a psychotherapist. Why? I think they're worried about the professional's insurance and their reputation. They recommend them to psychologists because they've got university degrees [...] and they're covered by Ahpra. So, to a certain extent, they're safeguarding themselves. Now. Hear the other side. Well, you recommended me to a psychologist. I can't see the psychologist for three months. Right? And the psychologist is charging \$150 an hour. I could see a psychotherapist next week; they're only charging \$80 an hour. [Psychotherapists are] saying we have been underutilised for few years since we've been cut off, and we're not really registered. Sure, we're not as highly trained and skilled as a psychologist, but we can still serve a very useful purpose [...] we're ideally suited to handle those kind of slightly less complex issues. (CA5)

Another advocate proposed that having the ability to search a register of practitioners would facilitate referrals between professionals. They suggested that such a register would promote practitioner confidence in referring consumers to reputable, registered practitioners. They considered having such a resource as ample justification for statutory registration.

I don't know whether, as part of the registration process, that then means that there is a generated list somewhere in the system that a GP can go to the computer and look up; who in my area does this and can find a list and refer patients [...] if registration facilitates greater referral capacity, that's another good reason to have all of these things registered. (CA2)

Several advocates remarked on the perceived elitism among registered professions, where the existence of registered and non-registered professions was considered to create an occupational hierarchy. Advocates perceived registered practitioners were

practising under authority from the state, while non-registered practitioners were not. This was suggested to cast doubt in the minds of consumers about the capability of non-registered professions as healthcare providers and engender a belief that registered professions were “better” or “legitimate” compared with non-registered practitioners.

People go, Well, they're registered with them [Ahpra], so there's that pseudo there. It's an authority [...] There's that sort of semi-authoritative thing [...] most people would think that there's probably something wrong with those professions that aren't registered [...] because it doesn't have that imprimatur of, Oh, government says it's good. (CA1)

There's a risk that they're setting up a kind of a hierarchy that this profession is better than that. (CA4)

In contrast to the view from one advocate that the care received from non-registered practitioners was as good as that obtained from registered practitioners, another advocate perceived that non-registered professions were viewed with disdain and stated this would change with registration since registration was seen to “elevate” the profession. This was one of several advocates who mentioned that registration raised professional standing. They considered the elevated standing of registered professions was due to perceived higher practitioner qualifications under registration mechanisms. The advocate claimed the purported denigration of non-registered practitioners was because of an absence of registration and inferior qualifications compared with registered practitioners. The comments indicated that lower qualifying awards undermined practitioner credibility and legitimacy in the eyes of other healthcare professionals, some of whom might be healthcare “competitors”. Differentiations made between professions because of qualifications were considered by the advocate to be historical, inferring a long-term rivalry between certain professions, compounded by different regulation mechanisms under which professions were governed.

I think [registration] would also help to legitimise [non-registered professions] in the public mind. (CA1)

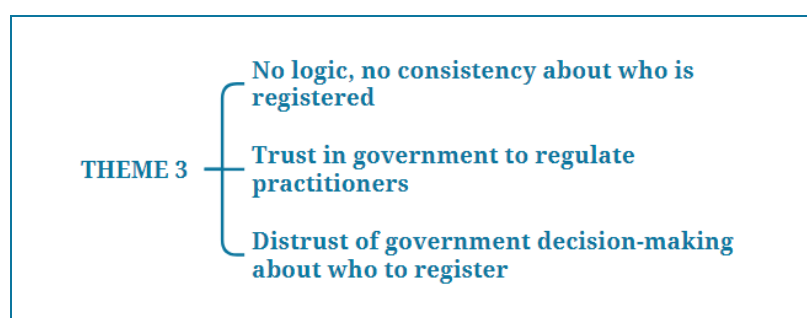
What's running through my mind is that the non-registered ones are looked down on [...] once they become registered, they're probably elevated in status a bit. Right? [...] certainly, it elevates the standing of the profession [...] but the non-registered professions] they're looked down on. I think it's all qualifications and there's a bit of competition between the different professions. Every profession looks after its members, and if they can put them on a platter and elevate the importance and keep at bay some competition. [...] some of it's historical, and, of course, people have been to university and got better qualifications – they want that standing. (CA5)

8.4 Theme 3. I don't want "boys' club" regulation

Most consumer advocates called for independent statutory oversight of non-registered health professions, although there was little agreement about which professions should be subject to registration. These advocates stated governments were best placed to provide the required regulatory oversight of non-registered practitioners, but most disagreed with government assessments about the professions that were not registered. Despite a common view of governments' role in regulating health practitioners, most advocates were sceptical that governments would maintain a public interest perspective when deciding which professions to register.

Figure 8.4 presents the sub-themes generated for this theme.

Figure 8.4: Theme 3. I don't want "boys' club" regulation.



8.4.1 No logic, no consistency about who is registered

There was considerable commentary about which professions should be subject to registration. While individual advocates held firm views on which professions

registration should be applied to, there was little consensus among them and little agreement with government decision-making about professions not subject to registration. Advocates pointed to the perceived inconsistencies between registered and non-registered professions, particularly in cases where practitioners were considered to provide similar health services. One advocate stated government decisions about registered professions were “*arbitrary*” and “*haphazard*”, implying little logic was used by governments in deciding on which professions to register. The decisions made by governments regarding registered professions were said to establish an uneven distribution of professions into registered and non-registered classes, which the advocate claimed created unjustifiable inconsistencies.

There's that question [...] about who's in and who's out, and that has always been, as far as I can tell, a pretty arbitrary thing [...] the haphazard application of [registration] makes for a line that looks like that. There's no neat line [between registered and non-registered professions], and I don't know that there ever could be. But the one they've gotten, they've tried to defend is complete rubbish on the grounds they tried to defend it [...] of course there's anomalies, absolutely. (CA1)

Psychotherapy and sonography were two non-registered professions receiving consistent support for registration. One advocate challenged the distinction between non-registered psychotherapists and registered psychologists, as these professions were perceived to have similar practice scopes. They questioned the characteristics of psychology practice that ostensibly required registration, while psychotherapy apparently did not. They inferred that registration of some professions had been based on partisan decision-making, had received preferential treatment, or were registered for reasons other than public protection.

I would say psychotherapists should be registered, sonographic, yes. (CA5)

So what makes them special, that psychologists that they need to be Ahpra registered, whereas psychotherapists don't have to be? (CA4)

For some advocates, registration was tied to issues of access to care and payment of subsidies for healthcare provision. Conversely, non-registered healthcare was associated with unsubsidised health services, which were said to restrict consumer access to these services. Comments from one advocate suggested that registering certain non-registered professions and subsidising their practices would facilitate greater consumer access to care.

[The government should] set up a system that enables access to the right care, and they don't. And they don't do it through funding mechanisms. But equally, they don't do it by promoting or supporting some of the practitioners, that there's plenty of research and evidence to suggest could be very beneficial for people in certain circumstances, and that access is not being facilitated. And some of that care would be amongst the self-regulated slash unsubsidised service providers or professions. (CA1)

Perceptions of professions requiring registration were frequently rationalised by contrast with similar registered professions. Typically, advocates placed consumer protection considerations central to their assessments of professions. To support their views, they described specific and potentially serious risks posed by certain non-registered practices and practitioners. Some advocates spoke more familiarly about some healthcare practices that may have influenced their perspectives regarding registration. Two advocates stated that government perceptions of non-registered professions were due to a lack of knowledge and, potentially, political risk exposure. By focusing on consumer protection, advocates inferred that government decision-making about registration did not maintain the same focus on the public interest.

Why is an audiologist out and an optometrist is in? I mean, what, one organ's worth more than the other? [...] I think a lot of this is based on people not understanding what those professions do. [...] So speech pathologist, if someone has a stroke, and they can't speak, they can't swallow, they risk choking. I mean, at what point is that not important? [...] why would a Chinese medicine practitioner, I mean, there'll be people that go, oh, they're not real anyway, the Chinese medicine practitioner. But regardless, they're in [the NRAS]. Before you talk

about are they in or out, what's the distinction? And I find it very difficult to understand what the rationale is between them. [...] from a policy point of view, I'd be looking at, you don't necessarily want to argue Chinese medicine out. But you do want to draw the distinction that says, or draw the fact that well, what is your distinction, government, ministers, in making a decision that Chinese medicine was in and Western herbalists and naturopaths are out? Is that to do with potential political backlash more than healthcare, or what? (CA1)

Another advocate remarked that professions such as audiology and speech pathology need not be registered, nor was registration considered necessary for social workers or dietitians. Speech pathology was not viewed as sufficiently risky by the advocate to warrant registration. They stressed the need for registration for practitioners who could cause consumer harm, such as naturopaths, who they considered should be registered because of their role in prescribing medications. Much like the previous quotation, comments by this advocate suggest familiarity with healthcare practices appears to have a bearing on opinions regarding which professions should be registered.

A speech pathologist that's more like a teacher than a healthcare professional [...]. So what about an audiologist? Probably similar. [...] I suppose, in a nutshell, it comes down to what harm they can cause the patient. Whereas a speech pathologist, well, they're not causing any harm, they mightn't be able to improve their speech. Where can they cause harm that they need to be regulated? [...] I think naturopaths probably should because they're giving you pills and medicines. [...] The other areas, social work, you're not prescribing drugs and medicines, dietitian, speech pathologists and audiologists. (CA5)

A few consumer advocates considered other types of potential harm. The potential for financial exploitation was one reason given for applying further regulatory measures to professions. In the following quotation, although the advocate previously implied audiology did not cause harm to warrant registration, they considered hearing aid sales by audiologists required further regulatory controls.

Now, we've got [the audiologist], that's hearing. So it depends. If they're selling hearing aids or devices, it needs to be controlled. (CA5)

Massage therapy was one profession for which there was general agreement that registration was unnecessary because of the perceived low risk of harm. When giving reasons for this view, an advocate stated that massage therapists were unlikely to cause serious harm or death, suggesting registration should be reserved for only the riskiest of professions.

To an extent, there's a question about what potential harm could be caused by people who are practising without the appropriate level of training, and while I'll accept everybody's had a massage, masseuse, who's probably gone a bit hard, a masseuse is unlikely to kill you.
(CA3)

Now massage. Look, I don't think that needs to be regulated. (CA5)

In a departure from classifying health professions according to the risk of harm, two advocates perceived that “*evidence*” should be included in the registration assessment criteria. One of these advocates remarked that professions should be registered if there is evidence of effectiveness for the profession supporting public health objectives.

One [additional assessment criteria] would be what's the evidence base for this profession contributing to the health and well-being of the population? (CA1)

The second advocate stated that professions should be registered based on whether they practised “*evidence-based medicine*”. They contrasted professions considered non-evidence-based, yet were registered, with professions viewed as evidence-based but were not registered. The advocate remarked there were professions in both registered and non-registered groups that were not practising “*evidence-based medicine*”, alluding to a lack of logic in government decision-making. For this advocate, the “*science-based*” professions of audiology, counselling, and dietetics should be registered, whereas registered professions described as “*sketchy*”, such as Chinese medicine, should not be. They contended that registration bestowed authority and legitimacy. Extending this status to professions deemed to be unscientific would, according to the advocate, deceive consumers, grant “*unscientific*” professions undue approval, and make

governments appear foolish. These comments indicate that perceptions of “evidence-based” practices influenced perspectives on registration.

I like the idea that there are these established science-based, evidence-based medical practices [...but] an audiologist, or a counsellor, or a dietitian, they're not registered [...] I find it weird that some of the more sketchy ideas around Chinese medical practice, or chiropractic and osteopathy, are on the registered list, and other ones like Western herbalism and naturopaths are on the non-registered list. There's mixed views as to where they should be, but I just find it weird that they're not all in the same group. [...] In general, I would say nothing should be on the non-registered occupation list at all [...] The only caveat I would have to that is that there are items on both of these lists that are not actually evidence-based medicine, [or] known to do anything beyond a placebo, and having them have the auspices of officialdom through regulation and societies and stuff, gives people the false impression that they are legitimate. [...] If I make government approve Western herbalists, that makes the Western herbalist look very legitimate to people that don't know much about Western herbalism and that makes the governments look inept and idiotic to those who do. (CA2)

8.4.2 Trust in governments to regulate practitioners

Consumer advocates were divided over the adequacy of self-regulation to oversee non-registered professions, with some considering it a valid type of regulation while others spoke of the limitations of self-regulation that registration was perceived to overcome. One advocate contended that self-regulation was adequate if it was well-managed in terms of clinical oversight, training, and practice. They inferred these practice characteristics should be benchmarked to external standards.

I think a well-managed, self-regulated health profession tied to a particular standard of training and quality practice and where there's clinical oversight by the rest of the profession [...] I have no problem with that. (CA1)

Another advocate pointed to specific regulatory mechanisms perceived to give assurances regarding practitioner quality, such as the National Code of Conduct (NCC). Although the advocate viewed the NCC as a potentially weaker form of regulation than registration, they stated it provided a minimum level of consumer safety and an adequate regulation mechanism by ensuring minimum professional standards. The advocate's chief concern was ensuring consumers were aware of their rights and the bodies they could turn to in case of need. These comments and concerns imply that this form of regulation was at greater risk of failure because consumers may be unaware of complaint avenues open to them when problems occur.

I think [the National Code of Conduct], that's the, if you like, the fallback position, because then at least there is kind of a quasi-setting down some sort of quality standards, you must do this, do this, do that, whatever. The key thing, then, that people know where to go to make a complaint, can get that addressed. (CA4)

Although certain advocates perceived registration was prone to limitations in safeguarding the public, two advocates considered consumers of registered health services were afforded protections and mechanisms of redress that were considered unavailable to consumers of non-registered services.

But at least there's some level of protection and recourse available [for consumers of registered professions], and it's far from perfect and no one should pretend that it is [...] and ultimately, who's best placed to judge the circumstance on whether you got bad dental practice, and that's another dentist. And famously, dentists, like many professions, are reluctant to dob in⁷⁷ their own. So, no one should pretend it's a perfect level of protection, but at least it's a level. (CA3)

Some consumer advocates described the “failures” of self-regulation and spoke of the need for independent oversight of health professions. One referred to the self-regulated

⁷⁷ To “dob-in” refers to the practice of informing against another person or reporting a person to the authorities. See: <https://www.collinsdictionary.com/dictionary/english/dob-in>.

environment as a “*boys’ club*”⁷⁸ and a “*gentlemen’s agreement*”⁷⁹, inferring a regulatory arrangement in which professional associations maintained control. The advocate commented that independent oversight, such as that in place for registered professions, brought fixed requirements suggested to be lacking under self-regulation. To reinforce the point regarding the absence of mandated requirements for self-regulated professions, the advocate commented on how readily self-regulation could be rendered ineffective because it was “*easier to break*”. Examples of stated failures of self-regulation in other industry sectors were used to support arguments regarding the ineffectiveness of self-regulation, where profit was viewed as the business priority. The primacy of profit was considered inappropriate when it came to public health issues. Comments implied that government oversight gave reassurances regarding upholding consumer rights and ensuring independent governance. In contrast, association oversight was suggested to be fraught with personal and professional interests, unsatisfactory performance, and a disregard for the health and safety of consumers.

It's like an independent thing that isn't a boys' club or the gentlemen's agreements [...] there's actually hard rules and requirements. [...] Ah, self-regulation is problematic because that is easier to break. Like looking at the banking system, the aged care system, the electricity system. A lot of these self-regulating systems are not self-regulating very well. [...] There is a lot of dodgy stuff going on that is not good for consumers because when it is a business that is self-regulating itself, the priority can easily become what is the most profitable thing that we do, which is very bad when we're dealing with a health thing. (CA2)

⁷⁸ A “*boys’ club*” refers to an organisation, typically a male-dominated organisation, that excludes or mistreats women. See: https://en.wiktionary.org/wiki/boys%27_club. In this account by the advocate, a boy’s club may be inferred to mean that self-regulation was controlled by certain groups, such as professional associations, that favoured one group, such as association members, to the detriment of another, such as consumers.

⁷⁹ A “*gentlemen’s agreement*” is a non-binding arrangement between parties based on the principle of honour to maintain the arrangement. See: <https://www.collinsdictionary.com/dictionary/english/gentlemens-agreement>. In this account by the advocate, a gentlemen’s agreement for self-regulation may be inferred to mean a non-legal arrangement instituted by professional associations and dependent on the ‘honour’ of the association to maintain the agreed arrangement.

One consumer advocate had much to say about self-regulation, wavering between distrust of self-regulation because of its inadequacies due to “*vested interests*” of professional associations and a view that it could work well given the right conditions. The ‘right’ conditions were seen to be a professional body with high ideals that monitored members, although this could result in loss of membership because of increased monitoring costs. The advocate suggested that tension existed between “*vested interests*” in maintaining membership numbers on the one hand and maintaining high professional standards on the other. They considered these limitations to be overcome by registration.

Allied health, we talk to a lot of them. They talk about self-regulation. They all claim it's effective, but you know, I've got my doubts about self-regulation. I've seen it work in so many areas, and it's failed, generally due to vested interests. I'm sure, in some instances, it can work well if you really got a peak body that prides itself and audits all claims and audits its members. But that costs money, right? It pushes up fees, which could mean reduced membership. (CA5)

The same advocate went on to describe other reasons for what they regarded as inadequacies of self-regulation relating to complaints handling. They remarked on the potential bias and inevitable conflict when professional associations were required to investigate complaints against members who were likely to be colleagues. Similar to the dilemmas perceived for associations trying to maintain high professional standards in the face of potential diminishing membership, the advocate described the competing interests of self-regulating associations to retain membership against the need to effectively manage consumer complaints against their members. The advocate inferred that, like other professional sectors, when it came to business versus consumer priorities, precedence was likely given to business needs. The advocate described the requirement for impartiality and independence in handling complaints, which they perceived registration provided. They stated that lay representation could strengthen complaints panels and provide a better balance between independence and subject matter expertise to appropriately investigate and adjudicate on consumer complaints.

I don't think the association often has the resources; often, they're colleagues, and they don't want to lose a member. We've seen in other forces, like the police, every time they've got to investigate themselves, too often there's shortcomings because someone knows someone in the force that knows them, and you're always a bit more lenient on your colleagues [...] they can always make excuses for shortcomings. [...] those ones that aren't covered by Ahpra would have to have a complaints hearing process, and I'd like to think would have at least an independent patient representative on it because if we're all just a profession, it's going to be biased, right? So a bit like all bodies for setting up groups to hear complaints, they've got to be independent and come up with the right outcome. (CA5)

A few consumer advocates also viewed self-regulation as limited because statutory health complaints entities were perceived to inadequately investigate complaints brought against non-registered practitioners. These entities were said to be reluctant to apply appropriate sanctions when necessary. An advocate voiced doubt over the ability of complaints commissioners to satisfactorily perform their role because, in their view, complaint commissions had limited knowledge of health practices within their purview. They suggested that without adequate knowledge of health professions, commissions were constrained in their ability to discharge their statutory functions.

With the health complaints commissions [...], they generally try and resolve complaints in an amicable way. [...] They never recommend you go to a lawyer. They never recommend adverse media coverage [...] they try and resolve things very quietly, and it'd be very rare where they'd recommend that the healthcare professional is deregistered. [...] Another concern I've got is the skillset [...] I don't think that they'd have the skillset to do good. Do they really know what a naturopath does unless they have some personal experience? Do they really know what a psychotherapist does unless they've got some personal experience? (CA5)

The advocate summed up their views regarding self-regulation by stating:

Look, generally, in most areas, self-regulation doesn't work. (CA5)

8.4.3 Distrust of government decision-making about who to register

Consumer advocates expressed a distrust of governments maintaining the primacy of public protection in deliberations regarding registration for non-registered professions. One consumer advocate stated governments could not be relied upon to assess professions for registration according to objective measures. Some advocates perceived that governments were laggards in assessing non-registered professions for registration. They commented on reasons for the apparent inaction of governments and inferred this had more to do with politics than policy. Advocates identified the following “barriers” to action by governments: the costs associated with registration, a view that government priorities lay elsewhere, a reluctance by government officers to perform assessments, the complexity of the policy process in registering professions, and the difficulties associated with resolving such complexity. Some advocates appeared unconvinced by government arguments precluding the registration of additional professions. They expressed resignation over the “politics” of the situation while not abandoning their pursuit of policy reform on behalf of their constituents. One advocate likened the situation to a battle. Another advocate placed the onus of responsibility for the current state concerning registration with the federal government. The acceptance of government inaction by one advocate reflected their view that governments considered there was no pressing issue to be resolved.

I think funding is fundamentally an issue, and that might be one of the reasons why they haven't done it [...] they might be better off just saying, Oh, look, we don't want to [register more professions] we don't want to take on more work [...] I don't trust federal governments at the moment and haven't done for a while to actually be motivated to [register professions] for the right reason, and I've seen too little to suggest that their motivation is about the public good. (CA1)

I come [up] against the barriers that the others are coming up against, that it's hard, it's complicated, it costs money, it takes time, it gets in the way of us doing what we should be doing, which is far more important. I hear all of that stuff. It's more box-ticking. It's more bureaucratic. I hear all that stuff all the time, and I think it's wrong, and I'll keep on fighting the fight. But I understand the inertia of we're doing okay, doing it the way we're currently doing it. (CA3)

Government staff providing advice to ministers were singled out by one consumer advocate who suggested that “*bureaucrats*” potentially lacked objectivity and their advice to ministers was potentially biased. The advocate stated governments would likely question the validity of some professions, inferring a government tendency to cast around for a pretext to justify inaction. The advocate also said that when seeking information and advice about non-registered professions, governments would turn to medical and nursing personnel rather than the professions concerned. Advocates were sceptical of public officials and government agency staff prioritising consumer welfare. One advocate said that government officers served their ministers rather than the public.

And they [Ministers] will all be briefed by their bureaucrats [...] there'd be some stuff about questioning the validity of the particular profession and its care, and they probably consulted the AMA⁸⁰ on it rather than anyone else [...] why talk to the people involved when we can talk to them? Or, they've got the Chief Nurse and Chief Medical Officer to advise on it. [...] I think the essence is governments, agencies serve ministers now, they don't serve the public. That's what they're there for. They're a pseudo-political apparatus, and they don't challenge and don't necessarily have enough content knowledge. (CA1)

The same advocate considered how registration decision-making might ideally function to improve consumer access to services. They identified the need for government officers to be knowledgeable, objective, and “*dispassionate*”. However, they doubted

⁸⁰ AMA: Australian Medical Association.

this vision of decision-making could be realised because cost and other issues were seen to override consumer needs. The advocate suggested that in any assessment of professions for registration, officers were overly influenced by factors that hindered consumer access to a broad range of critical health services. One of those factors was considered to be costs. Another was that government officers were perceived to lack objectivity.

In the ideal world, you want to facilitate access to services from an independent point of view, but an independent, and here we go into theories of governments, et cetera, a dispassionate, objective, but well-informed group who are going to go, the evidence really suggests sonographers are critically important to picking up early childhood auditory problems, and we should facilitate access. Do they do it? No. So, and that's for reasons of cost, et cetera. So, they are failing in their job of objectivity. (CA1)

8.5 Chapter summary

While only five consumer advocate participants were interviewed for this study, they reported consistent views on most matters relating to occupational regulation. This includes the need for government oversight to protect consumers from bogus and unethical providers and ensure practitioners are qualified and competent.

There was little agreement among advocates about which professions should be registered, and divergent views on whether registration improves care. Some advocates appeared to have more detailed knowledge about the scope and risks of practice of certain professions, which may have influenced particular positions regarding regulating these practitioners. Risk of harm featured strongly in the rationales for registering specific professions, and some advocates identified risks as being broader than physical harm.

While most advocates endorsed government-authorised registration of health professions, there was little trust in governments to maintain a public interest perspective when making decisions about which professions to register.

Even though the perspectives offered in respondent accounts came from their positions as consumer advocates and not necessarily as consumers of non-registered health services, they provided in-depth views on a broader range of health professions than might otherwise have been provided had consumers themselves been interviewed.

The next chapter presents the results of interviews with government health policy actors regarding the regulation of non-registered health professions. This is followed by a chapter on the findings from interviews with professional body representatives.

Chapter 9

KEEPERS OF THE FIELD Perspectives of health policy actors

9.1 Introduction

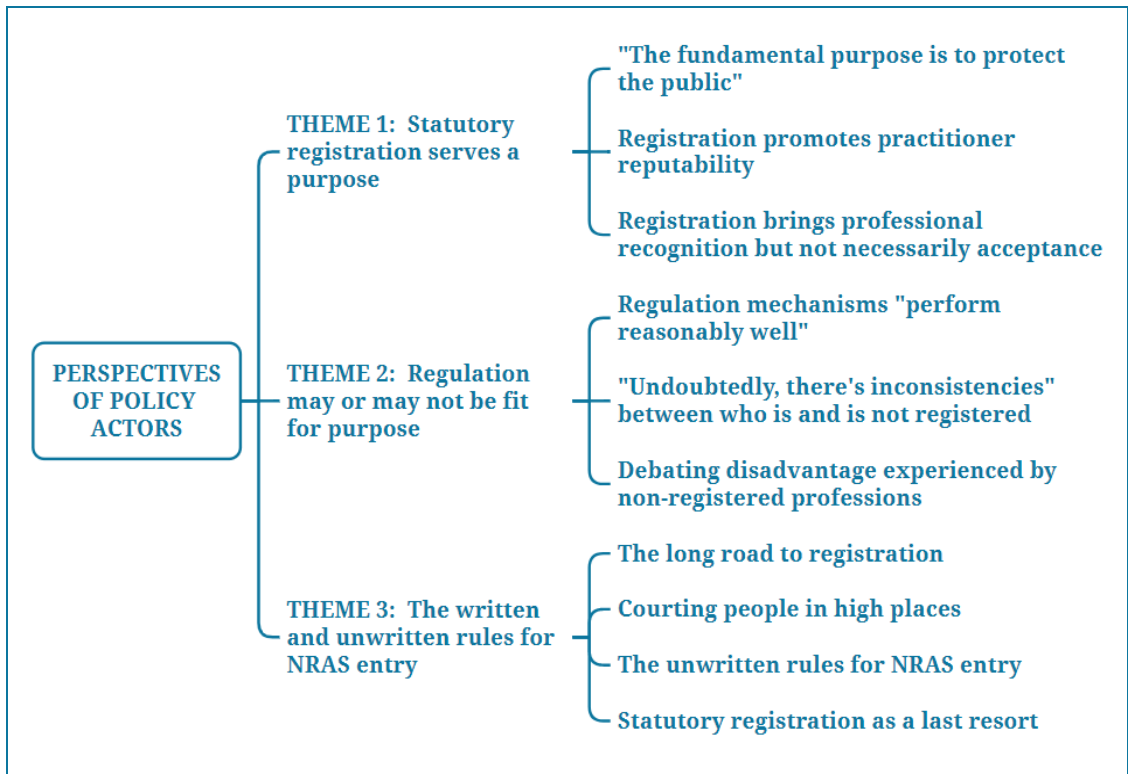
To ascertain the attitudes of government health policy actors, twelve semi-structured interviews with fifteen government health policy officers were completed between 17 March 2022 and 5 September 2022. Interviews were conducted with informants from the health departments of every Australian state and territory and the Commonwealth Department of Health, the Australian Health Practitioner Regulation Agency (Ahpra⁸¹), and the Office of Best Practice Regulation (OBPR). Three interviews were conducted with two informants present, and one interview had an observer present who did not participate in the interview. One policy actor from a sub-national jurisdiction withdrew from the interview at the 46-minute mark and requested their responses be excluded from the research and the audio recording be deleted. Two policy actors asked for a copy of their transcripts to review. They did not return the transcript or respond to a reminder email advising that if no correspondence to the contrary was received within one week, it would be assumed the officer agreed the transcript could be included in the analysis.

Topics discussed during the interviews included the purpose of registration, the adequacy of existing regulation mechanisms for non-registered professions, and the complexity of ministerial decision-making regarding registration. The perspectives of interviewed policy actors were broadly consistent across the cohort, although there were some differences in the perspectives offered, such as the impacts of registration on non-registered professions and practitioners.

⁸¹ The Australian Health Practitioner Regulation Agency uses sentence case for its acronym. See: <https://www.ahpra.gov.au/About-Ahpra.aspx>.

Following coding and analysis, three themes and ten sub-themes were generated from the data. These are presented in Figure 9.1.

Figure 9.1: Themes and sub-themes generated from interviews with health policy actors.

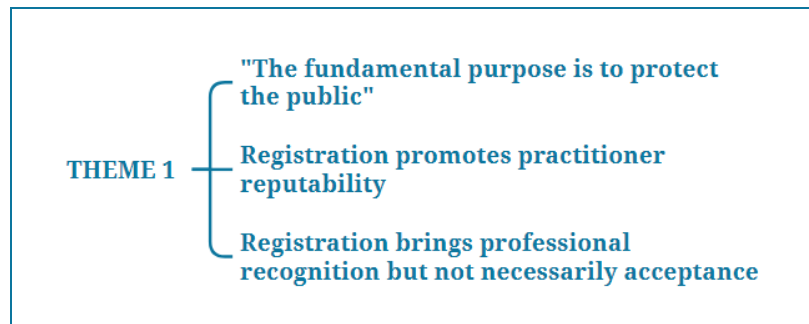


9.2 Theme 1. Statutory registration serves a purpose

Interviewed policy actors widely regarded statutory registration as serving a specific purpose, including promoting public protection, boosting practitioner accountability, and ensuring providers were qualified and safe. Most informants stated that although it was not its intended purpose, registration also promoted practitioner recognition, reputability, and legitimacy. These views featured strongly in informant accounts on perspectives regarding regulation. Several policy actors appeared to take pride in being part of a registered profession. A few informants commented that registration did not guarantee recognition, and the status said to arise from registration did not necessarily bring acceptance from other registered practitioners.

Three sub-themes were identified from the data relating to this theme. These are set out in Figure 9.2.

Figure 9.2: Theme 1. Statutory registration serves a purpose.



9.2.1 “The fundamental purpose is to protect the public”

Every policy actor in this study commented on the public safety objectives of the National Registration and Accreditation Scheme (NRAS). Informants universally regarded registration as a mechanism designed to protect the public. Most informants expanded on the consumer protection objectives by commenting on aspects of registration that contributed to patient safety, such as the “consequences” and penalties registered practitioners were subject to. One informant described re-registration processes as a reminder to practitioners of their “obligations” to the profession. Another repeated an edict from Ahpra regarding public protection, suggesting lip service was paid to consumer safety objectives. Several informants pointed to the statutory nature of registration to reinforce the consumer-protective nature of the NRAS.

It is now firmly anchored in a patient safety perspective. (GPA5)

It's a national-based scheme where [the] objectives are about protecting the public, as well as enabling Australians to have access to the services provided by registered health professionals. (GPA1)

Well, obviously, the fundamental purpose is to protect the public. (GPA4)

[NRAS] remind[s] us what our obligations are and hold us to account for the profession that we hold. (GPA14)

Protect the public [laughs]. It's what's drummed into us from Ahpra. Do no harm! (GPA11)

9.2.2 Registration promotes practitioner reputability

A common view among informants was that registration provided assurances to consumers that practitioners holding a statutory title were safe, appropriately trained, well-qualified, and accredited to a national standard. Policy actors in this study spoke of “*registration standards*”, “*common standards*”, and “*nationally consistent*” requirements gained through registration that served to reassure consumers of the quality of care provided by registered practitioners irrespective of their location in Australia. The standard requirements informants referred to were minimum qualifications, training and education standards, course accreditation standards, skills and knowledge, continuing professional development requirements, standards of practitioner conduct, and professional ethics. Several of these requirements were summed up by one informant as professional standards that “*defined you as a profession*” (GPA1).

[Registration] gives the public the surety that training courses and accreditation standards are consistent across the whole country. (GPA8)

You can reasonably expect, as a member of the public, that the services that you get from somebody who was registered will meet a standard [...] that you're going to get services at a certain level and that a person is trained and suitably qualified. (GPA1)

When I think about our regulatory framework, we've got codes, we've got standards for practice, we've got safety and quality frameworks. There's a number of elements that wrap around who we are as professionals that support and guide us in our practice. (GPA14)

Few informants explicitly referred to the professional standards of non-registered professions. However, many statements from most interviewed policy actors regarding standards for registered professions suggested that informants considered non-registered practitioners were not subject to the same obligations and demands as registered practitioners. Most policy actors in this study inferred that practice entry requirements established under statutory registration were higher than those set under

self-regulation, resulting in better-trained, safer practitioners and more consistent course accreditation standards. Due to the voluntary nature of professional standards under self-regulation, non-registered practitioners were suggested to be less well trained and qualified, may not have consistent national accreditation standards, and may not be subject to the same accountability and sanctioning requirements as registered professionals. These perspectives are evident in the following informant accounts, where distinctions are drawn between registered and non-registered professions and where informants suggested non-registered professions were ‘on their own’ in setting professional standards. To indicate the perceived distinction between the two professional groups, one informant referred to registered professions as “regulated” and non-registered professions as “unregulated”.

Informant: I suppose the penalties, well, I don't know there's legislation that applies in general terms for people who offer services to the public [...] when people have been deceiving other people, but the difference [between registered and non-registered professions], I guess, is that with a regulated profession, the public is able to have a minimum standard of a professional, of an entry into that profession, there's a minimum set of standards for someone to meet to pass the threshold to enter that profession.

Interviewer: And that minimum standard isn't necessary for the non-registered professions, is that what you're saying?

Informant: No, not at all. If they're organised enough, the unregulated, well, the self-regulated professions can establish that for themselves. (GPA2)

Lots of professions have their own professional associations of one description or another, where they're trying to standardise codes of conduct, quality of practice, public safety, trying to improve public safety, and this [NRAS] is really just a version writ large of that. (GPA3)

[Registration] sets standards [...] that they understand the rules of the game in the sense that we understand the parameters in which we have to work professionally, both in terms of skills and qualifications in the work they do, but also in terms of professional conduct. They understand the consequences of breaching that because it is statutory. (GPA5)

Informants commented on the heightened accountability measures that statutory standards were considered to impose on registered practitioners, including potential deregistration. Statutory standards were said to provide effective mechanisms of monitoring and accountability. By pointing to strengthened arrangements for registered professions, some informants implied that non-registered professionals were not subject to the same monitoring, accountability and disciplinary measures as registered professionals.

[T]here would be some kind of consequence if a certain person who was practising didn't meet those [professional] standards [...] some sort of assurance that you are going to get services at a certain level [...] and if they don't meet that, then there's consequences for you to be on the register. (GPA1)

So it means that the profession is going to be more accountable, perhaps, than it has been before [registration]. (GPA3)

With national registration, it does mean that things like registration standards and including things like continuing professional development, etc, can be nationally consistent and probably, potentially have a stronger sort of, you know, approval and monitoring process. (GPA4)

One informant stated that registration gave consumers greater assurances about the advice provided by registered practitioners. They inferred that the advice offered by non-registered practitioners was not as reliable and that non-registered practices were less rigorously regulated. Several interviewed policy actors stated a belief that registration was perceived as an essential mark of “*integrity*”, a valuable commodity for practitioners and a distinguishing symbol setting them apart from others in the eyes of consumers. By stressing the assurances registration offered consumers, informants suggested this established a key distinction between registered and non-registered professions because self-regulation could not provide the same quality assurances.

Being regulated by a statutory body under a framework of law would give me more assurance if I was going to a practitioner that was under that kind of framework. [...] It certainly seemed more rigorous to be under the statutory. (GPA4)

I think at its heart, [registration is] meant to be an assurance. If you've registered, you've attained something, you've achieved something [...] I think the professional groups see it as a way to help maintain their integrity as a profession. [...] So I think registration, in some ways, it's become more important for the professions in terms of their own integrity [...] and people know who they are. But I also think it's become more important for the public in terms of, at least important for them to understand what the value of that registration actually is. (GPA1)

Informants underscored the importance of occupational titles where title holders were required to meet minimum standards to gain entry to practice as suitably qualified and legally sanctioned practitioners. This was said to be verifiable through a statutory register or listing of credentialed professionals. A title was implied to offer a signal to consumers of practitioner quality and reputability. To emphasise the reputability of registered practitioners, informants used terms such as “*fit and proper*”. A policy actor stated that entry to the NRAS with its annual re-registration requirements meant registered practitioners were declaring they could be “*trusted*” to do “*the right thing*”.

It gives a sense of assurance that those people who are registered, you can go and find out about them straightaway on the public register, you can look them up, you can see their qualifications [...] the boards are about registration standards, and they're about making sure that the people who are registered are fit and proper to hold the title. (GPA2)

So I can put my hand on my heart and say, every year I register, I'm doing the right thing. I'm registered to fulfil the role and function of a [registered profession], and you can trust that I hold a licence that allows me to do that. (GPA14)

Through these and other comments, several interviewed policy actors implied that non-registered practitioners, who were not subject to the rigorous requirements of NRAS,

may not provide consumers with the same assurances, may not be fit or proper practitioners to hold a professional title, may not behave professionally or ethically, and may not be trustworthy or do the right thing.

9.2.3 Registration brings professional recognition but not necessarily acceptance

The majority of policy actors in this study commented on the perceived prestige of NRAS registration, variously described as professional “*recognition*”, “*legitimacy*”, “*validation*”, and “*respect*”. A few informants added that, from their perspective, the elevated professional standing deriving from registration was an unanticipated benefit. One informant described registration as a “*club*” open to those holding the proper credentials. Another stated registration invited registered practitioners to join broader conversations about Australian healthcare, conversations which were implied to be closed to the non-registered. Yet another informant offered the view that, under registration, practitioners were defined as health professionals, a designation suggested not to apply to non-registered practitioners.

These sentiments conveyed a sense of worth bestowed upon registered practitioners. The impression given by these comments is that, in contrast to the status, worth, and inclusion of registered professions, non-registered professions were potentially devalued, unrecognised, disrespected, invalidated, delegitimated, excluded from discussions about the health system, and not considered as health professionals.

I think the NRAS is seen by many professions as not just being about a regulatory system but about professional recognition and that for many [...] they view, and it's not an unreasonable assessment to make, that NRAS is a validation of sorts, that you are a recognised and respected and defined health professional within the Australian healthcare context. I don't think Health Ministers view it that [way...] I think it provides lots of things. Of course, professional recognition, it does that. (GPA5)

Even though it's not meant to, I think it does add a certain legitimacy to the profession. [...] It's also joining in an ongoing dialogue with the broader health system, which I think is good. So, I think there are a couple of outcomes and benefits to being involved in [NRAS]. (GPA3)

This is why professions all love being registered. It means that only the right sort of people can join their club. (GPA1)

Although many interviewed policy actors stated registration elevated professional standing, one informant presented the view that professional recognition and acceptance eluded some professions despite registration. These professions were described as being lower in the healthcare “*hierarchy*”. The informant suggested that, in addition to classifying professions by registration status, a ranking of registered professions by other characteristics was being maintained and that other factors were important in achieving professional acceptance. The policy actor implied that the professional hierarchy widely regarded as operating in the broader healthcare system had been preserved in the NRAS. They stated that the position of professions in the NRAS hierarchy was being maintained by factors beyond the registration scheme, factors not readily amenable to change.

Some of the professions that are included in the [NRAS] scheme, that would be lower in the hierarchy of professions in the Scheme, would feel that, yes, they're pleased to be in this scheme [...] but I think that, if they were asked, they would say, it probably hasn't brought the acceptance, and the understanding, and the acknowledgement that they would have hoped it would bring. [...] As community attitudes change, I do think that will help shape future conversations. But I do think there's a very long way to go in terms of that. [...] Even within the more established professions, there's still many times when those hierarchies are very firmly embedded in the conversation. Even within mainstream health services, ways of doing things differently to draw on the skills of a wider range of occupations in a different way is very difficult to achieve. (GPA13)

But some of those registered professions put themselves above all others, irrespective of the registration. [It is] reasonably clear that the doctors hold themselves to be the premier medical professional in this country, and I don't think the NRAS is the reason they think that. There are lots of reasons why that position is held by some doctors. It's perhaps just reinforced by an NRAS model for some of them. Others are not so arrogant. (GPA5)

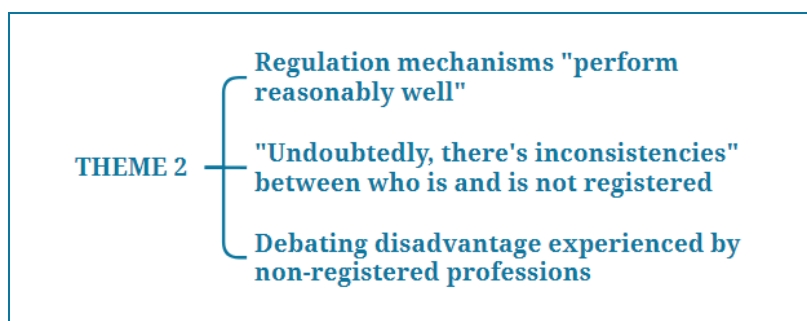
9.3 Theme 2. Regulation may or may not be fit for purpose

Most policy actors interviewed for this study regarded the current regulation arrangements for non-registered professions as adequate. These policy actors considered the self-regulating mechanisms in place performed “*reasonably well*”. Despite these views, some deficiencies with self-regulation were identified, such as the difficulty in mitigating risks associated with practitioners working in isolation.

When comparing the list of registered and non-registered professions, several informants described inconsistencies between the two groups. A few non-registered professions were singled out as requiring further regulation. When contemplating whether non-registered practitioners were disadvantaged by being excluded from the NRAS, a small proportion of informants claimed they had observed distinctions being made between registered and non-registered professions. In contrast, one informant said that if non-registered professions considered they were being disadvantaged, NRAS was not the reason for this.

Three sub-themes were identified from the data relating to this theme. These are set out in Figure 9.3.

Figure 9.3: Theme 2. Regulation may not be fit for purpose.



9.3.1 Regulation mechanisms “perform reasonably well”

Many policy informants in this study indicated that the mechanisms for regulating non-registered professions, including co-regulation arrangements, were largely adequate. While a few interviewed policy actors perceived deficiencies with self-regulation, the range of measures was generally considered appropriate for non-registered professions

and, by extension, was suggested to adequately protect consumers. Together with the National Code of Conduct (NCC), Medicare was deemed satisfactory for regulating most non-registered professions because to qualify for Medicare rebatable consultations, non-registered practitioners must hold professional association membership, thereby submitting themselves to the association's standards. This co-regulation arrangement prompted one informant to observe, "*while it is voluntary* [to be a member of an association], *it is career-limiting to not be*" (GPA5).

According to interviewed policy actors, the NCC was a suitable mechanism for dealing with culpable non-registered practitioners. Although a few informants remarked that the NCC was not equivalent to the NRAS, they considered that health complaints entities generally provided effective mechanisms to address consumer concerns regarding non-registered practitioners. Several policy actors described weaknesses of self-regulation. These weaknesses included voluntary association membership allowing providers to practice without association oversight, the retrospective nature of NCC legislation with no provision for practitioner screening before entering practice, varied scopes and health settings covered in jurisdictional NCC legislation, and the fact that the NCC was not in force in all jurisdictions, limiting its effectiveness nationally.

The absence of practitioner screening was considered particularly concerning in cases where providers worked in private practice because these practitioners were not subject to third-party regulatory mechanisms, such as employment screening, which was said to provide another layer of quality assurance. Informants describing these inadequacies implied that although they acknowledged the usefulness of measures and systems in place for regulating non-registered practitioners, policy actors were not confident these mechanisms captured all possible circumstances the NRAS was designed to capture. It suggests that although many informants viewed existing mechanisms as satisfactory, they were also aware of their limitations and that policy actors considered these mechanisms less than ideal for some non-registered professions and practitioners.

I think our systems perform reasonably well. I think consumers of health services do have recourse if issues come up [...] I wouldn't necessarily say there was an equivalency [between self-regulation and statutory registration]. Obviously, there are really key differences, but if there was a sexual assault, for example, if there was something really serious, you'd see that would be dealt with in a similar fashion [under the NRAS or the National Code of Conduct] those different structures, again, those more rigorous structures of the National Law, are there for the higher volume and higher risk levels. (GPA7)

Informant: So people like massage therapists, for example, [there] is a negative licensing type scheme whereby it sort of becomes ideally the National Register, and it basically flags people who have done misconduct or malpractice.

Interviewer: Is negative licensing in place in [your jurisdiction]?

Informant: Unfortunately, not so. (GPA4)

Sometimes people talk as if there is nothing in the space, but actually, there are a whole range of regulatory requirements for practitioners, and I'm not trying to suggest that they're the same, so obviously, something like the Code of Conduct doesn't include the things that the National Scheme includes. [...] I think one of the other things that is important to be aware of with the National Code is that different jurisdictions, because it operates within state and territory legislation, different jurisdictions define its scope, [...] I mean, it's entirely right that [the National Code of Conduct] is retrospective, but I think it still has value. So, all I'm trying to say is I don't think its value should be discounted. (GPA13)

The other regulatory arrangements that are in place, as you know, even though it's a bit of a hodgepodge⁸² and didn't quite get implemented the way I think it was envisaged, we've got the National Code of Conduct for healthcare workers now, [...] it's not active registration, but it's dealing with the odd ones who do the wrong thing or poorly performing, that actions can be taken. [...] I think there are some gaps [in self-regulation], particularly those that work in private practice. (GPA6)

⁸² Hodgepodge is defined by the Cambridge Dictionary as “a confused mixture of different things”. See: <https://dictionary.cambridge.org/dictionary/english/hodgepodge>.

While acknowledging the usefulness of voluntary mechanisms for practitioners who do “*the right thing*”, one informant noted the limitations of self-regulation when practitioners “*do the wrong thing*”. These were suggested to include limited powers to hold practitioners accountable or impose appropriate sanctions when required.

[Self-regulation] doesn't have much teeth, for when things don't go as they should or when people do the wrong thing. I mean, I still think it's a useful tool for the 99% of people who are doing the right thing. But someone doing very much the wrong thing, it's quite limited. [...] It doesn't really have much that can enforce anything. (GPA4)

On the other hand, another interviewee considered that a range of safeguards existed to ensure the safety of health providers in Australia, inferring these provided sufficient coverage for all health professions, including non-registered professions. Within these layers of regulation, NRAS was viewed as but one of those mechanisms.

There are many, many checks and balances in the health professions providing their services in an appropriate patient safety context, [...] and there is a plethora of regulatory environments that ensure or provide added layers of protection to that. [...] I'm not suggesting that everybody is caught by every system. I'm saying that the system, there [are] many, many regulatory systems that intersect and overlap to ensure health professionals in this country are held to a minimum standard of appropriate skills and qualifications to provide safe patient care. One of them is the NRAS. (GPA5)

One informant commented that the *National Law* and self-regulation could achieve similar outcomes with a sufficiently determined and organised self-regulating association and a sufficiently informed public. The informant identified the role the associations and consumers were perceived to play in assessing credentials for non-registered practitioners. To underscore the point about alternative regulatory mechanisms, the informant referred to the scale and size of the NRAS, likening it to a “*beast*”, a large organisation with an extensive workforce and considerable associated costs. These comments and those from other interviewed policy actors indicated a reluctance to feed the NRAS “*beast*” with more professions and practitioners. They gave

the impression that the NRAS had a finite capacity, containing traps and “hurdles” that precluded further professions from being accommodated. These considerations were suggested to predominate over the need to register additional professions irrespective of consumer safety issues or limitations and failures of self-regulation.

Informant: I just think it comes down to how organised [the associations] are and how much they're driven to improve. [...] If there's enough momentum within that profession, then they will set the standards for that profession.

Interviewer: There's no barrier to entry, though.

Informant: Oh, well, there's a barrier to being a membership of that [association] club.

Interviewer: There'll be a barrier to entry to the association, but there's nothing preventing practitioners from actually setting up shop.

Informant: Correct. That's right.

Interviewer: And do you think that's acceptable?

Informant: Well yeah, it has to be acceptable at some kind of level. But if there's enough public awareness, [...] a consumer can go and ask questions about whether or not that person's a member of a professional association or if there's certificates on the wall [...] then we're kind of achieving similar things.

Interviewer: I don't know that the public actually do that. [...]

Informant: There's some fundamental kinds of issues with how far do we go with regulating everything? [...] and it's a massive cost. [...] We've created this scheme, which now runs into the 10s and 10s of millions of dollars. And it's a beast. There's a couple of hundred FTE⁸³ just in the office in [our jurisdiction] in Ahpra. [...] It all comes at a cost. (GPA2)

[I]t's really complicated because of its sheer size, and the breadth of professionals that are in it, now 16 professions [...] coming up to 850,000 practitioners nationally, more than 15% of the national workforce [...] What I'm saying, there's these hurdles you have to clear and because it's already big, as you know, almost 850,000 workers, sixteen professions. (GPA8)

⁸³ FTE refers to full-time equivalent or the total number of personnel employed in an organisation working the equivalent of a full-time worker.

These views suggest that, from a government perspective, regulating non-registered professions was largely left in the hands of and wholly reliant on professional associations and their approaches to good governance. Under these arrangements, consumers rather than governments were asked to vet practitioner credentials to assess whether practitioners were “*fit and proper*” to practice. The arrangements were suggested to be required, not because they were necessarily effective, but because of the size, complexity, and cost of the NRAS. These factors were implied to have a bearing on whether further professions should be considered for registration. The comments alluded to a government passively outsourcing its regulation role to others rather than determining the most suitable regulatory settings for individual professions by conducting assessments of professions against the IGA criteria. Interviewed policy actors considered self-regulation appropriate for some non-registered professions, and many informants continued to promote self-regulation even though most acknowledged the superiority of the NRAS as a mechanism for practitioner regulation. Informants also appeared to struggle with reconciling what they viewed as the ideal regulation arrangements for at least some non-registered professions with the practical resourcing implications and complexity of registration under the NRAS.

9.3.2 “Undoubtedly, there’s inconsistencies” between who is and is not registered

Almost all policy actors in this study stated there were “*inconsistencies*” between professions that were and were not registered. A few informants identified non-registered professions with scopes of practice comparable to registered professions or professions they said required further regulatory intervention. Several informants would not be drawn into discussing perceived differences or inconsistencies between the two professional groups. Other interviewed policy actors appeared to struggle to articulate and explain why some professions were registered and others were not. Most interviewed policy actors raised the historical context of the NRAS to partly explain the discrepancies between the two professional groups. Many informants spoke of the “*history*” of state- and territory-based registration and the agreement of governments to “*harmonise*” the state-based schemes that were often perceived to be in conflict between jurisdictions and created mobility issues across state borders. A few informants

cautioned that any perceived similarity to a registered profession should not be used to justify registration, since the inclusion of some registered professions was more of a historical artefact than based on meeting the IGA criteria. Nevertheless, many interviewed policy actors did make such comparisons or commented that certain registered professions may not meet the IGA criteria if assessed today.

I'd now wonder about whether one or two of them, and the one that I'd have in my mind is around occupational therapy, whether they would actually now be accepted. (GPA1)

It's not an ideal situation. If you sat down and designed [which professions were to be registered] today, it wouldn't look like it is. But that's not how it developed. It's historically who was around the [registration] table at the time. (GPA11)

I think there are also some, frankly, historical reasons, reasons to do with the kind of history of regulation in different states and territories across the country, and so it's not quite as straightforward as assessment of the risks of harm. (GPA13)

You cannot look at the list today based on the prevailing logic of patient safety, which I understand is definitely where the Scheme is currently anchored. But it was not anchored to a binary decision by health ministers in 2010 that these professions over here represented an unacceptable patient safety risk, and these did not. And therefore, we will register these and not register those. That is not the historical context for the creation of the NRAS. (GPA5)

Despite the fact that we have those six criteria, some of these professions were added to the Scheme because they were already regulated in one or more states and territories. Now, no one's going to apologise for that because that's just what happened, and we are where we are. (GPA2)

When presented with a list of registered and non-registered professions and invited to comment on any perceived discrepancies, informants viewed the list from different perspectives. One informant considered the question from the viewpoint of safeguarding the public, while another took the consumer perspective and how they

might perceive the two groups. Several informants referred to the strength of self-regulation arrangements for certain non-registered professions as influencing their perspectives on whether to register. Others considered the perceived risks of professional practice in their deliberations, such as autonomous practice, manipulating body parts, using invasive procedures, and performing diagnoses. A few informants proposed similarities between professions based on the scope of practice or other factors. Several interviewed policy actors commented that there were discrepancies between professions that were and were not registered, which they considered might necessitate further regulation of some non-registered professions, without commenting on which. A few informants perceived that some non-registered professions could be registered, and other informants questioned whether some registered professions should have been registered in the first place. Even though there was no consistent view regarding which non-registered professions might have sufficient justification to make a claim for registration, there was agreement among informants regarding inconsistencies between the two professional groups.

Why is a psychologist there [registered] but a counsellor and psychotherapist, why are they not [registered], because they could still, they would have an equivalent level of risk. (GPA3)

Why are osteopaths registered and why aren't audiologists? I mean, it's a good question. I mean, why not stop registering some of them? (GPA7)

Informant: Look, my observations are that, undoubtedly, there's inconsistencies. Umm, look, and all I can say is, yes, on the face of it, there's inconsistencies. [...]

Interviewer: Can you point to some inconsistencies?

Informant: Oh, well, like, umm [9 seconds] Yeah, I don't know, I don't want to paint myself into a corner here. [...] I'm just saying, yes, on the face of that, there's inconsistencies.

Interviewer: Which way?

Informant: Both ways, both ways. (GPA2)

I think the [non-registered] ones on the right, I think you could provide some arguments for [registering] some of those. (GPA6)

I think what I'd go back to are those things about what makes a profession dangerous. So drugs and poisons for that lot [of non-registered professions] – no. Invasive procedures, I think, mostly no for that lot. [...] If you're a psychotherapist, I could see a lot of issues to do with the nature of that work, why you'd potentially think there are risks to the public around the nature [of] that work. Potentially, for the naturopath, more about the products that they're involved in. Much like why, so you could ask yourself, why is a Chinese medicine practitioner regulated, but a naturopath isn't? I think I could see that argument. (GPA1)

One interviewed policy actor stated that the reasons for the inconsistencies might defy explanation. They suggested the machinery of government, with its frequent ministerial and staffing changes, was not conducive to dependable, consistent decision-making and may be partly responsible for discrepancies in the registration status of professions.

Look, there might not be any rational explanation [why some professions are registered and others are not]. Again, those departments change, ministers change. (GPA7)

Another informant argued that because people elected governments and governments had determined which professions should be registered, the public, therefore, supported government decisions that not all health professions required registration. This suggests that government decisions relating to registration were considered to enjoy the support of the populace by being elected to govern irrespective of constituent views or the opinions of those who did not vote for the government.

Governments and, I would say, by extension, the community, because they elect governments, have made the decision that not every health professional in this country requires registration at the level of the NRAS to provide high-quality patient services. (GPA5)

Several informants suggested their role in the department was not to advise their minister on HPR policy based on the IGA criteria or other evidence. Instead, their role

was suggested to be implementing the wishes of the government of the day, absolving themselves of responsibility for providing policy advice.

I mean, for me, as an employee of a government department, obviously, we take direction and advice from our Minister's office.
(GPA7)

There were a few professions that informants did not consider required registration because of perceived lower practice risks. These professions included clinical perfusion, exercise physiology, and social work. Another reason for precluding professions from registration contention, irrespective of practice risks, was the small number of practitioners in the profession, for example, clinical perfusion and orthoptics, because these were considered impractical to register.

I'm not so worried about the [regulation of] social workers. (GPA1)

Orthoptists [...], the issue there is, is it reasonable and is it practical? Because I know they're a very small profession. (GPA6)

In the passages below, massage therapy is considered a profession that should not be registered, in this instance, because of a perceived lack of professionalism. The reason for the exclusion of massage therapy, according to the informant, was that the profession was not considered to “belong” in the NRAS. This suggests registered professions held proprietorship of the Scheme rather than professions being assessed for inclusion based on individual risk-based assessments and other criteria, as defined in the IGA assessment criteria. Many professions described as ‘belonging’ to the NRAS were said to be part of the prevailing medical establishment possessing substantial “status and power”. These characteristics were suggested to be some of the factors determining which professions should be accepted into the NRAS.

Oooph! How the hell would they demonstrate they belong? [...] Well, this is, again, it's just me, but I'm saying you look at your [registered] list on the left-hand side. These people regard themselves as professionals. You know what I'm saying? I think that's the reality. They're medical practitioners, they're osteos, they're physios, they're psychologists, they're pharmacists. What do they want a massage therapist in their scheme for? [...] I'm saying the Scheme in its origins, it was to rationalise all these boards and so forth that already existed in these long-standing professions, and I think the reality is a lot of them had a lot of social and economic and political capital to begin with, didn't they? [...] I wouldn't know if they were ever talking about the need to keep any of these [non-registered] professions out of [NRAS]. I can't say that. But what I'm saying is that the Scheme was put together, as you know, and then it comprised all these professions that have a long-standing status and power. (GPA8)

This account implies that although the NRAS was established to protect the public, acknowledged by every policy actor interviewed, the National Scheme was viewed by this and other informants as instead being reserved for those perceived to “belong” and worthy of registration. These policy actors inferred that while the NRAS protected consumers, the NRAS itself required protection from outsiders or intruders, from those who did not fit in, from those who did not belong.

9.3.3 Debating disadvantage experienced by non-registered professions

Opinions varied among policy actors in this study on whether non-registered professions were disadvantaged by their exclusion from the NRAS. Several informants stated they were aware of or had observed differentiations based on whether a profession was or was not registered. In contrast, others said they were unaware of any differentiations or disadvantages experienced by non-registered professions. One policy actor stressed governments’ legitimate use of registration status in decision-making regarding policy matters unrelated to the NRAS. They stated they had observed friction and prejudice based on registration status but appeared to contradict these perspectives by also remarking they had not seen any “genuine mistreatment” because of registration. They

implied that the disadvantages and differentiations they had observed were inconsequential, infrequent, or justified because of government policy requirements.

Having some professions within your professional leadership that are registered [...] and having others that aren't, it can be a bit of a rub. [It] doesn't always work as well as you'd like it to. So I can see why a scheme that excludes some professions, essentially, may cause some problems for some of the stakeholders [...] I've seen projects and schemes make differentiations based on whether you were registered or not [...] So yes, I would say that there are times when I've seen that kind of differentiation made. I can't say I've seen a lot of genuine mistreatment of these professions based on whether or not they were registered. [...] And if I'm in government, of course, I'm going, if I need to say, well, we actually need our regulatory framework to be part of their decision-making, well, of course, they're going to go with the National Scheme, and that might be a way that that's differentiated. (GPA1)

Another policy actor in this study questioned whether any perceived “disruptors” experienced by non-registered professions were due to the NRAS or were based on other factors associated with non-registered providers. While not denying non-registered professions had experienced disadvantages, the informant stated they had not personally observed such differentiations and contended there were many potential reasons for the claimed disadvantages unrelated to registration.

I think the descriptor that that vast range of disruptors is driven by lots and lots of different, varied decisions, and I don't think they all necessarily relate directly or indirectly to NRAS registration. [...] I think for many of them, government decisions around inclusion of professions in various - and access to services is always a multifaceted decision, and it's not anchored to one or other criteria. And again, in my experience, the NRAS registration or not, is not ever the only criteria for whether a health professional is engaged for service. It's whether the professional's scope is appropriate for the service to be delivered. (GPA5)

Other interviewed policy actors described the unintended exclusion of non-registered practitioners because of a lack of awareness about which practitioners were registered or limited knowledge about registration in general, even among government officers. Such comments alluded to the use of registration as a shorthand method to identify health professions, resulting in preferential practitioner treatment based on registration status.

[During COVID lockdowns] *I had to go back to [those writing the health orders] time and time again because they'd say the registered professionals can stay open, and I'd say, well, you have just excluded dietitians, speech pathologists.* (GPA11)

One informant stated they had observed intentional prejudice where registered practitioners were said to promote themselves to gain a competitive advantage and devalue practitioners in non-registered professions. The informant suggested that registered practitioners engaging in this type of self-promotion were acting to protect and extend their professional territory while seeking to exclude non-registered professions from scope expansion opportunities. The informant stated some registered practitioners were recasting the NRAS as a scheme for safe professionals and were misappropriating registration to advance their professional interests at the expense of non-registered professions.

There may be some registered professions that use [registration] as a bit of an opportunity to further their or promote themselves [laughs]. [...] Like, we're registered, so we are safe. [You] cannot consider expanding the scope of practice of a non-registered profession, because they are not registered, therefore they are not safe. (GPA6)

9.4 Theme 3. The written and unwritten rules of NRAS entry

Every interviewed policy actor commented on the policy and decision-making processes for assessing non-registered professions for registration. Informants identified several formal factors considered to support decision-making, the most important of which was the IGA criteria. The criteria were largely endorsed by almost all policy actors in this

study, and the processes involved in decision-making were viewed as relatively “straightforward”. However, over two-thirds of informants considered the policy process, including ministerial decision-making, complex and onerous. Decision-making often relied on informal and unwritten rules, and the bureaucratic machinery supporting decision-making was described as “slow-moving” by one policy actor. Decision-making determinants that were considered to add to the complexity were the requirement for cross-jurisdictional ministerial consensus in decision-making, government inertia, ministerial “appetite” for registration, the costs of registration, specific characteristics of professional bodies, and the role of champions, ministerial advisers⁸⁴, departmental policy officers, and the Office of Best Practice Regulation⁸⁵.

Four sub-themes were generated from the data. These are set out in Figure 9.4.

Figure 9.4: Theme 3. The written and unwritten rules for NRAS entry.



9.4.1 The long road to registration

Almost all policy actors in this study remarked on the suitability of the IGA criteria for assessing professions to determine registration eligibility. Most criteria were considered relevant, although an informant declared that the criterion ‘Is regulation possible to implement?’ was not as useful as others. The informant claimed this criterion was inconsequential because any profession could be registered with sufficient government

⁸⁴ Ministerial advisers are government-appointed staff who are not employed by the public service but by ministers as personal staffers employed to provide policy advice. See: <https://www.apsc.gov.au/publication/strengthening-partnerships-final-report/chapter-one-understanding-system>.

⁸⁵ The Office of Best Practice Regulation was renamed to the Office of Impact Analysis on 18 November 2022 (DPMC, n.d.) after stakeholder interviews for this research were completed.

resolve and resources, provided it met all other criteria. The comments alluded to the dependency of decisions on the consideration and judgement of decision-makers despite rigorous assessment criteria and a well-documented policy process.

I think as a set of criteria, I think they cover pretty much the most important things. (GPA1)

I do think they're reasonably good criteria. [...] I do think that they go to some of the critical issues. (GPA13)

Number four [Is regulation possible to implement?] seems to me to be a bit irrelevant. It's always possible if you [...] invest the resources. [...] I don't think four adds a lot of value. (GPA8)

There appeared to be different interpretations among interviewed policy actors on how some criteria informed decision-making. One informant emphasised the perceived subjective nature of decision-making regarding the risk of patient harm and identified characteristics they considered influenced perspectives of risk. The informant remarked that the threshold level of risk, that is, the point at which harm becomes unacceptable, prompting government action, changed over time. It was influenced by the views of health ministers, societal expectations and tolerances, and information gathered as part of the regulation impact statement (RIS) consultation process. This was said to preclude any definitional guidance on unacceptable risk.

The criteria is, as I said, subjective. But they need to convince health ministers that those criteria, the risk, is sufficient to warrant registration. [...] No, I can't [identify at what point practice risks require registration] because that's also not a static point in time either. It's a combination of, as I said at the beginning, society at the time, historical issues around the views of health ministers themselves. I mean, they are people. All of these things. And also, as I said, the RIS is supposed to tease out what the perspective of patients and the broader community is about where that risk lies. So it's never, by definition, a static point in time, which I respect is frustrating for associations that are seeking entry because we cannot give you a quantum of patient safety risk or this is some objective measure. The criteria is not like that. It is all subjective. (GPA5)

In contrast, a few informants offered perspectives on assessing significant risk, including assessments of practice and practice settings of individual professions and assessments based on frequency and seriousness of harm.

I don't know what the [risk] threshold is, but it's related to volume and severity. (GPA8)

Interviewer: Do you have a view of where that line is, about whether it's a significant risk of harm or not for an occupation?

Informant: Yeah, probably, but probably only in a kind of case-by-case, looking at examples and a situation. (GPA13)

No interviewed policy actor pointed to formal or published guidelines on assessing risk. When asked about decision aids used in assessing the risks of health professions, one informant stressed the interpretation and complexity involved in decision-making. The informant highlighted the difficulty in gathering data on evidence of practice risks for professions with fewer regulatory mechanisms. They suggested that non-registered professions faced challenges when making claims for registration because self-regulation mechanisms were not conducive to good data gathering that would provide evidence of risk to support registration claims.

The times when I have done [an assessment of professions] have been in terms of the criteria, like using those criteria, and the explanatory guide as a guide, I guess, as a decision guide. [...] Obviously, there are elements of judgement involved in what is significant risk of harm. And also, some of the evidence for some of these things is not straightforward. So it's not always easy, when professions are not regulated to a significant extent, to know exactly what harms are occurring. So, in a sense, the debate can become circular because it's much easier to know about professions that have significant levels of profile and whether harms are very easily apparent and harder to make those assessments about some other occupations. [...] One of the things that is difficult is getting a good picture of the kind of story of what happens occupationally and developing an evidence base for different kinds of risks that there might be. (GPA13)

A potential reason for the perceived inability to establish a standard perspective of threshold risk is that different policy actors in this study held diverse views about what types of risks should be included in assessments for registration. This was potentially due to inadequate formal guidelines or decision aids, which left decision-making open to individual interpretation. Some informants considered only physical risks of harm to consumers, with one informant suggesting patient harm equated to death. This informant implied that they were looking for “*shocking*” professions before registration should be considered, such as documented cases of extreme harm caused to patients. Other informants included financial, psychological, and emotional harm in their risk considerations. One interviewed policy actor stated that risks to practitioners and, to a lesser extent, risks to governments, such as regulatory, financial, and political risks, were also included in assessments.

Informant: [I]f you're providing treatment that is invasive of somebody's bodily boundary, then it's relatively straightforward to persuade people that the nature of this intervention can have a significant risk of harm. If the work that you're doing is the sort of work that social workers do [...] does indeed mean that there is a significant risk of harm. However, that would not be the case for everybody in the regulatory space. [...] So I'm saying not everyone who would be engaged in these discussions, or in fact, people in other stakeholder groups as well, not everyone would share that view. [...] But I think what that fails to take account of is the nature of the client group, and the particular dynamics and the nature of where the work often occurs, so that just as there are for individual registered health practitioners, in particular situations where working with vulnerable people, you get relatively high instances of sort of boundary violations and things, I think that the nature of people, the working environments of people like social workers, there is also those sorts of same risks that are generally very often working with people in their homes or in other places where there isn't necessarily a great deal of external supervision or support. You know what I'm telling you?

Interviewer: I do. [...] Does that mean that some of your peers see a significant risk of harm in physical terms, the physical risk of harm [...] while others might have a broader view of harm?

Informant: Yeah, that's exactly what I'm saying, yep. (GPA13)

I don't have a whole lot of data, but I can't say I've seen speech pathology slaying people in their thousands as a result of their services. I can certainly see some risks, but I can't say I've seen a whole lot of examples where I'd say this is a shocking profession and it needs to be registered. (GPA1)

These comments indicate that policy actors were perceived to have different views regarding the types of harms that should be considered and the threshold risk when such harms become unacceptable. The varied interpretations may extend to other assessment criteria and potentially to how individual professions are perceived. This may create problems in assessing professions for registration, as some interviewed policy actors suggested decision-making relied on personal interpretations of harm rather than standard risk guidelines and other decision-making aids.

While the assessment criteria for registration under NRAS were largely considered relevant and covered the essential components for assessing a profession, they were also perceived as unnecessarily complex by over two-thirds of policy actors interviewed. Most informants stated or suggested that registration decision-making processes were lengthy, onerous, and overly bureaucratic.

So the process is, I don't know if it's appropriately bureaucratic. It is a process that tries to find a way to allow each state and territory to have its own [...] governance over the [NRAS] thing while at the same time trying to find some harmonious way of making it work for the nation. And, you know, there's nothing about that that is easy. (GPA2)

The stated complexity of the criteria is perhaps why a few informants suggested there were different views between government officers and professional bodies on the criteria and the assessment of professions against them. A small number of informants suggested that professions seeking registration did not sufficiently consider the criteria in their registration proposals, particularly the criteria regarding public protection and the adequacy of self-regulatory arrangements. This may be because, as one informant stated, the criteria were potentially opaque, containing appreciably more substance than was apparent on the surface. They inferred that the complexity of the criteria

created difficulties for decision-makers in making registration determinations and potentially for professions in putting forward registration claims.

I think it's a complex set of criteria. [...] I think that they're not always as straightforward as people might imagine to make judgements about. (GPA13)

I said [to the professional association], look, you read these criteria carefully, and you really think about how your profession operates and the kinds of clinical settings that it operates in, and then have a good old read of these criteria. Do the activities of the occupation pose a significant risk of harm to the health and safety of the public? Well, yes, they do. But do the existing regulatory or other mechanisms fail to address health and safety issues? Well, no, they don't. Because the way the settings that occupation work in are highly, highly governed, highly managed. (GPA2)

In the following passage, another informant considers the criterion regarding the adequacy of existing regulation arrangements, which they assumed confounded professional bodies. The informant suggested that although professional bodies may claim existing mechanisms do not effectively regulate a profession, policy officers and ministers may disagree. Because of this difference, the interviewee implied there was no common understanding of what constitutes adequate or effective self-regulation, no measures of evidence of effectiveness, and varied perspectives between government and non-government stakeholders on the threshold for acceptance of self-regulating mechanisms.

Look, I think the criteria are fine and as with everything, that criteria are sufficiently broad to apply, able to be adapted to the, I guess, the social construct of the day, if I put it that way. You know, it's reasonable to ask the question, which is probably where experience tells me people struggle, is the question around whether any other form of regulation is effective in regulating the profession. (GPA5)

The majority of interviewed policy actors also spoke of the need for cross-jurisdictional ministerial agreement as a critical factor in the failure of non-registered professions to

progress their registration claims. This requirement was introduced as part of the *National Law* and was perceived by several informants to have “*raised the bar*” in securing an agreement to proceed with registration. Many informants commented on the difficulty of gaining ministerial consensus. One spoke of circumstances where a Minister might propose registration of a profession, while another “*four or five other Health Ministers*” may not see the need. Another informant suggested that if the national policy process were not so onerous and cross-jurisdictional agreement was not required, decision-making regarding registration could be streamlined. A third informant speculated that because of the requirement for cross-jurisdictional agreement, some non-registered professions may have already gained statutory registration in some jurisdictions had the *National Law* not been introduced.

In moving to something that is, from our perspective, as significant as national statutory regulation, I think that means that the bar that has to be met actually has become higher. So, in a sense, it becomes harder, I think, to get agreement across all of our states and territories [...] if we hadn't done that [the NRAS], I reckon some of these [non-registered] professions would have been registered in a number of jurisdictions probably before now [...] because the criticism's right, it is complex, it's very complex getting [cross-ministerial] agreement. (GPA13)

Other factors perceived to increase the complexity of decision-making included frequent ministerial or departmental changes and government election cycles that were perceived to forestall decision-making. An informant stated that, at times, no substantive decision-making regarding registration was possible for several months because of an impending election in one or other jurisdiction, during which time no major policy decisions could be taken. These periods of hiatus potentially disadvantaged professions aspiring for registration, as flux in the policy cycle distracted from decision-making across the jurisdictions.

The steps are fairly straightforward. However, they're also not because government processes don't move quickly, and it can be difficult to get a government to take something forward. And then if you do, well, are all the other jurisdictions going to agree? And you have officers and ministers changing all the time, and so views might change, and so it's pretty difficult to get something forward. (GPA7)

Something else that factors into a lot of these national projects [...] is elections because when a state jurisdiction is having an election, they then have a period of caretaker before that, and you know, when you sort of multiply that by eight for all the states and the Commonwealth, you know, sometimes depending on the year and the timetable for different areas, you can actually have situations where you essentially have to put things on hold for four months. (GPA4)

Two-thirds of informants referred to the registration of paramedicine⁸⁶ variously describing the decision-making process as “torture”, “a lot of work”, “lengthy”, and taking “multi-years”. Informants making these comments inferred that the challenges experienced with paramedicine had influenced their judgements on further registration. In interviews, some policy actors pinpointed where the challenges were perceived to lie. In the first of the following interview extracts, a policy actor comments that some Health Ministers were reluctant to consider other professions for registration because of the perceived challenges in pursuing registration for paramedics. The informant further states that this first case for testing the IGA criteria and process following the full implementation of the NRAS established a precedent that made registration virtually unachievable for other professions. The informant inferred this was the case irrespective of whether or not a profession met the assessment criteria. In the second account, the informant likewise considers the “protracted” process established to assess new professions for registration, which resulted in delayed decision-making for paramedicine.

⁸⁶ Paramedicine was included as a ‘non-registered’ profession since it was not registered on 1 July 2012, the date set for selecting non-registered professions examined in this research.

What I'm getting at here is that Health Ministers who went through that torture, and there were a couple of them that were long-standing Health Ministers that sort of saw that right through, were very, very reticent to embark on any more of that kind of malarkey⁸⁷ when it came to other professions that wanted to get into the Scheme. That just set the kind of bar at an almost insurmountable level. (GPA2)

I think that in terms of the paramedicine debate, I think it did mean it protracted the decisions and the process by a considerable, by years probably, by a very long period of time. But it did mean that a lot of the issues were canvassed very, very thoroughly along the way. So, I think it meant that by the time Ministers made a decision, they were pretty clear about what it was they wanted to do. They probably would have been clear if ministers, if there wasn't a national agreement to use this process, a decision [regarding registration] may well have been made earlier. (GPA13)

A few informants referred to the “hoops” or “hurdles” involved in gaining registration, and several suggested that the perceived difficulties in the OBPR assessment of a RIS had a bearing on present-day registration decision-making. The review of the paramedicine RIS by the OBPR was a particular operational challenge perceived by the majority of interviewed policy actors as highly bureaucratic. Several informants implied that part of the reason for the lengthy and onerous decision-making processes for registering paramedicine was the stringent OBPR requirements. In the passages below, the informants describe the challenging task beyond ministerial agreement to proceed with a RIS through the OBPR processes, which one informant described as even more challenging than gaining cross-ministerial agreement.

I know people were very tired at the end of that process [to register paramedics], which was a good five years of work of trying to prove something that seemed blindingly obvious to Health Ministers. [...] And if you can get through this first part, which is to submit something to the Health Ministers [...] and they agree [...], that's only the beginning of a much, much bigger process that has to follow after that. (GPA2)

⁸⁷ Malarkey is a colloquialism which means nonsense or rubbish. See: <https://www.collinsdictionary.com/dictionary/english/malarkey>.

If a profession wants to join the Scheme, there's a few hoops they've got to go through. (GPA3)

And then if you do [gain Ministerial agreement], then you've got the regulation impact statement phase, and that's a fairly involved process. (GPA7)

While the OBPR was charged with ensuring that assessments of proposals for inclusion of further professions in the *National Law* met best practice guidelines, most informants commented on the decision by ministers to proceed with the registration of paramedicine without OBPR finalisation of a compliant RIS. Several interviewed policy actors inferred they and their ministers considered the OBPR had erred in their assessments of the paramedicine RIS, creating unnecessary activity and bureaucracy.

So with paramedicine, there was a consultation was done in 2012 [...] But ministers made a decision in 2016. [...] a RIS needs to be finalised with the OBPR before ministers make a decision. Now, there's nothing to stop ministers from making a decision, but it's on the [OBPR] agency to get that through the [RIS] process. Now, in the case of paramedicine, [...] the actual decision RIS was not submitted to the OPBR for formal assessment, and that's why it's non-compliant with the regulatory impact analysis framework of that time. It's not to say that ministers didn't have enough information in front of them. What it is saying, though, is that a RIS was not prepared and formally assessed by the OBPR. So there's not that independent review, as is required. (GPA9)

So they [the OBPR] published a paper that said Health Ministers have made a decision that is non-compliant with best practice guidelines. Health ministers were aware of that at the time. But the [jurisdiction's] Minister just bludgeoned it through because we're all pretty sick of it by that point [laughs]. We were over it. (GPA2)

One informant stated the OBPR was overly focused on costs in its RIS assessments, and the perspective taken by that Office was perceived to be primarily an economic one rather than one based on public health interests. The informant stated that the view taken by the OBPR should be broadened to encompass an expanded range of factors beyond those currently considered. The informant also expressed a desire for the OBPR

to work more co-operatively with policy officers, make an increased effort to understand a broader range of viewpoints, and act to facilitate decision-making rather than be a perceived hindrance to assessments of regulatory policy change. The informant considered that the way OBPR assessed the paramedicine RIS would make it difficult for professions currently registered to meet registration requirements. This and other comments by informants suggested the policy processes established to support decision-making regarding registration were, perhaps unintentionally, leading to decisions vetoing registration even in cases when all ministers agreed to proceed. Another informant stated the OBPR had little expertise in assessing health risks. According to the informant, the role of the OBPR was to evaluate the quality of evidence presented in the RIS and ensure policy officers exercised appropriate due diligence in executing the requirements of the RIS process. These informants implied that the OBPR might be more focused on issues such as the regulation of particular industry sectors and activities of a more economic nature. They also inferred that OBPR may not be sufficiently knowledgeable or familiar with assessing policy changes for the health sector.

I think that the nature of the sort of OBPR process is very focused on costs and benefits in ways that are driven a lot by economics [...] I don't think it's unfair to say that the sort of primary driver for establishing the Scheme are really to be looking at cost and benefits with an economic lens as well as a lens from a range of other perspectives. [...] I do think that there's room for OBPR to be broadening the lens with which it looks at things. [...] I'd like to think that over time [laughs] they'll start to be able to engage more, I was going to say more collegially, and that's not really that they weren't engaging collegially, it's just that the lens with which they look and the criteria, that threshold basis for which they use for their decision-making is a basis that's actually very hard for most health occupations to meet, and would be for many of the ones that are already in the Scheme if they had to meet it. (GPA13)

Firstly, the OBPR [...are] not experts in health risk, right? The government agencies involved they're the policy experts, they're often regulatory experts or medical professionals. [It's] their expert advice that goes into their analysis and their judgements. The role of the OPFR is not to really question those assessments, right? Because that's policy officers and experts making those decisions. [The OBPR's] role is to look at the underpinning evidence and data, the analysis, the consultation process, to make sure that good policy practice was followed. (GPA9)

Although OBPR was seen to be overly focused on economics, most policy actors in this study were also focused on economics in the form of registration costs. Informants identified two primary types of costs. One was the annual registration fees paid by registrant practitioners to meet the self-funding requirements for ongoing maintenance of the NRAS for that profession. The second, and from the perspectives of many informants, the most critical cost associated with the NRAS was the cost to governments to assess and, if agreed, prepare the profession for registration. When considering government-related costs, some informants placed this in the context of available government budgets. Informants suggested that part of the assessment for registration included weighing up the claim by a profession against other government priorities and projects. Professions with scopes of practice that spanned more than one departmental portfolio, such as social work⁸⁸, were particularly problematic for some policy actors in this study. This was because health departments were said to bear all registration assessment costs. This was perceived to add to the difficulties in achieving agreement for registration.

So, if Health Ministers have a budget, and it's allocated for Health Chief Executives Forum, along with all the other priorities that they're dealing with, all the other reform projects they're trying to invest in, they've got a defined budget. Do they believe that investment in this space warrants the outcome? Because it is a costly process. (GPA6)

⁸⁸ In Australia, government responsibility for the provision of social work spans community services departments and health ministries.

It's about getting sophistication into the kind of benefits versus the costs of why these groups should be regulated. I think that's where the debate should be. (GPA1)

This sort of sits under the Minister of Health, but some of those professions, again, say social work, you know, for us in the [jurisdiction] that might be working in [department A, B, and C]. So, health would have to meet the cost of regulating those professions that sit across a lot of different areas. (GPA11)

Several informants referred to the costs associated with the policy process for registering paramedics. One informant stated that, given the costs involved in assessing paramedicine, assessment of other professions would be carefully considered. One informant put a figure on the estimated cost of the preliminary assessment of paramedicine to emphasise the scale and importance of the issue for policy officers and governments. These views indicate that, in addition to setting a high bar for registration assessment, paramedicine may have also set a cost benchmark such that further claims for registration may be unduly influenced by the costs incurred by registering paramedicine. The comments by informants implied that professions aspiring to be registered may require a more convincing argument and a more significant benefit/cost ratio than was assessed for paramedicine to gain agreement for registration.

I'd have to go back on how much it costs, but just that preliminary assessment process [for] paramedicine, I think, cost \$400/\$500,000. That was out of AHMAC's joint budget. (GPA6)

Look, just from my perspective, putting the paramedics in was an absolute massive, expensive task. So, considering the next profession is going to have to be a pretty strong case, and really going to have to be considered carefully. (GPA12)

9.4.2 Courting people in high places

Policy actors in this study spoke of various factors considered to “influence” ministerial decision-making. The influences were viewed from the perspective of ministers as decision-makers and from the individuals and groups perceived to be in a position to

exert an influence. These influencers included government champions, representative bodies of registered professions, ministerial advisers, and OBPR officers. Although informants did not overtly declare their influence, they, too, made comments suggesting their potential influence on ministerial decision-making.

In considering professions for registration, interviewed policy actors questioned the ministerial “*appetite*” to pursue a registration agenda. They suggested there was little appetite for regulatory change, even though some non-registered professions may have qualified for registration assessment, according to the views of a few policy actors. Ministerial appetite was referred to in light of “*other options*” available to regulate professions where the likelihood of further registration was implied to be low. Two informants framed ministerial resolve for further registration in terms of political “*will*”.

Oh, look, I'm sure there's them and others [that may qualify for registration], absolutely. [...] But again, [laughs] I suppose, all that is fine. What's the appetite of health ministers to add more professions to a regulatory scheme that's already fairly large if there are other options available? (GPA2)

When this has been brought up in conversations, certain current parties do not want to have to regulate this [non-registered] workforce because of the challenges in the Commonwealth. [...] I have to be really careful around the political agenda and appetite for my state government and serving our government of the day. [...] So I have to be really considered in my role and provide strategic informed advice around what is the best course of action that would inform a decision. (GPA14)

I don't think the criteria itself is not really problematic. It's really about political will. (GPA5)

[Registration is] always possible if you have the will. (GPA8)

Regardless of submissions and perspectives put forward by professions, ministers were considered impervious to petitions when it came to assessing professions for

registration because, ultimately, decision-making rested on the “*appetite*” of health ministers.

And it does come down to the appetite of Health Ministers or decision-makers at the end of the day. People like you and I can kind of yell and jump up and down all we like. But at the end of the day, it's the decision-makers and what information and the appetite that they have to pursue that agenda. (GPA2)

A few interviewed policy actors spoke of the “*interests*” of Ministers considered relevant to registration decision-making. Ministerial interests were characterised as wide-ranging, although there were few explicit details of what these interests might be. A few policy actors stated that ministerial interests depended on their views and the government's views at that time. These informants implied that, rather than working to a commonly agreed, consistently applied assessment of professions, ministerial decision-making was susceptible to change from one minister to another and from one political party to the next. There were also suggestions that exposure to political risk influenced ministerial decision-making considerations.

Informant: [Ministers] obviously make that decision [regarding registration] as government bodies and as political bodies, and they make those decisions in the interests of the government, the community, their political interests, and any other factors that influence them in the context of their particular jurisdiction.

Interviewer: And when you say political interests, what does that mean to you?

Informant: Well, it probably means whatever the Minister of the day wants it to mean. [...] A conservative government might make small government-related decisions and a Labor Government might make large government-related decisions. (GPA7)

I've seen the shift over time, by the views of government and the policy of the day as to what extent do we regulate and what extent do we not? (GPA6)

In informant interviews, a few policy actors commented on the willingness of ministers to meet with professional bodies about issues of concern, the implication being that when it came to discussing matters of interest to professional bodies, ministers maintained an open-door policy to all professional bodies on an equal basis.

I'd say that all Health Ministers, I can certainly speak for [my] Health Minister, is always happy to talk to stakeholders and meet with them and has met with many, I imagine, stakeholders, not necessarily in the context of an NRAS submission, but certainly is open to meeting all those stakeholders and talking to them about their issues. (GPA5)

Conversely, another informant contended there were differences in how receptive ministers and policy officers were to advances from professional bodies. They commented that ministers paid greater attention to certain professional bodies, such as the Australian Medical Association (AMA) and the Australian Nursing and Midwifery Federation (ANMF), compared with other professional bodies, such as those representing the non-registered professions in this study. This selective attention was referred to by the informant as a “*hierarchy of attention*”.

Informants inferred that governments more readily engaged with professional bodies perceived to hold a higher position in the healthcare hierarchy rather than assessing the necessity for resolving problematic issues or meeting consumer needs. The “*hierarchy of attention*” was said to adversely impact the capacity of professions lower in the hierarchy to be heard by governments and health departments. This implies that not only were ‘lower’ order professions restricted in gaining access to ministers, but their access to departmental officers was also circumscribed.

I think that's almost certainly true [for some associations to gain the ear of government]. I think it's truer for some groups than others. But if we're talking about making the assumption that many of the professional bodies you have been talking with are bodies that are connected with the professions that you had on your list, I think that [3 seconds] one of the things that is in the health space, I think there does continue to be a bit of a kind of hierarchy of attention amongst professions, and I certainly think that that does impact the capacity of

professional organisations to get a voice. [...] I think I'm just saying both a number of the professions that you're talking about and with have less capacity than, say, the AMA, or the ANMF, both internal capacity, but also the capacity to catch the attention of both government and health department. (GPA13)

In terms of healthcare hierarchies, another policy actor described their understanding of three levels of practitioners in the healthcare system and the nature of the informant's engagement with those practitioners. The informant distinguished between these professional groups by referring to registered professions, self-regulated professions comprising non-registered 'allied health' professions, and "non-regulated" professions that fell outside the allied health designation, which the informant inferred were part of a lower-order group. The cadres the informant routinely engaged with were the registered professions and self-regulated allied health professions.

Informant: We deal with the registered professions and the self-regulated professions. So dietitians, speech pathology, sonography social work. I deal with all of those organisations. [...] What I don't have a lot to do with are what I would call the non-regulated professions. Apart from when they're writing to the Minister, and I'm doing briefings.

Interviewer: When you say non-regulated professions, who are you referring to?

Informant: Naturopaths, massage therapists, myotherapists. (GPA11)

Having multiple professional bodies representing a profession, particularly if not united in their views on professional matters such as registration, was identified as a barrier to engagement with policy officers and ministers. From the perspective of one informant, the difficulty was considered to be the inconsistent views between professional bodies representing the same profession.

In the following account, the informant describes the practical difficulties of dealing with multiple professional associations with different perspectives on professional matters. The policy actor implies that associations with diverse opinions are prone to varied and unreliable governance processes. They suggested that having a single representative

body would facilitate a profession's engagement with government and government engagement with the profession, such that policy officers favoured or rewarded professions according to how well-organised and united professional bodies were. The account by the informant also alludes to policy actors actively avoiding professions with multiple representative bodies or perceiving them in an unfavourable light because of supposed challenges associated with tackling and resolving disagreements between associations, irrespective of the risks posed by the profession or the strength of the profession's claims.

By avoiding engagement with multi-association professions, policy actors may inadvertently reinforce the acceptability of maintaining different professional standards, which, in turn, may elevate risks to consumers. Yet, the purpose of registration was universally agreed to by interviewed policy actors as consumer protection, and a commonly identified benefit and goal of registration was nationally consistent professional standards. This indicates a disregard for the public protection paramount guiding principle of the NRAS. Avoidance of certain professions may also hinder efforts by professional bodies to achieve desired outcomes when their registration objectives conflict with the views of another association.

Informant: [When you have multiple professional associations], you get very diverse views in the advocacy that comes to the department or to the Minister. So, it's about having a consistent view and voice, I think, isn't it, in the matters you're going to raise? [...] Massage therapy does not have one voice. [...] So when I deal with Speech Pathology Australia, I know that they're the body that accredits speech pathologists [...], but when there are a number of different bodies that represent massage, myotherapy, those type of things, counsellors, the same.

Interviewer: Is that an issue from your perspective?

Informant: [4 seconds] Yes. If you've got some body that's saying it's accrediting the quality of people, and then some bodies, as in more than one body, how do you know that the processes are consistent and reliable, and the governance is in place if you've got more than one body? (GPA11)

Another informant spoke of the “*strength*” of some associations in pursuing their professional agendas with governments. The policy actor inferred that gaining traction with governments was dependent on the perceived strength of a profession’s voice. When it came to professions with a seemingly “*weaker*” voice, the informant alluded to the difficulties these professions faced in progressing their registration claims. They commented on the alternate path taken by one non-registered profession to improve their self-regulating status by working with mechanisms and levers they could control, which required no government support. This suggests that associations with a stronger voice and a greater presence in the healthcare system were likely more successful in pursuing their professional goals, while the marginalised or those on the fringes of the system remained unseen and unheeded by governments and left on their own to work through their regulatory issues.

Informant: I think it's a bit of comes down to perception and how strong professional associations are in the eyes of the public and in the eyes of people like health ministers. Now, if you take the AMA, [...] the AMA's say on things is incredibly important, rightly or wrongly. So, I think it does, it's difficult to answer the question because it's dependent, really, on the voice of that profession.

Interviewer: What if it's a profession with a weaker voice?

Informant: Yeah, well, that's it. I'm just trying to think of an example. Another profession that I've observed, who were very vocal in relation to registration, were massage therapists [...] and at some point a few years ago, I think they've made a decision that it seems to be fruitless pursuing registration. So, they turned their minds to how they could actually improve their own standing with the mechanisms that were available to them. (GPA2)

A point raised by the same policy actor is that governments held in high regard the opinions of the AMA, even though, as the policy actor suggests, such influence may not be appropriate. The esteem accorded to particular professional associations was echoed by other informants when referring to the influence of the medical and nursing/midwifery associations. Even though these associations have no formal role in registration decision-making, they were regarded as powerful influencers on

governments⁸⁹. These organisations were perceived to attract the attention of government and health department officers, and their positive regard was described as lending “weight” to any proposal for registration.

It would carry some weight if the AMA, or the Nursing and Midwifery Federation, or one of the major medical colleges like the Royal Australian College of General Practitioners, if some of those groups cast a view in this regard [for registration of a profession], I think that will be significant. (GPA7)

Informants identified other individuals who were considered to have an influence on government decision-making. In addition to the challenges in gaining cross-jurisdictional agreement, a “champion” in government, such as a jurisdictional health minister, was viewed as vital to the success of a registration claim and an “operational reality” of decision-making. Informants stated that if there was no jurisdiction willing to “champion” a profession’s claim for registration, then there was no minister to take the case forward to other ministers, no one to push the merits of the case, and it was suggested, no likelihood of success, regardless of the strength of the claims.

It's engaging with almost a champion or a health minister who is willing to [...] there's got to be a minister who sees this as an issue and is willing to take this forward as a proposal. (GPA6)

So to get into the Scheme [...] somebody's got to champion the necessity of doing it. I know that's not in the criteria. But that's an operational reality. (GPA8)

The sonography association are quite active in their case, to come in and be attached to the Medical Radiation Practice [Board]. So, I think they're fairly advanced in their case. I think probably one of their limiting factors is finding a jurisdiction to sponsor them. (GPA11)

⁸⁹ During the community consultation phase of a regulation impact analysis for assessing a profession for registration, any person or group may lodge a submission giving their views on the proposed change. In this regard, any professional body may have an influence on decision-making. Irrespective of such influence, professional bodies of registered professions do not have decision-making powers directly related to statutory registration.

The role of ministerial advisers was also viewed by a few interviewed policy actors in similar terms to champions because of the gatekeeping role advisers played in gaining access to ministers. From the perspective of one informant, advisers screened out all but the most serious issues to pass on to their ministers, with political risk considered a decisive factor in escalating an issue.

Informant: The advisers are there to act as a fence. If the issue is serious enough, they'll pass it up.

Interviewer: How does an adviser determine whether it's serious enough?

Informant: I don't know. I don't know. But part of it is topicality, and part of it is political risk. (GPA8)

In this study, policy actors did not often raise their own role in influencing government decision-making. More frequently, their influence was by implication without overtly declaring it. At times, the part played by informants in decision-making was described in obscure terms, which required clarification to understand any influence exerted. When discussing their role in presenting recommendations to the Health Minister about registration, one policy actor distanced themselves from decision-making by referring to their recommendations as being made by “you” rather than ‘I’ or ‘we’. This suggests some informants were unwilling to discuss or uncomfortable about discussing their role in giving policy advice to ministers.

Informant: So [associations] would tend to come and meet with [a national body], they would tell us their case [...], and then we would do a briefing and whether that goes to the CE, or goes to the minister. And then those things were talked about in the national forums. [...] So all the jurisdictions talk about those things as well. So again, the level of influence and sway from something like my position is quite a number of steps removed. [...]

Interviewer: So, at any stage, do you make recommendations on the proposal by a health occupation?

Informant: Where you would present options, and you could say the most likely option, yes. (GPA11)

At other times, the potential influence of informants was clear.

I mean, I would have to be very truthful in any advice I gave to our Health Minister around what kind of work's involved in adding a profession to the Scheme. (GPA2)

Much of the commentary regarding influence suggests many individuals and groups were perceived to either facilitate or obstruct a profession's claim for registration. Informants suggested that any barriers to registration were potentially overcome by cultivating the goodwill of influencers such as advisers, policy officers, and powerful associations in a position to prevail upon decision-makers. These actions, though, conflict with the IGA criteria and objectives of the *National Law*. Tensions between the formal criteria and the “*operational reality*” of decision-making were, at times, explicitly referred to by informants and, at other times, implied by informant comments. This, in itself, suggests that tensions and negotiations between formal policy or guidelines and operational decision-making are an inherent aspect of government business when it comes to determinations regarding the regulation of health professions.

9.4.3 The unwritten rules for NRAS entry

Additional factors that informants perceived as influencing registration decision-making include practitioner qualifications and the preparedness of professions for registration. However, these, too, were suggested to conflict with the IGA criteria and the *National Law*. All interviewed policy actors agreed that decision-making was subject to multiple influences that were not necessarily transparent or formalised. One informant remarked that decision-making had improved over time. Comments indicated that despite a broad view among informants that the IGA criteria were appropriate and effective, most still considered decision-making a political process.

I think in any processes there's a fine balance between hard guidelines, evidence base, et cetera, and then the view of stakeholders and the view of governments of the day. And I think all of those interfaces in terms of the final decision-making process. Sometimes, I think those decisions have been influenced more one way than the other. [...] I think there's multiple influences and multiple elements of decision-making. I do think there's been greater clarity over time. (GPA6)

During the interviews, several informants declared they, or family members, were practitioners of a registered profession. At times, these declarations came before comments the informant considered required disclosure before responding to certain questions. Most informants did not verbally entertain the possibility that their position as a registered professional or that of a family member might influence or cloud their judgement regarding how non-registered professions should be registered. Nor did they state that these potential conflicts did not influence their judgement. This apparent 'blind spot' suggests that any influence, if it existed, may have been unconscious and not perceived as such.

One informant, however, did consider the potential for their position as a registered professional to influence their judgement regarding the regulation of non-registered professions that were suggested to be rivals. Having identified as a registered practitioner, the informant argued in favour of their registered status based on higher qualifications. They stated the 'rival' non-registered professions should be regulated via "lower" mechanisms than the NRAS because 'rival' practitioners possessed lower qualifications and were, therefore, implied to be ineligible for registration. Moreover, it is noteworthy that while the informant acknowledged the risks of harm posed by the 'rival' professions, they did not mention the risks their own profession posed to allow for comparisons. Later in the interview, the informant expressed disappointment in the distinctions drawn between registered and non-registered professions, which they themselves had previously drawn, stating the NRAS was not about "winners and losers".

Well, I'm a registered [practitioner], so [it] could be a bit difficult, but my answer is I think that the level of qualifications and what have you required, [it] makes sense to me that [practitioners in my profession] are registered. Whilst I can see [non-registered profession A] and [non-registered profession B] may pose some risks to the public in different shapes and forms, I'd say that they should, in my view, they should either be picked up through a lower-level regulatory scheme or through a negative licensing process. [...] It's a bit unfortunate that the National Scheme is kind of made out as the gold standard for your profession to be involved in. [...] It's unfortunate that it's portrayed in that way, when I think the Scheme's not really about having winners and losers. (GPA1)

Most informants described specific actions non-registered professions could take to support their claims for registration. These actions include a profession “*readying itself*” for registration by strengthening self-regulation mechanisms and demonstrating its “*fit*” with the NRAS. Demonstrating “*fit*” was stated to be how well-structured and well-advanced the profession was in establishing self-governance structures. These structures were said to indicate the “*maturity*” of the profession and the professional body. The profession’s maturity and the association’s governance characteristics were considered to establish the profession’s credentials as a well-managed professional outfit. These characteristics were viewed as important considerations in whether a profession had the required prerequisites to enter the NRAS. The commentary indicates that, in addition to agreeing to the centrality of the IGA criteria in assessing professions for registration, most informants also focused on professional governance in their registration deliberations.

Another sort of two-step process will be to really strengthen the self-regulation and then try and transfer into NRAS. (GPA4)

It's also about the maturity and organisation of a profession to be able to show that they can fit into that national scheme with the board and an accreditation arm. (GPA11)

A few informants regarded professions with effective self-regulatory governance processes as so well-managed that self-regulation was perceived as adequate, and registration was considered unnecessary. One informant remarked that “robust” professional association governance made it easier to define the profession, thus meeting one of the assessment criteria. By meeting this criterion, the informant also inferred it was more difficult for these professions to meet another criterion of the inadequacy of existing regulatory mechanisms in managing the risks of practice. The informant implied this predicament created a no-win situation for certain non-registered professions.

Where a profession or an occupation, and this is where some are between a rock and a hard place⁹⁰, is that where a profession can be reasonably well-defined, in terms of their qualifications and have a robust professional association and everything, that would be easier to define and to interrogate. But it also is harder because they've already got systems and processes that sit around them. (GPA6)

[T]he assessment whether other existing mechanisms are sufficient. [...] Speech pathology have a pretty active professional body and they have a range of requirements about admission to the professional body [...] But I think what you'd say is the position of government, as it stands today, that is sufficient for the speech pathology profession, provided there are codes of conduct in the sectors that they work in, and there generally are. So I think that's the level, and I'd say yes, for most of the [non-registered professions], that [self-regulation] is entirely appropriate. (GPA1)

Another action informants perceived professions could take to demonstrate “fit” with the NRAS involved standard-setting, though it was unclear from responses how such actions influenced registration decision-making. In the following exchange, the registration preparedness activities ostensibly required by governments, which most

⁹⁰ “Between a rock and a hard place” refers to a difficult situation of having to choose between two equally unpleasant courses of action. In this context, the informant means that the professional body is caught in a dilemma of either maintaining high standards, which obviates the need for registration or allowing standards to fall to demonstrate the need for registration. See: <https://www.collinsdictionary.com/dictionary/english/to-be-caught-between-a-rock-and-a-hard-place>.

professions claimed to have in place, were, similar to the previous account, paradoxically argued to obviate the need for registration in what could be regarded as a regulatory 'Catch-22'⁹¹.

Informant: It's not the Scheme's responsibility to get a profession ready. There's an awful lot of work involved that a profession would have to put in place if they were going to be in a position to move to national registration.

Interviewer: Just so I'm clear on what that might be, all of these occupations, the professional bodies have codes of conduct, most of them have complaints mechanisms, they all have standards of practice, they all accredit education providers. Apart from the things I've mentioned, what else do they need to have in place?

Informant: Well, if they've got all that in place, why are they seeking national registration? (GPA12)

9.4.4 Statutory registration as a last resort

While most policy informants stated there was a need for additional regulatory measures for some non-registered professions, none went so far as to consider the expansion of NRAS to accommodate any non-registered occupation. On the contrary, informants expressed a clear reluctance to extend registration to additional professions. While acknowledging the need for further regulation of certain professions, one informant questioned “*the burning platform*” for registration for some professions. Several informants questioned why some professions were not registered, though none identified which professions should be registered because they either knew little about the profession or were reluctant to disclose their views.

From a public safety perspective, what is the burning platform to say that dieticians must be admitted to the Scheme? I can't quite see it. (GPA1)

⁹¹ Catch-22 refers to a dilemma or difficult circumstance that cannot be resolved because the conditions necessary for its resolution are paradoxical or conflicting. See: <https://www.oed.com/search/dictionary/?scope=Entries&q=catch-22>.

Interviewer: Are there any non-registered occupations that stand out to you as maybe having a claim for national registration?

Informant: [3 seconds] ummm [5 seconds] hmmm [4 seconds] ummm [clears throat] [5 seconds] let's see [4 seconds] ummm [5 seconds], yeah look, I mean, it's umm a [4 seconds] I think there's, there's for and against on a number of them. (GPA7)

Some informants spoke of a “*Commonwealth proposal*” mooted by government at that time. The proposal was described as a credentialling scheme initiated by the Commonwealth Government to raise professional standards and bring greater transparency to non-registered professions participating in government-funded programs. One interviewed policy actor stated that the credentialling scheme would assist governments as employers of non-registered health practitioners by simplifying employment entry assessments and reducing recruitment administrative processes.

There could be some real advantages to [the jurisdiction] in employing, in a recruitment and employment process of having some certification arrangement that would make things a hell of a lot easier for us as an employer. We would be able to go right, you're certified, yep, we can employ you, rather than us having to double check, is that social worker eligible for membership of the AASW? If they're not, do they meet all the requirements for eligibility for membership, etc, which is quite onerous. (GPA6)

Apart from the Commonwealth proposal, informants considered the possibility of establishing different levels of registration within the NRAS with less rigorous requirements for the non-registered professions entering the Scheme. Some made the case for a separate statutory scheme developed explicitly for non-registered professions. The schemes proposed by informants were variously described as “*less onerous*” than the NRAS, a “*lower level*” registration, “*different layers*” of regulation, or “*a different scheme*”.

I could see an argument about a lower level kind of registration or regulatory process for them, but that was actually less onerous, and justifiably so, and that actually would be good news for the profession and good news for the public, I think. (GPA1)

I think it would be good if it was kind of one system but with many different layers. Not lots of different systems being run by different people with different approaches. So it might be good if, say, for example, everything did come under national registration, but there was three or four different types of national registration, and different professions went into different ones. (GPA4)

For some informants, the perceived advantages of a different scheme or layers in the NRAS related to reducing the regulatory infrastructure and burdens imposed by the National Scheme that were considered unnecessary for non-registered professions. Other informants considered it would be less challenging or “easier” for non-registered professions to gain entry to an alternative scheme rather than attempting NRAS entry.

I think there is a case to say regulating some of those professions to a lower kind of regulatory bar and needing a lower regulatory infrastructure. (GPA1)

Informant: You could conceive of a sort of a different scheme for some of these [non-registered] occupations.

Interviewer: So why would you have a separate scheme? What would be the advantage of doing that?

Informant: I only wonder if, well, [3 seconds] because it might be easier. (GPA8)

After this last informant made these remarks, they identified the difficulties non-registered professions were considered to face when attempting to gain entry to the NRAS. They suggested these difficulties made the Scheme a highly contested domain. Their proposed solution of a different scheme was based on the perceived impediments that professions would encounter in demonstrating NRAS eligibility and the potential obstacles and oppositions they faced. These obstacles and oppositions were alluded to as the politics of registration decision-making, with resistance from some groups and

support from others. The informant repeated a question they had previously posed about whether non-registered professions “belonged” in the NRAS. For this informant, an alternative scheme was a more viable option for non-registered professions as it was perceived they would be unable to mount convincing arguments to demonstrate they belonged in the NRAS.

Informant: To demonstrate that you belong in the National Registration and Accreditation Scheme, for the way that it is, is a pretty tall order. [...] [3 seconds] I mean, it's in the real world, who's going to object to them being brought in? Who's going to fight it? Who's going to support it? What are the reasons for both of those positions?
Interviewer: Why is that relevant?
Informant: Because it is. (GPA8)

While most policy actors in this study expressed a reluctance to register further professions, a small number stated or suggested a need for further examination of certain non-registered professions to assess the adequacy of current governance arrangements and risk profiles. A few interviewed policy actors stated they knew little about non-registered professions, one informant referring to this lack of knowledge as a “blind spot”.

That's a bit of a blind spot, I think, at least for me, and possibly in our wider area, because, you know, we know what professions are in NRAS, we know which ones aren't in and [...] we get higher level visibility of various complaints that have been submitted to Ahpra and the outcome of more serious complaints because we see it in the Ahpra updates, etc. But in terms of these unregistered [...] professions, I really have no idea what the, I do for some of the larger groups, but I don't really know what the professional association for dietitians has in place to regulate them or what they do or if there have been any complaints about dietitians in the last five years, what they've been in relation to, etc. So, yeah, it is a bit of a blind spot. (GPA4)

I would have to caveat this in that I'm not familiar enough with the practice of each of those [non-registered] professions. (GPA6)

Another informant stated that a comprehensive assessment of non-registered occupations would facilitate an understanding of the extent of any problems with regulation for these professions and the adequacy of current regulatory governance arrangements. They suggested that governments should undertake these assessments. They perceived assessments should identify the current regulation arrangements for the professions, their risk profile, the education and qualifications standards, details of providers practising with inadequate qualifications, and documented harms committed by, or convictions brought against, practitioners. The informant implied that such an examination would provide an evidence-informed assessment about which, if any, non-registered professions required further investigation or subsequent action by governments, such as formal registration consideration.

It would be good to map all of these [non-registered] professions with [...] what kind of regulation exists. What's the level of risk? What are the harms to the public that are identified or proven each year, [the] level of convictions and so on? What are the standards for their qualifications and training? And even though they're not protected title, what's actually happening within that profession? What's the incidence of those professionals who lack the same level of training or qualifications? It'd be good to find out all of that in order to get a sense of the nature of the potential problem. (GPA3)

9.5 Chapter summary

While there were consistent views among policy actors on most matters relating to HPR, there were also some differences of opinion. Informants universally agreed on the public safety imperative of the *National Law* and its mandate to ensure the competence and reputability of practitioners within its remit. They agreed that registration brought increased respect and legitimation to a profession but not necessarily professional acceptance. Even though a few deficiencies were identified with self-regulation, such as for practitioners working in private practice, informant perspectives were similarly consistent regarding the adequacy of existing regulatory mechanisms for non-registered practitioners.

Most policy actors participating in this study agreed there were inconsistencies between the professions that were and were not registered. These informants often struggled to identify reasons for the discrepancies, although many pointed to the subjective nature of policy decision-making and the multiple influences on the decision-making process. Most, but not all, informants agreed that non-registered professions had experienced disadvantages due to their exclusion from the NRAS.

There was widespread agreement on the suitability of the AHMAC assessment criteria, and most informants also agreed on the complexity and bureaucracy involved in registration decision-making, particularly in light of the requirement for cross-jurisdictional agreement.

Although many policy actors in this study identified the lack of government appetite or interest in further registration, they agreed that professions could improve their chances of a favourable hearing by lobbying ministers and their advisers, identifying a government champion, and cultivating the goodwill of powerful professional associations. As well as the power of influencers to sway governments, policy decision-making was considered subject to a range of influences, including the political leverage exerted by non-registered professions whose ability to engage with departmental policy officers appeared to be dependent on professional unity and their classification as allied health professions. Decision-making by governments was viewed as a political process. The role of policy actors in influencing ministers, while not overtly referred to by informants, was evident in several comments. Many informants considered professions higher or lower in the hierarchy of health professions had greater or lesser capacity to “*catch the attention*” of governments. Even though many policy actors stated further regulatory measures were required for certain non-registered professions, informants were reluctant to extend registration because NRAS provisions were not considered proportionate to need, and non-registered professions were not perceived to have a place in the National Scheme. However, a small number of informants considered there was insufficient information about non-registered professions for informed decision-making on registration and a thorough examination of these professions was required to assess whether further regulation was appropriate.

The review and exploration of the perspectives and experiences of consumer advocates in the previous chapter and of policy actors in the present chapter offer two critical points of view regarding the regulation of non-registered health professions. The next chapter completes the presentation of results from this study. Chapter 10 features the perspectives and experiences of a third group of interviewed stakeholders, professional body respondents, regarding the perspectives and experiences of regulation for the non-registered professions.

Chapter 10

A PLACE IN WHICH FIELD? Perspectives of profession representatives

10.1 Introduction

Semi-structured interviews with 26 participants from 24 professional bodies representing 14 professions were conducted between 22 March 2022 and 1 July 2022. The following professional bodies agreed to have a representative participate in an interview:

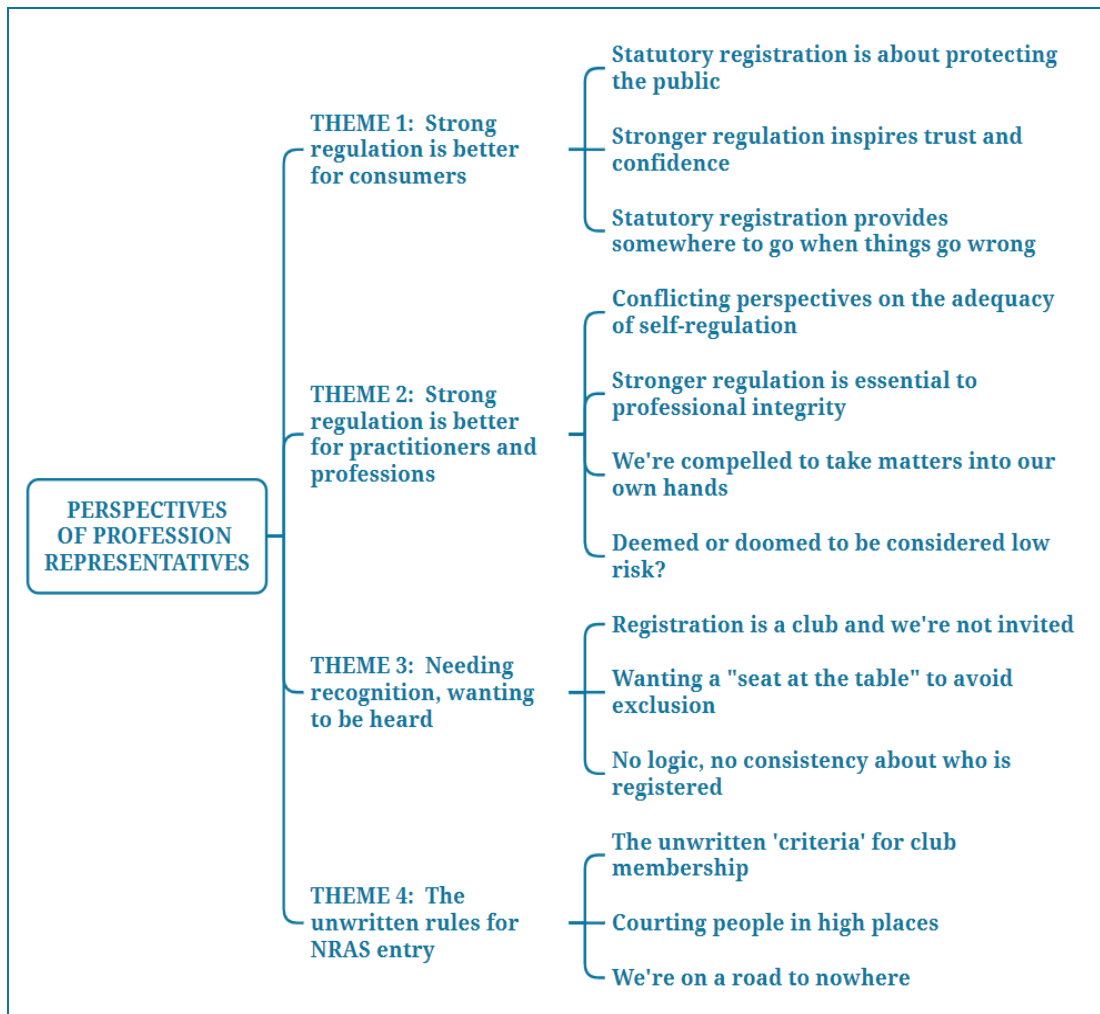
- Allied Health Professions Australia;
- Audiology Australia;
- Association of Massage Therapists;
- Australasian College of Paramedic Practitioners⁹²;
- Australasian Society of Ultrasound in Medicine;
- Australian and New Zealand College of Perfusionists;
- Australian Association of Social Workers;
- Australian Counselling Association;
- Australian Natural Therapists Association;
- Australian Orthoptic Board;
- Australian Register of Naturopaths and Herbalists;
- Australian Sonographer Accreditation Registry;
- Australasian Sonographers Association;
- Australian Traditional Medicine Society;
- Council of Ambulance Authorities⁹²;
- Exercise and Sports Science Australia;
- Independent Audiologists Australia;
- Massage and Myotherapy Australia;
- Myotherapy Association Australia;
- National Alliance of Self Regulating Health Professions;
- Naturopaths and Herbalists Association of Australia;
- Orthoptics Australia;
- Psychotherapy and Counselling Federation of Australia; and
- Speech Pathology Australia.

⁹² Paramedicine was included as a 'non-registered' profession since it was not registered on 1 July 2012, the date set for selecting non-registered professions examined in this research.

Two professional associations declined an interview, the Australasian College of Paramedicine and Dietitians Australia. Dietetics was the only profession for which no representative was interviewed for this study. Two professional associations each had two respondents take part in the interview. Interview respondents were drawn from a large and diverse group of professions encompassing three professional subgroups: professional associations, peak professional bodies, and voluntary registering organisations. This made for a range of perspectives and opinions regarding health practitioner regulation (HPR) and reasons offered in support of regulation preferences. There was broad consensus on issues such as the need for public protection, though there were diverse views about how this was best achieved. All representatives commented on the perceived adequacies or inadequacies of various regulation mechanisms and frequently proposed measures to enhance regulation arrangements. Over half of all representatives favoured registration for the represented profession. A few representatives preferred self-regulation, and several supported co-regulation. Both positions were frequently accompanied by commentary expressing the desire to maintain “*control*” of the profession. A minority of representatives were undecided about the preferred regulation model, describing the appeal of both self-regulation and registration. At times, respondents from different professional bodies representing the same professions expressed contrasting views regarding HPR.

Following coding and analysis of interviews, four themes and 13 sub-themes were generated from interview transcripts. These are presented in Figure 10.1.

Figure 10.1: Themes and sub-themes generated from interviews with profession representatives.



10.2 Theme 1. Strong regulation is better for consumers

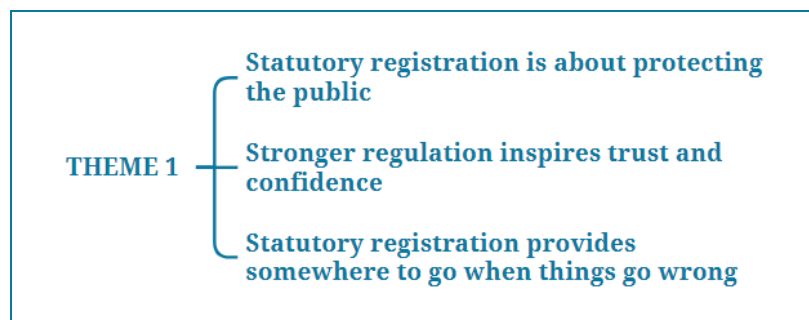
Representatives commonly identified a preferred regulation model that they considered was more effective and better for consumers. Despite differences in the type of regulation favoured, almost all respondents advocated for regulation that safeguarded the welfare of consumers, fostered public trust, promoted confidence in the profession and its practitioners, and ensured complaints were well-managed.

Just over half the respondents considered these aspirations were best achieved through registration. A majority of respondents expressed the belief that patients and other professions assumed or expected non-registered practitioners to be registered. This was concerning for many respondents in the absence of the statutory mechanisms they

perceived assured practitioner quality and reputability. The comments and concerns regarding consumer protection, public trust, and practitioner quality largely informed respondent views regarding the most appropriate type of regulation for a profession.

Three sub-themes were identified from the interview data relating to this theme. These are set out in Figure 10.2.

Figure 10.2: Theme 1. Strong regulation is better for consumers.



10.2.1 Statutory registration is about protecting the public

In response to questions regarding the perceived purpose of registration, most representatives stated it was designed to protect the public. A few respondents commented that the regulatory mechanisms established to protect consumers also protected practitioners. These respondents considered that registration had a mutually beneficial relationship between consumers and practitioners, where registration of practitioners protected patients, which protected practitioners and the profession. For these representatives, the statutory protective mechanisms of the NRAS were not considered possible under self-regulation.

The purpose of statutory registration is, at its heart, it is meant to be something that protects the public. (PAR9)

So it's protecting the public; that's the central one, always is. It's always what registration is about and should be about, is about protecting the public. But the fringe benefit of protecting the public is you protect the profession, and you protect the practitioners in the profession because they're not having to defend themselves against people who are not educated. (PAR1)

A few respondents commented that registration was also established to ensure cross-jurisdictional consistency and improve practitioner mobility across jurisdictional borders. For one representative, registration was seen to advance a government agenda under the guise of patient protection and healthcare quality, as the following statement illustrates.

It was not all about safety. It was all about political expediency and making sure that they could get some kind of uniformity and workforce mobility, and it's been dressed up as safety and quality. (PBR4)

Several representatives supporting self-regulation stated registration was unnecessary, particularly in light of registration costs, because of the insignificant risks to consumers that the profession was perceived to pose. These representatives suggested that, having weighed up the options and the insignificant risks posed by the profession, the disadvantages of registration outweighed any benefits.

There's not enough risk associated with [the profession] to justify [registration]. (PAR8)

You know, in the end, we're not perceived as dangerous enough to warrant the financial investment from the government. (PAR14)

10.2.2 Stronger regulation inspires trust and confidence

Statutory regulation mechanisms, most often identified as registration but also co-regulation, were considered to promote confidence in and provide assurances about a profession and its practitioners. Representatives frequently spoke of the need to gain the confidence of consumers and other health professionals through their preferred regulation mechanisms. At times, respondent comments were framed as promoting assurances regarding the good character of practitioners. The assurances participants perceived were promoted by registration and co-regulation related to the quality of practitioners, high professional standards, and currency of practice. One respondent stated registration would demonstrate that an association could professionally manage its practitioners. Others took the view that registration gave consumers confidence that

there was a solid foundation of professional standards behind their practitioner. Several representatives remarked that statutory registration or co-regulation would identify and address poor practitioner performance and misconduct. These respondents stated the ability to monitor and manage practitioner performance under statutory mechanisms would, in turn, boost confidence in the profession. These sentiments indicate many representatives were intent on presenting an image of a high-quality, professional body of practitioners meriting the trust of consumers and health providers. For these respondents, only statutory forms of HPR could deliver these benefits.

To be a registered professional [...] implies trust and integrity and honesty, and framework and that you're going to do the right thing for your patient. (PAR11)

[I]f you're working with a person and they're sharing their sensitive health information with you, you want to understand, you would want confidence that your person is going to be current, up to date, going to give you good health advice, they're not going to tell you to do something that's dangerous. (PAR4)

[Registration] allows the public to have confidence in whoever they're choosing as their practitioner. (PAR1)

A view offered by more than half of all respondents was that consumers were often unaware of which professions were registered, had little understanding of registration as a governance mechanism, or had no way of distinguishing between registered and non-registered practitioners. Several representatives also commented that other health practitioners and service providers were sometimes unaware of the registration status of practitioners. A few stated that consumers and healthcare providers often assumed health professionals were registered. One respondent argued that consumers expected the same mechanism of regulatory governance for all health practitioners. These assumptions and expectations weighed heavily on the minds of several respondents, who implied consumers might be duped by non-registered providers because self-regulation mechanisms were insufficient to assure practitioner quality. The comments suggest many representatives perceived that even though consumers had little

understanding of the mechanisms governing health practitioners, they nevertheless expected such mechanisms to include standards of care, norms of accountability, and measures to minimise opportunities for exploitation by unscrupulous providers.

It'd be really interesting to ask the public who they think should be regulated because we found that when we asked that question, they already thought we were when we weren't. (PBR6)

In terms of doctors and other colleagues, frequently, they think [the profession] comes under the registration scheme. [...] I think [consumers] probably would have a reasonable expectation that all the services they receive and seek services from, that they would have an equal level of regulation. (PAR17)

An aged care facility [...] had Ahpra⁹³ registered as part of the staffing requirements, and I said to them, you know, you won't have any dietitians or speechies⁹⁴ now working in your aged care facility? And they go, What do you mean? I said they're not Ahpra registered, and they were flabbergasted. (PBR5)

An alternative view given by a representative was that registration in and of itself was “not important” to consumers. The respondent spoke of consumer expectations for respectful, well-qualified practitioners who acted honourably. They considered these attributes ethically necessary regardless of registration status. Having registered and non-registered practitioners was considered a source of confusion for consumers. Other representatives asked how consumers would view their practitioner if they became aware the practitioner was not registered. These representatives implied that the absence of registration could undermine consumer confidence in the competence and integrity of non-registered practitioners.

⁹³ The Australian Health Practitioner Regulation Agency uses sentence case for its acronym. See: <https://www.ahpra.gov.au/About-Ahpra.aspx>.

⁹⁴ “Speechies” refers to speech pathologists.

They would expect that they're seeing a professional who is well-qualified, who is current, who has integrity, who is going to treat them with respect, and who is not going to exploit them. How is that different between the self-regulated profession and registered? [...] having them split apart like that, from a risk standpoint, doesn't add up. [...] just the way NRAS [was] set up and who they let in and who they don't let in. How's the consumer supposed to understand that? (PAR4)

10.2.3 Statutory registration provides somewhere to go when things go wrong

Most representatives described the procedures in place for the professional body to receive and investigate consumer complaints, and almost all respondents identified perceived deficiencies with these procedures. Deficiencies included inadequate processes and practices for complaints lodgement, investigation, and resolution. Although a small number of representatives commented on the effectiveness of the National Code of Conduct (NCC) in maintaining consumer safety by removing rogue practitioners from practice, most respondents held unfavourable views regarding the role of health complaints entities. Health complaints entities were described as absent in some states/territories, and consumers were said to be unaware of where or how to lodge a complaint in jurisdictions where they were in place.

The response was that basically, they were implementing the Code of Conduct for health workers [...] and look, in a lot of ways, they were right; it did clean up the industry a lot. There's a lot less cases now reported than there were, say, five years ago. (PAR8)

[Health complaints entities are] only in those states and territories where the Health Complaints Commission structure has been rolled out and implemented. (PAR6)

There isn't a single complaints-handling mechanism, and people making a complaint get sent around the [association] houses. (PAR5)

Complaints capture was considered inadequate from a consumer perspective because it was perceived to thwart attempts to collect data on practice risks. One respondent

noted the futility of demonstrating risk without adequate complaints data. These deficiencies were suggested to hinder building a case for registration.

There were many, many years when we didn't even have a Health Quality Complaints Commission in the state; [it] got shut down. So, how are we ever going to capture risk when there is no organisation or domain to report the risk in the first place? (PAR11)

In contrast, NRAS was perceived by most representatives to ensure complaints were appropriately lodged, managed, and resolved. NRAS was claimed to provide a single entry point regardless of which professional was the subject of the complaint. It was said to possess broad legislative powers to thoroughly investigate a complaint, apply appropriate sanctions to culpable practitioners, and publish details of complaints and penalties imposed for public scrutiny. These provisions were considered to be unachievable with self-regulation.

They can then make a single complaint to Ahpra, to the [...] Board, and it will be addressed. (PAR5)

Ahpra gets a complaint from the public, they go through the process of actually scrutinising that, and it's all public record, and I just think there's a benefit to that model and the teeth that that model has under the National Law that we can't achieve unless it's at that level. (PAR12)

Several respondents viewed that adequate management of consumer complaints under self-regulation was hampered by voluntary association membership because practitioners could effectively avoid complaint investigation and continue practising unhindered by simply relinquishing association membership. For multi-association professions, there was the added concern of the ease with which practitioners could move between associations to avoid complaint investigations. Through their comments, representatives inferred that while they were responsible for self-regulation, they could not reach all providers purporting to practise, had no control over practitioner movements, could not appropriately sanction practitioners when necessary, and were powerless to keep consumers safe from poor-quality practitioners.

It's obviously not compulsory to be a member of the [association]. So we've got 16,000 [members]. [...] On government websites and such, they think that there's around 40,000 [practitioners], some say as high as 44,000. [...] So when you say it's self-regulating, and we call it self-regulating, and everyone says it's self-regulating, in actual fact, the [association] doesn't hold much power there, right? (PAR6)

Voluntary registration suffers from the deficiency [of] what are the protections for the public in terms of if anything goes wrong. And if an inquiry for complaint is made [...] and a negative finding is made, that person [may] withdraw from the organisation. Well, okay, that's fine. It's voluntary. I don't have to be a member. (PAR19)

If we have a problem with a member and we expel that member, that doesn't stop that member [from] joining another professional body and continuing to practise. (PAR12)

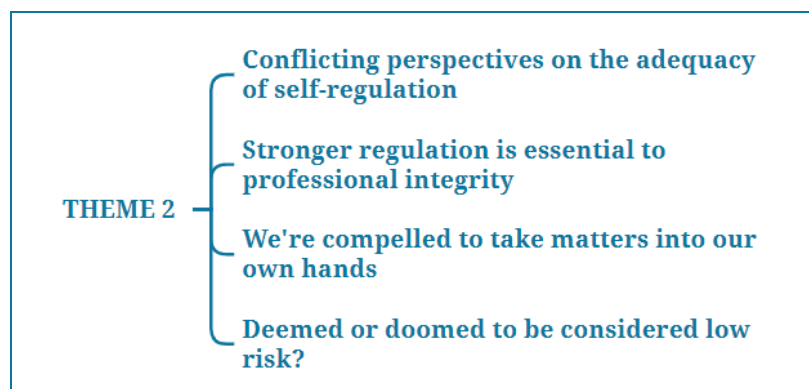
10.3 Theme 2. Strong regulation is better for practitioners and professions

Although a few representatives argued self-regulation was working for their profession, most considered it was not. Respondents who did not favour registration expressed apprehension about the cost implications on practitioners and possible loss of control of the profession. Most representatives identified inadequacies in the current regulatory settings, chief among them were the perceived conflicts of interest of some associations and the lack of independence and transparency. These representatives commonly voiced concerns about maintaining the profession's integrity. For many respondents, professional integrity was a critical consideration in seeking registration. The perceived inadequacies of self-regulation appeared to frustrate many respondents because their efforts at self-regulation remained unacknowledged by governments, prompting a few professional bodies to strengthen their governance mechanisms while continuing to pursue registration or co-regulation. Most respondents considered registration necessary to distinguish between qualified practitioners and unqualified providers. Irrespective of the type of regulation supported, almost all representatives called for the protection of occupational titles to ensure practitioner bona fides. Many claimed that registration would raise educational standards and promote professionalism among

practitioners. The majority of respondents stressed the need for government monitoring of practitioners to establish adequate accountability measures. Supporters of registration detailed the risks of practice to lend weight to their claims, and most commented on aspects of practice they perceived raised the risks to consumers. Despite the perceived risks, several respondents indicated that being considered a low-risk profession by governments was unalterable; they stated a belief of being forever cast as a safe profession. According to these respondents, governments' perception of the safety profile of the profession consigned them to a self-regulation status with no prospect of being granted registration.

The four sub-themes identified under this theme are set out in Figure 10.3.

Figure 10.3: Theme 2. Strong regulation is better for practitioners and professions.



10.3.1 Conflicting perspectives on the adequacy of self-regulation

The few representatives supporting existing regulatory settings stated that self-regulation was an effective governance mechanism, making registration unnecessary. While noting the benefits of statutory regulation mechanisms, those favouring co-regulation or those ambivalent about regulation schemes spoke of the perceived benefits of self-regulation. Benefits were identified as preserving strong industry links and avoiding overly bureaucratic processes to rapidly respond to member and profession needs. Respondents who described these benefits alluded to their loss under registration.

You've just got more autonomy, you can make, you're more agile, you can actually change quickly [...] say, for example, if we want to review our code of conduct and tighten it, we can, it's not like we have to go through layers of bureaucratic processes to make that change [...] So from that point of view, it's great to have that flexibility and autonomy that comes with self-regulation. (PAR16)

We think the biggest risk [with registration] would be losing the industry linkage. (PAR4)

A few respondents identified several concerns regarding registration. One was the cost to practitioners, which representatives perceived could reduce practitioner incomes, the implication being that registration costs might lead to a loss of practitioners and a shrinking of the profession. Another cause for concern was the impact of registration on professional associations, where respondents described possible declines in association membership and fears over their ongoing viability and survival. Representatives not favouring registration were concerned about governments regulating practitioners and were fearful of diminished or loss of control over the profession and the survival of the association. They were apprehensive about moving to a regulatory framework that was suggested to be filled with uncertainty.

[The profession] doesn't necessarily have to be registered [...] it's an expensive and costly impost on the members, and frankly, they don't earn enough to justify it. (PAR8)

I think self-regulation, I mean, it's working, it's an industry, you bring in regulation, like, who knows what that will look like. [...] it could kill the industry. (PAR7)

I probably have a little fear, but the smaller organisations have the bigger fear of what does that look like? Will we even exist? They know that the physios, about 60% of the [registered] physios are [professional association] members. They're going, Well, if that happened to us, we wouldn't survive. (PBR5)

One representative favouring self-regulation stated registration was an instrument of state control, providing a veneer of professional governance to placate consumers and offering illusory benefits to professions. As illustrated in the following excerpt, for this representative, there was no substitute for an appropriately self-governed profession, a view apparently endorsed by both major political parties in Australia.

I don't think any form of government regulation can outdo competent, well-done self-regulation. [...] we've been told by both sides of government that they won't regulate us because they couldn't regulate as well as we do. [...] So it comes back to what is regulation. A government control to give a false perception of standards, accountability. But it gives the public a false sense of comfort, safety, which is what governments want. (PAR15)

However, the same representative was prepared to forego the stated advantages of self-regulation if incentives to register were viewed as sufficiently attractive. In this instance, the respondent considered the imperative to access government Medicare rebates overrode the imperative for self-regulation because rebatable consultations would reduce consumer costs, lower government expenditure, and broaden the reach of the practitioner workforce, particularly to underserved areas.

The fact is, there are 4000 [non-registered practitioners] that could come into MBS⁹⁵ under the same standards [...] particularly in rural and regional areas. [...] We've demonstrated with experts that we would save the government money by bringing in [non-registered practitioners] into MBS. [...] If the government guaranteed me that we would get access to MBS tomorrow if we regulate, I'd take it. (PAR15)

Such weighing up of choice between rebates and registration was also referred to by another respondent representing the same profession, again leaning in favour of

⁹⁵ MBS refers to the Medicare Benefits Schedule, which is a listing of Medicare services subsidised by the Australian Government. Medicare rebates refunded to consumers for allied health services are generally 85% of the government-set schedule fee. See: Chapter 5, Section 5.3.2 for more information on Medicare.

government rebates, in part because rebates were perceived to offer greater “*recognition*” than registration.

Respondent: [S]ome of those bureaucrats have had different ideas about how we might achieve MBS.

Interviewer: Do you think that achieving MBS is more important than achieving statutory registration?

Respondent: That's a good question, and I would just say, yes, because there's another aspect of this, which is actually recognition of [practitioners]. (PAR18)

Although a few representatives advocated the benefits of self-regulation, the majority emphasised its inadequacy as a form of practitioner and professional governance. A common topic raised mostly by representatives supporting registration was the perceived lack of independence and transparency under self-regulation. This was frequently contrasted with Ahpra, which was considered independent of associations. Representatives spoke of the need for a body such as Ahpra to set mandatory requirements and standards “*to take any bias out of it*” (PAR12). These comments suggest respondents perceived that self-regulation allowed personal interests and preferences to take priority over public interests and consumer expectations. Several representatives inferred that self-regulation failed both consumers and practitioners.

As far as I'm concerned, self-regulation, I think, is rubbish. I think self-regulation is always going to fall down because you haven't got that oversight, and you haven't got that independent, removed body that can really steer or provide that compliance framework or that ethical framework. (PAR11)

There is, I think, still in the public's mind, a view that organisations tend to look after themselves. (PAR19)

One respondent stated that informal co-regulatory arrangements provided by private health insurers made self-regulation effective because of incentives offered to practitioners to join an association. Without this “*quasi-regulation*”, self-regulation was

considered ineffective. Respondents implied that institutional providers such as health insurers were performing regulatory functions on behalf of governments.

Look, without the health funds, self-regulation wouldn't be anywhere near as successful because the health funds require members to be accredited through an association to get their provider status. That was an enormous change; in fact, it's quasi-regulation when you look at it. Yeah, you take that element out of it, and self-regulation wouldn't work, I don't think. (PAR8)

Most respondents considered attempts to establish education standards and practice entry qualifications problematic under self-regulation. These representatives stated self-regulation was inadequate because there was no mechanism compelling professional bodies to set appropriate education standards, and there was nothing forcing education providers to meet standards set by professional bodies. A few representatives indicated that professional standards-setting was one of the primary purposes of registration, where practitioners across the profession were required to meet minimum requirements to practise. High standards were suggested to provide a guiding structure and set a quality benchmark for raising and maintaining the quality of practitioners. Respondents expressed doubts that some professional bodies could be relied upon to set appropriate qualification standards under a self-regulatory regime or that some education providers could be relied upon to meet the standards set. For these respondents, government regulation was required to apply the statutory force to ensure high standards were set and met.

It gives [a profession] a framework to hold itself against, so it gives it education standards so that all [professionals] who are trained in Australia have to have a minimum level of education that is robustly held against standards. (PBR2)

If those heads of schools don't want to abide by something, or they don't want the standards changed, because it doesn't suit them for a particular reason, they have the power to actually just go, No, we're not [going to change the standards] and there's not a lot the [association] can do. (PAR6)

Well, the most important purpose is to ensure a minimum standard of education. (PAR1)

The ability to establish and maintain high educational standards was considered an unattainable goal by a few representatives from multi-association professions. This was due to perceived disincentives to higher training levels for associations wanting to increase membership, and inter-association disagreements over standards. Some respondents described differences of opinion between associations representing the same profession regarding practice entry qualifications, which allowed prospective members to “shop around” for an association with lower standards. Several representatives stated that some professional bodies accepted lower qualification standards to attract members. They inferred that current regulation arrangements regarding education standards allowed competing interests to proliferate and enabled additional representative groups to form and gain influence over the profession. Representatives called for registration to remove standard-setting from the purview of what was alluded to be vested interests. Without a legislative mandate, stagnant standards were suggested to hinder the profession’s advancement.

Oh, you're out of this course. We'll accept you [in] a number of different professional bodies to say, No, you have to meet the Ahpra [education] requirement, and then you can join any association you want. [...] So with people like [our association] who tend to push higher standards and other groups that may not necessarily push higher standards, it means we're on a level playing field, and I think that's a good thing, and it's pushing the profession in the right direction, and you're not held back by your weakest [association] group [...] because depending on [which association] you go to [right now] depends on what qualification they recognise. (PAR12)

A few respondents contended that by maintaining professional standards, self-regulating professions performed the role of a government regulator in accrediting education programs, assessing practitioner eligibility for access to government-funded programs, and evaluating the qualifications of overseas practitioners. Some representatives appeared frustrated because they were forced to assume this

regulatory role while lacking any formalised delegation from governments and without the resources, data, or authority that statutory regulatory bodies had access to in order to perform these functions.

So basically, associations end up becoming the sort of regulator, on behalf of the government, of minimum standards that qualify people for provider status. (PAR9)

So, we do the accreditation of the university degrees. [...] it's a big part of our work as part of being self-regulating [...] It costs our organisation between a million and 1.2 million a year to undertake these functions [...] that we don't get reimbursed. (PAR6)

We set the standards, we accredit the university programs, we assess people with overseas qualifications, we do all of the certification of our members, we run robust code of ethics and complaints processes. We do all of that. The professional peak bodies, like ourselves, do that. That's where the cost is. (PAR17)

10.3.2 Stronger regulation is essential to professional integrity

Nearly half of the interviewed representatives claimed statutory registration was essential to maintain professional integrity, while a few viewed registration as a potential threat to practitioners. Most respondents considered professional integrity equated to high standards of practitioner competence and ethics, which were assured through adequate monitoring and accountability measures. These respondents regarded monitoring and accountability mechanisms as lacking under self-regulation. They implied that under self-regulation, practitioners had little accountability and practised with few restraints. The perceived difficulty in holding non-registered practitioners accountable was often contrasted with accountability measures and sanctions said to operate under the NRAS. The NRAS was stated to have the potential to end careers, while in most instances, this was not considered possible for non-registered practitioners, even with prohibition powers granted by the NCC legislation. In contrast, statutory monitoring and sanctioning of practitioners via the NRAS were seen to protect consumers, with threats of deregistration viewed as effective deterrents to unsafe

practitioners. Many representatives viewed the measures available under the NRAS as yet another reason to support registration.

With registration, if people do things that are problematic [...], then they can be deregistered [...]. Whereas currently, there's no system of that at all, people can do all sorts of things. [...] what registration does is provide a foundation for the profession [...] So you will weed out people who do the wrong thing. (PAR1)

If you're not Ahpra registered and a [non-registered provider] does something inappropriate, boohoo, what happens? [...] they don't become disbarred. However, if something inappropriate happens with us now, then we lose the right to practice. It's generally a pretty good safety net. (PAR10)

Many representatives appealed for statutory mechanisms to monitor professional practice and identify practitioner problems so they could be dealt with as they arose. Most implied they were powerless to enforce penalties on practitioners who had transgressed, citing the ease with which providers could move between associations or leave an association and continue practising. One respondent said monitoring of practitioners required the “legal power” of the NRAS, and several mentioned the need for the “teeth” of government to impose appropriate practitioner sanctions.

We really need to be registered. [...] the role that we play in public health needs to be monitored, it needs to be set, it needs to be standardised, we need to have expectations placed upon us. (PAR13)

You need that [...] legal power that comes with Ahpra [...] and have the teeth to actually carry that out. (PAR12)

I'm very aware that we don't really have the teeth of a government body. If somebody does something really rogue, we can deregister them, but somebody can employ them anyhow. (PBR1)

A small number of representatives supporting self-regulation and co-regulation also acknowledged the effectiveness of monitoring and sanctioning mechanisms under the NRAS. They stated that statutory mechanisms were an advantage when dealing with

errant practitioners and inferred that self-regulation mechanisms did not support professions when punitive measures were necessary.

That's one of the good things about NRAS is by having that Health Practitioner National Law is that if you do have individuals who are not sticking up with the evidence base, there's an actual pathway to take action against them. You don't have that backing with the self-registered health professionals. (PAR4)

A few representatives held opposite views regarding practitioner accountability within a self-regulating framework, and their perspectives were used as rationales for maintaining the status quo. As illustrated in the following account, one respondent stated self-regulation offered better accountability measures and maintained higher professional standards than registration, citing global research to support their contention. When asked about the research, the representative referred to “Google” as the source of their information.

Respondent: There's no correlation between regulation, standards, quality, accountability. There is no data or research that actually supports that. [...] If you go to a lot of the data and research worldwide, it suggests that actually, or quite a few of the professions that are regulated, actually have lower standards of accountability than organisations that have accountability through their own processes. Interviewer: Now, that's interesting. So, can you point me to some of those resources? Respondent: Ah, oh look, you only have to go into, just go to Google, look at statutory regulation and research on accountability. (PAR15)

What was suggested by the range of comments is that most representatives, irrespective of HPR preferences, agreed on the problems faced by self-regulating professions in monitoring and sanctioning practitioners. The point of difference between them was the identified solution. Many opted for registration with statutory governance, several preferred to maintain professional oversight with statutory imprimatur to ensure necessary enforcement authority through co-regulation, and a small number declared there were few or no issues with self-regulation requiring

regulatory intervention. What underlies these views appears to be who controls the profession. Many representatives perceived that governments should take control, several wanted to maintain professional control with formal authority from governments, and a few desired direct and exclusive control over the profession.

In addition to issues of control over the activities and governance of professions, representatives were also concerned about control of occupational titles. Most respondents pointed to the advantages of having legal protection of practitioner titles granted through registration. The absence of title protection for non-registered professions⁹⁶, described as *“the biggest”* issue by one respondent, was a common concern raised by the majority of representatives. Protecting occupational titles via legislation was considered essential so consumers and health practitioners could distinguish between qualified and unqualified practitioners. Respondents regarded ‘qualified’ practitioners held appropriate qualifications and were members of a reputable association. Representatives often framed their concerns regarding the lack of title protection as *“anybody can call themselves...”*. Almost all representatives across the continuum of regulation preferences described issues over the ease with which *“rogue”, “dodgy”, “predatory”, “unqualified”,* or *“underqualified”* persons could establish practice as non-registered providers. Respondents expressed annoyance and frustration over their inability to prevent title misappropriation and prohibit bogus providers from practising under professional titles. A few representatives cited instances of practitioners deregistered from NRAS who went on to practise as non-registered providers with no relevant qualifications or accountability measures.

All the previously deregistered nurses who now call themselves [practitioners] and all the previously deregistered whatever's, the deregistered chiropractors who are now [practitioners], the deregistered doctors who are now [practitioners]. [...] I think that's our biggest thing. I mean, how do we counter that? (PAR1)

⁹⁶ Dietitians Australia, a professional association representing non-registered dietitians, has trademarked the title ‘Accredited Practising Dietitian’. Even though this a form of title protection it is not a statutory title under the National Registration and Accreditation Scheme. See: <https://search.ipaustralia.gov.au/trademarks/search/view/2089105>.

The fact that there is no protection of title, someone can be doing what they're saying is [a non-registered profession], and they're not even qualified and there's no protections around that. (PAR17)

Co-option of occupational titles was especially concerning for professions with few co-regulatory arrangements to incentivise association membership. Several respondents expressed concerns about the reputational damage to professions and the standing of their practitioners due to bogus providers, a situation which respondents suggested brought the profession into disrepute. The absence of title protection was considered to elevate the risks to consumers, create confusion about who was qualified, and raise doubts about practitioner bona fides. Representatives not favouring registration also called for title protection, one contending its absence was one of the “*major downsides for the self-regulated professions*” (PAR4).

I am concerned about the potential for people without quality qualifications or any, for that matter, being able to practise in Australia and the potential harm that causes not only to their patients or clients but also to the reputation of [the professions across the board. (PAR14)

There have been a number of people who [...] claim to be a [non-registered professional] and they've had no training in that area. They may have come from a nursing background or another type of background, claim to be a [non-registered professional], which they can do technically. (PAR12)

[If] you don't receive funded services, so you purely see private people you don't have to be registered anywhere [...] and so is there a risk then that people are actually pretending themselves to be a [professional], for example, providing services, and then they're going to be dodgy. (PBR5)

The perceived importance of title protection was such that one representative was prepared to support a Commonwealth Government proposal for statutory certification of non-registered practitioners participating in government-funded programs in return for title protection, even though the proposal was considered inadequate. The

comments below illustrate the views of many representatives regarding the importance of title protection to professions. Comments suggested that, irrespective of issues raised by non-registered professions regarding bogus and unqualified providers posing as health practitioners, respondents considered complex policy decision-making processes to be the dominant concern of government officers.

When we looked at the detail [of the Commonwealth proposal], it actually would be lowering the bar. From where I sit, we've done a lot of work to raise the bar to make sure our members meet Ahpra standards [...], and then this [Commonwealth] scheme comes along [...] the one thing that we really would like, that we currently just can't have is protection of title. And if they offered that, it would just be like, where do we sign up? If you can legislate it and have protection of title, then we would have been really fhhh. They said, We won't do it. Well, why won't you do it? And they said, It's too hard. You have to get all the states and territories to agree to it. Huhhhh. It was very frustrating.
(PAR16)

10.3.3 We're compelled to take matters into our own hands

The majority of respondents described measures taken by professional bodies to strengthen self-regulation arrangements due to dissatisfaction with the perceived failings of self-regulation. For many, the measures appear to have been borne of frustration with inaction and inertia by governments, repeated rebuffs to appeals for registration or co-regulation, and the stated realisation by several respondents that statutory measures were unachievable. Representatives concluded their only option was additional voluntary mechanisms, despite these being considered insufficient and unenforceable. A few indicated a strategy of implementing arrangements “*mirroring*” Ahpra, and in a small number of instances, it was described as preparing the profession for registration. One respondent detailed the establishment of the voluntary standard-setting body, NASRHP, following a meeting with a government workforce agency at which “*all they cared about was the registered professions*” (PBR5). Several respondents deployed tropes such as having a “*seat at the table*” or entering “*the tent*” to clarify their

reasons for enhancing self-regulation measures, with the aim of preparing the profession for registration or gaining government support for co-regulation.

In every aspect [we] try and be as similar as possible to Ahpra. [...] I think [registration] gets us a seat at the table to help make decisions for healthcare in Australia. (PBR2)

We're trying to introduce things that mirror statutory registration as a kind of readiness tactic. (PAR9)

[From government] it was almost like, Stop asking, you're not getting in, and this is why you're not getting in. Go do something differently because you're not going to get in [...] in the absence of being nationally registered, [we established NASRHP] to provide that registration profession base to give assurances. [...] I think if they recognise NASRHP as this [statutory] entity is probably more likely than us hopping in the bigger [NRAS] tent. (PBR5)

A minority of respondents spoke of complex and confusing regulation arrangements for non-registered professions, described by a respondent as a patchwork of regulatory measures with little coherence and inadequate governance. Several representatives commented on the previously mentioned Commonwealth certification proposal, which was universally opposed by those who mentioned it.

We've got such a hodgepodge⁹⁷ of a system [...]. It comes under the states as self-regulating supposedly [...] we come under the Health Complaints Commission, yet, the Health Complaints Commission isn't equal in every state and territory [...], and if you look at the state-based legislation, the health setting is not exactly the same in each state and territory. And now there's talk of overlaying this new [Commonwealth] system. Just crazy. (PAR6)

The Commonwealth proposal was considered piecemeal and tokenistic. It was said to exclude some non-registered professions or some members of the same profession

⁹⁷ Hodgepodge is defined by the Cambridge Dictionary as “a confused mixture of different things”. See: <https://dictionary.cambridge.org/dictionary/english/hodgepodge>.

working in non-government-funded health settings. The proposal excluded title protection and had no ongoing professional development requirements to safeguard consumers. In the following account, the representative opposes the Commonwealth proposal using dismissive metaphors and emphasising exclusions. They contrasted the perceived benefits reaped by the Commonwealth under the proposal to the benefits denied to the professions. The respondent inferred that finding solutions to government problems, such as curbing spending on funding programs, was the main focus of governments, above all others, such as patient safety or practitioner quality.

[The Commonwealth proposal is] a *dog's breakfast*⁹⁸. It's a token, ooooh, we got to do something. So, okay, we'll have this sort of Mickey Mouse register in inverted commas that says, if you're Commonwealth funded, you need to register, but if not, well, whatev-v-ver. So, if you're in a state education department, nah, if you work in a state hospital, nah. But if you're funded under Medicare or DVA⁹⁹, that'll give us some data. Yeah, great! It won't give you anything useful at all, no title protection, nothing about safety. Oh, you've got to have the right qualifications. Great! Nothing about continuing professional development. Nothing. So, at the moment, the position of [the professional body] is, we don't like it. (PBR4)

This representative and other respondents commenting on the Commonwealth proposal gave the impression that government acknowledged the need for further credentialling or regulation of some non-registered professions yet appeared unwilling to consider appropriate statutory mechanisms. Based on an account from another representative, the unwillingness may potentially be due to perceived difficulties in gaining cross-jurisdictional agreement. To fill the perceived breaches in self-regulation, representatives implied the Commonwealth preferred to overlay another framework on what was already seen as a complex, confusing, inefficient, and ineffective patchwork of regulatory measures. Representatives implied governments would go to great lengths

⁹⁸ Dog's breakfast is defined by the Cambridge Dictionary as "*something or someone that looks extremely untidy, or something that is very badly done*". See: <https://dictionary.cambridge.org/dictionary/english/dog-s-breakfast>.

⁹⁹ DVA: Department of Veterans' Affairs.

to develop add-on proposals and schemes, irrespective of their ineffectiveness and inefficiency, to avoid registering additional professions.

10.3.4 Deemed or doomed to be considered low risk?

The perceived risks of patient harm frequently featured in accounts by profession representatives, partly in response to reviewing the Intergovernmental Agreement (IGA) assessment criteria during stakeholder interviews. Most representatives raising issues of patient risks tended to support registration. Respondents commonly stated that governments viewed their profession as low-risk. Some stated or inferred they agreed with government assessments, a few respondents appeared resigned to their low-risk classification, and others appeared despairing of being continually cast as a low-risk profession when they perceived otherwise. These representatives remarked that governments did not understand the risks of the profession, did not adequately capture complaints to identify the extent of risk, or were disinterested in further exploring the profession's risks. The government stance was stated to be despite the ongoing evolution of practice and continued expansion of professional scopes. Where there were multiple representative bodies, views on perceived risk invariably differed among respondents, as did the regulation arrangements considered appropriate for the profession, potentially due to variations in professional standards between associations. One respondent implied the government definition of risk was “killing” patients, and another flippantly suggested practitioners should cause harm to give weight to registration claims.

We haven't been seen to kill a patient or kill a child or be on the front page, 'A [non-registered professional] killed the patient'. Therefore, we're not deemed a risk. (PAR3)

Talking to [practitioners] and basically saying to them, go out and cause significant harm to patients, because once you've done that, the government will be interested in registering you. (PBR1)

In providing explanations for supporting specific types of regulation, a minority of representatives identified characteristics of professional practice they claimed raised

the risks of harm to consumers and strengthened the case for registration. These characteristics included practising in isolation, autonomous practice, and operating solo practices without clinical monitoring and opportunities for clinical collaboration. Prescribing medicines, administering interventions, carrying out invasive procedures, and diagnosing conditions were also seen to elevate practice risks. Settings where consumers were required to disrobe and working with some groups, such as vulnerable individuals, were considered to raise the risks of exploitative practices. A respondent stated that working with vulnerable individuals came *“with a series of both risks and responsibilities”* (PAR9). Another argued that anyone directly working with patients could lay claim to registration. While for many professions, the identified characteristics were an unavoidable aspect of clinical practice, they were implied to be well-controlled by adequate practitioner training and competency. Where they were seen to present risks was in the absence of governance structures that allowed unqualified and unscrupulous providers unfettered freedom to practice.

So, I think sole practitioners are high risk. And then if you've got a sole practitioner that is able to either administer or perform an intervention that could cause death or permanent disability, those two things together, I think, are important indicators. (PBR6)

Protecting vulnerable people from not just healthcare professionals but from exploitation, from abuse, from all the atrocities that we know go along with power. (PAR6)

We need appropriately qualified people needing to ensure that we're going to prevent the public from experiencing severe adverse reactions and potentially death. And that's where the submissions come back to you need to highlight how dangerous you are. [...] generally, we're a very safe practice. But in the hands of somebody who's not safe, this is what can actually occur. (PAR12)

In supporting views about self-regulation, a few representatives argued that the profession was safe or presented low risks. The perceived low risks of practice were commonly underscored by contrast to registered professions considered to be at high risk of patient harm, inferring registration should be reserved for only the riskiest

professions. A few representatives implied that admitting to practice risks might reflect poorly on the profession.

If you look at the complaints [...the profession] doesn't even come [onto] the radar. We're not even statistically on the radar. Psychologists are right up there with the GPs and psychiatrists. And these are all regulated [laughs]. (PAR15)

I don't know if we want to be seen as being really, really risky. If the evidence is not there to demonstrate that, then I think that's okay. (PAR4)

I think our board would argue that we want to present ourselves as not risky and not have, signal potential significant harm to the public. Because our techniques [...] are inherently safe. I might argue in the opposite direction. (PAR13)

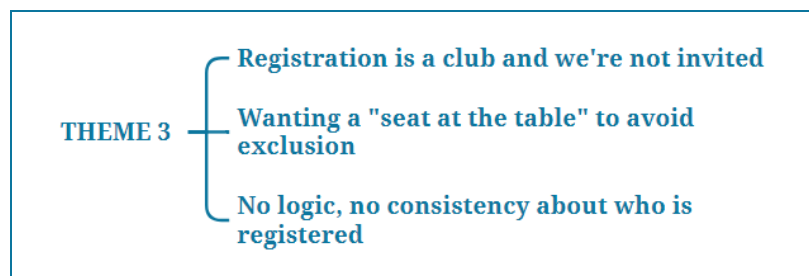
10.4 Theme 3. Needing recognition, wanting to be heard

Most representatives identified perceived barriers to professional advancement faced by non-registered professions. They described the obstacles to professional progress because of the absence of registration. Respondents expressed disappointment in what were considered disadvantages experienced by practitioners, the stated divisions between registered and non-registered practitioners, the partitioning of professions into registered and non-registered classes, and the apparent invisibility and marginalisation of non-registered practitioners due to their exclusion from the NRAS. For many representatives, the disadvantages they attributed to NRAS exclusion informed their views regarding regulation. Most of these representatives considered that registration would overcome the disadvantages, resulting in elevated professional status and greater interprofessional collaboration. Respondents regarded government decisions about professions that were and were not registered as having little logic. Almost all representatives supporting registration used comparisons with registered practitioners or with other countries to substantiate their claims. Differences of opinion between professional bodies representing the same profession on whether registration was necessary were seen to reduce the chances of gaining a favourable hearing from

governments. A few respondents spoke of attributes such as the profession's size or "weight" that were considered to influence governments.

The three sub-themes identified under this theme are set out in Figure 10.4.

Figure 10.4: Theme 3. Needing recognition, wanting to be heard.



10.4.1 Registration is a club and we're not invited

A few representatives expressed frustration over the perceived inability of governments to listen to professional bodies or understand their concerns about self-regulation or other professional issues. One respondent, referring to the perceived government focus on registered professions, suggested governments were indifferent to matters raised by non-registered professions and even lacked an interest in listening to the community.

I just don't know if the government will listen. (PAR11)

Governments should listen more to what's going on, and rather than just a small cohort of so-called medical practitioners, they should listen to the community and look at what's actually going on. (PAR8)

Getting in through the [government] door is difficult at the best of times, and finding the right person, and then you've usually only got a very short period of time. So to have [...] them actually understand the issues and the differences and how the systems are essentially creating barriers for access to services, it's not a five-minute conversation. (PAR4)

Around two-thirds of respondents commented that registration had created professional divisions. The divisions were considered to operate at two levels. The first was intra-association divisions over registration that were not directly referred to but

were implied by respondent comments. One representative described feeling “torn” between their personal views on registration, the views of association members, and those of the professional leadership. Others identified divisions between association board members because of tensions over registration.

My personal opinion would probably differ from that of the official opinion of the association [...] [sigh, 5 seconds] Probably to a certain degree, that I might be a voice that in conversation would say, hey, can we have another discussion about this [registration]? But when I put forward that question or suggestion, and it gets a little bit shot down, Oh no, we don't want to talk about it, then, I'll step back [...] from that fight. (PAR13)

Comments indicated tensions over occupational regulation beset some professions and professional bodies. Several respondents commenting on this tension implied that the type of occupational regulation under which a profession operated was a choice to be made by professional bodies. The selection of the best-perceived regulation model depended on the opinions and perspectives of the professional body. Given the diversity of views on occupational regulation, a government policy that delegates the responsibility for submitting registration claims to professional bodies may not deliver the most appropriate regulation for non-registered professions.

We have been pushing [the peak body] at times to refocus on registration. This has kind of created some antagonism between [us as an association] and our peak professional body. [...] So we've pulled back on pushing for registration because we want to collaborate with our peak professional body. [...] I believe that it's our association making that decision to [seek registration] or not to. I think they're the barrier. And I can't figure out why that might be the case. Maybe, I don't know why, maybe there's more power in them having their own self-regulation, or maybe there's funding they receive to be self-regulated. (PAR11)

The second level at which divisions were said to operate due to registration was described by most representatives as the “tiering” of professions. NRAS was perceived

by these respondents as having created a “two-tier” system of health practitioners. They claimed registration divided professions into higher (registered) and lower (non-registered) classes that segregated professions according to importance and quality. The ‘upper-class’ professions were alluded to as forming an exclusive club that lower, non-registered professions were barred from joining. According to these respondents, this type of “tiering” meant non-registered practitioners were not afforded the respect they deserved. It resulted in various adverse consequences, such as being considered “less competent”, “second-class”, or “inferior”. Many representatives stated that exclusion from NRAS had had a detrimental effect on the professional standing of non-registered practitioners.

There's this two-tiered system that's been set up. [...Members say] I feel like I'm a second-class health professional. (PAR16)

Unregulated workforces do not often get the respect they deserve from the regulated workforce. They're seen as inferior and at a lower standard. (PBR6)

I feel like we're the cheaper sister to our [registered] allied health professional colleagues. (PAR11)

Several respondents indicated that, although governments had not intended to create professional divisions, the NRAS had done just that. Because of perceived divisions between professions, non-registered practitioners were considered marginalised to the extent that they could not fully contribute to the health system. One respondent remarked that the perceived “tiering” of professions prompted the establishment of the standard-setting body, NASRHP.

Just creating that tiered system within the healthcare sector [...] and by not recognising us at that same level, that you are actually impacting potential outcomes for Australians, because [our practitioners] don't have the same recognition or the same opportunities or the same ability to contribute to the system. (PAR4)

The initial intention was not to be a way of dividing the health professions into the good and the not-so-good or the important and the not important, that wasn't the point. But that's effectively what that [NRAS] structure has done. (PAR20)

[By establishing the NASRHP], we just wanted to eliminate another reason for the sort of tiered system that was being created in the healthcare sector. (PBR5)

However, the establishment of NASRHP demonstrates that hierarchical “*tiering*” was not limited to registered and non-registered professions. When the ineligibility of certain professions to apply for NASRHP membership was questioned, one representative offered reasons such as the qualification level, even though some self-regulating professions met the educational standard considered necessary. According to the representative, the proposed solution to accommodate the ineligible professions was establishing a hierarchy of NASRHP membership, not unlike the “*tiering*” of registered and non-registered professions the respondent had objected to earlier in the interview.

Interviewer: There's a group of 16 occupations in the National Scheme. But there's many more that reside, what you would say, outside the tent, and quite a number of them would like to be inside the tent, including NASRHP as a peak body or as a board. Yet, NASRHP, from what I'm hearing, won't entertain including groups such as [professions A, B, and C] in your tent.

Respondent: I wouldn't say it's a no, never. We, it was very strategic at first round. We're just doing AQF¹⁰⁰ level seven, get ourselves set up and recognised, and get a name for ourselves. [...] So it's not a never, but what we talked about was looking at our standards and going there may be some of those standards that won't be applicable for that group. [...] And so, do we have a tiered system within [the NASRHP]? (PBR5)

¹⁰⁰ AQF refers to the Australian Qualifications Framework, a national policy guide for qualifications in the Australian education and training system. AQF level 7 is classified as a bachelor's degree. See: <https://www.aqf.edu.au/framework/aqf-qualifications>.

Several representatives commented that some registered professionals deliberately created divisions between professionals for personal advantage and to elevate their importance. Often, the tactics deployed were not articulated by representatives but were seen to intentionally segregate registered and non-registered professions, creating barriers to interprofessional practice. However, the divisive tactics were viewed as more than class segregation. One respondent stated that registered professionals manufactured distinctions to increase economic rewards and power, divert government funding away from self-regulating professions, and exclude non-registered practitioners from the health system as untrustworthy providers. The comments implied a misappropriation or weaponisation of registration to maintain interprofessional tensions, wage “turf wars”, overcome competition, and eliminate rivals.

So particularly in areas where I'm going to say there could be a bit of a turf war kind of concept of in my association, one of them is the physios will say, Well, we're registered, and so we're better, and so we should have better access. Well, Ahpra is not about that; it's regulating, it's about protecting the public. (PBR5)

It's sold by the professions that are regulated to stop competitors coming to the marketplace. It also enables them to silo services through government regulation and funding. [...] So what [the registered professions] can say is, Oh, no, we don't want the government to fund these non-regulated people. [...] But certainly, you give all the money to us because we're regulated by you. So you can trust us [...], and government buys it. [...] It's a game of money, pies, power, but certainly not standards, accountability, checks and balances. [...] I just see prejudice or bias. What I see is protectionism by registered occupations to try and keep out competitors. [...] When I met [the Health Minister], he had been told by the [professional association] how great [registered professionals] were and everybody else was useless. (PAR15)

10.4.2 Wanting a “seat at the table” to avoid exclusion

A few respondents commented that self-regulation hindered collaboration and communication with registered professionals. They stated registration would remove

barriers to interprofessional collaboration and referrals from GPs. Increased referral rates were considered to result from greater confidence in the guaranteed training standards due to registration and a growing “respect” for practitioners as registered professionals. Greater interprofessional collaboration due to registration was sometimes framed as being in the public interest because of perceived improvements in the quality and safety of registered practitioners. Several representatives contended registration would elevate professional standing and bring professional “recognition” from the public and other professions. Comments suggested representatives were seeking professional acceptance from registered practitioners who would view non-registered practitioners as competent and credible professionals and as worthy and trusted colleagues.

I think that [self-regulation] then stops collaboration, or hinders collaboration, maybe doesn't stop but hinders collaboration and hinders respect between professions. (PAR11)

Registration [...] allows greater interprofessional communication, which I think is actually really important from a safety perspective. (PAR1)

Other professions [will] look to us as a more competent profession. So medical professionals will now think, okay, [these practitioners] are now under [...] the National Scheme, that means that they've got a certain level of education behind them, and so I can confidently refer to them. (PBR2)

Certainly, the advantage for me for regulation is public recognition and professional recognition. (PBR3)

Several representatives spoke of feeling invisible or voiceless, a perception reinforced by the stated biases of government departments when dealing with registration claims or other issues relevant to non-registered professions. One representative noted the singular focus of the Department of Health was on medical and pharmacy personnel, leaving little or no room for other practitioners. For this individual, professions outside of medical, nursing, and allied health were non-existent to departmental officers.

[In] the Department of Health, the culture is doctors, doctors, doctors, doctors, doctors, doctors, and doctors, oh, and pharmacists occasionally. They once in a while mention nurses, and allied health gets a guernsey¹⁰¹ about once every pancake Friday¹⁰². They are totally focused on doctors and pharmacy and drugs. Drugs are everything. That's the focus of the Department of Health [...]. It's not that they are not focused on allied health. They're not focused on nursing, either. And if you're not part of nursing or allied health, if you're not part of any of those things, they're not focused on you at all. You don't exist. (PBR4)

The perceived invisibility of non-registered professions was said to result in being overlooked when relevant legislation was proposed, such as extending practice scopes to allow practitioners to perform procedures or administer medications traditionally provided by specialist doctors. The lack of visibility was sometimes contrasted with the claimed high visibility of certain registered professionals who were ostensibly “*not ever overlooked*” and were “*always*” central to government deliberations on policy matters. Constantly being overlooked by governments and dismissed by registered professions was said to destroy professional self-worth.

So, by not being included under Ahpra it means that sometimes we can't do things that are within our scope of practice. We're not considered when legislation is being made [...] it's very relevant to us, but there's no sort of visibility of us [...] if you think of physiotherapy or optometry, they're not ever overlooked in terms of those things. It's very much like they're front and centre. They're included, they're thought of, and I think we sometimes fly under the radar a bit. (PAR20)

¹⁰¹ In Australian English, “*getting a guernsey*” means being selected or gaining recognition for something. See: <https://www.collinsdictionary.com/dictionary/english/get-a-guernsey>.

¹⁰² Pancake Friday is a reference to Shrove Tuesday, a day of feasting before the commencement of the Christian Lenten period of several weeks of fasting, self-reflection, and repentance. “*Once every pancake Friday*” refers to an event that never happens since pancake day is held on a Tuesday. See: https://en.wikipedia.org/wiki/Shrove_Tuesday.

I can't imagine physiotherapists ever doubting their place in the world. [...] Having worked with a lot of them, I know where they think they belong. [...] Had the government not knocked us back on earlier attempts [at registration] because, Oh well, you're so safe and really don't make any decisions anyway. That whole self-perception, self-esteem of the profession, professional self-esteem just leaches away. (PBR1)

A view put forward by one respondent from a registered profession supports the perspective of being overlooked as a non-registered practitioner. The respondent stated that registration had not delivered any benefits but had removed barriers to professional progress. They inferred that being non-registered was used as grounds for disregarding discussions about professional advancement and advanced practice scopes. With registration, however, the profession now sat among the “prestigious” registered practitioners, suggesting they now felt seen and acknowledged.

[Registration] hasn't enabled anything for us, but it's removed a barrier. A lot of conversations we used to have about [...] working outside [our traditional] services, Yeah, but you're not Ahpra registered. So it's removed a barrier. [...] I do think it's beneficial. I think it's beneficial in terms of recognition of a profession, and this may be a perceptual thing, but now we sit amongst the physiotherapists, the medical practitioners. There's a prestigiousness about that. (PAR10)

Around one-third of representatives reported instances of perceived disadvantage experienced by practitioners, which they claimed resulted from NRAS exclusion. Disadvantages were said to include ineligibility for employment opportunities, government grants, educational scholarships, certain bank loans, and telecommunications discounts. Several representatives expressed frustration at being excluded from public health orders that allowed registered practitioners to continue practising during COVID-19 lockdowns. A few respondents stated that over time, the perceived “discrimination” had diminished, particularly after several non-registered professions lobbied the Commonwealth Government to issue a statement reinforcing

the purpose of the National Scheme¹⁰³. Some representatives contended that discrimination was still occurring, one stating, “COVID brought it all out again” (PBR5).

The main thing that [self-regulating professions are] calling for is to stop the discrimination. (PBR4)

So we have found it's actually led to legitimate barriers in who can be employed within hospital systems and public health sectors. It has actually impacted progression. [...] So, say someone has worked as an excellent clinician, and now there's a team leader position. They tend to only allow for Ahpra registered professions, and they'll specifically say, this is what we want. [...] a lot of [employers] just go, No, we don't understand how [self-regulation] works. We want the Ahpra registered because then we've got the confirmed quality, and we know that you have insurance, and we know that there's the systems in place should you do anything untoward. (PAR4)

Much of the commentary from respondents implied that being overlooked, invisible, disadvantaged, and traduced as professionals informed respondent preferences regarding registration. Representatives inferred their exclusion from NRAS led to their preclusion, whether inadvertent or intentional, from opportunities in the health sector. Professional aspirations for acceptance, recognition, and professional advancement were suggested to elude professions under self-regulation. For many, the perceived solution was NRAS inclusion.

10.4.3 No logic, no consistency about who is registered

Most representatives mentioned perceived disparities between professions that were and were not registered. The difficulties experienced in gaining entry to the NRAS were contrasted with the perceived ease with which registered professions were admitted over a decade earlier. They inferred that the decisions regarding the initial inclusion of professions under the *National Law* had little to do with risk and suggested that political influence was involved.

¹⁰³ See Communiqué:

<https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31799&dbid=AP&chksum=Do7bKOrNq5bLPPvgI6dqfw%3d%3d>.

It seems we kind of go, ooh, you guys got in on regulation early, so had a good lobby group back in 1930, got yourself on the [registration] list. Dang! You're there whether you're dangerous or not. [...] It's just been too hit-and-miss. (PBR1)

The majority of representatives made comparisons between non-registered and registered professions to substantiate their claim for registration. Comparisons included assessments of risks and scopes of practice, comparisons of providers at a clinic or other health setting, and even comparisons with professions outside the health sector. Despite the stated government claims of consistency and transparency, one respondent viewed the mechanisms in place to regulate non-registered professions as “a soft approach” (PAR11). Many others could not comprehend a government position denying registration to self-regulating professions. One respondent stated that the government was in a bind and uncertain about how to resolve the quandary over registered and non-registered practitioners. Another respondent proposed a solution to the perceived conundrum over which professions should be registered by declaring, “*just regulate everything in terms of healthcare*” (PAR11).

If a psychologist is registered, I can't understand why a counsellor or psychotherapist shouldn't be registered because I would have thought there could be a similar scope of practice. (PAR12)

We regulate accountants, we regulate engineers, we regulate a whole bunch of professions. (PBR1)

Every single clinical person in that department [...] they all are under Ahpra. So that entire site is under Ahpra except for [us]. (PAR5)

I sit here, look at it, and go, why are those ones registered, and why are those ones not? You know, to me, it's become political. The government got themselves into a mess. (PAR16)

Another perspective offered by a representative of a registered profession was that consumers of non-registered professions did not require the same level of protection, due to the perceived lower level of potential harm compared with the perceived risks of

their profession, paramedicine. In exploring these perspectives, the representative conceded they may have adopted views similar to those expressed by registered professions when paramedicine was seeking registration.

Respondent: We've got one purpose, protection of the public. That's the only purpose.

Interviewer: So, do you think consumers of these [non-registered] occupations should be protected as well?

Respondent: I don't think so. Not to the same degree because the level of harm is so much less potential harm. [...]

Interviewer: It sounds to me like now that [paramedicine is in the NRAS], we're comparing these occupations with paramedicine. It sounds to me what you're doing is what you experienced from the other registered professions when you were not registered.

Respondent: Yeah. You're probably not wrong. (PBR6)

The respondent implied, having earned their entry to the NRAS by right of “risk”, non-registered professions had not earned the cost of admission because they could not demonstrate sufficient risk. In addition, while the respondent compared the risk of non-registered professions to the risks of paramedicine, they did not make any risk comparisons between registered professions and paramedicine to assess perceived differences. This suggests that risk was being deployed to maintain current NRAS membership arrangements.

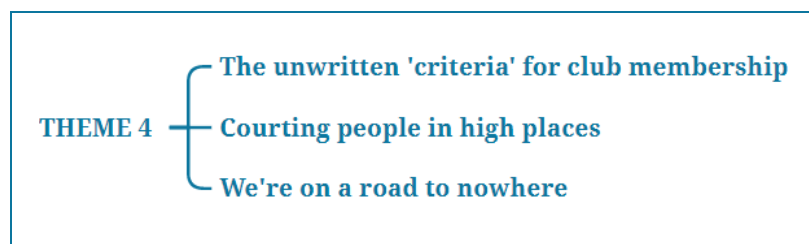
10.5 Theme 4. The unwritten rules for NRAS entry

Nearly half of all interviewed profession representatives identified characteristics and attributes considered to distinguish registered from non-registered professions. Two primary distinguishing features, qualifications and evidence-based practice, were identified as core requirements for registration. These requirements not only informed perspectives on which professions should be registered but also specified which should be designated as allied health professions or were eligible for NASRHP membership. Respondents were more likely to support registration for certain professions if they had existing knowledge of or experience with the profession. In petitioning for registration, most representatives questioned the government’s “appetite” for change. Almost all

representatives mentioned challenges in engaging with government officers or government processes. They spoke of the difficulties experienced when discussing their claims or navigating the IGA criteria and process. In most instances, professions were seeking registration, but some respondents were pursuing other avenues, such as greater statutory protections under a co-regulation framework or Medicare rebatable consultations. Several representatives commented on the need to enlist support from allies such as champions and lobbyists to advance registration claims. Most respondents considered that costs borne by governments were a significant impediment to registration.

Figure 10.5 presents the three sub-themes identified for this theme.

Figure 10.5: Theme 4. The unwritten rules of NRAS entry.



10.5.1 The unwritten 'criteria' for club membership

Several representatives claimed that practitioners required degree-level education qualifications to be considered for registration. Achieving this qualification was seen as a mark of a mature profession. Respondents suggested that professions with lower than degree standards would not be accepted or taken seriously by other health professionals. One respondent stated that mechanisms other than the NRAS should be used to regulate professions with lower qualifying awards. Another commented that if practitioners were permitted to enter the NRAS with lower qualifications, the perceived distinction of the NRAS would be debased. Several respondents acknowledged that degree qualifications were not part of the formal assessment criteria but nevertheless stressed their importance for NRAS admission. Others claimed that the degree requirement was implicitly “*embedded*” in the IGA criteria. Several representatives supporting self-regulation or co-regulation appeared to accept their exclusion from the

NRAS based on a lower qualifying award. These perspectives suggest NRAS was seen to require an entry 'pass' beyond the assessment criteria, one based on educational qualifications. A lower qualifying award was implied to provide grounds for eliminating the profession from registration contention.

Probably it's another unwritten rule is that to be a health professional, you need an undergraduate degree as a minimum because if you dilute that too much, then the whole kudos of registration gets diluted.
(PBR6)

I think registered professions have to have a degree qualification.
(PAR8)

But people that have less training, that are still providing healthcare should probably be registered also, but it would just be regulated in a slightly different way, I suppose, depending on what the training looks like. (PAR20)

Much like qualifications, a small number of representatives perceived that operating within an evidence-based paradigm was intrinsic to the IGA criteria. One respondent questioned the evidence base of certain professions they considered “*fringe pathologies*”. The respondent invoked the tenet of “*the scientific method*” as a corollary to “*best practice*” and “*accepted practice*” to make determinations on whether a profession should be considered for registration.

I think evidence-based practice, if not in the criteria explicitly, is certainly embedded there in terms of what one might call the practice of a profession based on best practice, accepted practice, and based on the scientific method. [...] I think the ones that might get out without statutory registered might be counsellor, might be Western herbalists, might be naturopath, but that's a dicey one because what I'm grappling with, what I'm having a great deal of trouble grappling with is that I'm trying to not allow my perceptions to overcome my analytical assessment in terms of the level of risk. And the next question, of course, is what happens if they're not registered? And that takes them out of the system or back into fringe pathologies, and that's a danger as well. (PAR19)

Another representative used evidence-based practice to distinguish allied health practitioners from “*alternative practitioners*” and determine eligibility for consideration as an allied health professional. Even though the respondent remarked that their organisation considered certain professions as “*alternative*” and therefore not evidence-based, they distanced themselves from the comment by stating the comment was a “*general opinion*”. Nevertheless, the representative suggested that until the professions established an evidence base for their practice, they would not be considered part of the allied health group.

Respondent: That's a very strong requirement, [working in] an evidence-based paradigm [...] and there are other professions that may, at some stage in the future, move into the allied health space. [...]
Interviewer: So then, let me pose a question around Western herbalist, naturopath. Would you consider that they...
Respondent: We would consider them alternative practitioners.
Interviewer: And so, therefore, you would consider that they don't have that evidence, they don't work within that evidence-based paradigm?
Respondent: That is the general opinion. It's not my opinion. That is the general opinion.
Interviewer: And where's that opinion coming from?
Respondent: I think it's a very broad opinion. I think if you scratch the surface anywhere, that's a very broad opinion. Including the government, I can tell you. (PBR4)

Several other representatives also inferred that working within a perceived evidence-based paradigm should be included in the IGA criteria. One respondent argued that evidence-based practice was more important than qualifications in determining NRAS eligibility. They questioned the qualifications of a registered profession based on the assumption that it did not operate in a “*science-based*” paradigm. The respondent drew on the perceived authority of general practitioners who were assumed to support their views. The respondent contrasted their profession, which they considered evidence-based yet was not registered, with a registered profession perceived to practise outside accepted scientific disciplines.

Respondent: With chiropractics, there were some risk events [...], and they moved those non-university degree or non-university trainings from one side [non-registered] to the other [registered].

Interviewer: With chiropractic, that's a master's level qualification.

Respondent: It is, however, it's not. Yeah, this is where it gets a slippery slope and probably not where I really want to go for this because it's tricky. But there [are] professions that are considered in the space of health and science, and then there's professions that are more not considered so science-based and evidence-based. So, if you were to ask most GPs if they would support the use of chiropractics, they would say, No, because the science around chiropractics actually isn't there.

(PAR11)

These views suggest some representatives established distinctions between professions based on factors outside the formal assessment criteria, similar to the distinctions drawn between registered and non-registered professions based on risk. These respondents inferred that certain non-registered professions lacked the proper evidence-based credentials to be considered for registration or classification as allied health. A few representatives also appeared to disagree or were dissatisfied with previous government assessments and decisions regarding the registration of particular professions. They seemed frustrated that their profession remained non-registered even though they held the 'right' qualifications or evidence-based credentials, according to their viewpoint. Their disagreement with government decisions was based on perspectives and beliefs regarding the evidence base and qualifications of professions, just as their profession was denied registration based on other factors.

When considering whether non-registered professions should be registered, representatives often relied on their knowledge of the profession to make a judgement. Although a few representatives would not be drawn into offering opinions, several commented on their knowledge of or experience with non-registered professions. Knowledge and experience of a profession appeared to elicit support for registration, sometimes substantiated through comparisons with registered practitioners, while unfamiliarity invariably led to a lack of support for registration. This suggests personal experience or knowledge strongly affects how professions are perceived and how their

claims for registration are viewed. Respondent perspectives indicated that although most appealed for government objectivity in assessing professions for registration, objectivity was not necessarily a concern for representatives offering opinions regarding registering other professions.

Respondent: I'll give you an example. [Someone I know] goes to a counsellor following an incident that occurred three years ago. So he's been seeing the same counsellor for three years, every fortnight. But nothing has changed. So is that counsellor, should that counsellor be referring him to someone else?

Interviewer: Do you have a view on whether counsellors should be registered?

Respondent: I do. I think they should. Yeah. I think it's too easy to become a counsellor, and you're dealing with a really vulnerable group of our society. (PBR6)

One respondent considered it prudent to use the personal experience and knowledge decision-makers had about a profession to improve their chances of a favourable hearing regarding registration.

You're trying to connect, trying to tap into, say, that emotional side of things as well. That they're thinking, Oh, my God, my daughter's pregnant, or my friend's sister's pregnant or whatever, and oh my god, they're having scans, and this person scanning them is not even regulated. [...] I don't want to be putting my mother or my sister or my child in an environment where someone's scanning them who's not regulated. (PAR5)

Most representatives viewed registration costs to governments as a significant impediment. One respondent described costs as “*the biggest hurdle*” to registration. Many respondents inferred that cost issues overrode risk considerations and public safety concerns in government decision-making about registration. A few representatives identified cost-minimisation strategies to accommodate further professions in the NRAS. The comments on costs allude to financial issues and budget

considerations as having an undue influence on government decision-making despite the risks the profession may pose.

The only thing stopping them [from registering more professions] is they're worried about cost. Whereas there should be a focus on patient care. (PAR2)

I think the challenge has been all along that the government appears more concerned around cost than what should be the criteria for safety of the public. (PAR17)

I think the risk [for the profession] is there. It's real. Absolutely, it's there. So, if you're just looking at that, I think it's a no-brainer. But ministers and governments think about costs, bureaucracy and other things, which is going to play on their mind about do we want an increasing number of professions regulated. (PBR3)

A minority of representatives perceived that 'smaller' or 'lightweight' professions would struggle to convince governments of the need for registration. Larger professions were seen to have a "*louder voice*" and a greater presence. These attributes were suggested to attract government attention to the profession and its agenda. Representatives of smaller professions commented on unsuccessful efforts to achieve registration. They stated that when it came to registration or other professional claims, governments considered the size, strength, or influence of professional bodies in deciding whether to engage with them. Respondents implied governments were, in effect, 'sizing up' the profession to determine whether they deserved attention. A few respondents, however, indicated that attracting government attention required more than a large workforce. One stated that even though theirs was "*one of the biggest self-regulating health professions*", they saw themselves as a "*small player*" (PAR6) compared with registered professions. Another representative also acknowledged their large workforce but considered themselves underweight when it came to influencing government policy.

The bigger the workforce, I think, the greater the chance of regulation [...] you've got a louder voice because you're bigger, you're typically going to have louder unions. So size is important. Absolutely. (PBR6)

It's just, it's kind of a struggle just to, but you know, once again, we're just such small numbers. (PAR3)

I think that the industry is likely to always struggle because we've got a fair amount of numbers, but I don't think we have enough weight within healthcare to really have a big bargaining chip. (PAR9)

Over half of all representatives perceived that progressing claims for registration required unity across the profession, or claimed professional disunity hindered engagement with governments and their officers. This was considered particularly problematic for multi-association representatives, who had been informed that governments wanted a single, unified body to engage with regarding matters of professional interest. If unity was unlikely, governments were said to view professions as not having their “*act together*”. Where professional bodies disagreed over registration, governments were said to describe the profession as undecided on which direction to take. A few representatives implied professional disagreements over registration were due to personal or conflicted interests. Whatever the reason, disagreement and disunity were perceived to hinder professional advancement, such that professions contended they could not move forward on critical regulation reforms requiring government support. Several representatives viewed the government requirement for a unified voice as a pretext to avoid dealing with professional claims, a deliberate “*tactic*” used to delay government action or a barrier to effective engagement with governments.

There has to be unity in the profession. (PAR5)

An old fallback position of government is get your own act together. [...] So until you get a unified voice, it's very convenient for governments to turn around and say, Well, you're not unified [...] There's a lot of tactics and bureaucratic ways of keeping the barriers up. (PAR8)

I would also argue that it has been quite convenient for various government bodies of relevance to quote that division and lack of agreement as an excuse for inaction. (PAR9)

In pressing for registration, one representative identified unfavourable media coverage as an asset. Bad press was considered to bring attention to the profession, and while perhaps unwanted, it was seen to raise the profession's profile and strengthen its case. Conversely, positive media coverage signified a low-risk profession, reducing the likelihood of a favourable government response.

Public opinion, press, poor media. You're not going to get across if you've got lots of good media because you're not a risk. If you've been featured on Four Corners¹⁰⁴, that's really helpful. (PBR6)

While governments were perceived to require professional unity as a condition of engagement, comments regarding bad press suggested that professions that 'get their act together' may have the opposite effect to that intended. This is because an absence of bad press could disadvantage groups with robust self-regulating mechanisms, even if the profession poses a significant risk to consumers. Similar to previous comments regarding deliberately harming patients, governments may inadvertently encourage poor behaviour among self-regulating occupations by giving attention to professions based on adverse publicity rather than any systematic, proactive assessment against the IGA criteria.

10.5.2 Courting people in high places

Engagement with government and non-government actors to progress claims for registration generated much commentary from most representatives. In discussing government receptivity to appeals from professions, many representatives referred to the need for ministerial "*appetite*" to progress professional claims. Respondents suggested or explicitly stated that governments had little appetite for further registration of professions. A few representatives identified the difficulty in obtaining cross-jurisdictional agreement for registration, and others spoke of the challenges in

¹⁰⁴ Four Corners is an Australian television program broadcast nationally and marketed as "*The home of Australian investigative journalism*" where journalists "*expose scandals, trigger inquiries, fire debate and confront taboos*". See: <https://iview.abc.net.au/show/four-corners> and <https://aso.gov.au/titles/series/four-corners/>.

accessing ministers to discuss their issues, predominantly relating to registration but also to increase consumer access to services.

There's no appetite to go further [with registration], particularly among several states. (PBR4)

You have to get the Commonwealth and each of the jurisdictions, the states and territories, to agree. That is quite a challenge because it means the interaction, at an important level of decision-making, has to take place across every state, every territory, and with the Commonwealth. (PAR19)

I think because of that [experience with paramedicine registration], there isn't a lot of appetite for, or in fact, I would say there's zero appetite to add any more boards [to the NRAS]. (PAR5)

Gaining access to ministers was a concern raised by many respondents, one stating that registered professions were invariably given priority. For most representatives, the barriers faced by non-registered professions in accessing ministers and government officers translated to insufficient patient protections and unnecessary restrictions on health services. A few respondents suggested that they experienced difficulties beyond accessing ministers and indicated that governments were unmoved by their entreaties. Respondents implied they could not 'cut through' with their messaging, regardless of whether or not they met with ministers and government officers. According to many representatives, government inertia contributed to the perceived reluctance of policy officers to engage with professions. One respondent alluded to the unpredictable nature of government decision-making, which invariably ran along party lines, because when governments changed, so did policy positions. Comments indicated that while governments may consider themselves receptive to deputations from non-registered professions, the perspectives of profession representatives differed. Respondents suggested that government decision-making relied more on subjectivity and political discretion than objectivity and systematic evaluation.

We had really good traction in [jurisdiction A] for a bit. But then that [Minister...] was only hanging on by a knife edge, like three votes. [...] but then she was, in the next breath, she was gone. So it's so fraught. (PAR6)

Enlisting the support of others to progress claims for registration was identified by most representatives as an essential political tactic. Champions in government, Chief Allied Health Officers, advisers, government officers, and lobbyists were considered important allies to improve the chances of receiving a favourable hearing by ministers. Champions in parliament, in particular, were viewed as crucial in taking a case forward and advocating for the profession. Respondents suggested there was little hope of progressing registration claims without strong allies.

Unless you have got a fairly strong organisation with means, and you've got a lobbyist in Canberra¹⁰⁵, you've got Buckley's¹⁰⁶. (PBR1)

I think that it should be just assessed on its merits [...] it sort of says that it's assessed against this criteria, and then they have a preliminary assessment, but you need that person in the room saying, this is important, and if you don't have that person in the room, then the chances are a lot lower. (PBR2)

While not explicitly stated, allies were suggested to provide the networks, the know-how, and the 'know-who' to influence those in power. One representative viewed their

¹⁰⁵ Canberra is the capital city of Australia. It is the location of the Australian Commonwealth Seat of Government and where the Australian Parliament sits. See: <https://www.nca.gov.au/education/canberras-history/canberra-seat-government#>.

¹⁰⁶ The term "you've got Buckley's" is a reference to Buckley and Nunn, a department store operating in Melbourne, Australia in the 20th Century. "Buckley's chance" is a punning reference from "you've got two chances, Buckley's and Nunn" (none). See: https://en.wikipedia.org/wiki/Buckley_%26_Nunn.

"You've got Buckley's" may also be a reference to William Buckley, who, in Australian folklore, was said to have survived for 32 years living with the Wathaurong indigenous community of the Kulin Aboriginal Nation during the early part of the 19th century in what is now known as the Bellarine Peninsula in South-Western Victoria, Australia. The term "you've got Buckley's" refers to "having no chance" or "it's as good as impossible" for Buckley to have survived. See: [https://en.wikipedia.org/wiki/William_Buckley_\(convict\)#%22You've_got_Buckley's_chance%22](https://en.wikipedia.org/wiki/William_Buckley_(convict)#%22You've_got_Buckley's_chance%22).

parliamentary champion as more than a standard bearer for professional claims. The champion was considered more important than the formal registration submission or the strength of the case. They were viewed as a trusted emissary who knew when to press forward because of a favourable opportunity or pause because of an unfavourable political climate. The champion gave advice not otherwise available and without which the profession's claim for registration could not have proceeded.

One of the things that we learnt, [...] it's not about the submissions you write. It's not about the cases that you put. It's who can do the work for you in the back rooms of politics. Because if it wasn't for [the Senator], sort of pushing it with Labor, pushing it with South Australia's Best [political party], pushing it with Families First [political party] over there. Doing those backroom conversations constantly. And also liaising with us to go, No, we've got to do this now, or we've got to keep it quiet at the moment, because this is what's going on in the government [...] and also telling us things, reassuring us with things that we would never have possibly known. (PAR6)

There was also a view from several representatives that, because health departments employed many registered professionals, there was a tendency for departments to favour or demonstrate partiality towards registered professions. One representative stated this was the reason for difficulties experienced by non-registered professions in pursuing their professional agendas with government.

The reason why [registered professions have] got significant support from the Department of Health is because there's a lot of clinicians who are embedded within the Department of Health [...] and they advise and they guide government on policy, and they are as biased as you can get. (PAR15)

Several respondents stated that ministerial advisers and government officers showed little interest in engaging with professional bodies of non-registered professions regarding their issues. This was said to be because of professional rivalry or reluctance to take on more work. Comments by profession representatives inferred that some government officers and advisers allowed their personal and professional interests to

influence their obligations to serve the public interest. Respondents suggested that some government officers may consider approaches or proposals from professions as bothersome and to be discouraged. These representatives alluded to advisers and government officers as acting as sentries, their perceived influence and obstructive conduct being greatly enhanced by the power they held in gaining access to ministers.

[The Minister's] adviser was a physiotherapist. He wouldn't let me, he blocked it. I went to walk up to her. I handed her my card, and he just walked across in front of me. (PAR7)

There was a significant aspect of how much extra work was this going to be [...] we were talking to her about registration, and she was clearly trying to remind us of all the other regulatory options that are available to us. Because not being registered meant we weren't anything to do with her, and so one less profession to be causing trouble. (PAR1)

A few representatives also identified the need to gain support from registered professions to improve the chances of success regarding submissions for registration. A few spoke of this need as preparatory work to clear the path for registration and “*behind the scenes*” lobbying of other health professions, most notably medicine, nursing, and midwifery, to forestall any objections. As well as being considered a prerequisite to proceed with the registration, it was also suggested that a submission for registration was unlikely to succeed without such support or that objections from certain groups could prevent the progression of a profession’s claim. These representatives regarded this groundwork as essential because registration was considered unlikely if broad-based support was not forthcoming. In this respect, political tactics were viewed as critical adjuncts to the drive for registration.

So from a political sphere, they want to make sure that making a decision isn't going to put anyone else's nose out of joint¹⁰⁷. (PAR5)

¹⁰⁷ To put someone’s “*nose out of joint*” means to upset or offend a person. See: <https://www.collinsdictionary.com/dictionary/english/to-put-someones-nose-out-of-joint>.

You do need support from the other health professions to give your application to become registered the level of recognition it requires. So, without support for the profession to be regulated by the other health professions, it's a really difficult process [...] I think that's the reality of regulating a workforce is that there's a lot of stuff that has to happen behind the scenes in order for the boxes to get ticked later on [...] because regulation of a health profession is as much political as it is occupational. (PBR6)

A few respondents suggested that the perceived need to forge alliances lost sight of the purpose of the *National Law*. Representatives implied that while the risk of patient harm was espoused to be the concern of governments, their conduct and that of their officers belied this tenet. Although alliances were seen as politically necessary to achieve their goals, representatives were aware that this detracted from risk claims and distracted from the purpose of registration.

And if it comes down to political lobbyists, reports from Deloitte, and, you know, political manoeuvrings, if that's what it takes, then the process is broken because that doesn't protect vulnerable people. (PAR6)

10.5.3 We're on a road to nowhere

Many representatives described the IGA assessment process as long, complex, and challenging to navigate, suggesting even greater bureaucracy than usual for government processes because of the perceived barriers faced by non-registered professions. Although representatives generally supported the IGA criteria, many viewed the complex assessment process as not supporting decision-making. A few inferred that the complexity surrounding registration was deliberately created to delay government decision-making. The presumed delaying tactics for assessing non-registered professions were contrasted with the immediate needs of patients seeking care. One respondent suggested the criteria and process were designed to wear down professional bodies, and a few respondents likened the assessment process to jumping

through “hoops” or over “hurdles”. One representative summed up the view of many by stating that gaining registration was “bloody hard” (PBR6).

They're pretty keen not to do it, aren't they [laughs]? You can jump through lots and lots of hoops and eventually sort of stumble and just stop jumping [...] I'm struggling to understand what all of those steps would value add [...], and it seems to me it's a process which is designed toward not regulating as opposed to supporting regulation. (PBR1)

Massively slow, unbelievably slow. Massive, massive wheels turning very, very slowly. [...] It seems excruciatingly complex and challenging and unnecessary [...] everyone is just jumping through hoop after hoop after hoop, and most of them are on fire [...] So a massive leap of faith is required, which appears to be their intent to decrease their need to have to do anything [laughs]. (PAR1)

It looks like a typical government process full of bureaucracy and full of great big hurdles to jump to make regulation not possible. (PAR11)

Others were more pragmatic, one acknowledging “we haven’t got a burning platform” (PAR16) for registration because the profession was “not in crisis”, suggesting governments were unlikely to take notice until the profession had reached crisis point. Several respondents appeared defeated by the complexity of the assessment process and the persistent rejections of their calls for registration. These respondents gave the impression they were battling a lost cause. Others suggested they had given up the fight and were managing as best they could under existing arrangements.

I have been kind of bashing my head against a brick wall for the last 30 years and getting nowhere. So I guess that's where we've kind of just left it going for the self-regulation thing. And, you know, maybe it's time to try it again. I don't know. (PAR3)

We could bash our heads against the wall and trying to pursue it and waste a lot of money, or we can get on with it, accept the way things currently are in terms of we're self-regulating. (PAR16)

One respondent claimed to know the stance of each jurisdictional government on registration. When asked how they came by the information, they stated it was their job to know and described their professional relationships with senior jurisdictional personnel. Later in the interview, the same respondent commented on how they were privy to such information and suggested that their knowledge was a product of their proximity and access to people with power.

Respondent: New South Wales, definitely, they're dead against it? But Western Australia's not particularly interested. Victoria mmmmm, ambivalent, South Australia's a bit more interested. Queensland a bit more interested. But they're all over the place. [...]

Interviewer: How do you know that?

Respondent: Well, that's part of my job to know that. [...] And see, I know all the jurisdictional Chief Allied Health Officers and advisers, you hear these, when you're in my position, you hear these sorts of things. [...] I haunt the halls of Parliament House. (PBR4)

Most representatives acknowledged that self-regulation was not working despite their best efforts. According to these respondents, self-regulation permitted personal interests and opinions to override public interests and consumer expectations, where preferences for occupational regulation were implied to hinge on the greatest perceived benefit to professions and professional bodies. Representatives stated that existing regulatory arrangements allowed associations preferring to remain self-regulated to continue steering the profession unnoticed and largely ungoverned by an independent body. Many respondents also implied registration was unachievable, though some suggested they would keep trying. However, several representatives considered the process for seeking admission to the NRAS was designed to prevent registration. Comments suggested that even though representatives widely supported the IGA criteria as an objective assessment for registration, human or subjective factors were also involved and considered of greater importance when making those assessments.

A few representatives commented that the present situation of devolving to professional bodies the responsibility for seeking admission to the NRAS was unacceptable, and the process for assessing professions obstructed registration

attempts. The IGA criteria and process were suggested to be a road that led nowhere because governments had not taken accountability for assessing non-registered professions for registration.

I know there's some self-regulating professions that are very comfortable self-regulating, and I understand that. But the majority of them don't. The majority of them do want to be registered. So I think the fact that we've got this high bar through this narrow lens and this is the criteria for submission, I just think it's a criteria and a process designed to keep professions out. [...] See right now, if we weren't bleating, as we do, if we weren't out there telling people about the risk, no one would know. No one would know. So, if you just relied on the profession, and the profession didn't want to, so I know there's some professions that don't want registration, right? So you go, what if there was risk in those professions, but those professions didn't want [to acknowledge] the risk? Is it good enough to rely on just the professional association [to apply for registration]? No, it's not. It's not. (PAR6)

10.6 Chapter summary

The selection of profession representatives for participation in this study was designed to encompass a range of professional bodies to gain a broad cross-section of opinions. Twenty-six respondents representing 14 professions were interviewed. Stakeholder views were dominated by respondents supporting registration. Most interviewees considered registration best protected the public and practitioners, inspired confidence in the profession, and provided the most effective mechanism for handling consumer complaints. A few representatives supported further statutory measures for similar reasons but maintained that practitioner governance was best managed under a profession-led co-regulation arrangement. A small number of respondents argued that further statutory measures were unnecessary. These patterns were repeated throughout the interviews, with perspectives strongly informed by the preferred regulation model. Those favouring self-regulation typically emphasised the low risks of the profession and the costs and restrictions imposed by registration. Representatives pursuing co-regulation stressed the advantages of self-regulation and registration,

seeking to maintain professional control via self-regulation while gaining the benefits of registration under the auspices of government. Those preferring registration emphasised the weaknesses of self-regulation, were sometimes despairing about the prospect of being forever cast as low-risk professions, and outlined measures taken to strengthen self-regulatory oversight in the absence of, or in preparation for, registration.

Almost all representatives identified perceived disadvantages resulting from NRAS exclusion, commonly described as being overlooked by governments for funding and opportunities for expanded practice scopes. These disadvantages were considered to be primarily unintended. Many respondents frequently mentioned the need to be viewed as a legitimate profession worthy of equal respect to registered practitioners.

There was little alignment between respondents on which non-registered professions should be registered, and sometimes the reasons given for supporting registration were unrelated to the IGA criteria. Factors perceived to influence government engagement with professions or decision-making about registration included costs, professional cohesion and unity, and the opinions of powerful government and non-government actors. The impression given by most representatives was the futility of their efforts to meaningfully engage with ministers and government officers to pursue their professional claims.

This chapter completes the presentation of results from Phase 3 of the research on stakeholder interviews. The next chapter presents the final phase of the research in which a theoretical analysis and interpretation of stakeholder perspectives of HPR for non-registered professions is presented. The chapter applies a framework of Bourdieusian concepts to the themes and perspectives arising from the primary analysis of stakeholder documents and interviews in order to gain further insights from stakeholder accounts.

Research Phase 4

THEORETICAL ANALYSIS AND INTERPRETATION OF STUDY RESULTS

In Chapter 3, Section 3.3.4, I introduced Bourdieu's theories as a conceptual framework for analysing and interpreting stakeholder perspectives of regulation for non-registered professions in Australia. For Bourdieu, the field is a social space where individuals and groups struggle for dominance. Capital refers to the material and symbolic resources held by individuals. Habitus signifies the largely unconscious acquired characteristics and learned preferences of social actors. Doxa denotes the belief systems and worldviews operating in a field, and *illusio* indicates the stake social actors have in competing for resources in a field. Symbolic power and symbolic violence describe the power wielded by social actors and the subtle and often invisible 'violence' exercised over subordinate groups (Bourdieu, 1977b; Bourdieu & Wacquant, 1992). This thesis introduces a fourth 'capital', the notion of risk that frequently featured in stakeholder accounts.

Together, these concepts provide a framework to facilitate the analysis and interpretation of study results to address the fourth research objective that seeks to theoretically explore, analyse, and interpret stakeholder perspectives of health practitioner regulation for non-registered professions.

Chapter 11

A BOURDIEUSIAN ANALYSIS AND INTERPRETATION OF STAKEHOLDER PERSPECTIVES OF REGULATION

11.1 Introduction

This chapter elaborates on the results of the documents analysed and stakeholder interviews conducted in light of the theoretical concepts of Pierre Bourdieu. It situates the results from all previous results chapters within a Bourdieusian framework of economic, cultural, social, and symbolic capital, and the use to which symbolic power and symbolic violence were put to support stakeholder positions and perspectives. The chapter explores and proposes habitus and doxa as the underlying motivations and causal mechanisms offering the most plausible explanations driving stakeholder attitudes and perspectives.

Bourdieu's concepts provide a language to facilitate an understanding of stakeholder views. The works of other commentators are also cited to support the analysis and interpretation offered in this chapter. Exploring stakeholder perspectives through a Bourdieusian framework provides the foundation for a proposed theoretical explanation for the observed findings. By theoretically analysing and interpreting the study results within a Bourdieusian framework, this chapter aims to recontextualise, transform, and transcend the primary data presented in the results chapters to better understand the HPR field in Australia.

11.2 The influence of economic capital on stakeholder perspectives

In interviews conducted and documents analysed, stakeholders articulated issues relating to costs, financial benefits, and weighing the costs against the benefits of registration. The analysis also identified stakeholder assumptions regarding the costs of self-regulation. These findings are consistent with the Bourdieusian concept of economic capital. The following section details the influence of economic capital on stakeholder perceptions of regulation.

11.2.1 The costs of registration

Interviewed policy actors and some profession representatives commented on registration costs to government and non-government stakeholders, with respondents primarily seeking to avoid financial costs to government and practitioners. These comments may be regarded as expressing a desire to preserve or prevent the loss of economic capital, comments that were invariably associated with supporting current occupational regulation arrangements. In explaining their views, respondents sometimes referred to the need to uphold the public interest by minimising taxpayer/government spending or advocating for practitioner interests by avoiding increased patient fees or containing practice costs. These perspectives were also identified in the scoping literature review, where some practitioners argued against registration due to the potential for increased patient fees, financial loss to practitioners, or loss of livelihood.

11.2.2 The costs of self-regulation

Implicit in arguments regarding the financial costs of registration are assumptions by interviewed policy actors and some profession representatives that registration should be avoided because of the substantial costs. In other words, that self-regulation is 'cheaper'. This argument may be flawed since it is based on the premise that self-regulation is an economically efficient way of assuring workforce quality. This assumption may only consider the direct costs to government without taking into account the broader societal costs of self-regulation. Self-regulation may be economical for centralised areas of government that have a minor role in directly regulating non-registered practitioners (Priest, 1998: 270). However, Price and Verhulst contended, *"it is naïve to suggest that self-regulation does not involve significant regulatory costs"* (2005: 152). This suggests that while self-regulation may be economical for governments, which would otherwise incur costs for establishing registration for health professions and ongoing stewardship functions of the National Scheme, it may only generate these direct efficiencies by cost-shifting to others. The unmeasured financial costs are distributed and duplicated across multiple players. This view was reinforced by Priest, who wrote that self-regulation *"imposes costs that are dispersed across the*

population [...and] transfer[s] potential liabilities for regulatory actions to the self-regulating organizations” (1998: 269). Therefore, cost-benefit analyses for assessing registration should consider these broader costs and savings as well as those identified by policy actors in this study in assessing and implementing registration.

Policy actors stated there were many layers of regulation governing the self-regulated professions, including various co-regulatory arrangements. The administrative obligations imposed by these layers of regulation all come at a cost to the government and non-government institutions acting as co-regulators to ‘credential’ practitioners or professional bodies of self-regulating professions. Administrative costs associated with credentialling of non-registered practitioners for employment purposes are borne by public and private institutions, such as hospitals and private or government employers. These costs were alluded to by policy actors, one of whom remarked that having certification arrangements for non-registered professions through the *“Commonwealth proposal [...] would make things a hell of a lot easier for us as an employer”* (GPA6)¹⁰⁸. The costs of credentialling to employers were also identified in the final report on options for regulating paramedics (AHMAC, 2015: 41-44). Administrative costs are borne by organisations such as health insurers and government departments and agencies, including the Australian Taxation Office and Medicare, which assess professional association eligibility for credentialling members to access funding, rebates, and other entitlements. If employers and institutions credentialling non-registered professions establish bespoke credentialling arrangements similar to the range of mechanisms mapped in Chapter 5, Section 5.3.2, ‘National co-regulation arrangements’, the duplication and inconsistencies between institutions and credentialling systems create a widely distributed system of regulatory functions. This adds to the complexity, reduced efficiencies, increased costs, and greater risk of regulatory failure if an employer fails to conduct proper due diligence before employing a practitioner. This type of failure was referred to by a few profession representatives, one of whom stated that employers

¹⁰⁸ The ‘Commonwealth proposal’ was described by several interviewed respondents as a credentialling scheme to raise professional standards and bring greater transparency to non-registered professions participating in Commonwealth Government-funded programs.

“can actually employ somebody that doesn't have those qualifications if they want to” (PAR3). Another example of regulatory failure due to poor credentialling practices was raised by profession representatives who commented on the ease with which *“dodgy”* non-registered practitioners were said to move between employers because of fragmented credentialling systems. The assumption that self-regulation is ‘cheaper’ also overlooks the uncosted volunteer work performed by multiple professional body personnel who administer self-regulating schemes, costs which do not appear to be considered in cost-benefit analyses for registration (AHMAC, 2015: Section 5).

Registration carries greater efficiencies across the sector for a range of institutions by having a single regulatory agency managing practitioner credentialling and other profession-related administration arrangements. The marked inefficiencies associated with self-regulation can be exacerbated when unforeseen or unpredictable events occur, requiring a swift response. One policy actor spoke of the difficulties in determining which non-registered professions could provide *“essential health services”* during COVID-19 lockdowns, alluding to inefficiencies in the absence of registration. Determinations on what constituted an essential health service for non-registered professions were made separately in each Australian state/territory, with inevitable jurisdictional inconsistencies. In contrast, all registered professions were quickly, collectively, and nationally defined as ‘essential’ in public health orders, attesting to the efficiencies under a registration scheme.

The economic arguments against registration require further examination since the costs of credentialling and regulation are nonetheless borne, but by parties beyond centralised governments, and are distributed among public and private entities, the sum of which may be greater than the cost of implementing registration for non-registered professions. Even so, Priest argued, *“[s]elf-regulation can be politically attractive”* because governments have no direct responsibility over self-regulating bodies and thus incur savings in terms of administration while allowing governments to claim the public interest is served (1998: 269). This perspective implies that under self-regulation, failures in patient care may be seen as the profession's responsibility, although this was contested by one consumer advocate who placed responsibility for any such failures

with governments. Government responsibility for the quality and safety of the health workforce was described in two government reviews (Productivity Commission, 2005: 52; AHMAC, 2014b: 15), most recently in the 2014 review of the NRAS, which stated, *“State and Territory Health Ministers bear ultimate responsibility for the safe practice of health professionals in their jurisdictions”* (AHMAC, 2014b: 15).

11.2.3 Potential economic rewards from registration

In contrast to the perspectives regarding registration costs, profession representatives alluded to the potential for greater economic rewards deriving from registration, or in Bourdieusian terminology, the potential for registration to attract economic capital. Professional respondents stated or suggested these rewards would flow from practitioner eligibility for government grants, scholarships, rebates, allowances, benefits, and discounts, and from employment, promotion, and scope expansion opportunities. Exclusion from these rewards, which profession representatives attributed to their self-regulating status, together with other perceived discriminative practices against non-registered professions, informed the views of many profession representatives regarding regulation. This was cogently communicated by one profession representative, who stated the *“main thing that [self-regulating professions are] “calling for is to stop the discrimination”* (PBR4).

11.2.4 Weighing up the costs and benefits of registration

In discussing the case for or against registering non-registered professions, policy actors emphasised the need to weigh the costs against the benefits. Freiberg stated that cost-benefit analyses are best suited to policy change proposals where data are available and financial assessments are possible (2017: 140). While the direct operational costs to government in assessing a profession for registration may be readily identifiable and calculable, quantifying societal or patient impacts in economic terms may not be. As well as one policy actor making the same point, this view is found in the wider literature. For instance, Boyfield noted that in regulatory impact assessments, the quantified *“costs and benefits for government are usually the easiest to assess, yet disturbingly it appears they may carry more weight than they should, relative to the other groups”*, including

consumers, organisations, and voluntary bodies affected by regulation (2007: 7-8). Haines observed that socio-cultural concerns may influence debates over what counts as a cost, including the cost of death or injury, and what counts as a benefit, as well as *“who bears the cost and who gains the benefits”* (2011: 56). This type of ‘distributional impact’ or the impact of regulatory policy on different groups (OECD, 2025: 38) was described by respondents in all stakeholder cohorts, including comments by advocates and profession representatives that governments gave insufficient attention to patient safety issues and placed undue emphasis on costs when making decisions about registration. The OECD also noted the challenges of quantifying intangible benefits and recommends applying different techniques to determine the full range of benefits and *“better capture impacts on people and their environment”* (OECD, 2025: 38).

The many policy actors in this study who emphasised the cost imposts of registration on governments may have been prioritising government economic interests over a broader assessment of the public interest. For instance, no policy actor stated that in cases of uncertainty in assessing a profession for registration, the weight of assessment should fall in favour of public protection, as suggested by the Australian Government guiding principles of regulatory policy stewardship, in which the first principle is that government commits to valuing regulation as an asset that protects the health and safety of Australians (DOHAC, 2020: 20).

In reviewing risk-based regulation, van der Heijden noted the view of other scholars *“that risk as an approach to regulatory governance has resulted in the process of ‘responsibilisation’ in which citizens are increasingly expected to take the responsibility to protect themselves”* (2019: 19). Consumer advocates in this study made similar remarks about what they considered to be the preoccupation of governments with issues other than consumer safety. One advocate stated this translates to consumers assuming the responsibility for advice provided by non-registered practitioners. Responsibilisation of consumers is also inconsistent with the guiding principles of regulatory policy stewardship that aims to protect the health and safety of Australians (DOHAC, 2020: 20).

The economic self-interest of stakeholders, whether conveyed by policy actors seeking to minimise government costs or profession representatives wanting to minimise practitioner costs and increase financial gain, is evident in these perspectives. They indicate that respondents were attuned to the financial impact of preferred regulation models and put forward economic arguments to support regulation preferences to minimise the losses or maximise the gains.

11.3 The importance of cultural capital to professions

Respondents offered several reasons for supporting or opposing registration for specific professions, including arguments relating to educational qualifications, occupational titles, professional credentials, and evidence-based practice. These stakeholders considered that some of these factors conferred professional status on the registered practitioner. Multiple profession representatives considered professional standards of such importance in gaining the acceptance of government and other professions that they took individual action to improve their voluntary standards. The standards and credentials referenced by respondents correspond to Bourdieu's concept of cultural capital (Bourdieu, 1986: 243-248).

11.3.1 The institutionalised cultural capital of standards, titles, registers, registration, and qualifications

Standards, titles, and registers

For many interviewed stakeholders, nationally consistent, minimum standards of education and training accreditation, minimum practice entry qualifications, exclusive use of occupational titles, and a register of qualified practitioners were among the essential assets to be gained from and the main reasons given for supporting registration. The importance of registration to establish assets such as standards, titles, and registers also featured prominently in the scoping literature review on stakeholder attitudes to regulation, presented in Chapter 2, Section 2.4.4, and stakeholder documents reviewed in Chapter 7, Section 7.3. The assets described by respondents may all be considered forms of institutionalised cultural capital (Bourdieu, 1986: 247-248). They symbolise the characteristic resources held by a professional group to distinguish

credentialled from non-credentialled providers, with the state's institutional power used to enforce such distinctions (Swartz, 1997: 186).

Most interviewed profession representatives stated or suggested that adequate standards, titles, and registers were unachievable with self-regulation, a view emphasised by stakeholders from multi-association professions in particular. These stakeholders commented that the desired cultural assets of standards, titles and registers could not effectively be established or maintained without registration because attempts outside of statutory mechanisms had faltered in terms of profession-wide coverage, effective enforcement, and acceptance by other associations. Profession representatives expressed frustration at their inability to establish the standards and protect the occupational titles they considered necessary to maintain patient safety and achieve professional advancement. They viewed registration as the only way to feasibly achieve these assets. These stakeholders appear to bear out the contention put forward by Gunningham and Rees of associations that demonstrate *"multiple selves"*, driven by private interests as well as moral aspirations (1997: 372-373).

Australian workforce policy is inadequate from the viewpoint of some profession representatives because efforts to achieve registration were driven by difficulties in maintaining voluntary standards and registers. Some professional bodies persisted in pursuing registration to secure the desired professional assets, reap the ensuing benefits, and halt their perceived disadvantage compared with registered professions. For these professions, registration was being driven from within the profession to access the rewards of *"professionalism"* (Evetts, 2003: 409).

Borthwick wrote that Bourdieu *"recognised the extent to which titles are imbued with powerful symbolic importance"* and are used to confer status and rank, what Bourdieu referred to as symbolic capital (Borthwick, 2014: 2). Bourdieu maintained that resources such as qualifications and professional titles were inseparable. However, Bourdieu considered a title holds unique value because it functions to secure *"symbolic profits [...s]ince the title is in itself an institution"*, and its institutionalised value may be used to defend or maintain the value of the work performed (1985: 733). The persistence of some professional bodies in seeking cultural capital resources may be seen as the

pursuit of symbolic capital to achieve status and rank and maintain the value of their work. The symbolic capital importance of occupational titles and the qualifications underpinning those titles was suggested by one interviewed policy actor who stated that professional standards and qualifications “*defined you as a profession*” (GPA1), or as Bourdieu noted, they act as markers of professional “*distinction*” (1996a: 482).

The ‘distinction’ of registration

The cultural capital considered by most respondents to possess the greatest ‘distinction’ was registration because it was perceived to provide the vehicle for achieving other desired cultural capital resources and economic rewards. Policy actor participants suggested that the standards established under registration were higher than those set under self-regulation. They spoke of professional standards and other professional assets as being fundamental to the requirements of a registered profession. The cultural worth embodied in qualifications was such that some policy actors regarded a bachelor’s degree, which draws on the institutionalised cultural capital of universities and colleges, as the mark of a professional and a prerequisite for NRAS entry. Several profession representatives also expressed the view that a bachelor’s degree was necessary for admission to NRAS. Perceiving degree qualifications as advancing through a gateway of professional competence was noted by Bourdieu, who stated, “*educational qualifications function as a condition of entry to the universe of legitimate culture*” (1996a: 28). The view that legitimisation derives from specific qualifications was evident in the perspectives of many profession respondents who indicated that registration would establish a professional culture of high standards, titles, registers, and other professional resources. Bourdieu likened this type of “*socially legitimate[d] definition*” and authorisation of persons as “*official acts of consecration*” (1994: 12). For profession representatives, the difference between voluntary standards and standards ‘consecrated’ under the NRAS is analogous to Bourdieu’s conceptualisations of state-sanctioned cultural capital, as:

an essential difference between the officially recognized, guaranteed competence and simple cultural capital, which is constantly required to prove itself. In this case, one sees clearly the performative magic of the power of

instituting, the power to show forth and secure belief or, in a word, to impose recognition. (Bourdieu, 1986: 248)

Such was the way many interviewees spoke of registration, particularly concerning the recognition and legitimacy registered professions were considered to enjoy as members of NRAS, an institution sometimes referred to as a “club” by study respondents. The importance, recognition, and legitimacy attributed to registration, as conveyed by most respondents, were considered to derive from the state’s ability to confer symbolic capital to NRAS and bestow privileges to those within its “club”. Findings from this study suggest that the symbolic capital of registration also derives from the power to determine who can legally practice a ‘profession’, a power that almost every interviewed profession representative stated was denied them under self-regulation. Exclusionary closure of a profession to maintain professional exclusivity was only considered enforceable through registration. As such, the state, through its agents and officers, is the most important source of symbolic power (Özpolat, 2023: 664) by being the gateway to registration. Bourdieu viewed the power held by state agents and institutions in the “bureaucratic field” as a “kind of meta-power, power over all powers: the bureaucratic field is a field that overshadows all fields, a field in which interventions are decreed” (2014: 367).

‘Othering’ based on lower qualifications

Some policy actors in this study referred to the distinctions between higher and lower qualifications in assessing a profession’s ‘worthiness’ for registration, with lower qualifications presented as a rationale for NRAS exclusion. Comments from these respondents were suggestive of Parkin’s claim that educational qualifications are employed as an exclusionary closure strategy to limit entry to a profession and enhance professional status (1979: 54). Many profession representatives considered the benefits of protecting practice entry and promoting professional status to be unavailable to them because of an inability to maintain high educational standards under self-regulation. Using qualifications to determine registration worthiness and drawing on NRAS membership to demarcate professions instead of applying merit-based assessments

predicated on risk and other criteria is an example of Bourdieu's concept of symbolic violence, not exercised forcibly but as a dominating,

gentle violence, imperceptible and invisible even to its victims, exerted for the most part through the purely symbolic channels of communication and cognition (more precisely, misrecognition), recognition, or even feeling. (Bourdieu, 2001: 1-2)

Consequently, this form of violence remains unrecognised by perpetrators and victims.

Policy actors were not the only stakeholders in this study giving opinions suggestive of symbolic violence and using qualifications as their weapon. Like several policy actors, some profession respondents stated educational qualifications were embedded in the IGA criteria. This appears to have given these representatives license to offer opinions about excluding non-registered professions from registration contention based on lower qualifying awards and used delegitimising discourses to discredit the qualifications of registered and non-registered professions alike. An example is the dismissive attitude towards the qualifications of registered chiropractors by one profession representative who stated, *"It is [a master's qualification], however, it's not"* because the qualification was *"not considered so science-based"* (PAR11). This type of discourse is suggestive of symbolic violence. It may also be viewed in terms noted by van Dijk, that justification for discrimination against certain groups is rationalised through language that serves to reproduce power and dominance, by representing one's own group in favourable terms while casting the *"other"* in a negative light so that privileged *"access to valuable social resources"* is considered *"just"* (1993: 263). In this study, the respondent considered the valuable resource to be registration with all the benefits this carried, which chiropractic was suggested to be unworthy of. It is contradictory that profession representatives participating in this study sought government assessments to be objectively applied to their profession, yet did not maintain objectivity when offering opinions about the regulation of other professions. The contradiction illustrates the pervasiveness of personal opinions, ideological positions, fundamental beliefs, and personal interests when these run contrary to the IGA assessment criteria and are driven by professional rivalry. It calls for methods and measures to minimise and limit these subjectivities to ensure HPR decision-making is based on assessments against the criteria.

The argument that professions should not be admitted to the NRAS without minimum qualifications is a predicament some professional bodies have found difficult to resolve. This is because the very nature of voluntary self-regulation provides no mechanism to enforce educational standards and qualifications. Under Australian common law provisions and National Code of Conduct (NCC) legislation, where this is in place, health practitioners of non-registered professions have the freedom to practise with no qualifications and no practice entry controls via association membership or other regulatory measures. Several profession representatives stated this allowed conflicted interests to flourish and professional bodies to maintain primacy in regulatory governance. The quandary faced by some professional bodies attempting to establish or maintain professional standards intensifies in direct opposition to the established co-regulatory partnerships. Fewer partnerships offer practitioners less incentive to join an association, which may see associations lower the standards to attract membership, a scenario communicated by a few representatives of multi-association professions. Reflecting comments made by policy actors and profession representatives, it appears HPR is more likely to 'work' where considerable economic and cultural capital resources, such as co-regulation partnerships, exist outside of the statutory regulatory structures, or where strong regulatory/exclusionary mechanisms exist, such as registration.

Another consideration is that while several policy actors and profession representatives described co-regulation as performing a useful quasi-regulatory function, these arrangements may engender government complacency about adequate regulation for non-registered professions, a perspective suggested by comments from several policy actors, one stating:

I'm not suggesting that everybody is caught by every system. I'm saying that the system, there [are] many, many regulatory systems that intersect and overlap to ensure health professionals in this country are held to a minimum standard of appropriate skills and qualifications to provide safe patient care. (GPA5)

The quasi-regulatory nature of co-regulation, as it operates in Australia, requires further examination as a regulatory mechanism, since most co-regulation arrangements do not assess education accreditation or practice standards.

Along with the potential for complacency with quasi-regulation arrangements, government inattention to quality assurance mechanisms for non-registered professions, as conveyed by numerous profession representatives, may forestall proactive consideration of further regulatory action. One policy actor referred to the “*plethora of regulatory environments that ensure or provide added layers of [consumer] protection*” (GPA5), inferring these layers negated the need for government action and despite their implicit assumptions about the effectiveness of the arrangements and coverage of these mechanisms across all non-registered professions. The weaknesses of formal co-regulation arrangements may play out in practice, as research commissioned by WHO has noted the challenges associated with practitioner regulation in many countries with weak professional, that is, statutory, self-regulation mechanisms. These challenges stem from inadequate expertise of professional bodies to appropriately apply workforce governance mechanisms, potential for conflicted interests among professional bodies that may prioritise professional privileges and defence of occupational boundaries, and poor transparency in how professional standards or competencies are determined, monitored, and sanctioned (Rajan et al., 2022: 103).

Building cultural capital by raising standards

Findings from this study suggest that many profession representatives viewed professional standards as holding immense value. Taking a Bourdieusian view, these representatives considered the cultural capital of professional standards to have symbolic capital value, and the desired standards could only be achieved with the institutionalised cultural capital of registration. Other policy actors also commented on the worth, or symbolic capital value, of standards under registration. One policy actor, though, viewed standard-setting as the responsibility of non-registered professions without the need for government support, stating, “[i]f they're organised enough, the unregulated, well, the self-regulated professions can establish that for themselves” (GPA2). This was suggested to be irrespective of practice risks or other relevant claims for registration.

The stated belief in the value of standards combined with frustration over the perceived inadequacies of self-regulation, the continued government disregard of appeals from

professional bodies, and the ‘othering’ experienced by non-registered professions led several professional bodies to assume responsibility for instituting measures to raise their standards. These actions were identified by profession and policy actor informants, one policy actor remarking that an association:

made a decision that it seems to be fruitless pursuing registration. So, they turned their minds to how they could actually improve their own standing with the mechanisms that were available to them. (GPA2)

Despite the belief expressed by several profession representatives in the ineffectiveness and unenforceability of voluntary standards, these bodies, nevertheless, established or revised their voluntary standards to mirror those of the NRAS. In some instances, actions taken were an attempt to provide credentialling mechanisms for their profession, albeit voluntary, by establishing a stand-alone registering or standard-setting body. Other professional bodies acted in response to the externally perceived inadequacies of existing standards. In all cases, the actions taken were described as a reaction to the establishment of NRAS, to fill a gap in regulatory arrangements rather than offer a replacement for NRAS registration. These (re)actions led to developments such as the National Alliance of Self Regulating Health Professions (NASRHP, 2025) and voluntary practitioner registers for professions such as counselling (ARCAP, 2022) and naturopathy (ARONAH, n.d.). In some instances, the actions of professional bodies to enhance self-regulatory measures were taken in the hope they would expedite registration decision-making, actions that some policy actors perceived as prerequisites to registration. Some professional bodies also implemented additional voluntary measures to halt the exclusion of non-registered professions from government health service policy changes that invariably privileged registered professions. By taking these actions, profession representatives may have endeavoured to stem the erosion of capital resources despite the view that the actions were not the ultimate solution but only those within their power. While representatives suggested the steps taken were borne of frustration with inaction by governments and bureaucratic inertia, the findings suggest the additional mechanisms and measures may have introduced greater complexity in HPR and added to the costs of self-regulation.

It is also possible that additional self-regulatory measures taken by some professional bodies may have been a tactic to avoid further government regulation, a concept referred to as “*regulatory chill*” (Brooks & Lauber, 2024). One profession stakeholder suggested this type of regulatory avoidance action in a document analysed for this thesis. In response to media comments about the need for further regulation of the profession, the professional body stated it had established “*an independent complaints committee [and] disagree[s] with statement[s] suggesting the requirement for further regulation*” (AUDIO_ACAud_2019_Doc2: 1).

11.3.2 The embodied cultural capital of evidence-based practice

Evidence-based practice (EBP) may be considered another form of cultural capital that featured in the accounts of some profession representatives and consumer advocates in this study. EBP was viewed by these stakeholders as a critical tool of practice, suggesting it was considered a cultural capital resource. Respondents characterised EBP in terms resembling Bourdieu’s embodied cultural capital, the knowledge, information, and skills agents acquire through education, enculturation, socialisation, and other normative traditions (1986: 244-246). The embodied cultural capital of EBP was such that some respondents perceived it as the ‘legitimate’ form of healthcare practice, presenting it as a reason for supporting or opposing registration for specific professions. In the terminology of Bourdieu, the embodied cultural capital of EBP was used by some stakeholders to demonstrate cultural superiority over others and limit access to capital resources (such as registration) for those with perceived inferior capital (Lamont & Lareau, 1988: 159). Similar to stakeholder commentary about qualifications, some respondents expressed the view that operating within an EBP paradigm should be part of the IGA criteria, while others commented that EBP was “*embedded*” in them.

Participants used EBP in one of two ways. The first was to classify certain professions as practising legitimate and accepted medicine and, therefore, were considered worthy of registration. The second was to use EBP to label certain practices as unacceptable and unworthy of registration and to question the legitimacy of certain professions already registered. A few respondents applied the EBP label to draw class-based distinctions between professions, for example, medical and non-medical professions, or to establish

a separation between “*allied health*” and “*alternative medicine*”. These class-based divisions go beyond simply classifying those perceived to practice or not practice in an EBP paradigm. The distinctions suggest that those perceiving they practice in a culturally rich, evidence-based paradigm use EBP as a weapon against others considered to operate outside of EBP. The means by which some respondents used EBP to discredit certain healing paradigms to enact exclusionary closure can be considered a form of symbolic violence exercised by those holding prevailing biomedical views of healthcare against professions embracing different healing epistemologies. Palatchie reached a similar conclusion regarding the arguments of those opposing the state regulation of Chinese medicine in New Zealand (2021: 8-9).

Comments by respondents to maintain differences and distinctions between professions also act to maintain social hierarchies, positions in the field, and boundaries between socially constructed fields (Tholen, 2016: 1073). Examples of these fields in this study include self-regulation, NASRHP, allied health, and alternative medicine, with EBP potentially being used to mask interprofessional tensions. In emphasising these differences, respondents referred to ways of thinking to validate certain health practices, thus legitimising some professions while devaluing others. These actions can be considered an example of the exclusionary practices employed by individuals who believe they possess culturally superior capital. The distinctions are used to justify the relegation of the culturally impoverished (in this research, the professions considered non-evidence-based) to an inferior position in the field (Lamont & Lareau, 1988: 158-159). Bourdieu referred to this tendency as “*valorizing*” certain cultural capital held by one group while discrediting that held by another (Bourdieu & Wacquant, 1992: 99). ‘Valorising’ certain capital resources is the preserve of those who have the power and possess the ‘right’ capital, which has been raised to the symbolic level through misrecognition or misperception. The combination of symbolic power and symbolic capital is weaponised even though these agents may be in the same situation as those against whom the symbolic violence is directed, but who do not have the power or accepted capital with which to defend themselves. For instance, professions widely regarded as operating in an EBP paradigm, such as medical practitioners and

physiotherapists, may not themselves always be following EBP (see, for example, Ebell et al., 2017; Liu et al., 2021: 4-5).

The use of EBP as a tool of cultural capital reflects long-standing complexities and tensions around the legitimacy of knowledge that translate well to arguments of legitimacy of professions. These tensions are also found in the wider literature. Some writers have observed that what counts as evidence is contested and have questioned the notion of a single form of evidence or definition of science (see, for example, Barry, 2006; Clark-Grill, 2007; Gieryn, 1983; Rycroft-Malone et al., 2004). Bourdieu maintained that “*scientific fact is constructed*” (1992: 43). He considered differences in cultural practices (such as EBP and so-called alternative or complementary medicine) were little more than variations of “*cultural goods*” (Bourdieu, 1996a: 176). Governments, too, have questioned the dogma of a single, accepted form of evidence, fraught as it is with limitations in research capability, translatability, subjectivity, and the codification of practices (CHC, 2015d: 48-49). In the 2013 final report of the NCC for health workers, a proposed clause requiring healthcare workers to have an “*adequate clinical basis*” for treatment was not recommended because:

Determining what is ‘evidence based’ and an ‘adequate clinical basis’ is problematic. For instance, it is often assumed that the treatments offered by medical and allied health professionals are evidence based and that those offered by complementary or alternative medicine practitioners are not. However, this is not always the case. There are gaps in the evidence base for both orthodox and unorthodox treatments. (CHC, 2015d: 48)

In the present study, the same profession representatives exercising symbolic violence using an EBP argument also expressed feelings of inferiority and being undervalued as non-registered professionals, a clear reference to the symbolic violence directed at their self-regulating status by others. It further illustrates the contradictory views of profession respondents who, on the one hand, object to unfavourable distinctions being drawn about them based on their regulation status, while at the same time drawing pejorative distinctions about other professions based on different factors, such as EBP.

Irrespective of stakeholder views, neither qualifications nor EBP are explicitly mentioned in the IGA criteria. As detailed in Chapter 5, Section 5.2.2, the assessment criteria require

professional bodies to demonstrate the feasibility and practicality of registration, including evidence of a “*core and government accredited qualification*” (AHMAC, 2018a: 16). However, in the criteria, there is no reference to minimum qualifications to demonstrate eligibility for registration.

11.4 The need to cultivate social capital to progress professional claims

Respondents from all stakeholder cohorts stressed the importance of establishing relationships with government ministers, government officers, and others to progress their professional claims. The need to cultivate beneficial relationships is found within the Bourdieusian concept of social capital, the networks and membership groups social actors move within and the productive relationships they forge (Bourdieu, 1986: 248-252).

11.4.1 Social capital as a source of power

Most study respondents, including most policy actors, indicated that establishing the right connections and knowing, associating with, and gaining support from the right people in government and powerful professional groups were necessary preparatory steps to advance professional agendas and progress registration claims. According to these respondents, cultivating professional relationships by lobbying government and non-government parties was required to achieve registration, even if all assessment criteria had been met. In Bourdieusian terminology, fostering professional connections with powerful individuals and groups was considered “*the product of investment strategies*” to build social capital (Bourdieu, 1986: 249).

As part of their research into access and influence in Australian politics, Wood et al. noted that:

Relationships matter in politics because they affect both the opportunity to influence and the likelihood of influence. Individuals with personal connections are more likely to get time with policy makers and a sympathetic hearing when they do. (Wood et al., 2018: 20)

Cobb and Elder claimed that what makes its way onto the government agenda tends to reflect the priorities of those most actively involved in politics, including “*not only office*

holders, but also those to whom they are most attentive and whose views they are most likely to know" (1983: 179-180). Accordingly, the political agenda is biased to advantage some and disadvantage others (Cobb & Elder, 1983: 14). This observation reflects comments from one consumer advocate and multiple profession representatives in this study. Some stakeholders, including one policy actor, stated that establishing relationships with the right people in government, while necessary, was not a certainty. These respondents claimed ministers and health department officers gave more "attention" to certain professions. A few of these respondents considered that the selective attention was based on the position of professions in the healthcare "hierarchy". They stated this limited the opportunities for professions "lower in the hierarchy" to access and influence government ministers and policy officers. Consequently, these professions were said to struggle to advance their professional claims. This view was articulated by Cobb and Elder, who contended that access to decision-makers is a function of the "legitimacy" of the group seeking access (1983: 92). The idea that some groups have ready access to government ministers and officers, and the notion that these dominant groups exert influence to hinder HPR policy change was observed by McCready, who stated that policy-makers "yield easily to opposition from established groups that object to [...] proposed legislation" regarding licensure and credentialling of evolving professions (1982: 74).

Lewis observed, "[d]ecades of change have certainly reshaped the landscape of health policy and politics, but interpersonal networks and organised interests persist" (2005: 72). From Lewis's perspective, the most powerful organised interest was the medical profession, whose "cultural authority" exerted an influence on the policy debate even when excluded from formal decision-making (2005: 80-81). Many interviewees, including policy actors, commented similarly on the opinions of the medical associations and the nursing and midwifery association. These opinions were considered to extend to views regarding registration that were stated or suggested to have a strong influence on ministerial decision-making. The influence of special interests on policy-making in Australia was noted by Wood et al., who remarked that these interests "can sometimes successfully hijack the policy-making process" (2018: 5). 'Hijacking' the HPR policy

process for reasons other than the public interest may be considered an act of symbolic violence.

11.4.2 Social capital and symbolic violence

By attempting to influence HPR decision-making, as respondents in all stakeholder cohorts suggested, the medical profession may be reinforcing existing divisions between professions, potentially against the best interests of consumers. An example in Australian regulation history is the Victorian Branch of the Australian Medical Association (AMA) opposing a 1998 Victorian Ministerial Advisory Committee proposal to register Chinese medicine practitioners. The proposal accepted a recommendation for registration based on an assessment of the IGA criteria, acknowledgement of the significant increase in demand for Chinese medicine health services, and consumer complaints dealt with by government departments and agencies (Vic DOHS, 1998: 1-3). Despite the finding that registration was indicated, the Victorian AMA disregarded the evidence and opposed the proposal, arguing that Chinese medicine did not meet the assessment criteria and that registration would provide *“government imprimatur to an ‘occupation’ which is so fragmented that it cannot agree on minimum standards”* (Vic DOHS, 1998: 18)¹⁰⁹. Registration of Chinese medicine practitioners commenced in Victoria in 2002 and was legislated nationally ten years later.

A more recent example is from the 2014 independent review of the NRAS, including a proposal for registration of non-registered professions because of issues relating to the unintended consequences of their exclusion. The National AMA opposed the proposal not on the grounds of insufficient risk or an inability to satisfy other assessment criteria but because NRAS inclusion *“would give health care workers undue status and*

¹⁰⁹ In the review proposal, the Victorian Branch of the AMA was one of three professional bodies opposing the registration of Chinese medicine practitioners. Also opposed to the proposal were the Australian Medical Acupuncture Society, representing registered medical practitioners, and the Australian Traditional Medicine Society (ATMS), representing Chinese medicine practitioners, whose executive was identified in the report as consisting primarily of private college owners (Vic DOHS, 1998: 18). In the analysis of documents for the present study, ATMS was one of two organisations identified as not supporting registration for the professions it represents (see Chapter 6, Table 6.4 and Section 6.4.1, and Chapter 7, Section 7.5.1). The other organisation not supporting registration in the documents analysed was the NSW Government in a submission to the review of regulation arrangements for paramedics.

credibility” (AHMAC, 2014b: 26). These perspectives exemplify the symbolic violence exercised by powerful groups using personal ideology to influence the policy process by devaluing the credibility and standing of certain professions in protection of their privileged positions. It is another example of dominant groups purporting to follow EBP but not following the evidence in the policy arena. This type of symbolic violence exercised by various dominant groups against professions of lower perceived status was communicated repeatedly during interviews, the most obvious example being the comments made about massage therapy by policy actors, two of whom were registered in what were suggested by informants to be rival professions. The actions of the medical profession in attempting to influence contemporary policy-making in Australia are not limited to decisions concerning non-registered professions. Research has reported that orthopaedic surgeons and the orthopaedic association in Australia attempted to use their power to influence state decisions relating to contested task domains and role boundaries for podiatry, a registered profession, and the use of occupational titles by podiatric surgeons (Borthwick et al., 2024: 2, 4).

The esteem accorded to the medical profession, in particular, and nursing and midwifery, and the social and symbolic capital these groups are considered to possess, according to many study respondents, can be likened to Bourdieu’s description of the advantages conferred by *“noble birth”* with all the rights and privileges assuring success in the field (1996b: 373-374). The ‘credit’ of symbolic capital of the medical profession may also be considered in terms expressed by Bourdieu, as *“the power granted to those who have obtained sufficient recognition to be in a position to impose recognition”* (1989: 23). This ‘power’ is perhaps why one interviewed policy actor remarked that despite some professions having achieved registration, *“it probably hasn’t brought the acceptance, and the understanding, and the acknowledgement that they would have hoped it would bring”* (GPA13), possibly referring to the medical profession which has not recognised or accepted these professions. The examples presented suggest that, as well as considering their influence on health policy, there are broader issues of the medical profession’s hegemony in healthcare that require attention if health policy is to serve the needs of consumers.

A further means by which symbolic violence is exercised is by referring to non-registered practitioners as 'healthcare workers'. Restricting the terms 'profession' or 'professional' to certain practitioners may privilege these professions while relegating others to insignificance. Labelling non-registered health practitioners as healthcare workers was the subject of strong objections from some associations of non-registered professions in submissions to the consultation paper for the NCC in 2015. The NCC final report noted that these representatives preferred *"terms such as 'practitioner' or 'professional'"* (CHC, 2015d: 23). A few policy actors in this study made similar differentiations between professionals and other workers. When considering massage therapists as non-registered practitioners, one policy actor commented that registered practitioners *"regard themselves as professionals"* [GPA8]. This framing not only suggested that massage therapists are not professionals, but it was also used to justify their exclusion from the NRAS. Lipsig-Mumme observed that *"[r]egulation by the state defines the professional"* and state *"recognition"* was crucial from a legal perspective to distinguish *"professions from other labour"* (2006: 473). In this view, occupations are considered professions when defined as such by law and their practitioners are licensed (Lipsig-Mumme, 2006: 478). In Australia, the distinction between health professions and other labour is enshrined in law. The *National Law* defines a health profession as:

- a) Aboriginal and Torres Strait Islander health practice;
- b) Chinese medicine;
- c) chiropractic;
- d) dental (including the professions of dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist);
- e) medical;
- f) medical radiation practice;
- g) midwifery;
- ga) nursing;
- h) occupational therapy;
- i) optometry;
- j) osteopathy;
- ja) paramedicine
- k) pharmacy;
- l) physiotherapy;
- m) podiatry;

n) psychology.

(*Health Practitioner Regulation National Law Act 2009 (2024)* (Qld): 72-73).

This definition excludes all non-registered professions. Together with the legal definition of a health practitioner as *“an individual who practises a health profession”* (*Health Practitioner Regulation National Law Act 2009 (2024)* (Qld): 72), this leaves non-registered occupations with few legal options to describe their practices and practitioners. The legal definition of a health profession was the subject of commentary in the recent ‘Scope of Practice Review’ in Australia, in which an amendment to the *National Law* was proposed to include *“additional specified professions in the definition of a ‘health profession’”* (Cormack, 2024: 123, 126). The non-registered professions of audiology, dietetics, counselling, exercise physiology, social work, sonography, and speech pathology were identified by the review as a *“starting point”* for this amendment (Cormack, 2024: 129). Irrespective of the professions included, a legal definition of health profession marginalises non-registered professions and practitioners, exposes them to a range of exclusionary practices, and sanctions the use of symbolic violence by others, as evident in the comments of respondents in interviews and documentary sources analysed for this research. Symbolic violence is exercised by individuals and groups when they state or imply that non-registered professions are ‘unprofessional’, do not comply with the rigour that defines a ‘profession’, are not evidence-based, or lack sufficient qualifications for registration, as conveyed by many interview respondents.

11.4.3 Social capital and cross-jurisdictional agreement

Many policy actors and profession representatives considered one of the greatest perceived difficulties in gaining registration was the need for a unanimous cross-jurisdictional agreement to proceed with a formal assessment. Although not explicitly referred to by respondents, achieving agreement requires professions to build social capital with nine health ministers and gain sufficient interest from one to champion their cause while persuading other health ministers to support their claim. Most policy actors remarked on the difficulty in gaining cross-jurisdictional agreement. One policy actor commented, *“it’s very complex getting agreement”* (GPA13) because the absence of

support from just one health minister is potentially sufficient to overturn a claim, irrespective of its strength. This reinforces the view made by a few policy actor informants regarding the subjective and political nature of decision-making, even though informants regarded the IGA criteria and process to be objective and appropriate for assessing professions. The challenges in gaining cross-jurisdictional agreement also reinforce the views expressed by several profession representatives that the criteria and process were designed to prevent action on registration and further professions from entering the NRAS.

Cross-jurisdictional agreement, as applied in assessments for registration, is an example of the theory of emergence (Elder-Vass, 2010: 4-7) where Health Ministers, meeting as a collective Ministerial Council, possess 'causal powers' to proceed with or block registration, collective powers which only came into existence with the establishment of the NRAS. Before NRAS, decisions on which professions to register resided solely with the health minister of each state and territory. The causal powers of the collective Ministerial Council resulted in the South Australian Health Minister taking the legislation for the registration of social workers to the state's parliament after failing to gain cross-jurisdictional agreement to legislate nationally (COAG, 2016: 2). This suggests that registration assessment processes are failing to meet jurisdictional needs and potentially threaten the very point of having a national registration scheme.

Pacey (2018) reported the views of an Australian policy "*insider*" who suggested the cross-jurisdictional provisions in the *National Law* may be politicised by ministers:

you can't get a more accountable scheme [than the NRAS]. It's just for individual ministers they experience a level of frustration at times because they have to – the accountability is shared, and in some ways they can use that to their advantage because they can say to stakeholders, sorry I can't, I'm just one of nine or they can feel frustrated by it because they can't get things that they want. (Pacey, 2018: 51)

Although in the present study there was no suggestion that ministers politicised cross-jurisdictional accountability for their own purposes, respondents described other factors that may be construed as political manoeuvrings.

11.4.4 Intra-professional social capital

Abbott contended that the success of a profession's claims depends on a strong profession represented by a single professional body (1988: 82-83). In this study, some profession representatives and policy actors indicated that professional cohesion and unity were required when engaging with government policy officers. One policy actor also suggested that intra-professional unity and consensus were requisite to engagement and dialogue with ministers and their officers. Bourdieu might characterise these requirements as the need to build intra-professional social capital as a prerequisite for cultivating extra-professional social capital. These requirements disadvantage certain non-registered professions because of professional environments marked by little or no agreement between associations about occupational regulation, a situation which itself is caused or exacerbated by an absence of registration, according to some profession representatives. These stakeholders indicated that the lack of consensus and cohesion between professional bodies meant government policy officers tended to avoid dealing with their professions. From the perspectives of some policy actors, professional bodies unable or unwilling to find common ground do not speak with *"one voice"* (GPA11) or *"don't know what direction to take"* (GPA12). These policy actors viewed discord as a matter for the professions to navigate and resolve. They placed the onus of responsibility onto professional bodies regarding how and when to tackle regulation issues. They exercised choice about how and when to engage with professional bodies, including an active decision not to engage, irrespective of potential consumer safety issues or the strength of a profession's claims. From the perspectives of several profession representatives, calls by government policy officers for professional unity, such as *"get your own act together"* (PAR8) or emphasising intra-professional tensions by stating *"you don't actually know what you want"* (PAR7) were regarded as a tactic to avoid dealing with the professions or a convenient *"excuse for inaction"* (PAR9).

By calling for professional cohesion, professional bodies disagreeing on issues such as occupational regulation, professional standards, and handling of consumer complaints were expected to reach a consensus before engaging with government policy officers.

These expectations illustrate the exercise of symbolic power by state actors over professions with multiple representative bodies. It creates barriers to government engagement and the progress of claims when progression may be warranted. By emphasising professional unity, itself potentially frayed by the absence of registration, over the merits of statutory registration as the primary consideration for engagement between professions and government, policy officers may be contributing to inconsistent standards. In the present study, several representatives of multi-association professions suggested the potential role of policy officers in facilitating the establishment of inconsistent self-regulation standards. Respondents inferred that the actions of policy officers in avoiding professional bodies allowed associations to independently establish professional standards according to their personal or professional convictions and permitted the erosion and co-option of professional development infrastructure, as inaction favours those who do not push for higher standards. Professional representatives pressing for higher standards expressed sentiments of frustration, claiming they were being held back by the “weakest” association. The divisions between associations representing the same professions also diluted the voices of those pushing for higher standards because of their inability to meaningfully engage with government policy officers.

Expectations that associations divided over professional matters can reach agreement without government intervention may be unrealistic (Priest, 1998: 298-299). Almost 30 years ago, a submission to a Victorian Ministerial Advisory Committee Review called for registration of Chinese medicine because professional associations had not “*found unity, accord and substantial common ground without government registration, and that self regulation is unlikely to change the situation*” (Vic DOHS, 1998: 17). The review committee concluded:

Despite over 20 years of efforts, the [Chinese medicine] profession has been unable to establish a self regulatory system that has the wide support of the majority of groups within the profession. There is no reason to believe that efforts at self regulation will be any more successful in the future. (Vic DOHS, 1998: 20)

These sentiments reflect the views of a few representatives of multi-association professions in this study who considered the professional divisions under self-regulation irreconcilable. Respondents stated that disputes over standard-setting supported their arguments for registration and government intervention. They indicated that interprofessional discord and disunity over professional standards were factors they considered registration well-equipped to ameliorate. Differences of opinion over professional matters are not restricted to multi-association professions, however, as the document analysis showed little correlation between single or multiple associations representing a profession and consistency of viewpoints regarding HPR (see Chapter 6, Section 6.3.3). Thus, professional consensus and uniformity of views at a particular point in time may relate to matters other than the number of representative bodies, a point made by Bucher and Strauss, who observed that unity on issues such as codes of ethics and licensure is not necessarily evidence of agreement in a profession but “of the power of certain groups” for control of the association (1961: 331-332).

The social capital marking and maintaining boundaries between professions, can be seen to operate in the HPR field. In this respect, understanding social capital is essential in any analysis of policy decision-making. The further a profession’s position from and connection to the centres of power, including the powers of the state and mainstream medicine, the more difficult it is to establish and maintain network connections and the greater the effort required to build and use those networks rather than having them readily accessible. Even so, in this study, representatives from some ‘mainstream’ professional bodies of non-registered professions remarked they had long been pressing for registration with no apparent success. Despite social capital connections, it appears these may be ineffective in influencing governments to progress registration claims. Therefore, the need to build interprofessional social capital with government ministers, policy officers, and other dominant professional groups, and the call to build intra-professional social capital, described by policy actors in terms corresponding to unity and unanimity, may be additional ‘unwritten rules’. According to some professional representatives, these unwritten rules are designed to deflect attention from government “*inaction*”, dissuade professions from progressing their claims, or

potentially divert the focus of professional bodies to resource-intensive yet unproductive lobbying activities. It may also be that social capital, and its associated symbolic power and violence, has been more influential in preventing governments from acting on registration through deliberate efforts by powerful players such as the AMA and policy advisers, as suggested by some profession representatives. This would go some way to explaining the effective closure of the NRAS field to new entrants.

Factors unrelated to the IGA criteria, such as professional cohesion, ministerial lobbying, and the influence of other professions, demonstrate that HPR policy decision-making by governments is embedded in a system that accepts and normalises subjective political discretion and opinions. It is a system that favours the status quo over evolution, entrenches pre-existing power structures, and prioritises inaction over action. While social capital may not be critical in influencing decisions regarding HPR, the widespread promotion and acceptance of lobbying practices suggests that, in relation to any approaches to government by professions, registered or non-registered, the old patterns of ‘who you know’ and ‘who you are’ may prevail over objective and considered assessments based on evidence, public safety, and health system improvement. It requires processes and measures to minimise social capital influences and apply merit-based judgements for government engagement with professional bodies. This view is consistent with Australia’s regulatory health policy framework, which calls on policy-makers and regulators to understand the needs and expectations of their stakeholders (DOHAC, 2020: 21).

11.5 The ‘capital’ of risk in demonstrating registration worthiness

Throughout the document corpus and across the stakeholder interviews, respondents frequently cited high risk, low risk, or the potential for patient harm to support favoured positions on regulation. Risk is at the core of the IGA assessment criteria, public protection is a paramount guiding principle of the *National Law*, and protecting the health and safety of Australians is the first principle of the Australian Government’s health regulation policy framework (DOHAC, 2020: 20). Due to the significance of risk in demonstrating eligibility for registration and the widespread commentary regarding risk

in stakeholder interviews and document accounts, findings from this study indicate that risk has been elevated to the level of ‘capital’ in the Australian HPR policy arena.

11.5.1 Definitional ambiguity of risk

Policy actor participants stated that low risk of harm was one of the main reasons professions failed to meet the IGA criteria, evocatively conveyed by one policy actor who posed the question, “*from a public safety perspective, what is the burning platform [for registration]?*” (GPA1). Yet most policy actors could not articulate what counts as risk or identify the threshold risk warranting registration. The concept appears so vague and ill-defined that these policy actors and other stakeholders in this study used risk to support arguments to suit their particular interests or beliefs about regulation. In addition, there were conflicting views within and between stakeholder cohorts about risks posed by various non-registered professions and which practices presented significant risks to consumers, potentially meriting a claim for registration. In the wider literature, this type of conflict was described by Smith, who considered:

risk as a tool for public policy making is inherently flawed because there is little agreement over what constitutes risk (even within government) and this creates conflicts of perceptions. [...] Because risk is linked to power, arguments about risk will always be political arguments, when the intention of risk assessment is to avoid politics by providing an assessment of the facts. (Smith, 2009: 215, 216)

There may be several reasons for the pronounced differences in respondent views on risk. One is that high risk was considered an asset to a profession seeking registration, while low risk rendered a profession ineligible for consideration. When registration or co-regulation was deemed necessary, profession representatives claimed the risk of serious patient harm from professional practice was unacceptably high. Conversely, if self-regulation was preferred, the profession was considered to demonstrate low risk. This suggests that profession representatives may mould their arguments to suit their regulation preferences. Another reason for different perspectives of risk may be that government policy officers were considered by many interviewed participants, including a policy actor, to have a view of risk limited to physical harm and death, while other respondents perceived a broader range of harms, such as mental and financial harm. A third reason is that a few profession representatives claimed health complaints entities

or professional bodies did not adequately capture the harm caused by non-registered professions. Consequently, the risk was unknown, and any harm caused was ultimately due to the profession's exclusion from NRAS. The claim of limited or lack of complaints information captured by Australian health complaints entities is partly supported by data presented in Chapter 5, Section 5.3.1, showing inadequate complaint reporting by almost all jurisdictions. A fourth reason for attitudinal differences regarding risk may be that objective, independent, and comprehensive assessments of risks posed by most non-registered professions have not been conducted.

11.5.2 Risk and risk assessment

Phipps et al. stated that minimising healthcare risks through regulatory reform involved *“a need for the regulatory bodies to have a clear understanding of what comprises risk in the professions under their remit”* (2011: 277). The last multi-profession review assessing practice risks was completed in 2013 with the review of options for regulating a range of non-registered professions (AHMAC, 2013). To assess risks, the review compiled case studies of documented harm, summarised data on complaints from several jurisdictional health complaints entities, and assessed risky and invasive activities performed by practitioners (AHMAC, 2013: 91-94, 135-148). The risks reported in this multi-profession review may, however, be underestimated. To support this claim, the example of paramedicine is presented as the only profession for which a profession-specific review has been completed since the commencement of the NRAS (AHMAC, 2015; AHMAC, 2012).

Textbox 11.1 lists the thirteen activities and procedures performed by health practitioners that are considered to carry risks and are used to assess the risks of a health profession. The count of risky and invasive activities for paramedicine in the multi-profession review was seven of these thirteen potential risks (AHMAC, 2013: 91), while the count established from the more comprehensive, profession-specific assessment was ten of thirteen (AHMAC, 2015: 111). From this analysis, it may be argued either that a thorough, profession-specific review to establish the risk profile of a profession likely gives a more accurate assessment of risks posed by a profession or that practice risks increase over time. It may also be argued that the risks assessed for other non-registered

professions in the 2013 multi-profession review have been underestimated, as a more detailed, profession-specific review, equivalent to paramedicine, has not been conducted for most of these professions. Over time, as scopes of practice expand and other health service delivery models are explored, it is also plausible that practice risks may increase if not appropriately managed (DOHAC, 2024d: 10).

Textbox 11.1 Health practice activities and procedures used to assess risks of a profession.

1. Putting an instrument, hand or finger into a body cavity, that is, beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening in the body.
 2. Manipulation of the joints of the spine beyond the individual's usual physiological range of motion, using a high velocity, low amplitude thrust.
 3. Application of a hazardous form of energy or radiation, such as electricity for aversive conditioning, cardiac pacemaker therapy, cardioversion, defibrillation, electrocoagulation, electroconvulsive shock therapy, fulguration, nerve conduction studies or transcutaneous cardiac pacing, low frequency electromagnetic waves/fields for magnetic resonance imaging and high frequency soundwaves for diagnostic ultrasound or lithotripsy.
 4. Procedures below the dermis, mucous membrane, in or below the surface of the cornea or teeth.
 5. Prescribing a scheduled drug, supplying a scheduled drug (including compounding), supervising that part of a pharmacy that dispenses scheduled medicines.
 6. Administering a scheduled drug or substance by injection.
 7. Supplying substances for ingestion.
 8. Managing labour or delivering a baby.
 9. Undertaking psychological interventions to treat serious disorders or conditions with potential for harm.
 10. Setting or casting a fracture of a bone or reducing dislocation of a joint.
 11. Provision of a primary care service to patients with or without a referral from a registered practitioner.
 12. Treatment that commonly occurs without any other persons present.
 13. Treatment that commonly requires patients to disrobe.
- (AHMAC, 2013: 62-63).

HPR reform is potentially failing to meet the challenges of these emerging risks despite the continuing push for extending the scopes of practice for a range of professions (Cormack, 2024; Leach, 2012; Queensland Government, 2014; Ward, 2019) and the rapidly evolving needs of contemporary healthcare practices (Wardle et al., 2016).

In the past 30 years, there have been five known profession-specific reviews of regulation arrangements for non-registered professions in Australia: an assessment of Chinese medicine practitioners culminating in their registration (Vic DOHS, 1998); an examination of the risks posed by naturopaths and Western herbalists which recommended registration (Lin et al., 2005) but was deferred by governments as they progressed the Productivity Commission review of the health workforce and remains unactioned to this day; a review of options for the regulation of paramedics resulting in their registration (AHMAC, 2015); an assessment for the registration of social workers, which was considered not to meet the assessment criteria (CHC, 2016: 2; Dawson, 2024: 69); and a review and in-principle agreement from the Ministerial Council to proceed with registration of audiologists pending further consultation (Queensland Government, 2024a; 2024b: 3). It could be argued that five national reviews of regulation arrangements for 15 health professions in 30 years is inadequate for a workforce of over 160,000 practitioners (ABS, 2021a), consulting with an estimated 10% of the Australian population each year (ABS, 2017), and receiving more than AUD\$367 million of public funding annually (DVA, 2021: 8; AIHW, 2022; NDIA, 2023: 44) (see Chapter 5, Section 5.4 for further information on these data). There have also been two known multi-profession reviews of non-registered professions, which failed to proceed, potentially due to the Productivity Review of the health workforce. A New South Wales review recommended monitoring of professions such as naturopathy and Western herbal medicine (NSW Joint Committee, 2006), and a review in South Australia concluded there was a need for formal registration assessment of professions such as counselling and naturopathy (SA SDC, 2009: 5, 79) but did not progress beyond the review stage.

While the apparent inaction of governments in HPR reform or the absence of a national HPR strategy for non-registered professions may be construed as unalterable, as conveyed by many profession representatives, there are signs of change. The audiology, Regulation Impact Statement (RIS) was assessed as compliant by the Office of Impact Analysis (OIA) (formerly the Office of Best Practice Regulation (OBPR)) and has received Ministerial “*in-principle*” agreement to be admitted to the NRAS, pending further

consultation with stakeholders regarding costs, implementation, risks, and impacts on First Nations communities (Queensland Government, 2024b: 3).

Another change relates to the OIA. One of the main hurdles in registering paramedics was reported by interviewed policy actors to be the difficulties involving the then OBPR. One policy actor described these hurdles as a *“much, much bigger process”* that lay beyond achieving cross-ministerial agreement. Accounts from these policy actors suggested much of the reluctance in considering professions for registration was due to the experience with paramedicine and, specifically, the difficulties in establishing a case for registration acceptable to the OBPR. According to one policy actor, the OBPR was overly focused on economic metrics. Another suggested OBPR was inflexible in their approach to assessments when the case for paramedicine was considered *“blindingly obvious to Health Ministers”*. Much like the dealings between profession representatives and government policy officers and advisers, policy actors expressed feelings of frustration over the *“insurmountable barriers”* posed by registration assessment and decision-making processes, difficulties that strongly informed their views regarding the registration of further professions. The comments of policy actors suggested powerlessness and a sense of being victims of the symbolic power of the OBPR. These comments echoed statements by profession representatives, suggesting powerlessness in their pursuit of registration and a sense of being victims of the symbolic power of government policy officers and advisers. In the case of paramedicine, the Ministerial Council pressed ahead with registration (CHC, 2016: 5). This decision was despite the RIS not meeting best practice guidelines, a requirement at that time (DPMC, 2016). Baldwin, Cave, and Lodge claimed that risk-based regulation systems *“are built on high levels of discretion and politically contentious judgements”* (2012: 293-294). Such discretion is evident in the Ministerial decision to register paramedicine.

In April 2023, National Cabinet (formerly COAG) agreed to changes to regulation impact analysis requirements whereby a RIS will no longer be mandatorily finalised by the OIA unless requested by relevant decision makers. Under the change, the OIA provides independent advice on the adequacy of a RIS when requested by health ministers (DPMC, 2023: 8). There is no information about the circumstances under which health

ministers, as decision-makers, may request the OIA to assess the adequacy of a RIS. Without formalised guidelines, deciding which path a RIS takes may, once again, rest on the interpretations of ministers or advice provided by policy officers or advisers. Changes to the mandatory assessment of a RIS by the OIA may also give ministers another avenue to politicise HPR by referring the assessment of professions they have no wish to register to the OIA, which may or may not finalise the RIS, while claiming action is being taken. Nevertheless, this move from mandatory OIA assessment presents an opportunity for ministers to proceed with registration where there is an obvious need based on evidence and informed by the IGA assessment criteria. Note that the most recent assessment of a decision RIS of a health profession to include audiology in the NRAS was considered compliant by the OIA in July 2024, expediting decision-making by the Ministerial Council in August 2024 (Queensland Government, 2024b: 3).

The final report recommending the NCC noted that a *“code-regulation regime should not be seen as a substitute for national registration for those professions where this is warranted”* (CHC, 2015d: 22). Some policy actors in this study considered that the NCC provided a suitable mechanism for maintaining patient safety for non-registered professions, and several suggested that the NCC negates the need for registration. This perspective has potentially impeded further action on registration, as any issues regarding the regulation of non-registered professions have ostensibly been resolved, although not for two jurisdictions which have yet to legislate and/or implement the NCC. In contrast, many profession representatives in this study held a different view regarding the effectiveness of the NCC as a public protection mechanism. While these respondents supported its introduction as a short-term measure to enhance consumer protections, the NCC was considered inadequate, reactive, and ineffective, and further regulation measures were deemed necessary.

Guidelines for assessing practice risks for registration, albeit limited, are available (AHMAC, 2018a: 15-17), although few policy actors referred to these. This suggests risk assessments, as communicated by policy actor participants, were primarily based on their perspectives and opinions rather than careful consideration of guidelines and evidence. Establishing more rigorous risk assessment models and guidelines may

mitigate issues associated with professional associations exaggerating practice risks to 'pass' the risk test or, alternatively, understating the risks and promoting the profession's safety profile to maintain self-regulation arrangements.

To uphold the Australian guiding principles of regulatory policy stewardship and ensure health policy regulation "*remains fit-for-purpose*" (DOHAC, 2020: 20), each health profession requires appropriate regulatory settings for the inherent risks of practice, which must be comprehensively identified and thoroughly assessed. This requires clarity and consensus at the level of policy advice and decision-making on what constitutes risk and the guidelines for determining threshold risks warranting registration. The UK Professional Standards Authority has argued that further work is needed to understand the risks and harms of healthcare professions because:

A coherent way of assessing the risks that arise from different kinds of professional practice, and a shared methodology for managing different kinds of risk, will be a crucial component of more rational regulatory design in future. (UK PSA, 2015: 8)

In light of these considerations, a comprehensive assessment of risks by an objective party independent of partisan professional bodies and policy officers is essential to ensure fidelity to objective public interest aims. Such an assessment would identify both the theoretical and actual risks posed by non-registered professions. Until profession-specific comprehensive assessments are undertaken, perspectives and differences of opinion on the risks posed by non-registered professions are likely to continue.

11.5.3 Risk and standards of education and training

Many interviewed profession representatives pointed to practice risks they perceived were minimised through appropriate education and training. This suggests they considered practice risks were at least partially attributable to unqualified or underqualified practitioners, a view supported by research (Lin & Gillick, 2011: C; Wardle, 2008: 137-139). An investigation by Lin and Gillick found that following the registration of Chinese medicine practitioners in Victoria in 2002, the Registration Board refused more than 170 applications for registration between 2003 and 2008, generally due to inadequate training/qualifications or insufficient evidence of competence (2011:

C). The authors concluded that refusing registration to providers with insufficient practice skills “*means that consumers have been protected*” (2011: C). The research also found that complaints increased as consumers became aware of Chinese medicine registration (2011: C-D). Even though a proportion of the increase may have been due to capturing ‘lost’ complaints because of multiple entry points and unclear reporting avenues, this finding reflects the perspectives of some interviewed profession representatives who suggested that recorded complaints were but a proportion of consumers who had reason to complain. Underrepresentation of consumer complaints may inaccurately portray a profession as ‘safe’, but there may be other reasons for an apparently low complaint rate. Previous research has described the under-reporting of complaints by consumers (Bismark et al., 2006: 18-19; Doron et al., 2011: 66-67; Healthwatch England, 2014: 2; Wessel et al., 2012: 3). Studies have found that between 13% and 25% of consumers who do not complain indicated this was due to lack of knowledge about where or how to lodge a complaint (Doron et al., 2011: 67; Healthwatch England, 2014: 13; Wessel et al., 2012: 3). The recent consultation paper for the Complexity Review of NRAS included comments about complaints handling, stating that consumers “*want a single point of entry to make a complaint*” (Dawson, 2024: 58). The consultation paper goes on to state:

the technical distinctions between [...] a registered and non-registered practitioner [...] mean little or nothing to the consumer. It should not be the complainant’s responsibility to navigate their way from one entity to another to find the right place. (Dawson, 2024: 54)

These observations and findings reflect comments from several profession representatives involved in this study regarding consumer uncertainty about complaint lodgement and the need for a single complaints-handling body. Some profession representatives contended that consumer uncertainty and dispersed complaints-handling responsibilities supported their arguments for registration.

11.5.4 Risk and self-regulation

By registering certain professions, policy-makers are inferring that other health professions, including those examined in this research, may be safely practised through

existing occupational regulation mechanisms, a view expressed by many interviewed policy actors. However, views regarding the adequacy of existing regulation arrangements may be based on assumptions of the effectiveness, comprehensiveness, and cohesion of these arrangements. The mapping of co-regulation mechanisms presented in Chapter 5, Section 5.3, showed incomplete coverage for many non-registered professions. Additionally, statements from most profession representatives conveyed in both interviews and documents described the inadequacies of co-regulation and self-regulation. From the perspectives of some profession representatives, these inadequacies were exacerbated by the loss of private health insurance rebates in 2019 for professions such as naturopathy and Western herbal medicine¹¹⁰. With the loss of private health insurance rebates, respondents claimed the profession also lost one of the few co-regulation arrangements encouraging association membership that provided regulatory oversight of practitioner education, practice, and ethical standards. This is further supported by a profession representative who stated in an interview that *“the health funds require members to be accredited through an association to get their provider status. [...] you take that element out of it and self-regulation wouldn’t work, I don’t think”* (PAR8). Although one policy actor considered it *“career-limiting”* to forgo association membership because of incentives offered by the co-regulation partners, this appears insufficient inducement for all practitioners to join an association, particularly in professions excluded from government-funded health service programs, an observation made by several profession representatives in this study. One of these representatives estimated their membership was less than half of those they believed practised in the profession, a situation they perceived exposed consumers to unacceptable practice risks.

¹¹⁰ Following the decision to remove 16 natural therapies from private health insurance benefits provisions in 2019, and after a six-year review of the research leading to that decision, the re-inclusion of seven natural therapies (naturopathy, WHM, Alexander Technique, shiatsu, Tai Chi, Pilates, and yoga) as eligible providers for private health insurance benefits was recommended on 27 March 2025 (DOHAC, 2025). On 14 April 2025, the recommendation was accepted by the Minister for Health and Aged Care (Butler, 2025).

The issue of ensuring regulatory mechanisms appropriately address risk was also noted by the UK Professional Standards Authority, which urged a rethink of occupational regulation for healthcare professions. The Authority stated:

there is no consistently applied justification for why some occupations are in the statutory framework, and why some are outside it. [...] While it may be true in a general sense that those professions that present the highest risk to patients are included in statutory regulation, it is also true that some of those that are outside statutory regulation may present a greater risk to patients than some of those that are inside. (UK PSA, 2015: 12)

Similarly, the first consultation paper for the Complexity Review stated, “[t]here is also some evidence that many allied health professions with a significant risk profile are outside of the National Scheme” (Dawson, 2024: 69). These views validate comments from respondents in all stakeholder cohorts regarding discrepancies between professions that were and were not registered. While some respondents considered certain professions carried practice risks warranting registration or greater regulatory oversight, the professions to which this view applied were not consistent among stakeholders. Similarly, although many consumer advocates and profession representatives offered firm views regarding which non-registered professions presented the greatest risks and consequently should be registered, the professions they identified often differed. Policy actors in this study commented on inconsistencies between registered and non-registered professions, and several stated that certain non-registered professions required greater regulation because of the potential for harm. Despite this, the solutions put forward by these informants in interviews were for different measures, other mechanisms, additional proposals, and separate schemes, no matter how inefficient or ineffective, to avoid the issue of registration. From Kingdon’s point of view, the reason for these differences is that the “values one brings to an observation play a substantial role in problem definition” (2003: 110). Corresponding to this view, the perspective offered by Cobb and Elder is that:

Policy problems are socially constructed. [...] Whether or not a situation is considered a public problem and what the problem is, if there is one, depends upon not just the facts but upon beliefs and values – beliefs and values that determine what is taken to be fact, what facts are considered relevant, and how those facts are interpreted. (Cobb & Elder, 1983: 172-173)

These observations support findings from this research on the values and beliefs that inform HPR decision-making in Australia and the diverse opinions regarding what is considered a policy problem. Sparrow remarked that policy problem identification is *“an inherently messy business, involving artful choice and instinct as much as analysis and science”* (2008: 97). Kingdon stated that in identifying a problem, there *“is a difference between a condition and a problem. [...] Conditions become defined as problems when we come to believe that we should do something about them”* (2014: 109). Lancaster et al. argued policy-making should be viewed *“as an ongoing process of managing the problematic, that is, the ‘governance of problems’”* involving many players and conflicting perspectives (2014: 148). The present research finds congruence with these views of ambiguity and multiple perspectives regarding occupational regulation. According to many respondents across the stakeholder cohorts, self-regulation was regarded as inadequate or a ‘problem’, although there was no consensus about the professions for which the problem existed. This ambiguity and lack of consensus regarding which professions should be registered dates back to before the establishment of the NRAS, when only half of the eighteen jurisdictionally registered professions were registered in all states and territories (see Chapter 5, Table 5.2). At that time, the eighteen professions registered in one or more jurisdictions were the only occupations considered for national registration, effectively barring other professions. After the introduction of the NRAS, although a multi-profession review of regulation for non-registered professions was conducted during 2011–2012 and a profession-specific review of regulation for paramedicine was completed in 2015, no national reform agenda was introduced to replace state-based reviews of HPR, which ceased with the NRAS in 2010. Professions not registered at the time and seeking entry to the NRAS were required to *“demonstrate that they meet the relevant criteria [...] and] develop their own nationally-consistent registration proposal for consideration by the Ministerial Council”* (COAG, 2008a: 22). This decision handed to professional bodies the responsibility for initiating registration assessments and developing a submission justifying the profession’s inclusion in the NRAS, a responsibility in which governments took a more active role before the NRAS was established. By default, the decision also transferred to

professional bodies the responsibility for ensuring the safety and quality of practitioners and, ultimately, the safety of consumers.

11.6 Where capital meets power: symbolic capital in health practitioner regulation

Smith considered risk an important instrument of power because it:

allows state actors to use knowledge as a mechanism for legitimizing decisions of whether to act. In a sense it presents the decision as scientific and therefore unquestionable. (Smith, 2009: 218-219)

Bourdieu referred to the “*legitimizing discourses*” that social agents use to provide normative justifications for the status quo (1977a: 188-189). In the present study, many profession representatives also commented on the discourses of government and policy officers using risk to justify the regulatory status quo. Yet occupation-specific assessments of most professions examined in this study have not been conducted. Where they have been conducted, most recommendations regarding non-registered professions have been deferred or disregarded. Delegitimising discourses of lower qualifications and non-evidence-based practice were also evident in rationales for precluding certain professions from registration consideration. Other delegitimising discourses communicated by policy actors included the ‘size’ and ‘weight’ of professions, the degree of professional cohesion, and the level of intra-professional disunity. These discourses were among the reasons offered by and informing the views of these policy actors regarding the regulation of professions and a profession’s engagement with government officers.

From the perspectives of various policy actors, small professions were not cost-effective to register, marginalised professions could be disregarded, divided professions that did not speak with “*one voice*” could be ignored, and low-risk professions did not meet the criteria. These respondents deployed a variety of delegitimising discourses to suit the circumstances of each non-registered profession. These discourses equipped policy actors with ‘legitimate’ reasons for avoiding or disregarding registration claims. However, policy actors almost invariably identified discrepancies in the registration status of registered and non-registered professions and stated further regulation of

certain non-registered professions was indicated. None, though, explicitly identified professions for registration under the NRAS. This may have been because of an unwillingness to voice an opinion in interviews, albeit anonymously, or a feeling of disempowerment or lack of expertise in offering a view, sentiments expressed or suggested by several policy actors. As such, delegitimising discourses may have been used to mask these sensitivities.

11.6.1 The symbolic capital of registration

The Bourdieusian concept of symbolic capital, the legitimacy and desirability granted to other capitals when they are perceived as valuable and worth pursuing (Bourdieu, 1998: 47), provides a frame to better view and understand the attitudes and beliefs of stakeholders examined in this study. Most respondents considered registration elevated professional standing and conferred practitioner advantages, including *“respect”* and *“recognition”*. These advantages can be understood as examples of the symbolic capital embodied in registration and licensure, in this case via the NRAS. Registration and the symbolic capital accompanying it bestows legitimacy and status to all who achieve it, even though it is misrecognised or misperceived as such (Bourdieu, 2000: 242). Bourdieu stated that symbolic capital *“rescues agents from insignificance”* (2000: 242). Noble observed, *“our ontological security is founded on our ability to be recognised”* (2005: 114). Interviewees in all stakeholder cohorts referred to the elevated status, prestige, recognition, and legitimacy conferred by registration. Some policy actors and a few profession representatives stated that registration did not exist to bestow status, one policy actor commenting that legitimacy was granted to registrants *“even though it’s not meant to”* (GPA3).

Statements from some policy actors and profession representatives suggested certain non-registered practitioners were ‘unworthy’ of recognition by being included in NRAS. The negative regard for non-registered professions by others was a view expressed by many profession representatives when describing how their practitioners were perceived. These professions face barriers to achieving positive regard for their practitioners because of the stigma attached to non-registered professions, as suggested by many profession representatives, and the obstacles to NRAS entry, the

exclusion from which appears to be the cause of much of the negative regard. In Bourdieusian terms, non-registered professions share in a “*common excommunication*” in which self-regulation as a ‘field’ may be considered a “*stigmatized area [that] symbolically degrades its inhabitants*” (1999: 129). The concepts of exclusion and stigmatisation reflect comments made by consumer advocates and profession representatives participating in this study. These respondents perceived the absence of registration disadvantaged professions by “*excluding*” practitioners, which rendered them “*invisible*” and “*inferior*”. According to some of these stakeholders, self-regulation was perceived to hold little value in the eyes of registered practitioners, who may have regarded self-regulation as an impoverished cultural capital because it was considered devoid of the symbolic capital granted to registration. Being overlooked by government officers and devalued by registered professionals was often used by profession representatives as a reason to support their claims for registration. This line of argument is a predictable outcome of an institution comprising some but not all players and regarded by almost every interviewed participant in terms overtly proclaiming or discreetly suggesting NRAS was like a prestigious ‘club’. Furthermore, according to several profession representatives and one policy actor, some members of the NRAS ‘club’ ‘weaponised’ registration to limit scope expansion and other opportunities for outsiders. The weaponisation of capital resources by dominant groups was predicted by Bourdieu, who maintained that forms of certain capital, as well as being signifiers of “*class*”, are used as “*weapons*” (1996a: 254). Comments from some policy actors, a few of whom were registered practitioners, suggest that weaponisation was partly due to professional rivalry. In Bourdieusian conceptualisations, rivalry between different groups is aimed at securing a more favourable position in a field and relegating groups considered unworthy to a lower position, in this case by consigning self-regulating professions to a perceived inferior position outside the NRAS. The potential rewards accrued by registered practitioners by promoting their registered status can be considered the same as those non-registered professions were seeking by inclusion in the NRAS. These rewards include economic capital in employment opportunities, social and symbolic capital by undertaking work usually performed by practitioners occupying

a more elevated position in the healthcare hierarchy, and cultural capital in gaining knowledge and building expertise to undertake expanded scopes.

The acclaim for the NRAS, both explicit and implicit, by respondents from all three stakeholder cohorts, referred to in both documents and interviews, suggests that registration has been transformed into what Bourdieu described as a prized symbolic capital resource without which one is considered a *“loser [...] in the symbolic struggle for recognition”* (2000: 241). Consequently, striving for registration and entry to the NRAS ‘club’ by some non-registered professional bodies may be the pursuit of symbolic and other capitals or an attempt to redress their perceived disadvantage rather than a demonstrated need based on risk and other criteria. The disadvantage described by many profession stakeholders may be exacerbated by the location of some professions in the self-regulating field based on their position in the health system more broadly. Those professions practising under different healthcare paradigms are doubly disadvantaged in their attempts to join the club, as not only do they appear unwelcome in the NRAS club but appear unwanted by other clubs such as AHPA and NASRHP, as presented in Chapter 5, Section 5.1.3, and evident in comments from certain profession representatives. This indicates that professional groups other than the medical profession also exercise what may be considered symbolic violence to exclude professions from their club because they were considered impoverished in capital resources.

11.6.2 The symbolic capital of co-regulation, self-regulation, and Medicare

Not all profession representatives in this study sought registration. These respondents considered co-regulation or self-regulation to be of greater importance, and capital resources, such as Medicare rebates, to be of greater value than registration. Respondents seeking Medicare rebates may be considered to have a greater stake in, or, as Bourdieu might argue, were subject to the ‘illusio’ of the Medicare field. What may be at stake for non-registered professions is the symbolic capital of Medicare as a passport to other economic, cultural, and social capital benefits, as detailed in Chapter 5, Section 5.5. Profession representatives preferring self-regulation perceived the status quo offered advantages they were unwilling to cede, despite the acknowledged benefits

of registration communicated by some respondents. Bourdieusian theory suggests these professions valued the symbolic and other capital advantages of self-regulation, such as control and autonomy, as well as the ongoing survival of the professional association, more than they valued the benefits of registration. These representatives may be subject to the *illusio* of self-regulation, just as those pursuing registration may be subject to the *illusio* of NRAS.

When commenting on the positions of other associations about regulation, a few profession representatives attributed the preference for self-regulation to conflicts of interest that particular individuals were unprepared to relinquish for the advancement of the profession. These conflicts were considered to include protecting membership revenues by accrediting lower qualifying awards and inadequate sanctioning of members following consumer complaints. Almost 20 years ago, Carlton observed that many associations *“have a history of opposition to reforms that threaten their traditional professional boundaries and the autonomy and independence of their respective regulatory bodies”* (2006: 44). This view is suggestive of the perspectives offered by a few profession representatives in this study regarding the perceived opposition to registration by some associations.

Whatever the personal, professional, or symbolic reasons for pursuing a particular form of regulation, this type of commentary distracts the attention of professional bodies and potentially government policy officers from the public interest principles guiding Australian health policy regulatory stewardship. Registration considerations must be raised above expectations of personal and professional advantages and beyond economic, cultural, and symbolic capital rewards to ensure healthcare professions are appropriately regulated for the inherent risks of professional practice. The formal process for registering professions, which requires professions to ‘apply’ for registration, may be implicated in these distractions by allowing the personal and professional interests of professional bodies to encroach on registration assessment considerations above the interests of the public.

11.6.3 The symbolic power of the state and state agents

Bourdieu observed that governments, their agencies, and officers wield enormous power (1999: 129). He argued that the authority conferred by the accumulation of symbolic capital, with its attendant symbolic power and propensity for symbolic violence, provided the authority to organise and control the structure of society (1987: 13-14; 1989: 23). Policy officers and the ministers they serve exercise symbolic power by influencing or controlling entry to the registration field, and they enact symbolic violence by barring entry to the field when entry is justified. According to Bourdieu, when capital, such as the cultural capital of registration, is elevated to the symbolic level through widespread acclamation and given official sanction by the state, as it has with the NRAS, the stage is set for the exercise of 'legitimated' symbolic violence (Bourdieu, 1989: 21).

Freiberg summarised regulation policy-making by observing that “[u]ltimately, the regulatory decision-making process is a political one” (2017: 179). Many comments by policy actors described the political nature of HPR decision-making. Cobb and Elder claimed that much of the decision-making in government occurs before formal decision-making processes, and where:

decision-making councils [...] may do little more than recognize, document, and legalize, if not legitimize, the momentary results of a continuing struggle of forces in the larger social matrix. (Cobb & Elder, 1983: 12)

These forces may include what Haines characterised as “*political risk assessment[s]*” (2011: 52) by governments as part of their decision-making deliberations. The concern of ministers regarding political risk was a view offered by some respondents from each stakeholder cohort. For instance, one policy actor stated that exposure to political risk was a factor in deciding what issues policy advisers raised with their ministers. Another policy actor commented that ministers make decisions regarding registration for reasons including “*their political interests*”. The political nature of HPR decision-making creates conflict between the processes and systems in place to promote the public interest by implementing HPR that protects consumers via an evidence-informed policy

framework, and the ability of policy officers to follow the evidence that should guide decision-making because of the political forces exerted on them.

Duckett and Willcox identified a broad range of parties considered to exert an influence on policy-making (2015: 136). These authors state that while public servants have a key role in shaping policy, their role has changed with increasing sources of policy advice coming from ministerial advisers, policy advocacy think tanks, stakeholder associations, and other agencies (2015: 136). Baldwin et al. proposed that “*public interest theory understates the degree to which economic and political power influences regulation*” (2012: 42). Consistent with these views, Cobb and Elder regarded the bias of the political system:

both reflects and legitimizes the prevailing balance of power among organized groups [...and thus] will represent the interests and most salient concerns of previously legitimized political forces. (Cobb & Elder, 1983: 10)

The wide-ranging ‘legitimised’ sources of influence, interests, and preferences were evident in the views expressed by some consumer advocates, many profession representatives, and most policy actors interviewed for this study. Consumer advocates and profession representatives stated that ministers, ministerial staff, and policy officers favoured the opinions of registered professionals, a view also expressed by policy actors regarding the influence on HPR policy-making by medical, nursing, and midwifery professional associations.

Cairney stated that policy analysts do more than generate evidence to reduce decision-maker uncertainty in policy-making. They considered that:

political action is about reducing or exploiting policy ambiguity [...]. They exercise power to win disputes, drawing on material resources and argumentation, or manipulating the rules used to make choices. (Cairney, 2023: 1821)

In contrast, Goodin et al. claimed policy analysts “*see themselves as possessing a neutral expertise to be put to the service of any political master*” (2006: 8). While policy actors may have viewed themselves as impartial, findings from this study challenge the neutral orientation of policy actors. Adams and Saks also challenged the traditional view of government agents as objective upholders of the public good, while professions

prioritise self-interest, arguing that such stereotyping *“fails to capture the complex interests and concerns of the key social actors”* (2018: 62). Like Kingdon’s view of the forces driving problem identification in policy development (2014: 148), Adams and Saks contended that in regulatory change efforts, government agents and professional groups may be driven by political, ideological, and economic motives (2018: 62), where:

The decision of legislators to regulate or de-regulate professions can be shaped by political interests, practical concerns, rational-legal constraints, and a variety of values and beliefs” (Adams & Saks, 2018: 66).

Haines stated that values per se do not exist, rather, *“values are a proxy for interests and power and influence that determine whose ‘values’ are heard and whose are not”* (2011: 46). Cairney and Oliver noted the tendency of policy-makers to rely on *“well-established beliefs and shortcuts based on their emotions and familiarity with information”* when making judgements (2017: 4). Interests, beliefs, and values were conveyed by respondents across the stakeholder cohorts, leading to a critical finding from this study. Through comments offered in interviews and documents, stakeholders brought to policy debates their own perspectives and perceptions of how HPR should operate for non-registered professions over and above consumer needs and documented criteria. Policy actors used factors beyond the IGA assessment criteria and process to justify views regarding the unsuitability of registration for non-registered professions, even though detailed examinations and assessments of most non-registered professions have not been conducted. Some consumer advocates and profession representatives stated that, irrespective of consumer needs, government policy officers lacked objectivity, were prone to bias, or were overly concerned about costs and workloads. Findings from this research suggest that, far from acting as Alford’s corporate rationalisers (1975: 14-15) seeking to challenge the structural interests of registered professions, most policy actors in this study expressed views supporting and reinforcing the structural interests of the dominant registered workforce.

Garcia-Villegas considered ideology synonymous with symbolic violence, both tendencies serving to maintain the status quo and dominate specific individuals by emphasising differences between groups (2003: 180). Applying this concept to HPR in

Australia, policy actors exercised symbolic violence through ideological comments to preserve the HPR field as it is. Even though these policy actors referred to the IGA assessment criteria to support their views, they also deployed what can be considered ideological capital concepts and 'unwritten' criteria. They communicated opinions and perspectives that may be construed as symbolic violence to legitimate their gatekeeping role, support their stated positions regarding how ill-suited certain non-registered professions were for registration, and maintain current field arrangements.

Goodin et al. observed that the task of policy analysts was *"to advocate the policies that they think right"* (2006: 7). Contrary to this view, it appears some policy actors in this study considered their role was supporting ministerial decisions rather than advocating for policies promoting public protection, consumer needs, or health system requirements. An institutional culture overly supportive of ministers, rather than giving *"frank and fearless advice"*, was the conclusion reached in an Ombudsman's review of the alleged politicisation of the public service in Victoria (Victorian Ombudsman, 2023: 4). The review found *"creeping politicisation"* and *"a public service overly responsive to the elected government of the day, whatever its colour"* (Victorian Ombudsman, 2023: 4, 5). The review presented two key sentiments from current and former senior public officials. The first was *"[c]oncern about what people saw as the quickening corrosion of longstanding Westminster principles of responsible government"*. The second was *"[f]ear that if they spoke up, if they were in any way identifiable as having done so, their careers would be finished"* (Victorian Ombudsman, 2023: 5). There may have been similar concerns among some policy actors in this study, one stating:

It's not my Scheme, it's not my Scheme. I'm just, you're just getting my opinion [...] and where my colleagues in other states and territories have had a good chat with you about what they think, I can't do that. It's not what I've been instructed to do. (GPA11)

Goodin et al. asserted that *"[f]rank and fearless advice is not always welcomed by those in positions of power"* (2006: 7). This contention is consistent with suggestions made by a few policy actors in the present study regarding discussions about HPR.

The tendency for some policy actors in this study to de-emphasise their role and influence in policy decision-making, at times by stressing “*personal*” views were being expressed, has previously been observed by Ball, who claimed:

civil servants are socialized to present their absence from the processes of policy-making. They are clearly often decisively influential but are almost always unwilling or unable to account for such influence. (1994: 110)

Although policy actors were not necessarily conscious of the actual and symbolic power they exercised, many of their comments suggest the privilege and power held by state actors. The power held by state agents was evident in the views expressed by respondents in all stakeholder cohorts. Many policy actors revealed the subtle ways in which their influence and power were exerted. Sometimes the influence was more obvious, for example, through comments such as “*I would have to be very truthful [...] around what kind of work’s involved in adding a profession to the Scheme*” (GPA2). Some policy actors dealt with the issue of work effort and costs involved in registration by referring to alternative mechanisms to the NRAS to overcome the acknowledged deficiencies of self-regulation. They expressed a clear disinclination to consider registration for other professions. Comments of this nature are suggestive of the subjectivities and partialities of policy actors, the symbolic power they exercise, and the gatekeeping role they play. Other examples from interviews with policy actors include comments such as, “*it’s all subjective*” (GPA5), “*what’s the appetite to add more professions?*”, “*there’s got to be an appetite*” (GPA2, GPA14), “*no one’s going to apologise for that*” (GPA2), and “*the community, because they elect governments, have made the decision that not every health professional in this country requires registration*” (GPA5). The belief that the body politic endorses government decisions by virtue of being elected is a demonstration of policy actors legitimating the decision-making powers of government by proclaiming the state, in and of itself, to be “*the voice of the people*” (Webb et al., 2002: 93). Under this maxim, the state claims to make decisions regarding HPR by public fiat that legitimates the exercise of authority and the use of symbolic violence (Webb et al., 2002: 93). A corollary of this argument is that symbolic power and violence are also directed at consumers using the services of health

practitioners who should be registered because the state has failed to introduce the protections they elected governments to enact.

In supporting their perspectives regarding registration for non-registered professions, policy actors commonly framed their views in terms of upholding the public interest or objectively evaluating professions against the assessment criteria. This rendering of the public interest and objectivity by policy actors was described by Bourdieu, who referred to:

the obligatory reference to the values of neutrality and disinterested devotion to the public good [...]. As if the privilege of embodying the public interest implied renunciation of all that is protected by the privacy of private life. (2000: 124-125)

Most policy actors in this study had an understanding of the history of NRAS, the IGA assessment criteria, and the regulation mechanisms for non-registered professions. However, a few had limited knowledge of the Scheme's history and criteria and little or no knowledge of the regulation mechanisms governing non-registered professions. For example, one policy actor, unaware that self-regulating professions did not have legislated occupational title protection¹¹¹, stated:

I was thinking in terms of protected title and minimum qualifications. I don't, I have to confess, I don't know for this right-hand side [list of non-registered professions] which ones are protected or are not protected. (GPA4)

As policy officers move on, knowledge and expertise are lost from government departments. As Tingle noted, the loss of “*institutional memory*” leaves the public service “*with neither its power base nor the capacity to provide a ballast to short-term politics*” (2015: 10). The loss of knowledge regarding HPR may explain the perspectives of some policy actors who appeared to know little about the history of the NRAS or appeared to uncritically support ministerial decisions because they may have felt unqualified to do otherwise. Furthermore, while many policy actors expressed feelings of frustration with the regulatory impact analysis processes, commentary, such as, “*it's*

¹¹¹ Dietitians Australia, a professional association representing non-registered dietitians, has trademarked the title ‘Accredited Practising Dietitian’. Even though this a form of title protection it is not a statutory title under the National Registration and Accreditation Scheme. See: <https://search.ipaustralia.gov.au/trademarks/search/view/2089105>.

not my scheme [...] it's not what I have been instructed to do", suggests broader issues of disempowerment regarding their role, the restraining effects of the structures within which government policy officers operate, and the symbolic violence they may be subjected to from above.

11.7 A Bourdieusian analysis and interpretation of the health practitioner regulation field in Australia

Figure 11.1 presents a conceptual model of the health practitioner regulation field in Australia and the forces exerted on it based on the analysis conducted in this research study.

Findings from this research support the premise that HPR in Australia operates as a Bourdieusian field. The HPR field comprises a series of smaller fields populated by players of different professions and bureaucratic institutions.

Taking a Bourdieusian view of the HPR field and situating it within a critical realist meta-theory, the diverse government and non-government regulatory institutions and organisations, laws, criteria, and processes of HPR comprise the 'domain of the actual', that is, the structures and events that constitute ontological reality.

This research has sought the epistemologically relativist views and opinions of healthcare stakeholders through the 'domain of the empirical' to identify the perspectives and experiences of the actual domain. Respondents in this study offered a view of 'reality' where they considered their perspectives and perceptions to be the 'right' views. The multiple and frequently conflicting accounts between stakeholders on the adequacy or otherwise of current HPR settings for non-registered professions and the applicability of registration to these professions exemplify the critical realist claim that social actors possess different perspectives of ontological reality.

Health practitioner regulation field in Australia

The domain of the actual (reality)

- Self-regulation**: voluntary registering bodies, psychotherapy, massage therapy, social work, dietetics, orthoptics, NASRHP, myotherapy, counselling audiology, naturopathy, sonography, clinical perfusion, exercise physiology, speech pathology, paramedicine, Western herbal medicine.
- Co-regulation**: Table showing regulatory status for various professions across different regulatory bodies.
- National Code of Conduct**: Map of Australia showing regulatory status by state/territory.
- National Registration & Accreditation Scheme**: Ahpra & National Boards, Australian Health Practitioner Regulation Agency. Lists regulated professions: Aboriginal and Torres Strait Islander health practice, Chiropractic, Dietetics, Medical Radiation Practice, Nursing and Midwifery, Occupational Therapy, Optometry, Osteopathy, Paramedicine, Pharmacy, Physiotherapy, Podiatry, Psychology, Speech Pathology, Veterinary, Western Herbal Medicine.

Perspectives and experiences of health practitioner regulation

The domain of the empirical (perspectives & experiences of reality)

Symbolic power → Symbolic violence

The domain of the real (causal mechanisms)

- Economic capital**:
 - Cost to government/taxpayers
 - Cost to patients/consumers
 - Cost to practitioners
 - Grants, rebates, funding, and entitlements
 - Expanding practice scopes
- Cultural capital**:
 - Entry to practice standards
 - Title protection
 - Professional standards
 - Register of practitioners
 - Degree qualifications
 - Evidence-based practice
- Social Capital**:
 - Cross-ministerial agreement
 - A "champion" in government
 - Position in the healthcare hierarchy
 - Professional cohesion/unity
 - Influence of other professions
- Symbolic capital**:
 - NRAS "club"
 - Registration as state-sanctioned cultural capital
 - NASRHP membership
 - AHPA membership
- The 'capital' of risk**:
 - High risk of harm
 - Low risk of harm
 - What is included as harm?
 - What is the threshold risk?
 - "What's the burning platform" for registration?

H A B I T U S

D O X A

Almost all profession representatives considered that self-regulation denied them one or more of the capital resources they desired. Policy actors spoke of the constraining structures of the registration assessment process they worked within that were perceived to hinder decision-making and largely informed their views that registration of further professions was not indicated. Their responses suggested they themselves were causal agents beyond the causal agency of ministerial decision-makers. They conveyed their agency by offering rationales for the continuing exclusion of non-registered professions from the NRAS field, rationales they considered relevant to regulation decision-making but did not always accord with the IGA criteria.

In documents analysed and interviews conducted, respondents in all stakeholder cohorts commented on the various HPR 'fields': NRAS, self-regulation, co-regulation, NASRHP, self-regulation, and the bureaucratic field. Other social structures, 'fields', were also referred to, such as healthcare, allied health, and alternative medicine. Respondents referred to these social structures in ways consistent with Bourdieu's contention that fields are sites of conflict and contestation between field occupants. Field conflicts were evident at different organisational levels. Conflicts over the preferred type of occupational regulation for a profession were reported among board members of the same professional association and between different associations representing the same profession. Different perspectives regarding occupational regulation were evident among consumer advocates, policy actors, and profession representatives. From the viewpoint of almost all stakeholders, the NRAS was the most dominant and highly sought-after occupational regulation field. When profession representatives spoke of professional "*recognition*", having greater "*visibility*", and sitting amongst the registered professions, they were, in Bourdieusian terms, referring to advancing their position in the regulatory field, improving their location in the healthcare hierarchy, and elevating their status among "*legitimate*" professions.

The research findings also support the proposition that stakeholder perspectives and experiences are largely driven by two causal mechanisms in the critical realist 'domain of the real'. The first is the habitus, the acquired, largely unconscious characteristics, conditionings, and preferences of respondents and the groups they circulate in. These

include the bureaucratic habitus of policy actors who are conditioned to ways of viewing the field of government, the habitus of profession representatives who are conditioned to viewing the field of professions and how, as outsiders, they attempt to influence the policy process in their favour, and the habitus of consumer advocates who are conditioned to viewing the field of their constituents and championing consumer rights.

The second causal mechanism is the doxa of stakeholders, the belief systems and taken-for-granted norms and worldviews operating in a field and held within the habitus. Perspectives communicated by respondents indicated that doxa served to shape, strengthen, and legitimate the individual and group habitus and determined the ideological perspectives stakeholders brought to regulation debates. Doxa informed stakeholder views about how things should be and the actions they should take. Together, doxa and habitus account for respondent views in interviews and documents, where varied ideological perspectives and stakeholder perceptions informed and influenced responses regarding issues of risk, qualifications, evidence, professionalism, criteria, self-regulation, and registration.

Habitus and doxa were operationalised by stakeholders through summoning or appealing for Bourdieusian capital, and the ‘capital’ of risk to support their perspectives on how non-registered professions should be regulated. Many professional representatives appealed for the cultural capital resources of standards, titles, and registers, and the symbolic capital of professional recognition, to justify their claims for advancement in the field. They expressed a desire for registration or statutory co-regulation to establish what Bourdieu, quoting Erving Goffman, referred to as a “*sense of one’s place*” (Bourdieu, 1989: 17) among registered professions in the NRAS or as state-recognised professions. However, respondents from all stakeholder cohorts perceived that some non-registered professions did not “*belong*” in the NRAS. From a Bourdieusian perspective, these stakeholders considered that these professions lacked a registration habitus (1998: 7-8) and, thus, should remain self-regulating or be relegated to “*a lower level of registration*”. These stakeholders were expressing what Bourdieu referred to as a “*sense of the place of others*” (Bourdieu, 1989: 19) outside the NRAS, where ‘other’ professions belonged. Whichever view was put forward by

respondents, they frequently cited what could be regarded as doxic reasons to support their views for inclusion or exclusion from the NRAS or other fields and summoned various capital resources to argue their position. As for which professions were considered to possess or lack a registration habitus, even though almost all respondents expressed frustration with the current scope of the regulation arrangements and many expressed the need for change to the regulatory settings for certain non-registered professions, there was no consistent view about what those changes should be or for which professions. In expressing their respective views, respondents were so entrenched in the familiarity of their doxic worldview, they were what Bourdieu described as “*fish in the water*” (Bourdieu & Wacquant, 1992: 127), in that they viewed their perspectives of reality as reality itself.

Not all perspectives, though, hold equal weight with decision-makers, nor are doxic-driven actions of different stakeholders of equal consequence. The research findings support the proposition that even though policy actors are not free to act as they please, they are also not fully constrained by the structures and mechanisms within which they operate (Bhaskar, 1989: 4; 1998: 37-38). Policy actors largely affirmed their support for the professions included in the NRAS. They offered perspectives that reinforced the current NRAS configuration and sought to justify the exclusion of non-registered professions. It appears the bureaucratic field is populated by policy actors, most of whom hold fixed ideas that are not entirely consistent with the regulatory policy framework, the objectives, or the objectivity of the IGA assessment criteria.

This leads to a key conclusion from this study. The habitus and doxa of all stakeholders shape their opinions and behaviours. However, the perspectives and actions of policy officers interviewed for this study and in the broader bureaucratic arena, the biases and worldviews they bring to their policy roles, and the external factors they consider have a bearing on HPR policy decision-making, can have significant impacts on the regulation of professions and outcomes for healthcare consumers. The biases and worldviews of policy officers, when exercised as symbolic power, operating through capital resources, and reified as behaviours that enact symbolic violence on non-registered professions to maintain the regulatory status quo when registration might otherwise be justified, deny

consumers the legislative protections afforded by the *National Law*. Decisions made by governments on HPR affect the healthcare provided to consumers. This is a view put forward by most interviewed consumer advocates and profession representatives. These respondents also noted the influence of policy advisers and policy officers in gaining access to ministers and having their claims heard. Unless there is a proactive way of designing out the biases of government officers, simply changing policy advice structures or decision-making frameworks is unlikely to change the situation because state actors are deeply embedded in the bureaucratic field with all the power and privileges these positions bring (Bourdieu, 2014: 367).

Bourdieu argued that the habitus can be changed. Ways of minimising the 'subjective' nature of policy decision-making are needed to facilitate a shift in the habitus of policy officers. Changing the habitus of policy officers may include the involvement of a broad range of consumer bodies in initial assessments of professions for registration, training to ensure a deep understanding of the IGA assessment criteria, the decision-making process, and the regulation mechanisms governing non-registered professions, and more detailed elaboration of and guidance on the IGA assessment criteria to support decision-making, particularly concerning risk and threshold risks requiring registration.

Among the reasons for the diverse views was that stakeholders, field players in Bourdieusian theory, desired different outcomes from HPR. Perspectives gleaned from documents and interviews indicate that some stakeholders sought to preserve what Bourdieu would describe as economic capital, while others attended less to economic capital and more to risk capital. Some called for intra-professional social capital before engaging with governments or their officers, while others considered this a vexing problem unlikely to be resolved without government intervention. Some stakeholders viewed the process for regulatory assessment against the IGA criteria as an intentionally constructed barrier designed to maintain the status quo, while others perceived that claims for registration by professional bodies were given insufficient consideration against the IGA criteria. Some stakeholders sought entry to the NRAS field, appealing for the cultural capital of titles, registers, qualifications, and standards along with the symbolic capital of 'distinction' they were considered to embody. Others invoked

cultural capital concepts to enact what Bourdieu described as symbolic violence against professions perceived as unworthy of registration, while promoting their NRAS eligibility and cultural superiority. Some viewed NRAS as a club they were barred entry to, while others viewed registration as inappropriate and excessive for non-registered professions. Some profession representatives argued that government policy officers acted as gatekeepers to the NRAS field, while policy actors viewed ministerial advisers as gatekeepers to ministers and described the Office of Best Practice Regulation as gatekeepers to much-needed regulatory policy change. Hence, the stance taken by stakeholders on regulation stemmed from what they most desired from it. These desires and needs were sometimes consistent with the IGA assessment criteria, but not always.

Contrary to Kingdon's contention that "[s]ometimes people in government feel they have solved a problem" (2003: 103), policy actors, consumer advocates and most profession representatives considered further regulation was indicated for certain non-registered professions. Given the widespread agreement on the need for HPR reform for a range of non-registered professions, perhaps what many respondents were communicating was the need for a comprehensive and profession-specific review of regulation arrangements for these professions, a need explicitly expressed by two policy actors, and a task already commenced with the review and assessment of audiology.

11.8 Chapter summary

This chapter has analysed and interpreted stakeholder perspectives of regulation by applying a Bourdieusian theoretical framework to gain further insights from the study results. Analysing the results in this way facilitated ways of viewing stakeholder perspectives that enabled causal mechanisms to be proposed, using judgemental rationality to arrive at the most plausible explanation for perspectives of the HPR field relating to non-registered professions. The analysis indicates that stakeholder perspectives were primarily driven by the tendencies, preferences, and ideological causal mechanisms of habitus and doxa that determined the attitudes and opinions stakeholders brought to regulation debates. Habitus and doxa were operationalised through summoning or appealing for Bourdieusian capitals and the 'capital' of risk to support stakeholder views. Stakeholders operationalised Bourdieusian and risk capital

concepts to argue for regulation arrangements that differed according to their particular position. Frequently, these capital resources and arguments were factors that sat outside the registration assessment criteria. Respondents from every stakeholder cohort conveyed concepts relating to the symbolic capital of registration, self-regulation, co-regulation, and Medicare. These capitals were, at times, communicated in ways suggestive of symbolic power and exercised as symbolic violence against those considered impoverished in, or devoid of, the 'right' types of capital.

The next chapter discusses the findings from this thesis by summarising the results of the document analysis and stakeholder interviews into a synthesis of stakeholder perspectives, and summarising the theoretical analysis and interpretation detailed in the present chapter. The synthesis and summary complete the presentation of findings from this research, allowing for a refocusing of attention away from stakeholder opinions based on regulation preferences and towards HPR policy and consumer safety. It presents several ways to achieve a better balance between consumer safety and the regulation of health professions.

Chapter 12

DISCUSSION

12.1 Introduction

The previous chapter addressed the final research objective, to theoretically explore, analyse and interpret the stakeholder perceived complexities, challenges, and opportunities associated with regulating non-registered professions and the perceived adequacy of and gaps in the current regulatory policy framework within which regulatory policy decision-making occurs.

This chapter draws together the key findings from the documents collected and interviews conducted to identify where they accord and differ within and between stakeholder cohorts. I compare, contrast, and contextualise the findings in terms of broader national and international insights and developments in HPR. I summarise the Bourdieusian analysis and interpretation of the HPR field related to non-registered health professions. In this chapter, I also present recommendations based on the findings from this thesis, a discussion of the research limitations, suggestions for further research, and a reflection on the use of Bourdieusian theory in HPR.

12.2 Key findings from primary studies of stakeholder perspectives

The present research found considerable accord between the perspectives identified in document sources and stakeholder interviews. Most stakeholder comments regarding HPR, sourced from publicly available documents, supported registration. While there was support for registration from many interviewed consumer advocates and profession representatives, there was an unwillingness from interviewed policy actors to support further registration and mixed views from government document sources on the need for registration.

Whether conveyed in interviews or documents, almost all respondents considered public protection to be the primary objective of the NRAS. Most respondents perceived

that registration fostered consumer trust and confidence in health practitioners, assured practitioner quality and competence, upheld professional integrity, and elevated professional standing. Although respondents had a common view regarding the public safety imperative of the *National Law*, suggesting implicit stakeholder support for the primacy of the public interest in matters relating to HPR, there were diverse views on the type of occupational regulation that best delivered this for non-registered professions. Interviewed consumer advocates and profession representatives frequently identified the need for registration for certain non-registered professions, however, opinions differed within and between the two stakeholder cohorts on which professions should be subject to registration. While interviewed policy actors noted discrepancies between professions that were and were not registered, and perceived that some non-registered professions required further regulatory measures, there was a disinclination to extend the registration to further professions. In all cohorts, stakeholder opinions about HPR for non-registered professions were rationalised by raising factors within and beyond the formal assessment criteria, factors that informed respondents' thinking and decision-making deliberations.

Most consumer advocates and profession representatives expressed the view that HPR was the job of governments, that consumers often assumed health professions were registered, and that, in general, statutory registration delivered better healthcare than self-regulation. The better healthcare afforded by registration was also a theme identified in the documents analysed. Policy actors considered registration to be a more effective occupational regulation mechanism for providing assurances regarding the quality and safety of health practitioners. Their perspectives on the role of governments in HPR were largely limited to policy reforms for the registered professions, with relatively few additional regulatory measures considered necessary for non-registered practitioners. Profession representatives and policy actors held similar views about the complexity of and influences on HPR decision-making, including the need for cross-jurisdictional agreement and for professional bodies to lobby governments and their officers to prompt government action and advance professional goals, matters that consumer advocates did not raise in interviews. There were no perspectives common to

consumer advocates and policy actors apart from those common to all three stakeholder cohorts.

Perspectives unique to each stakeholder cohort were also identified. Consumer advocates communicated concepts indicating trust in governments to regulate health practitioners, tempered by distrust and uncertainty about governments prioritising the public interest when considering which professions to register. Policy actor respondents spoke of the suitability of self-regulating mechanisms for most non-registered professions and the difficulties encountered and frustrations experienced in meeting Office of Best Practice Regulation requirements. Opinions differed between profession representatives regarding the adequacy of self-regulation mechanisms, the effectiveness of complaints handling, the risks posed by the professions, and whether non-registered professions should be registered. Some of these conflicting opinions came from multiple respondents representing the same professions.

These and other themes generated from the analysis of stakeholder documents and interview transcripts are summarised in Figure 12.1.

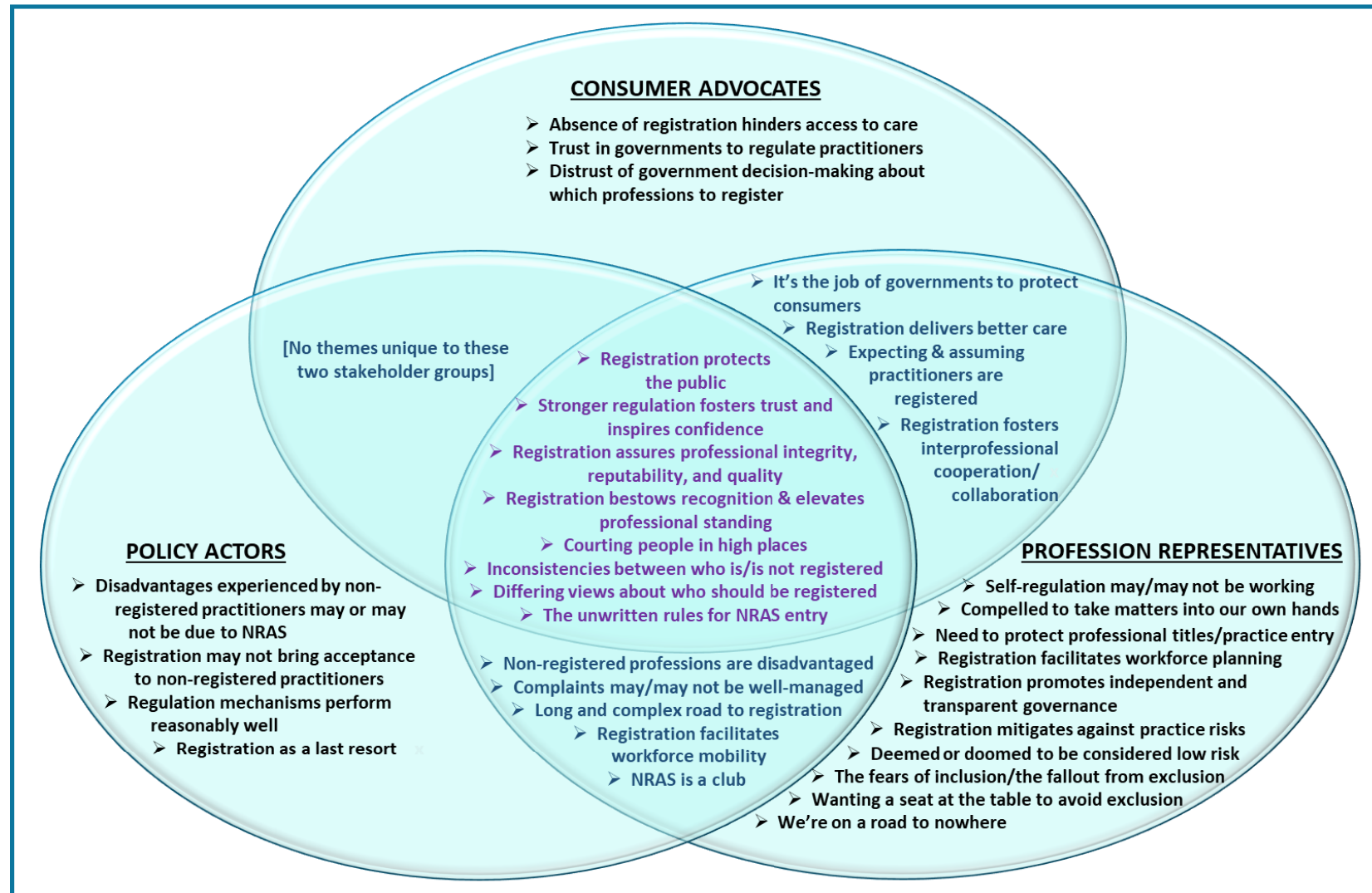
12.3 Key findings from an analysis and interpretation of stakeholder perspectives

Theoretical analysis and interpretation of results from this study indicate that the perspectives of stakeholders gathered from documents and interviews showed considerable congruence with Bourdieusian concepts.

Much of the written and spoken commentary from stakeholders aligned with Bourdieusian economic, cultural, social, and symbolic capital. Respondents from all stakeholder cohorts referred to these factors to justify or support their positions on regulation. Some commentary, particularly from policy actor respondents, was conveyed in language suggesting the exercise of symbolic power and violence.

Some policy actors and profession representatives used cost impositions to argue against registration for non-registered professions. In Bourdieusian terms, these stakeholders sought to prevent the loss of economic capital for governments, consumers, or practitioners.

Figure 12.1: Themes generated from stakeholder perspectives of regulation (documents and interviews).



Other profession respondents expressed concerns over the loss of economic benefits due to their exclusion from NRAS. The financial loss described by these respondents was ineligibility for grants, rebates, employment opportunities, and expanded scopes of practice. The importance of registration or self-regulation to economic capital accumulation or preservation was evident in these stakeholder responses.

In addition to economic capital, many stakeholders emphasised features of registration in ways Bourdieu would describe as cultural capital. Of all the cultural capital resources, most, but not all, respondents considered registration the most prized. It had achieved the level of symbolic capital for these stakeholders. Several profession representatives regarded other cultural assets, such as co-regulation, self-regulation, and access to Medicare rebates, to be of greater symbolic and actual significance for the profession.

For policy actors, the capital importance of registration stemmed from other cultural capital resources associated with registration, such as degree qualifications, professional standards, occupational titles, and practitioner registers. The significance of some cultural capital was such that multiple policy actors and profession representatives considered professions with lower qualifications were disqualified from registration contention, a perspective suggesting symbolic violence against these professions. For other representatives, the appeal of registration included attributes such as enforceable minimum qualification standards they perceived were unattainable under self-regulation, as well as features such as practitioner titles and registers. In all cases, the favoured attributes perceived to accompany registration were drawn upon to argue for or against registration according to the particular stance taken by the respondent.

Evidence-based practice was another cultural asset held in high regard by a few consumer advocates and profession representatives in this study. As with other cultural resources, some stakeholders stated that operating within an evidence-based paradigm was a prerequisite for registration eligibility. Conversely, not being perceived as operating within an evidence-based paradigm was seen as grounds for ineligibility. Views regarding what is and is not evidence-based were not elucidated by respondents. Nevertheless, these respondents expressed firm opinions about professions perceived

to fall into one group or the other. In drawing these distinctions, these stakeholders were promoting the symbolic capital status of professions classed as evidence-based and enacting symbolic violence on those they considered non-evidence-based.

The need for what Bourdieu termed social capital to achieve professional success was expressed by respondents when they commented on the importance of establishing professional relationships. The social capital communicated by profession representatives and policy actors included support from dominant professional associations, the need for a “*champion*” in government to take a case for registration forward and establishing intra-professional unity and cohesion as a prerequisite for cultivating relationships with government ministers and officers. A few policy actors considered it more difficult for some professions to gain the attention of, or build relationships with, ministers, government officers, ministerial advisers, and powerful professional associations. The challenges expressed by these stakeholders may be viewed as a form of symbolic power and symbolic violence by individuals and groups creating barriers to access. Many profession representatives also commented on the difficulties they experienced in engaging with government ministers and officers. For these representatives, attempts to build social capital were unsuccessful because of actions taken or barriers raised by dominant groups, such as policy advisers, policy officers, and powerful professional associations. For many stakeholders, progressing professional agendas was founded on knowing the right people and having the right contacts to open the right doors. That is, having a solid store of social capital resources.

Almost all stakeholders commented on risk or the potential for consumer harm under a self-regulating framework. Of all the factors on which stakeholders commented, risk was most often referred to in support of particular positions on regulation. A conclusion from this thesis is that risk was considered a capital resource by many stakeholders. They referred to a low risk of harm to maintain the regulatory status quo, while high risk was referred to in arguing for regulatory change, either through co-regulation or registration. However, there were differences of opinion over what constituted risk, with some policy actors stating or suggesting that risk was limited to physical harm. In contrast, other policy actors took a broader view of possible consumer risks, including

mental or financial harm. Consumer advocates stated that risk should be the primary consideration of governments when deciding on matters relating to HPR. Some profession representatives considered the current regulatory measures adequate for the practice risks, while other respondents representing the same professions considered the risks of practice unacceptable. Many profession representatives spoke of their inability to maintain consumer safety with current regulatory measures. Some expressed powerlessness in convincing governments of the risks of practice. According to these stakeholders, the profession's perceived risk was not adequately managed through self-regulation.

The findings indicate that while HPR is a policy issue, it appears to be impacted more by politics and power than by policy, and perspectives of appropriate regulatory measures were supported by economic, cultural, social, and symbolic capital arguments, as well as by the assessment criteria and purpose of registration. The politics of place in the health care hierarchy, of having access to and gaining the support of powerful individuals and groups, of considerations regarding practice risks when thorough assessments have not been conducted, and of the need for a single representative body or a single voice for multiple bodies have found their way into stakeholder opinions about HPR. Relatively benign concepts such as evidence and qualifications have been drawn into the territory of symbolic power and symbolic violence, where they may influence the policy process.

12.4 Towards a health practitioner regulation reform agenda

Based on the findings from this research, the issues identified by stakeholders in this study, and other concerns regarding HPR identified in the broader literature, the following section refocuses attention away from the power and politics of HPR and back onto HPR policy. It discusses several ways to achieve a better balance between consumer safety and the regulation of health practitioners.

Five topics are detailed in this section. The first is the need to amplify the consumer voice in HPR decision-making. The second is reducing government reliance on the advent of a crisis before taking action to review HPR policy. The third seeks

enhancements to the registration assessment guidelines for professional bodies and government policy officers. The fourth calls for governments to resume control of HPR reform for non-registered professions. The final topic to be covered is a call for governments to review the regulatory policy settings for non-registered professions to ensure practitioners are appropriately regulated for the risks of practice. These focus areas accord with the Australian guiding principles of regulatory stewardship in health policy (DOHAC, 2020: 20) and are consistent with the 2024 WHO global guidance on health practitioner regulation, which states:

Health practitioner regulation should strike the right balance between addressing the risk of harm to patients and ensuring public access to health services. Under-regulation can place patients at risk of harm from health practitioners, while over-regulation can place the public at risk of harm by reducing or removing access to health services. It is therefore essential that regulators define patient harm in the specific context, review existing mechanisms for patient safety in terms of the intended goals and identify the reasons behind any divergence. (WHO, 2024: x)

12.4.1 Amplifying the consumer voice

The paramount guiding principle of the *National Law* is public safety. Significant risk of harm is one of six guiding criteria for assessing professions for registration, and valuing regulation as an asset that protects the health and safety of Australians is one of seven guiding principles of the Australian Government's *Health Regulatory Policy Framework* (DOHAC, 2020: 20). Despite the emphasis on consumer safety, findings from this research indicate consumer bodies, as advocacy voices for their broader constituent communities, have little, if any, presence in the HPR field, even though laws are meant to reflect the society to which they apply (Legal Services Commission, 2024). In this study, not only were consumer voices underrepresented in the document corpus, with just three submissions located, they were also nominally represented in stakeholder interviews, with five of nine invited advocacy bodies taking part. Consumer advocates communicated distrust of and disenchantment with governments and government officers. They maintained that regulating health practitioners was the role of governments, but distrusted governments to prioritise the public interest when deciding which professions to register. These views may be considered to challenge the claim

made by one policy actor that elected governments enjoyed a public mandate for HPR decision-making.

Apart from comments regarding consumer risk and public protection, considerations of patients, consumers, and the public interest were not prominent in the accounts of many interviewed profession representatives in this study, compared with concerns regarding profession and practitioner issues. Consumer considerations were also muted in the commentaries of interviewed policy actors. Policy actor respondents conveyed a clear reluctance to support further registration irrespective of a profession's risk issues. This was in contrast to the views of almost all consumer advocates that registration was necessary for specific non-registered professions.

The UK Department of Health has noted the need for *“more effective mechanisms for engaging patients and the public in the decision making processes on professional regulation, drawing upon the expertise of stakeholders”* (UK DOH, UK Department of Health, 2009: 11). Wood et al. proposed that one way:

to get more open policy debate is to boost the voices of under-represented groups. This is not always easy. Often groups are poorly represented because they are poorly resourced and organised. (Wood et al., 2018: 67)

Consumer advocacy bodies should be actively encouraged to bring their voices to HPR policy debates. This is consistent with the participatory policy development and co-design principles espoused by governments (DISER, 2020; Holmes, 2011) and the guiding principles of the *Health Regulatory Policy Framework*, which aims to understand the needs and expectations of the community and actively engage and work with stakeholders on regulatory policy (DOHAC, 2020: 21). It is also in keeping with the OECD principles for stakeholder engagement to protect against potential conflicts of interest, guard against the risks of capture by special interest groups, and foster public and stakeholder confidence in decisions and actions (OECD, 2014: 90-91).

Findings from interviews with consumer advocates suggest little effort is being made by governments to proactively engage consumer groups in policy development. In 2020, Health Ministers issued a policy direction to Ahpra and the National Boards to consult with patient safety and healthcare consumer bodies regarding new and revised

registration standards, codes, and guidelines (CHC, 2019: 2). However, there appears to be no policy direction for government policy officers to be subject to the same requirement. Even though several policy actors in this study mentioned deputations from professional bodies to discuss regulation or other professional matters, no consumer advocate stated that policy officers had approached them or their respective organisations to discuss the issues raised by professional bodies.

Arundhati Roy pointed out, *“there’s really no such thing as the ‘voiceless’. There are only the deliberately silenced or the preferably unheard”* (2004, November 3: 1). It is difficult to know the position of policy actors regarding consumer and advocacy voices since consumers were infrequently mentioned in interviews. Recent developments in audiology may offer an insight. In 2017, two consumer advocacy organisations jointly lodged a submission on providing hearing services under the National Disability Insurance Scheme. *Inter alia*, the organisations called on governments to register audiology practice and practitioners to assure parents and carers *“that the audiologists who are and will be delivering services to their children, are qualified and experienced enough to undertake the complex, specialised paediatric work that is involved”* (Parents of Deaf Children and Aussie Deaf Kids, 2017: Appendix 2, page 10). This call appears to have gone unheeded because it took six years for governments to initiate a review of audiology practice and its regulatory arrangements in December 2023. This review was not commissioned because of pressure from advocacy bodies or the risks identified by these groups, but, in part, because of evidence of significant adverse outcomes in paediatric diagnostic audiology and cochlear implant care services (Queensland Government, 2024a: 8).

Van der Heijden observed that *“leading scholars of risk [...] call for the inclusion of ‘subjective’, qualitative data and knowledge of lay people in the assessment and management of risk”* (2019: 9). Consumer advocacy groups must play a key role in health policy development and decision-making, as recommended by various writers (Dower et al., 2013: 1975; Stark et al., 2021: 462) *“even if decision makers do not wish to share decision making power with citizens”* (Stark et al., 2021: 462). While the ultimate decision-making rests with health ministers, as respondents in this study repeatedly

communicated, policy officers should actively engage with consumer groups and work collaboratively in HPR deliberations. This observation was made by Wood et al. regarding policy development, stating, *“citizen engagement is a core responsibility of politicians and public servants”* (2018: 67). Furthermore, a broad cross-section of consumer groups should be consulted to ensure a *“range of voices”* (Wood et al., 2018: 67) are heard regarding health beliefs, healing paradigms, and healthcare practices pertaining to HPR. Despite the claim by an interviewed policy actor that elected governments enjoy community support for government actions on HPR, the inclusion of a range of voices in policy deliberations ensures community wishes are heard and not misinterpreted, since messages delivered to governments via the ballot box may be.

12.4.2 Minimising the reliance on ‘focusing events’

Kingdon observed that a *“focusing event like a crisis”* had a tendency to capture the attention of and prompt government action (2003: 94-95). In Australian healthcare, such ‘focusing events’ have been responsible for the only profession-specific reviews for registration since the establishment of the NRAS, for paramedicine, social work, and audiology.

In 2012, the Western Australian (WA) Government issued a consultation paper on options for regulating paramedics. This action occurred following a St John Ambulance¹¹² Inquiry (AHMAC, 2012: 3), instigated by the WA Health Minister after a 2009 Australian Broadcasting Corporation (ABC)¹¹³ Four Corners program reported on *“four deaths resulting from inadequate responses by the ambulance service”* (AHMAC, 2012: 45). Paramedics were registered under the NRAS in 2018.

¹¹² St John Ambulance is an organisation operating mainly in Commonwealth countries. St John Ambulance teaches first aid and provides first aid, ambulance, and emergency medical services. See: <https://stjohn.org.au/about>.

¹¹³ The Australian Broadcasting Corporation is Australia's national broadcaster. It is principally funded by the Australian taxpayer and is administered by a government-appointed board. The ABC is a publicly owned body that is politically independent and accountable. See: <https://www.infrastructure.gov.au/media-communications-arts/national-broadcasters/australian-broadcasting-corporation-abc>.

Following the deaths of two children in South Australia in 2011 and 2012, and “numerous state-level inquiries [that] have called for the registration of social workers” (*Social Workers Registration Bill 2018* (SA): 9), the South Australian Government proceeded with the registration of social workers in the state after the Health Ministers’ Meeting decided not to proceed with national registration (COAG, 2016: 2). Social workers will officially require registration in South Australia commencing 1 July 2025.

At the December 2023 Health Ministers’ Meeting, a review of regulation arrangements for audiology was announced (Queensland Government, 2024a: 3). This national review follows three hospital-based reviews, one in 2018 and two in 2023, resulting from significant adverse outcomes experienced by paediatric patients from failures in diagnostic audiology and cochlear ear implant care services (Queensland Government, 2024a: 8).

Registration of paramedicine, social work, and audiology was considered necessary before these focusing events, communicated in the documents analysed, but government reviews were only initiated once the focusing events occurred.

One further example illustrates the tendency of governments to delay action until a focusing event forces it, and, once forced, the speed with which governments and their agencies can act. In another ABC Four Corners program on 25 October 2021 (ABC Four Corners, 2021), a documentary on cosmetic surgery was aired, during which serious adverse effects of treatment for over 100 patients and serious hygiene and safety breaches were alleged (Ferguson & Day, 2021). One month later, on 30 November 2021, Ahpra and the Medical Board of Australia announced the establishment of an independent review of the regulation of medical practitioners performing cosmetic surgery (Ahpra and Medical Board, 2022: 4). In less than two years, legislation was passed to restrict the use of the title of ‘surgeon’ (DOHAC, 2023b) and new practice and advertising guidelines for cosmetic surgery practice were introduced (Medical Board of Australia, 2023). Yet problems with cosmetic surgery were identified 13 years before the ABC Four Corners program. As early as 2008, the South Australian Minister for Health identified growing concerns in the advertising and marketing of cosmetic procedures (AHMAC, 2011a: 15). This prompted a review by a Health Ministerial

Working Group which, in 2011, recommended a national framework to *“provide consumers with some assurance of consistency in standards of conduct in the cosmetic medical and surgical industry”* (AHMAC, 2011a: 6). In 2014, as part of the independent review of the NRAS, the Cosmetic Physicians Society of Australasia called for practice restrictions to be imposed on cosmetic medicine and surgery (AHMAC, 2014b: 41). No known action was taken nationally to tackle the issues concerning cosmetic procedures until the ABC Four Corners program went to air seven years later. As one profession representative remarked in an interview, *“If you’ve been featured on Four Corners, that’s really helpful”* (PBR6).

These are not the only examples where recommendations for further regulatory intervention appear to have remained unactioned for extended periods. For instance, additional occupational regulation or registration measures have previously been recommended for professions such as counselling and naturopathy (Lin et al., 2005: 14; NSW Joint Committee, 2006: xi; SA SDC, 2009: 1, 5), but appear to have remained unactioned, perhaps because they have yet to experience a focusing event, or at least one that receives sufficient media attention. The apparent disregard of government-commissioned review recommendations for statutory registration or greater regulatory oversight is not limited to Australia. Despite a 2009 recommendation from the CEO and Registrar of the UK Health Professions Council to the Secretary of State for Health for the statutory registration of sonographers (Seale, 2009, October), the profession remains unregistered.

Focusing events like those described should not be how issues find their way onto the HPR policy agenda. Actions taken by governments appear to be reactions to the potential political risk exposed by crises. Haines stated, *“the primary problem infusing regulatory reform is the reduction of political risk”* (2011: 232). As it stands, HPR policy for non-registered professions is reactive to crises that may be construed as exposing governments to political risk. There is no consideration of the precautionary principle where action is taken *“when credible threats of harm exist”* (Wu et al., 2023: 2). Moreover, there is no proactive HPR reform agenda, as there appeared to be before the NRAS, where Australian jurisdictions conducted reviews and inquiries to assess

appropriate regulation arrangements for health professions (see for example, Bensoussan & Myers, 1996 review of Chinese medicine; Lin et al., 2005 review of naturopathy and Western herbal medicine; NSW Joint Committee, 2005 review of Chinese medicine; NSW Joint Committee, 2006 review of Chinese medicine, counselling, dietetics, massage therapy, naturopathy, occupational therapy, social work, speech pathology, Western herbal medicine; SA SDC, 2009 inquiry into unregistered health practitioners). It could be argued that establishing the NRAS effectively halted ongoing sub-national jurisdictional HPR reform, but without any planned agenda for national, proactive, systematic assessments of further professions to replace these sub-national reviews.

Despite the rhetoric of public protection being the paramount guiding principle of the NRAS (CHC, 2020: 1-3), delaying action on recommendations for registration or assessments of practice risks until a crisis or series of crises demonstrates the significance and severity of the risks of practice is a breach of the public's trust in governments. In contrast to the swift action taken on cosmetic surgery once the significance of the problem was aired on national television, it has taken nine years for the NCC to be legislated and implemented in six of eight Australian jurisdictions. Two jurisdictions had already legislated and implemented the NCC prior to its agreement nationally in 2015 (CHC, 2015b: 1). Four jurisdictions legislated and implemented the NCC over a ten-year period to 2024. The remaining two jurisdictions have not yet legislated and/or implemented the NCC. Furthermore, unlike the NRAS, in jurisdictions where the NCC has been legislated, each state and territory has implemented the NCC differently according to the dictates of their jurisdiction, with inevitable inconsistencies, as highlighted by a profession representative in an interview.

12.4.3 Enhancing registration assessment guidelines

Alderson and Montesano argued that decisions on when to regulate an activity should be based on an analysis of public interest criteria that justify regulation (2003: 16). The authors claimed that public interest criteria aim:

to provide some objective standards against which to measure the public interest. [...] criteria allows for the assessment of a request in terms of objective

and verifiable (evidence-based) standards without recourse to political argument. A criteria-based request process allows for a pro-active, open and accountable assessment of the regulatory request to ensure that it is the public interest that is being served rather than the interests of those who seek regulation or the interests of those who grant regulation. (Alderson & Montesano, 2003: 16)

The IGA assessment criteria and process for adding new professions to the NRAS were established to achieve national consistency in decisions about the registration of health professions (AHMAC, 2018a: 7). The consultation paper for the Complexity Review notes evidence that the IGA assessment criteria and process *“accords with international best practice regulation principles”*, including a *“published and transparent process for regulatory assessment which complies with rigorous whole of government Regulatory Impact Assessment protocols”* (Dawson, 2024: 72, 73). As they exist today, the criteria and process attempt to avoid subjective evaluations of professions and provide an evidence-informed examination based on risk and other assessment criteria. A rigorous and transparent assessment mechanism limits the influence of opinions and beliefs of individual agents. It helps to curb the exercise of symbolic power by the state or other social actors. Findings from this research, however, suggest that even though there are tools available in the IGA assessment criteria and process that are intended to make decision-making more rational, rigorous, and accountable, social actors who are involved in or in a position to influence the policy process bring other perspectives that inform how non-registered professions should be regulated. It appears that old patterns, habitus, and the values and beliefs of respondents, doxa, are so dominant and entrenched that even when assessment processes have been designed to resist these forces through the establishment of formal criteria and procedures, they persist. Findings from this study indicate that the habitus and doxa undergirding respondent perspectives are so durable and resistant to change that most interviewed policy actors viewed the unwritten rules they applied for NRAS entry reflected a logical conviction of how reality is and should be for HPR decision-making.

The diverse views of study respondents regarding regulation for non-registered professions indicate the need for a mechanism of assessment that minimises the opportunity to interpret criteria and influence policy decisions in ways contrary to the

public interest. A first step in overcoming these forces to achieve policy decision-making based on criteria and established processes may be to acknowledge these forces, which this thesis has sought to accomplish, and design processes to withstand these inherent pressures. Until then, attitudes, opinions, perspectives, and experiences of certain healthcare stakeholders, such as powerful professional associations, policy advisers, and policy officers, will continue to have an undue influence on evidence-informed policy-making.

Interviews with some consumer advocates and profession representatives suggested that support for registration was more likely if the respondent had experience with or was knowledgeable about the profession. Several policy actors spoke of their lack of knowledge about non-registered professions. One interviewed policy actor stated, *“that’s a bit of a blind spot, I think, at least for me, and possibly in our wider area [...] in terms of these unregistered [...] professions.”* (GPA4). This ‘blind spot’ may be a further reason for government inaction on HPR for these professions. The perceived unfamiliarity of policy officers about non-registered professions was also identified by a few interviewed profession representatives and a consumer advocate, the advocate stating, *“I think a lot of this [inconsistency between registered and non-registered professions] is based on people not understanding what those professions do”* (CA1).

There is a need for tools to improve consistency and reduce subjectivities in HPR decision-making, particularly for risk assessments. Not all subjectivities in assessments and policy-making can be designed out, but perhaps the existing assessment criteria and process require elaboration or revision. While acknowledging the existence of the IGA assessment criteria for entry to the Scheme, the 2014 independent review of the NRAS identified stakeholder misunderstanding of the purpose and threshold for entry, confusion over the assessment criteria, and the need for further guidance to applicant professions, particularly in the area of risk (AHMAC, 2014b: 15, 24-27).

An attempt at clarification was made in 2018 (AHMAC, 2018a: 14-17), but this does not go far enough. The confusion and lack of clarity over the assessment criteria and process meant that interviewed profession representatives and policy actors applied their interpretations of the criteria and process to advocate for or argue against registration.

An example of the type of guidelines developed to facilitate compliance with government requirements comes from the Australian Government Therapeutic Goods Administration (TGA)¹¹⁴. In 2022, the TGA released detailed guidelines specifying the evidence required by medicine sponsors to demonstrate the efficacy of listed medicines and help sponsors understand their regulatory requirements regarding holding that evidence (TGA, 2022). The TGA established learning modules and a webinar to further assist sponsors in meeting their legislative obligations (TGA, 2023). The guidelines were also designed to help policy officers decide on the suitability of evidence rather than making their own interpretations. A similar commitment appears warranted to improve policy guidance for professional bodies wanting to progress HPR professional claims and for policy officers responsible for assessing and providing policy advice on those claims. Detailed guidelines and resources of the type established by the TGA would give professions and policy officers greater clarity on the requirements for meeting IGA assessment criteria for NRAS entry and provide transparency on how and why HPR decisions are made.

12.4.4 Re-establishing government stewardship of HPR reform

The NRAS was established to protect the public, facilitate workforce mobility, drive the provision of high-quality education and training, and enable innovation in education and service delivery. The National Scheme aims to enable the continuous development of a flexible, responsive, and sustainable Australian health workforce (COAG, 2008a: 3). Before the NRAS, more than 100 state/territory government bodies were involved in registering practitioners and accrediting education and training courses, resulting in fragmentation of responsibilities, ineffective coordination between responsible parties, and inflexible regulatory practices subject to influence by professional bodies (Productivity Commission, 2005: XIX). Some of these problems may, in part, be attributable to federalism. While the initial aim of the NRAS is largely agreed to have been achieved for the 16 registered professions, according to interviewed policy actors,

¹¹⁴ The TGA is an Australian Government authority responsible for evaluating, assessing and monitoring products that are defined as therapeutic goods. The TGA regulates medicines, medical devices, and biologicals, blood, tissues, and advanced therapies. See: <https://www.tga.gov.au/>.

the findings presented from this research indicate HPR fragmentation, ineffectiveness, inflexibility, and conflict of interest remain for the non-registered health workforce. In the HPR field in Australia, the purpose of the NRAS is clear and widely agreed upon. Processes exist for assessing professions for registration, although better guidance for professional and policy stakeholders is needed.

Despite an HPR policy position requiring professions to advocate for their registration, other voices 'unheard' by policy officers are professional bodies calling for government action to overcome the perceived inadequacies of self-regulation, calls that profession representatives stated remained unheeded by government. In interviews, some policy actors suggested that all a profession needs to do is show that it meets the IGA criteria, and a formal assessment for registration will follow. However, other factors were presented that forestalled engagement with policy officers, deterred associations from seeking registration, and prevented formal assessments from taking place. The present research indicates that respondents from every stakeholder cohort demonstrated partiality towards some professions and prejudice against others. The IGA assessment criteria and process for inclusion in the NRAS were arguably established to take the power and politics, bias and subjectivity out of decision-making. From its inception, the NRAS has been misused to embed power relations and the use of various capitals against non-registered professions, as communicated by profession representatives who maintained that distinctions between registered and non-registered professions commenced shortly after the NRAS was established. While some of these distinctions may have been unintended, one policy officer indicated that NRAS was deliberately weaponised to exclude non-registered professions. Unintended consequences and misuse of NRAS were identified as early as the first review of the Scheme (AHMAC, 2014b: 25-26), were communicated in documents analysed for the present research, and were described by profession representatives interviewed for this study. The misuse of NRAS is potentially exacerbated by an inadequate HPR reform agenda that has tended to assess non-registered professions as a group, rather than as individual professions, as occurred with paramedicine and, more recently, audiology. One of the recommendations in the final report of the 2014 NRAS review was for the Ministerial

Council to issue “a *communiqué* stating that [...] (the National Scheme) is for the purpose of additional regulation of specified professions only and is not to be used for any other purpose” (AHMAC, 2014b: 6). A *communiqué* was issued four years later (CHC, 2018).

The use of political and capital resources against non-registered professions, as conveyed in interviews with all stakeholder groups, is reinforced by a model that requires the professions themselves to apply for NRAS entry, thereby concentrating power in the Ministerial Council and its advising officers as gatekeepers to the NRAS. It is a model that permits conflicts of interest to flourish among the professional bodies that do and do not ‘apply’ based on their regulation preferences rather than occupational risks. In practice, assessment and decision-making about HPR occur in a manner counter to what the *National Law* was meant to achieve for Australian healthcare. It has, according to most profession representatives, created many of the problems for the non-registered workforce that it was designed to solve for the registered professions. Findings from this study suggest that the *National Law* with its supporting government and agency apparatus has become a power and political entity in and of itself, allowing government policy officers the latitude to use a range of capital resources imbued with symbolic power, a bureaucratic habitus, and doxic beliefs to deter, discourage, and even defeat non-registered professions, as suggested by comments of resigned acceptance from some profession representatives seeking NRAS entry. Despite claims ministers are “*always happy to talk to stakeholders and meet with them*” (GPA5), the study findings suggest some policy actor participants preferred the voices of profession stakeholders to remain ‘unheard’ or even ‘silenced’, except for those possessing the ‘right’ cultural, social, and symbolic capital. Jones noted the “*daunting odds*” proponents of new regulation face, because getting onto the political agenda requires “*crossing the legitimacy barrier*”, gaining the attention of government, and battling against entrenched interest groups (2016: 32). These same daunting odds were expressed by many profession representatives in this study when communicating their attempts to achieve their regulation goals.

Governments have devolved to professional bodies the responsibility for establishing a case for registration based on unclear guidelines and with little chance of engagement

with policy officers or ministers to progress their claims. Many consumer advocates and profession representatives taking part in this study considered that government action was needed to register certain non-registered professions. Yet HPR is embedded in a system that operates to prevent action by allowing other factors and powerful professional groups to influence decision-making processes, according to the views of most respondents in every interviewed stakeholder cohort. Inaction by governments has tethered non-registered professions to the self-regulation field, irrespective of practice risks, a problem that appears intractable from the perspectives of many profession representatives. For HPR policy to meet the needs of consumers, reforms are needed to the HPR assessment process that remove the onus of responsibility for pursuing registration from the domain of professional bodies and re-establishes the role of governments in setting an HPR reform agenda, as occurred prior to NRAS. The NRAS exists to serve the interests of patients and consumers. Entrusting professional bodies with the responsibility of making a submission for registration when the association's role is to protect the interests of the membership is not appropriate, an observation made by an interviewed profession representative. Abnegating responsibility for proactively assessing the regulatory settings of health professions potentially sets the system up to fail, as even minor opposition to regulation, sometimes orchestrated to protect interests other than the public's, can easily prevent action. The inability of professional associations to progress their claims with ministers because of opposing influences was suggested by respondents in all stakeholder cohorts when giving views about the influence of powerful registered professions, obstructive behaviours by policy advisers, or the perverse actions of conflicted professional association leaders seeking to maintain the status quo. Delegating to professional associations the responsibility for pursuing registration is costly in time, finances, skills and expertise that applicant professions may be unable to muster. It is unnecessarily wasteful of an association's time and resources when claims fail to proceed, and disadvantages smaller professions that do not have the resources to commit to such an endeavour.

Russell and colleagues, drawing on Aristotle, observed that uncertainty in the policy arena is generally a problem of action rather than a problem of evidence (2008: 43). This

distinction was apparent in the views of policy actors, most of whom identified the need for greater regulation for certain non-registered professions and described actions professional associations could take to progress their claims. Yet not one of these policy actors was willing to consider registration for these professions, preferring instead to suggest 'bolt-on' mechanisms and measures such as a *"Commonwealth proposal"* (GPA11), a *"lower level"* of registration (GPA1), *"different layers"* of regulation (GPA4), or *"a different scheme"* (GPA8), potentially *"because it might be easier"* (GPA8).

The opinions of some policy actors, as conveyed in interviews, do not adhere to the guiding principles of regulatory stewardship in health policy, such as valuing regulation as an asset to protect consumers, effectively engaging with stakeholders, and ensuring that regulation is fair (DOHAC, 2020: 21, 23, 27). If policy officers are taking into account factors beyond the IGA assessment criteria in their deliberations, this does not maintain trust in the system, a view stated or suggested by many consumer advocates and profession representatives. If officers are beholden to the established power dynamics dictated by powerful professional groups, this is not good regulatory governance. If there is little accountability or transparency in the way the IGA assessment criteria and process are deployed, then this, too, is not good regulatory governance.

To maintain public confidence in the objectivity and impartiality of decisions, ministers and policy officers need to be independent and need to be seen to be independent by acting with integrity, impartiality, and consistency, and having provisions for preventing undue influence (OECD, 2014: 46-47). For example, decisions regarding regulation should be publicly available, together with stated reasons for the decisions (OECD, 2014: 80). An example where this did not occur in Australia is the decision not to proceed with the national registration of social workers, with no publicly stated reasons given (CHC, 2016: 2).

12.4.5 Reviewing the regulatory settings of non-registered professions

Despite its claim of implementing best practice regulation (DOHAC, 2023a), Australia may be lagging other nations in regulating its healthcare workforce and protecting its citizens. Of the fifteen non-registered professions examined in this research, eleven are

registered in at least one international jurisdiction: audiology, counselling, dietetics, massage therapy, naturopathy, orthoptics, paramedicine, psychotherapy, social work, sonography, and speech pathology (see Chapter 1, Table 1.3). A few examples to illustrate the differences include that dietitians are registered in several reviewed Canadian provinces, Aotearoa/New Zealand and the UK, and psychotherapists and sonographers are registered in two reviewed Canadian provinces and Aotearoa/New Zealand. While not denying the decision-making powers of national or sub-national governments regarding which professions to register, these differences suggest such decisions may be subject to influences beyond formalised criteria and risk assessments. The present research points to some of these factors, including habitus and doxa and the influence of economic, cultural, social, and risk capital. One policy actor in this study stated that the international differences in health professions subject to statutory forms of HPR may be because government decision-making is subject to influences from the political and cultural settings of different nations. Context- and setting-specific fashioning of HPR policy is supported by the WHO, which stated that:

The foundation of an effective approach towards meeting regulatory goals is to understand the local context, including the social, cultural, economic and population health needs, the health system's capacity, workforce capability and public expectations. (WHO, 2024: 28)

Hence, governments and their officers should assess these various factors in their deliberations regarding which professions to register. The task commenced with the IGA in 2008 to reform HPR in Australia is not complete and may never be, a comment articulated by a policy actor who remarked, *"this fiction about it being a reform project needs to be abandoned. [...] It's constant. It's never going to stop"* (GPA8). Since the establishment of the National Scheme, there have been several reviews on different aspects of the NRAS (Ahpra, 2024c), as well as numerous changes to the *National Law* (Ahpra, 2024b). In contrast, between 2010 and 1 December 2023, only one proactive review of the regulation arrangements for a range of non-registered professions had been commissioned (AHMAC, 2013), two completed reviews of regulation arrangements for single professions, paramedicine and social work, were completed, both resulting from focusing events, and a Scope of Practice Review, commissioned in

April 2023, which recommended a “*public interest*” pathway into the NRAS for certain non-registered professions (Cormack, 2024: 123). The almost complete focus on the registered workforce to the neglect of non-registered professions requires redress as a matter of priority. Further reviews of non-registered professions are warranted. Since 1 December 2023, two further reviews potentially impacting the HPR settings for non-registered professions have been commissioned. The review of audiology, commissioned on 13 December 2023, has in-principle agreement from the Ministerial Council but is yet to be completed (Queensland Government, 2024b: 3). The Complexity Review of the NRAS, commissioned on 29 May 2024, considered further regulatory arrangements for the non-registered professions but has yet to be finalised (Dawson, 2024). Among its terms of reference, the Complexity Review was tasked with considering if the IGA assessment criteria for entry to the NRAS “*are still fit for purpose [...] particularly in relation to allied health professions*” (Dawson, 2024: 17). The review consultation paper supported further examination and scrutiny of the non-registered health workforce, stating, “*the policy alternatives to registration through the National Scheme have not been revisited in a systematic way for the last decade*”, and there is “*no system-wide view of how the broader health workforce is or should be regulated*” (Dawson, 2024: 75-76). The review emphasised the need to establish a formal process for gathering evidence of risks posed by non-registered professions (Dawson, 2024: 89-90).

As with previous multi-profession assessments, the Scope of Practice and Complexity reviews may not comprehensively assess risks of practice of non-registered professions, as the paramedicine example suggests. Furthermore, in the past decade, scopes of practice have broadened, and task shifting and task substitution have advanced, potentially exposing consumers to further risks (Alderson & Montesano, 2003: 15; DOHAC, 2024d: 10). In light of this, profession-specific reviews are needed to assess the risks of each non-registered profession. This is in keeping with the guiding principles of the *Health Regulatory Policy Framework*, which stipulates that the Australian Government, with the states and territories, will regularly monitor and review regulation to ensure it remains fit-for-purpose (DOHAC, 2020: 10, 27). While sixteen

health professions have been nationally registered under the NRAS, more than 60 other professions remain outside the Scheme, 15 of which have been the subject of this research. This is not to suggest all health professions should be registered. However, until a comprehensive review of each health profession is conducted based on formal criteria and objective assessments, the extent of risk and potential for consumer harm and corresponding eligibility and suitability for registration remain unknown. Accordingly, any claims of the evidence-informed and best-practice nature of HPR policy in Australia (DOHAC, 2023a) cannot be sustained.

The notion that HPR is dynamic and requires ongoing monitoring and improvement is a view reported in the literature (Mahat et al., 2023: 601). This suggests that HPR requires an ongoing reform agenda. In 2015, the UK Professional Standards Authority wrote that HPR required a “*radical overhaul*” to support changes to the healthcare workforce (UK PSA, 2015: 1). The Authority stated:

Each new organisation, and each new regulatory intervention, has been created in response to specific stimuli without the benefit of an overarching design, a controlling intelligence, or a coherent set of principles. (UK PSA, 2015: 5)

In documentary sources and stakeholder interviews, several profession representatives and a few policy actors spoke of the complex, fragmented, and confusing regulation arrangements for non-registered professions, which were considered or suggested to be ineffective and inefficient. Two respondents, a profession representative and a policy actor, described these arrangements as a “*hodgepodge*”¹¹⁵. Several interviewed policy actors and profession representatives commented on the “*Commonwealth proposal*”. The proposal was widely criticised by profession representative respondents, one describing it as “*lowering the bar*” on standards and another considering the proposal piecemeal, tokenistic, and a “*dog’s breakfast*”¹¹⁶ because of incomplete coverage of professions and inadequate consumer protection measures. It was also suggested by a

¹¹⁵ Hodgepodge is defined by the Cambridge Dictionary as “*a confused mixture of different things*”. See: <https://dictionary.cambridge.org/dictionary/english/hodgepodge>.

¹¹⁶ Dog’s breakfast is defined by the Cambridge Dictionary as “*something or someone that looks extremely untidy, or something that is very badly done*”. See: <https://dictionary.cambridge.org/dictionary/english/dog-s-breakfast>.

few respondents to be another regulatory layer with no connection to or coherence with existing mechanisms.

Gunningham and Rees stated, *“the most effective self-regulatory initiatives have involved an underpinning of government regulation, or third-party oversight, or more commonly both”* (1997: 406). Priest claimed that self-regulation was most likely effective under certain conditions. These include where expertise and resources were available to regulate the profession appropriately, there were relatively few industry players, there was a history of effective cooperation, consumers valued compliant behaviour and non-compliance could be punished, fair and adequate complaint mechanisms were in place, and there was an opportunity for public participation or oversight of the regulated party (1998: 301-302). Even though there was some support for self-regulation by respondents in the present study, most interviewed profession representatives and consumer advocates, and some policy actors identified weaknesses in each of the conditions detailed by Priest. Priest concluded her review of five models of self-regulation by observing that:

Self-regulation appears to work best where the government maintains a presence, either through supervision of self-regulatory functions or through residual enforcement powers. [There is...] sufficient evidence of regulatory failures to indicate that the government cannot completely abdicate responsibilities to self-regulators in those areas where there is evidence of a regulatory problem that indicates the need for a government regulatory response. (Priest, 1998: 302)

Such a need was identified by most interviewed consumer advocates and profession representatives. These respondents perceived that direct government involvement in regulating health professions was necessary to avoid the failures they had identified with self-regulation. Most policy actors also spoke of the need for further regulation of certain non-registered professions to manage the risks of occupational practice. While none of these policy actors proposed registration for these professions to deal with issues associated with self-regulation, most consumer advocacy and professional body respondents leaned towards statutory registration for several of the professions. However, irrespective of stakeholder preferences, a review of the regulation

arrangements of non-registered professions is required. This move would be consistent with guidance issued by WHO, which stated:

A universally applicable, ideal model of a health practitioner regulatory system does not exist. [...] health practitioner regulatory systems and their appropriateness should be evaluated periodically to identify any need for reform. Such reforms may range from incremental changes to an overhaul of the entire regulatory system. (WHO, 2024: x)

12.5 Recommendations

The individual and group habitus and doxa proposed by this thesis to operate in the HPR field in Australia describe the conditionings and belief systems of social actors and the spaces they inhabit. Findings from this research show that individuals in each stakeholder cohort had different perspectives of reality. Individuals often expressed views suggesting a different habitus and doxa from others in the same and other stakeholder cohorts. For instance, while some stakeholders shared opinions on the characteristics of a profession that they considered justified registration, they had different views about which professions demonstrated those characteristics.

To better deal with these subjectivities, I have drawn together a series of recommendations to assist in moving the policy discourse beyond individual and group habitus and above considerations of ideology informing agent actions. These recommendations aim to move the dialogue to a habitus and rule system encompassing the entire HPR field that aims to support decision-making and policy development in keeping with the guiding principles of the *Australian Health Regulatory Policy Framework*.

Recommendation 1

To ensure public protection available under NCC legislation is extended to all Australians and to complete the national rollout of the National Code, remaining jurisdictions should immediately implement the NCC where legislation has been passed and NCC legislation should be passed and implemented as a matter of urgency where no legislation exists.

Rationale

Due to the absence of an enforceable NCC in the Northern Territory and Tasmania, consumers of non-registered health services in these jurisdictions have fewer safeguards to deal with issues resulting from poor practice. Health complaints entities in these jurisdictions also have fewer options for dealing with complaints about practitioners.

Recommendation 2

To improve consumer complaint data reporting and ensure national consistency, amend health complaint entity legislation in every state and territory to include the mandatory, disaggregated annual reporting of complaints for each health profession against which a complaint is received, including that reporting of complaints be nationally consistent.

Rationale

Detailed reporting of complaints by almost all jurisdictional health complaints entities is non-existent or insufficient for proper analysis of complaint trends, identification of professions with problematic complaint profiles, and for educational purposes by professional bodies. The annual reporting of complaints by the New South Wales Health Care Complaints Commission is a useful model for this legislative change (NSW HCCC, 2024). The amended legislation could be introduced via jurisdictional NCC Acts, the *Medicare Agreements Act 1992* (Cth), or other existing mechanisms.

Recommendation 3

To ensure national consistency in the application of the NCC and to assess its effectiveness, health ministers should initiate an independent review of jurisdictional NCCs as a priority to identify potential amendments and provide adequate and comprehensive protections for consumers, including assessing the effectiveness of health complaints entities in enforcing NCC provisions (Freckelton, 2008: 418).

Rationale

The effectiveness of the NCC as a regulatory mechanism for non-registered professions is unknown. Despite published research pointing to examples demonstrating the effectiveness of prohibition powers under jurisdictional NCCs (Freckelton, 2020), the

NCC has never been reviewed by government, even though a review was recommended in the final report for its establishment a decade ago (CHC, 2015d: 7, 72).

Recommendation 4

To provide further clarity and guidance to professions and policy officers on the range of physical, mental, financial, and other risks of consumer harm, health ministers should initiate a review of the IGA assessment criteria and process. The review should involve a cross-disciplinary working group comprising consumer advocates, a range of registered and non-registered professional body representatives, and HPR policy officers, to ascertain the nature, breadth, and diversity of potential patient harms of non-registered healthcare professions and establish the threshold level of risk signalling registration may be indicated.

Rationale

There was considerable diversity of opinion or uncertainty among stakeholder respondents about the criteria and decision-making process regarding registration eligibility. Study participants introduced factors unrelated to the criteria as having a bearing on whether to register a profession. Some policy actor informants had a limited view of harm, and a policy actor stated that the Office of Impact Analysis should broaden its perspective on the criteria and its view of risk in its decision-making. Further guidance on the criteria and process is required to provide greater clarity to stakeholders and achieve greater consistency and fairness in registration decision-making outcomes.

Recommendation 5

To boost the engagement of consumer advocates in participatory policy development and be more open and transparent about decision-making, health ministers should establish formal channels for the inclusion of consumer bodies in HPR policy-making, including in the evaluation of professions for registration consideration prior to formal assessments against the IGA criteria. Furthermore, an enhanced role for consumer bodies in reviewing the IGA assessment criteria should be instituted (see Recommendation 4) and is consistent with the guiding principles of the Australian *Health Regulatory Policy Framework* to understand the needs and expectations of

consumers and actively engage and work with stakeholders (DOHAC, 2020: 21). These engagement mechanisms should be institutionally structured, inclusive, and transparent (OECD, 2014: 93-94). The mechanisms should include a range of consumer bodies for widespread consultation and involvement in HPR policy-related matters.

Rationale

Findings from this research indicate consumer advocacy bodies have little input in HPR policy consultations and no involvement in the pre-assessment stage of considering a profession for registration. The findings also suggest that governments make little effort to proactively engage consumer advocacy groups in HPR consultations and policy development. In the spirit of co-design and participatory policy development principles, consumer voices must be amplified in HPR policy debates and policy-making through the deliberate and active engagement of consumer advocacy groups by government officers.

Recommendation 6

To ensure appropriate regulatory settings are established for each health profession, health ministers to assume responsibility for proactively initiating registration reviews without relying on submissions from professional bodies. While professions may still lodge submissions for registration consideration, the onus of responsibility for initiating reviews of regulation arrangements should be removed from the remit of professional bodies. In calling for governments to take proactive ownership of registration reviews, I agree with statements from a stakeholder in a submission to the 2005 Productivity Commission's review of Australia's health workforce in which the Commission called for strong leadership to implement policy reform. The stakeholder remarked:

I am sure workforce reform requires, most of all, courage by health ministers, governments and senior officials to face down the powerful vested interests that oppose reform of the workforce and want to protect their privileged positions. Ministers, governments and officials must win the case for change and drive the process. (Menadue, 2005, cited in Productivity Commission, 2005: 307)

Rationale

Findings from this research demonstrate the limitations of devolving to professional bodies the responsibility of ‘applying’ for registration and self-assessment against the IGA criteria. This process was reaffirmed as part of the 2008 Intergovernmental Agreement (COAG, 2008a: 22) and may have led to dysfunctional behaviours from professional bodies, as indicated by the findings from this study. These behaviours include pressing for registration for reasons other than public protection or satisfying other assessment criteria, or accepting the expediency of government inaction to maintain the status quo. By relinquishing ownership of the initial step of identifying professions for potential registration, governments have allowed professional bodies the latitude to make representations not necessarily according to the most appropriate type of regulation for the risks of practice but according to preferences based on personal, professional, or political convictions.

Recommendation 7

To ensure appropriate regulatory settings are established for each health profession, health ministers should initiate a comprehensive review of non-registered health professions, commencing with the professions included in this research. The review should consist of a thorough examination of practice scopes, settings, and risks and be conducted in collaboration with consumer advocacy bodies to determine which professions should be reviewed and in what order. This could be facilitated by proceeding with the review in a series of tranches based on health service type. For instance, practitioners in the mental health disciplines, such as counsellors and psychotherapists, and psycho-social disciplines, such as social workers, could be reviewed in one tranche. Practices prescribing ingestive treatments such as dietetics, naturopathy, and Western herbal medicine may form part of a second review. Bodywork practices such as exercise physiology, massage therapy, and myotherapy may be another tranche. Professions in the special senses disciplines, such as orthoptics and speech pathology, may comprise a fourth review. To expedite the reviews, these assessment tranches may be conducted in parallel, led by different states or territories.

Rationale

The final key finding from the present research is widespread commentary from study respondents, including many policy actors, that further regulation of certain non-registered health professions may be required, although there was no common view about the professions to which this applied. Previous unactioned government reviews of non-registered professions also present evidence of the need for further regulatory measures. To determine which professions require further regulation, an HPR reform agenda is needed to proactively assess professions for actual risk and other assessment criteria. Establishing an HPR reform agenda for non-registered professions is in accordance with the Australian Government's life cycle approach to regulation, in which a guiding principle is that *"regulation is regularly monitored and reviewed to ensure it remains fit-for-purpose [and] is fair, transparent and resilient"* (DOHAC, 2020: 16, 27).

12.6 Limitations

This research has presented a number of study findings that contribute to the field of HPR policy scholarship. Even so, the research has several limitations to be noted.

First, the data obtained from document sources and stakeholder interviews are self-reported perspectives and perceptions. The research was designed to introduce greater rigour by broadening the data types collected and using varied data analysis methods. Broadening the data types was achieved through the inclusion of what Goffman referred to as *"frontstage"* and *"backstage"* communication (1959: 128). This study gathered frontstage communication from public domain document sources, and backstage communication was captured through stakeholder interviews. The document dataset was drawn from publicly available communication where commentators presented an account produced for public consumption. Hence, there may be response biases in these documents. To mitigate the potential bias from stakeholder self-reporting, a large corpus of documentary artefacts comprising a range of document types was collected. To mitigate potential recall bias from interview respondents, 42 interviews with 46 participants were conducted across three stakeholder cohorts.

Second, although a considerable number of interviews were conducted with professional body representatives and policy actors (26 and 15, respectively), the number of consumer advocates recruited was low, with just five agreeing to be interviewed, despite the best efforts of the researcher. While the volume of data generated from interviews with consumer advocates was considerable, further research with a larger sample of consumer advocates from a greater range of patient and consumer advocacy groups would be beneficial to further explore consumer advocacy perspectives regarding HPR.

Third, due to the SARS-Cov-2 (COVID-19) pandemic at the time of conducting this study, most interviews were held via videoconference, and one was conducted by telephone, where the intention was to conduct face-to-face interviews wherever possible. Videoconferencing and telephony communications may have altered the interview dynamics and impacted which participants were nominated for an interview. On the other hand, the perceived convenience of videoconferencing may have encouraged interview participation.

Finally, restricting this research to a single country limits the generalisability of findings beyond Australia. Broadening the research base by including international jurisdictions would have meant circumscribing the breadth of the study, such as eliminating one or more stakeholder cohorts or non-registered professions. Including other countries may have also necessitated limiting the depth of research by reducing the number of interviewees or stakeholder documents. The study, as conducted, should attract broad international interest for its findings on the perspectives of three stakeholder cohorts regarding fifteen non-registered professions, and provide guidance on a method for the data sampling, collection, analysis, and interpretation of these perspectives.

12.7 Future research

For scholars interested in health practitioner regulation, the findings presented in this thesis invite further research regarding the way in which policy decisions about HPR are made. Building on the work presented, future examination of this topic might explore five research avenues.

First, an important area for possible research is an HPR policy implementation evaluation of the NRAS to determine the factors required to ensure the NRAS is being implemented according to its intended purpose.

Second, extending on the NRAS policy implementation evaluation, it would also be of value to conduct a second policy implementation evaluation to examine the regulatory 'complexity', inefficiencies, and costs associated with self-regulation and co-regulation for non-registered professions. This would provide valuable information and baseline data on the actual costs and resources required for self-regulation compared with registration to facilitate more accurate cost-benefit analyses.

Third, research examining the HPR policy processes and how issues, such as registration for a profession are placed on the government policy agenda would help elucidate how these items come to the awareness and become the predominant concern of decision-makers, including negotiations between different interest groups, policy officers, policy advisers, and relevant ministers.

Fourth, the perspectives offered by advocates were drawn from their positions as consumer advocates and not necessarily as consumers of non-registered health services. Further research and data on consumer views of non-registered health services would be advantageous in determining the public's perceptions of HPR for non-registered professions.

Finally, this thesis has identified habitus as an important underpinning element influencing stakeholder perspectives. More investigation into how habitus influences decision-making would be a beneficial addition to research scholarship.

12.8 Reflections on the use of Bourdieusian theory in HPR research

Applying a Bourdieusian framework to the HPR field for non-registered professions has been of value in furthering the understanding of stakeholder perspectives. Engaging with Bourdieu's concepts in the context of this thesis brought new perspectives to explain phenomena that would not otherwise be known without the application of these concepts. While there are other pertinent theories, summarised in Chapter 3,

Section 3.3, the choice to use Bourdieu as an organising theoretical framework with the breadth of conceptual tools has been validated. It has given the discipline a vocabulary to convey what was found in the data. After applying the concepts, what has been gained is a language to describe the motives and methods of stakeholders seeking advancement in or maintenance of the HPR field through the use of economic, cultural, social, and symbolic capital resources, and the use of symbolic power and symbolic violence. Bourdieu's concepts and the critical realist philosophical orientation have also supplied a language to identify causal mechanisms, habitus and doxa, driving the methods and motives giving rise to stakeholder perspectives and opinions.

This research has demonstrated the applicability and versatility of Bourdieusian concepts to the field of HPR and the sociology of the professions. It adds to the body of knowledge on the application of theoretical frameworks that may be employed in research about these topics.

12.9 Chapter summary

This chapter completes the discussion of results from this research. It has brought together the views of three stakeholder cohorts from two data sources to present a view of the HPR field in Australia that potentially functions to preserve the regulatory status quo rather than uphold the guiding principles of the Australian *Health Regulatory Policy Framework* that aim to serve consumers and keep patients safe. It has set out a reform agenda and recommendations to refocus attention back onto HPR policy and the regulation of non-registered professions. It has discussed the limitations of this research and proposed topics for future research to continue advancing the field of HPR scholarship.

Conclusion

Appropriate health practitioner regulation (HPR) is essential to maintain patient safety and ensure cost efficiency. Both over- and under-regulation are problematic. Over-regulation is burdensome to practitioners and governments. Under-regulation exposes consumers and patients to risks of avoidable harm (UK PSA, 2015: 12).

As a field of study, HPR has an accumulating body of research. HPR for non-registered professions, however, is a field of inquiry that has largely been neglected in the scholarly literature despite the potential capacity of these professions to cause consumer harm. While there has been some research on the statutory registration of certain health professions, no previous study has specifically explored stakeholder perspectives of HPR for non-registered professions in Australia. Nor has any prior research canvassed the breadth of stakeholder views across the range of health professions as conducted in the present study. Australian studies of HPR seldom examine non-registered professions or investigate the views of consumer advocates or policy actors regarding these professions. This has been to the detriment of HPR scholarship.

The purpose of this thesis was to address this underexplored research area. The research builds on the existing literature and broadens the scope of regulatory inquiry in three ways. First, by investigating the perspectives and experiences of three stakeholder cohorts regarding HPR. Second, by examining fifteen non-registered health professions in the Australian setting. Third, by employing theoretical concepts to analyse and interpret the results, demonstrating their utility and feasibility, which may be used as a framework for approaching future HPR research.

This concluding chapter presents the contribution this thesis makes to the HPR field, the findings from the analysis, the conclusions drawn from the research, and the significance and impact of this research.

Research contribution

This research aimed to achieve four objectives detailed in Chapter 1, Section 1.1.2 regarding the regulation of non-registered health professions. A range of research methods and designs were used to address these objectives, including a scoping review, two separate document analyses, interviews with three stakeholder cohorts, and a theoretical analysis and interpretation of the results of these studies. From this work, all research objectives were addressed, and the following conclusions are drawn:

- Even though there is substantial support for statutory registration of non-registered health professions in Australia, as evidenced in the existing literature, considerable gaps in research knowledge were identified from the scoping literature review in terms of non-registered professions examined, stakeholder cohorts investigated, and interpretive frameworks and theories employed in research on attitudes to HPR.
- The NCC legislation remains unimplemented in two jurisdictions, some ten years following the agreement by the COAG Health Council.
- Eligibility of non-registered practitioners (or lack of) for benefits and entitlements by seven national-level government and non-government institutions shows the fragmented coverage of co-regulatory arrangements for non-registered professions, representing potential points of failure in consumer protection.
- Much of the regulatory activities and actions over the past thirty years have been directed towards HPR mechanisms relating to registered professions, and limited attention has been directed to the regulation arrangements for non-registered professions.
- The publicly documented positions and perspectives of regulation generated mainly from documents authored by professional bodies indicated substantial support for statutory registration because it was considered more effective for protecting consumers, practitioners, and the professions.
- All interviewed stakeholder cohorts identified discrepancies between professions that were and were not registered. Most interviewed consumer

advocates and profession representatives supported registration for certain professions. Most interviewed policy actors indicated a need for further regulation of certain professions, but were reluctant to consider registration because of perceived difficulties. There was no consistent view within or between stakeholder cohorts about which professions should be registered. Respondents from all stakeholder cohorts raised factors unrelated to the IGA assessment criteria to support their perspectives and positions on HPR.

Collectively, the results from the scoping review presented in Chapter 2, the findings from the study results detailed in Chapters 5 to 10, and the analysis and interpretation offered in Chapter 11 present the original contribution this research makes to HPR scholarship. This contribution is in five key areas of research knowledge.

First, this study presents the only known scoping review of the published literature regarding the attitudes of healthcare stakeholders to the regulation of fifteen non-registered health professions in Australia. The scoping review in Chapter 2 identified considerable support for the statutory registration of certain non-registered health professions. Reasons offered in support of stakeholder positions were often focused on profession and practitioner concerns, with less attention given to public protection and consumer safety issues. The scoping review revealed several factors relating to stakeholder attitudes regarding HPR where research knowledge was lacking. These factors were the limited cohorts of stakeholders whose views were canvassed, the few non-registered health professions examined, and the paucity of research employing a theoretical framework to explicate held views.

Second, this research sets out in Chapter 5 a compilation of the events and decisions leading up to and beyond the establishment of the NRAS. It described the regulatory policy history, institutional contexts and frameworks of occupational regulation for non-registered health professions. The chapter detailed the decision-making criteria and processes for determining professions requiring registration under Australia's *Health Practitioner Regulation National Law*. It presented the most comprehensive mapping to date of the implementation status of the NCC in Australian jurisdictions and the first mapping of benefits and entitlements for 15 non-registered professions by seven

national-level government and non-government institutions. The analysis showed the disjointed coverage of and discontinuities in the co-regulatory arrangements for non-registered professions.

Third, the research presented in Chapters 6 and 7 is the first examination of a large corpus of publicly available documents. I identified and elaborated on stakeholder positions and perspectives of regulation for 15 non-registered professions. The examination revealed substantial support for registration and less support for co-regulation, self-regulation, and 'hybrid' regulation models. Most stakeholders whose documents were analysed considered public protection to be the role of governments, and a majority perceived that registration was better for consumers, practitioners, and the professions. Some stakeholders documented apprehensions about the potential adverse impacts of registration on practitioners and professions, while others described the negative consequences of exclusion from the NRAS. Several professional bodies responded to the establishment of the NRAS by strengthening voluntary self-regulation mechanisms to mitigate the perceived adverse effects of their exclusion.

Fourth, this research included the first investigation of the perspectives and experiences of three groups of healthcare stakeholders explored through semi-structured interviews and presented in Chapters 8 to 10. Based on these interviews, common and distinctive attitudes about HPR were identified. Similar to the document analysis and scoping review findings, most interviewed profession representatives and consumer advocates supported registration for specific non-registered professions. Many policy actors in this study commented on the need for additional regulation mechanisms for certain professions but expressed a clear reluctance to extend NRAS to further professions because of the perceived difficulties with the assessment process. Most of the concerns voiced by interviewed policy actors and profession representatives focused on the operational complexity or implications of registration on governments or the professions, while the primary considerations for consumer advocate respondents were patient concerns and issues regarding the provision of healthcare services. In addition to the influence of the IGA assessment criteria and process on participant attitudes,

respondents from all stakeholder cohorts raised factors unrelated to the criteria to support their positions and perspectives on regulation.

The study's final contribution to research scholarship, presented in Chapter 11, is the first Bourdieusian analysis and interpretation of the HPR field in Australia for non-registered professions. The analysis shows that the influences acting on stakeholder perspectives trace their origins to the enculturated characteristics, conditionings, and preferences of respondents and the largely unconscious beliefs, ideologies, and norms operating in the HPR field and informing agent actions. These are the proposed causal mechanisms for the studied phenomenon. The causal mechanisms of habitus and doxa were operationalised by stakeholders summoning or appealing for Bourdieusian capital concepts and the 'capital' of risk to articulate and justify stakeholder positions and perspectives about HPR that conformed to their regulation preferences.

This study gives regulation scholarship a language to describe how state and other social actors might use their positions and power to reinforce particular views. The findings add to the regulation literature by concluding that Australia's HPR field presents an array of statutory and non-statutory regulatory mechanisms. It includes a variety of non-registered healthcare professions regulated via a range of mechanisms and arrangements marked by inconsistencies and discontinuities. As advanced by Bourdieu, this research finds that Australia's HPR field is a site of struggle and conflict, conflict over which field non-registered professions should occupy, and contests between professional bodies seeking to enter the National Scheme and policy actor gatekeepers seeking to bar entry to the Scheme. The findings add to critical debates regarding the underlying mechanisms that inform decision-making, maintain existing boundaries and hierarchies, and reinforce hegemony in healthcare.

The policy intent of the National Scheme was to bring national consistency to professions that were registered and establish nationally consistent education and practice standards. Yet, a common finding among respondents in all stakeholder cohorts is that HPR for non-registered professions in Australia is marked by inconsistencies. While much effort has been expended to ensure registered professions are appropriately regulated, the inefficiencies and fragmentation the Scheme sought to

overcome for these cadres have entrenched inefficiencies and fragmentation for non-registered professions and created barriers to registration when this may be justified.

Significance

Over 60 non-registered health professions have been identified in Australia, fifteen of which have been the subject of the present research. It is estimated that over 160,000 professionals are practising in ten of the fifteen non-registered professions examined. Around half of the 15 professions consult with an estimated 2.5 million consumers annually, and six professions receive more than AUD\$360 million in public funding each year. The current statutory and co-regulatory arrangements do not apply to all non-registered health professions in all Australian jurisdictions. In stakeholder interviews, the self-regulation mechanisms adopted by some professional bodies were described as robust by policy actors and profession representatives. Other profession respondents expressed concerns regarding disputes between associations representing the same profession about matters such as the minimum qualifications for entry to practice, the need for registration, and the difficulties in maintaining high education standards in the face of uncooperative educational institutions and disparate professional association standards. This speaks to the need to remove the responsibility for initiating registration assessments from the remit of professional bodies and for governments to assume ownership of the process for identifying further professions for registration. The need to review HPR arrangements is urgently needed to ensure appropriate regulatory settings are applied for the inherent risks of occupational practice for each non-registered profession.

Research impact

Findings from this thesis have been presented at the International Allied Health Conference, 1–5 November 2024. The findings were also presented to the Victorian Chief Allied Health Officer and staff on 2 April 2024 and at the Allied Health Perspectives Series for The Allied Health Academy on 13 February 2025. The thesis findings have been used as the basis for a submission to the *Consultation paper: Regulating for results: Review of complexity in the National Registration and Accreditation Scheme*, lodged on

13 October 2024. There are plans for this research to produce seven manuscripts for peer-reviewed publication.

Concluding statements

What emerges from this study is that health practitioner regulation in Australia is subject to multiple influences. The research identifies forces at play involving elements of policy, politics and power. It shows that the policies, processes, and criteria exist to objectively assess health professions for statutory registration based on practice risks and other formal criteria. Despite this, the politics of personal opinion and individual ideology of healthcare stakeholders informed and influenced positions on and perspectives of regulation, such that they intruded on the decision-making deliberations of those within the political arena and the expectations of those outside it. Healthcare stakeholders use the power within their means and the privileges of their position in the healthcare or bureaucratic fields to argue for regulation arrangements that accord with their worldviews, summoning various Bourdieusian capitals to support their arguments. This is particularly evident in the perspectives of policy actors in this study, almost all of whom held unequivocal views regarding regulation, a certitude born of position and power. The research shows that despite government public protection espousals, decisions regarding health practitioner regulation are subject to attitudinal factors and forces that can and do undermine the policy objectives of regulation.

For health practitioner regulation policy to meet the needs of health consumers, reforms are needed to minimise the subjective nature of policy decision-making and limit the ability of social actors to influence policy outcomes. It is the responsibility of governments to proactively assess non-registered health professions to ensure appropriate regulatory settings are in place to maintain public safety, a responsibility in keeping with Australian health policy regulatory stewardship principles and the public protection paramount guiding principle of the *Health Practitioner Regulation National Law*.

APPENDICES

Appendix 1: Search protocol for scoping review.

Attitudes to the regulation of non-registered health professions in Australia			
SEARCH PLANNING			
CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
audiology counselling dietician exercise physiology herbal medicine massage therapy myotherapy naturopathy orthoptic paramedicine perfusion psychotherapy social work sonography speech pathology	government regulation government registration government accreditation government certification government credentialling government licensing government legislation professional regulation professional registration professional accreditation professional certification professional credentialling professional licensing professional legislation practitioner regulation practitioner registration practitioner accreditation practitioner certification practitioner credentialling practitioner licensing practitioner legislation professional regulation professional registration professional accreditation professional certification professional credentialling professional licensing professional legislation workforce regulation workforce registration workforce accreditation workforce certification workforce credentialling workforce licensing workforce legislation registration statutory registration statutory accreditation statutory certification statutory credentialling statutory licensing statutory legislation professionalisation	attitude belief opinion perception perspective view experience reflection	Australia
AMED (Ovid)			

CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
ambulance.mp. paramed*.mp. audiolog*.mp. counseling/ counsel*.mp. dietet*.mp. dietician*.mp. dietitian*.mp. exercise physiolog*.mp. herbalism/ herbalis*.mp. herbal medicine.mp. herbal medicine practitioner*.mp. phytotherap*.mp. massage/ massage.mp. myotherap*.mp. naturopathy/ naturopath*.mp. orthoptic* perfusion* exp psychotherapy/ psychotherap*.mp. social work/ "social work*".mp. welfare work*.mp. sonograph* ultrasound* ultrasonograph* "speech patholog*".mp. "speech therap*".mp. exp speech language pathology/ exp speech therapy/	professionalisation.mp. professionalization.mp. ((government or profession* or practitioner or profession* or workforce or statutory) and regulat*).mp. ((government or profession* or practitioner or profession* or workforce or statutory) and regist*).mp. ((government or profession* or practitioner or profession* or workforce or statutory) and accredit*).mp. ((government or profession* or practitioner or profession* or workforce or statutory) and certification).mp. ((government or profession* or practitioner or profession* or workforce or statutory) and credential*).mp. ((government or profession* or practitioner or profession* or workforce or statutory) and (licens* OR licenc*)).mp. ((government or profession* or practitioner or profession* or workforce or statutory) and legislation).mp.	attitude*.mp. belief*.mp. opinion*.mp. perception*.mp. perspective*.mp. view*.mp. experience*.mp. reflection*.mp.	Australia/ Australia*.mp.

CINAHL (EBSCO)			
CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
"ambulance" OR paramed*" (MH "Counseling") (MH "Counselors") "counsel*" (MH "Dietetics") (MH "Dietitian Attitudes") (MH "Dietitians") "dietician" (MH "Exercise Physiology") "exercise physiolog*" (MH "Naturopathists") (MH "Medicine, Herbal") (MH "Herbalists") "herbalis*" "herbal medicine practitioner*" "herbal medicine" "phytotherap*" (MH "Massage") "massage" OR "myotherap*" "naturopath*" "orthopti*" "perfusion*" (MH "Perfusion") (MH "Psychotherapy") (MM "Psychotherapist Attitudes") "psychotherap*" "Psychotherapist*" (MM "Social Work Practice") (MH "Social Work") "social work*" "welfare work*" (MH "Ultrasound Technologists") "sonograph*" ultrasound* ultrasonograph* (MH "Speech-Language Pathology") (MH "Speech-Language Pathologists") (MH "Speech Therapy") "speech therap*" "speech patholog*" (MH "Speech-Language Pathologist Attitudes")	professionalisation professionalization (MH "Accreditation") "accreditation" ((government OR profession* OR practitioner OR profession* OR workforce OR statutory) AND (regulat* OR regist* OR accredit* OR certification OR credential* OR licens* OR licenc* OR legislati*))	(MH "Attitude") "attitude*" "belief*" "opinion*" (MH "Perception") "perception*" "perspective*" "view*" "experience*" "reflection*"	(MM "Australia") "Australia*"

Embase (Ovid)			
CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
ambulance.mp. exp paramedical profession/ paramedic*.mp. audiology/ audiolog*.mp. counseling/ counsel*.mp. dietetics/ dietitian/ dietetic*.mp. dietitian*.mp. dietician*.mp. "exercise physiolog*" herbalism/ herbalis*.mp. "herbal medicine".mp. "herbal medicine practitioner*".mp. herbal medicine/ phytotherapy/ phytotherap*.mp. massage/ massage.mp. myotherap*.mp. naturopath*.mp. orthopti*.mp. perfusion*.mp. exp psychotherapy/ psychotherap*.mp. "social work*".mp. exp social worker/ "welfare work*".mp. sonograph*.mp. ultrasound*.mp. ultrasonograph*.mp. exp speech therapy/ "speech patholog*".mp. "speech therap*".mp. exp speech language pathologist/	professionalisation professionalization ((government OR profession* OR practitioner OR profession* OR workforce OR statutory) AND (regulat* OR regist* OR accredit* OR certification OR credential* OR licens* OR licenc* OR legislati*))	exp attitude/ attitude*.mp. belief*.mp. opinion*.mp. perception*.mp. perspective*.mp. view*.mp. experience*.mp. reflection*.mp.	ex Australia/ australia*.mp.

Informat			
CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
ambulance paramed* audiolog* counsel* dietetic* dietitian* dietician* "exercise physiolog*" herbals* "herbal medicine practitioner*" "herbal medicine" phytotherap* massage myotherap* naturopath* orthopti* perfusion* psychotherap* "social work*" "welfare work*" sonograph* ultrasound* ultrasonograph* "speech patholog*" "speech therap*"	professionalisation professionalization ((government OR profession* OR practitioner OR profession* OR workforce OR statutory) AND (regulat* OR regist* OR accredit* OR certification OR credential* OR licens* OR licenc* OR legislati*))	attitude* belief* opinion* perception* perspective* view* experience* reflection*	Australia*

Ovid MEDLINE			
CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
ambulance/ ambulance.mp. paramedic*.mp. audiology/ audiologists/ audiolog*.mp. counseling/ counselors/ counsel*.mp. dietetics/ dietitian/ dietetic*.mp. dietician*.mp. dietitian*.mp. dietitian*.mp. "exercise physiol*".mp. "herbal medicine".mp. "herbal medicine practitioner*".mp. herbal medicine/ phytotherapy/ phytotherap*.mp. herbalis*.mp. massage.mp. myotherap*.mp. naturopath*.mp. orthopti*.mp. perfusion* exp psychotherapy/ psychotherapists/ psychotherap*.mp. exp social worker/ "social work*".mp. "welfare work*".mp. sonograph*.mp. ultrasound*.mp. ultrasonograph*.mp. exp speech therapy/ "speech patholog*".mp. "speech therap*".mp. Speech Therapy/	professionalisation professionalization ((government OR profession* OR practitioner OR profession* OR workforce OR statutory) AND (regulat* OR regist* OR accredit* OR certification OR credential* OR licens* OR licenc* OR legislati*))	exp attitude/ attitude*.mp. belief*.mp. opinion*.mp. perception*.mp. perspective*.mp. view*.mp. experience*.mp. reflection*.mp.	exp Australia/ Australia*

ProQuest Dissertation & Theses			
CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
ambulance paramed* "Community Health Paramedicine" audiolog* counsel* dietetic* dietitian* dietician* "exercise physiolog*" herbalis* "herbal medicine practitioner*" "herbal medicine" phytotherap* massage myotherap* naturopath* orthopti* perfusion* psychotherap* "social work*" "welfare work*" sonograph* ultrasound* ultrasonograph* "speech patholog*" "speech therap*"	professionalisation professionalization ((government OR profession* OR practitioner OR profession* OR workforce OR statutory) AND (regulat* OR regist* OR accredit* OR certification OR credential* OR licens* OR licenc* OR legislati*))	attitude* belief* opinion* perception* perspective* view* experience* reflection*	Australia*

PsycINFO (EBSCO)			
CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
ambulance MM "Emergency services" MM "Paramedics" paramedic* MM "Audiology" audiolog* MM "Counseling" counsel* dietet* dieti* "exercise physiolog*" herbalis* "herbal medicine practitioner" "herbal medicine" phytotherap* MM "Massage" massage myotherap* naturopath* orthopt* perfusion* MM "Psychotherapy" psychotherap* MM "Social Workers*" "social work*" "welfare work*" MM "Ultrasound" sonograph* ultrasound* ultrasonograph* "speech patholog*" MM "Speech Language Pathology" MM "Speech Therapy" DE "Speech Therapists" MM "Speech Therapists" "speech therap*"	DE "Professional Certification" DE "Professional Licensing" professionalisation professionalization ((government OR profession* OR practitioner OR profession* OR workforce OR statutory) AND (regulat* OR regist* OR accredit* OR certification OR credential* OR licens* OR licenc* OR legislati*))	MM "Attitudes" attitude* belief* opinion* MM "Perception" perception* perspective* view* experience* reflection*	Australia*

PubMed			
CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
(ambulance[Text Word])) (paramed*[Text Word]) (audiolog*[Text Word])) (counsel*[Text Word]) (dietet*[Text Word]) (dieti*[Text Word]) ("exercise physiolog*" [Text Word]) ("herbal medicine"[MeSH Terms]) ("herbal medicine"(Text Word)) (herbalis*[Text Word]) ("herbal medicine practitioner*" [Text Word]) (phytotherap*[MeSH Terms]) (phytotherap*(Text Word)) (massage[MeSH Terms])) (massage*(Text Word)) (myotherap*[Text Word]) (naturopath*[MeSH Terms]) (naturopath*(Text Word)) (orthopti*[Text Word]) (perfusion*[Text Word]) (psychotherap*[Text Word]) ("social work*" [Text Word]) ("welfare work*" [Text Word]) (sonograph*[Text Word]) (ultrasound*[Text Word]) (ultrasonograph*[Text Word]) ("speech patholog*" [Text Word]) ("speech therap*" [Text Word])	("accreditation"[MeSH Terms]) ("government regulation"[MeSH Terms]) ("professionalisation"[Tex t Word]) ("professionalization"[Tex t Word]) ((government OR profession* OR practitioner OR profession* OR workforce OR statutory) AND (regulat* OR regist* OR accredit* OR certification OR credential* OR licens* OR licenc* OR legislati*))	attitude* belief* opinion* perception* perspective* view* experience* reflection*	Australia*

Scopus			
CONCEPT 1 Professional terms	CONCEPT 2 Regulation terms	CONCEPT 3 Outcomes	CONCEPT 4 Limiters
ambulance paramed* audiolog* counsel* dietet* dietician dietitian "exercise physiolog*" herbalis* "herbal medicine practitioner" "herbal medicine" phytotherap* massage myotherap* naturopath* orthopt* perfusion* psychotherap* "social work*" "welfare work*" sonograph* ultrasound* ultrasonograph* "speech patholog*" "speech therap*"	professionalisation professionalization ((government OR profession* OR practitioner OR profession* OR workforce OR statutory) AND (regulat* OR regist* OR accredit* OR certification OR credential* OR licens* OR licenc* legislati*))	attitude* belief* opinion* perception* perspective* view* experience* reflection*	Australia*

Appendix 2: Scoping review study characteristics and summary of findings.

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
Bensoussan 2004	Quantitative. National postal questionnaire survey.	Naturopaths, Western herbal medicine practitioners, homeopaths, nutritionists.	795	Naturopathy, Western herbal medicine.	• More positive than negative changes were indicated to result from government regulation for: professional status (78.6%); practice standards (73.0%); education standards (72.7%); postgraduate education (59.6%); access to research infrastructure (58.4%); access to scheduled herbs/products (55.2%); quality of herbal medicines/products (46.5%); and defining occupational boundaries (41.3%). • Uncertainty was indicated regarding the impact of regulation on: practitioner income (56.1%); litigation (54.0%); patient costs (51.2%); and freedom of practice (37.6%). • Negative impacts were indicated to be more likely in: medical influence on practice (44.3%); litigation (26.7%); and freedom of practice (34.3%). • 44% indicated their training poorly prepared them for inter-professional communication. • 22% indicated they were poorly prepared for clinical training.
Braun 2013	Quantitative. Online questionnaire survey.	Naturopaths, Western herbal medicine practitioners.	479	Naturopathy, Western herbal medicine.	• 85% agreed/strongly agreed practitioners should be formally registered to safeguard the public, 8% disagreed/strongly disagreed, and 8% were unsure. • Responses indicated possible benefits of regulation were increased public safety, guarding against inadequately trained practitioners within and outside the profession, increased practice standards, increased confidence and credibility of the profession and its broader integration into the healthcare system. • A few (n = 9) who agreed with regulation did not agree that public safety was the main issue, stating that being a member of a professional association was the same as registration, so formal registration was not necessary. • A few (n = 9) also expressed concern that practitioners outside their profession could regulate their profession if formal registration occurred.
Canaway 2009	Qualitative. Semi-structured interviews. Snowball sampling.	Naturopaths (senior practitioners mostly in leadership roles).	7	Naturopathy.	• Registration was considered necessary to safeguard the public (because of the risk of drug/herb interactions), raise education standards in line with public expectations, ensure transparent complaints handling, guard against unethical practitioners who overpromise and overcharge, maintain professional and ethical standards, provide guarantees regarding practitioner education, may improve relationships with medical professionals, provide access to hospitals, protect the interests of the profession such as misappropriation of practice, could promote professional unity, it was not the job of the professional associations, and

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
					registration with a bachelor's degree as the minimum qualification would limit the proliferation of profit-oriented private colleges. • Potential positive impacts were considered to be increased status, legitimacy and acceptance, particularly by the medical profession, opening the way for Medicare rebates, accessing restricted herbs, aiding the removal of incompetent practitioners, potentially gaining a greater share of the healthcare market, establishing higher minimum education standards and greater consistency in the quality and length of training. • Registration was considered unnecessary because natural therapies were safe when offered by trained practitioners, a registered profession was not necessarily a safe profession, complaints handling was adequate, protection of title did not prevent unsafe practitioners from using different titles, it inappropriately defined the profession as unsafe, it only conferred status and bolstered self-esteem which is not its purpose, other registered professions disliked it, current self-regulation was working with most practitioners belonging to professional associations which monitored standards, and there was little to gain. • Potential negative impacts were restrictions to practice, loss of freedom to practise, standardisation of practice, could attract different types of people to the profession motivated by status and personal gain, potentially increased professional indemnity costs, additional costs of registration fees that would be passed onto clients, not all practitioners may be eligible for registration which would negatively affect them, an uncertainty regarding who the profession would be answerable to, greater emphasis on the scientific aspects of education, and less on the holistic approach, erosion of naturopathic philosophy, and closure of colleges unable to meet the new standards with loss of livelihood to college owners.
Cohen 2005	Quantitative. National postal questionnaire survey.	General practitioners.	579	Massage.	Massage therapy: • 49% of GPs agreed that the government should regulate massage, while 33% indicated the government should not regulate massage. • Many GPs indicated that therapies that did not involve medicines did not require regulation. • Some suggested self-regulation (e.g. industry accreditation) was more appropriate for some therapies than government regulation. • 91% of GPs indicated that massage did not or seldom caused harm. • Some commented that complementary therapies caused no harm in the hands of appropriately trained therapists.

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
					Naturopathy: 73% of GPs agreed that the government should regulate naturopathy, 11% indicated the government should not regulate naturopathy, and 16% were unsure. - Many GPs commented that therapies that had the potential to delay diagnosis or interact with conventional medication, such as herbal medicine or naturopathy, should be regulated. - Some suggested self-regulation (e.g. industry accreditation) was more appropriate for some therapies than government regulation. - Many GPs identified interactions between complementary medicines and pharmaceuticals as a major area of concern. - Some commented that complementary therapies caused no harm in the hands of appropriately trained practitioners. Western herbal medicine: 77% of GPs agreed that the government should regulate herbal medicine, 8% indicated the government should not regulate herbal medicine, and 15% were unsure. - Many GPs commented that therapies that had the potential to delay diagnosis or interact with conventional medication, such as herbal medicine or naturopathy, should be regulated. - Some suggested self-regulation (e.g. industry accreditation) was more appropriate for some therapies than government regulation. - Many GPs identified interactions between complementary medicines and pharmaceuticals as a major area of concern. - Some commented that complementary therapies caused no harm in the hands of appropriately trained practitioners.
Dooley 2010	Quantitative. Postal, online and print-based questionnaire survey.	Pharmacy assistants.	107	Naturopathy, Western herbal medicine.	75% strongly agreed/agreed naturopaths should be formally registered to safeguard the public, 2% disagreed, and 22% were unsure.
Hill 2005 Section 9 in Lin et al. 2005, summarised	Qualitative. Focus groups.	Consumers within a metropolitan area.	24	Naturopathy, Western herbal medicine.	- There were mixed feelings regarding the need for more consumer protection and government regulation. - The majority of participants thought there should be some form of regulation. - Because consumers are often vulnerable and place their trust in practitioners, several participants felt there should be qualifications (implying approved qualifications), and that providers should be regulated.

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
in Lin et al. 2009.					- Those agreeing with regulation said it was needed to raise the standard of practitioners, ensure consistency of care, and stop unethical practice. - Regulation was considered to imply recognition of practices. - Some practitioners were aware that regulation did not ensure quality care but thought it was important for consumers to know that a practitioner had undertaken a minimum standard of training. - A few perceived registration would not improve practitioner quality, but could restrict what practitioners could practise, inhibit the use of new treatments, and see the loss of an intuitive approach. - Concerns were expressed about the ability of professional associations to investigate complaints against their members, the possibility that poor practitioners could leave (or be forced to leave) one association only to join another, and the need for a body to hear complaints. - It was perceived that regulation would not address the critical issue of practitioner communication skills.
James 2013	Qualitative. Six focus group interviews with up to 8 participants, and 3 purposive interviews with up to 3 participants	Students enrolled in the Bachelor of Paramedic Practice.	48	Paramedicine.	- There was a prevalent but erroneous view among respondents that paramedicine was a registered profession. - Regulation and registration were seen as vital to the professionalisation of paramedicine. - Registration could improve clinical practice and patient safety. - Credible professionals, such as doctors and nurses, were registered and have continuing education as a vital component of the registration process. - Together with continuing education, regulation and registration were thought to require industry and public support for the achievement of professionalisation. - The allocation of government funding to achieve national registration was viewed as challenging. But paramedics were also identified as being responsible for the implementation of national registration because its absence was due to a lack of commitment by the profession and taking ownership of the process. - Public support was considered central to pressure government bodies. - National registration and professional credibility were also seen as reliant on continuing education to ensure standards were met and patients were protected.
Livingston 2010	Quantitative. Postal questionnaire survey.	General practitioners.	288	Herbal medicine, naturopathy.	91% strongly supported a national register for naturopaths and herbalists, requiring qualifications for listed members to be licensed. 84.0% agreed that herbal therapies should be regulated in the same way as pharmaceuticals and 7.3% disagreed.

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
Malhotra 2020	Qualitative. Semi-structured telephone interviews.	Naturopaths.	20	Naturopathy.	• A primary barrier to implementing integrated care models was perceived to be the lack of acknowledgement from conventional medical practitioners. • The current 'self-regulation model' and absence of statutory regulation was seen as a barrier to legitimising the profession. • The lack of a well-defined curriculum and standard training competencies framework was considered a barrier to being acknowledged by conventional medical practitioners as a legitimate profession and to establishing integrated models of care.
McCabe 2005a Section 6 in Lin et al. 2005, summarised in Lin et al. 2009.	Quantitative. Postal questionnaire survey.	Professional associations of naturopathy and Western herbal medicine.	11	Naturopathy, Western herbal medicine.	• 36% of associations supported statutory regulation, 36% supported the existing self-regulatory model, and 27% favoured a stronger (unspecified) type of regulation. • 64% of associations were negative about the existing self-regulatory model, in part because it had not produced a national, consistent, or effective regulatory system. • The need to protect the profession and practices was seen as a strong motivation by supporters and opposers of statutory regulation. • There was no agreement on working towards a bachelor's degree as the minimum qualification no uniform minimum standard of education, prompting concerns about inadequately trained or incompetent practitioners. • Caution was required to ensure regulatory effect on education did not diminish the underlying philosophy. • In the interests of public safety, a bachelor's degree was seen by some associations as the minimum education requirement for practitioners. • Some supporters argued that statutory regulation, and with it raised education standards, was essential to gain access to scheduled natural medicines. They were critical of the restraints imposed by the lack of statutory regulation on practitioner tools of the trade. • There was potential for conflict of interest if professional associations were associated with private education providers, whose commercial interests could conflict with raising education standards through registration.
McCabe 2005b Section 5 in Lin et al. 2005, summarised	Quantitative. Postal questionnaire survey.	Education providers of undergraduate and post- graduate courses.	19	Naturopathy, Western herbal medicine.	• Overall 53% preferred statutory regulation of practitioners, and 26.3% of providers supported either a co-regulation model or self-regulation. • 64% of private providers supported government involvement in regulation, 28.5% supported co-regulation, and 7% supported continued self-regulation. • 100% of universities (n = 5) supported statutory regulation.

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
in McCabe 2008.					• Overall, two-thirds of education providers either strongly or moderately supported education to the level of a bachelor's degree as the appropriate entry-level qualification for naturopathy and WHM. • Less than one-third supported an advanced diploma as the minimum standard. • There was ongoing conflict within the professions regarding regulation and education, the most appropriate model of regulation, the minimum education standards, the commercialisation of education resulting in lowered standards, lack of democratic processes or transparent policies in some professional associations, and the need for standards to be set by an independent body.
Reed 2021	Quantitative. Online survey.	Paramedics recruited via social media.	419	Paramedicine.	• 59.19% had a positive view of registration, 25.53% held negative views, 13.60% had a neutral view, and 1.67% were undecided. • 47.01% responded that patients would be safer under registration and 47.36% responded there would be no change to patient safety. • 78.04% responded that paramedics would be more individually accountable under registration and 18.14% responded there would be no change to accountability. • 39.86% responded that fairness of complaints handling would improve following registration, 28.88% responded fairness of complaints handling would decrease, 10.98% responded there would be no change, and 20.29% were undecided. • 54.88% responded that employment opportunities would increase following registration, 31.03% responded there would be no change to opportunities, and 8.59% responded there would be fewer opportunities. • 30.78% responded that the scope of practice would increase following registration, 55.13% responded there would be no change, and 5.25% indicated the scope of practice would decrease. • 19.81% responded remuneration would increase under registration and 68.50% responded there would be no change to remuneration. • 46% responded they had no concerns about the registration process, 46% indicated they had some level of concern, and 8% indicated they had physical symptoms of anxiety. • 41.05% responded that registration was not important to their professional identity, • 25.53% responded it was very/extremely important to their sense of identity, and 33.41% indicated is slightly/somewhat important to their sense of identity as paramedics.

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
Reed 2022	Qualitative online survey with free text questions included.	Paramedics recruited via social media.	419	Paramedicine.	• Respondents commonly considered registration as a safety mechanism for the community. • Patient safety was strongly linked to title protection and the ability to establish a professional entry process mediated by a body representative of the profession. • Many respondents linked community safety to practitioner accountability and standardisation of the profession, and many commenting on accountability saw it as a way to 'clean up' the profession. • Some regarded accountability as a tool to be used against paramedics, subvert workplace disciplinary practice and punish paramedics. • Some considered registration would place additional responsibility and burdens they had not previously had and many expressed a belief that complaints handling would be biased against paramedics. • Registration was viewed by many respondents as an enabling factor leading to greater growth of the profession. • Some respondents noted there would be clear national standards on who could practise as a 'paramedic' and some hoped that registration would create more continuity in clinical practice. • Registration was considered to provide a range of practice and career options. • Most respondents referenced registration as enabling paramedics to practise in a wider range of environments and roles. • Respondents were viewed as being hopeful that regulation would allow paramedics to be seen as having value in the health system. • Other respondents considered that the purpose of regulation was to extract revenue from practitioners. The cost to paramedics was seen by many as unfair, including the cost and effort of compliance with registration standards, especially continuing professional development. • Some viewed registration as supporting the egos of the paramedic establishment.
Reed 2023	Quantitative. Online survey.	Paramedics recruited via social media.	407	Paramedicine.	• 67.3% had a positive view of registration, 21.1% held negative views, 10.6% had a neutral view, and 1.0% were undecided. • 50.7% responded that patients would be safer under registration and 40.9% responded there would be no change to patient safety. • 74.3% responded that paramedics would be more individually accountable under registration and 21.1% responded there would be no change to accountability. • 40.3% responded that fairness of complaints handling would improve following registration, 21.8% responded fairness of complaints handling would decrease, 21.1% responded there would be no change, and 16.6% were undecided.

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
					• 60.7% responded that employment opportunities would increase following registration, 27.5% responded there would be no change to opportunities, and 6.2% responded there would be fewer opportunities. • 56.7% responded that the scope of practice would increase following registration, 35.8% responded there would be no change, and 2.7% indicated the scope of practice would decrease. • 30.0% responded that registration was not important to their professional identity, 36.9% responded it was very/extremely important to their sense of identity, and 33.1% indicated it was slightly/somewhat important to their sense of identity as paramedics.
Reed 2024	Qualitative online survey with free text questions included.	Paramedics recruited via social media.	407	Paramedicine.	• Respondents commonly considered registration was introduced for the safety of the community, standardisation of the profession, accountability, and professionalisation. • Regulation was considered to bring no change at all or had no effect which some considered meant the scheme was flawed or ineffective. • Regulation brought individual accountability, which some considered a trap, designed to punish paramedics. • The scheme created costs for paramedics, some perceiving this as the cost of the system, as unnecessary and punitive, or as government revenue raising by "taxing" practitioners for the right to practice. • Some participants considered registration advanced the professionalisation of paramedicine, especially for professional status in relation to other established health professions. Often, this was coupled with the recognition that paramedicine now held similar standards and accountabilities as other, more established professions. • Many participants raised challenges of compliance with registration standards. • Respondents expressed the belief that there would be increasing employment opportunities for paramedics, especially outside of traditional roles, and many expressed an aspirational goal of being used more effectively, creatively, and flexibly within the health system. • Some considered registration a conspiracy or agenda by government, education providers, and others to control paramedics, while others perceived it as blame-shifting or abandonment by employers and status-seeking by paramedics. • Participants who were supportive of regulation had expected greater change and reported a mismatch in their perception of the expectation that it would "clear out the deadwood" with the reality that the "deadwood" was untouched by regulation

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
					and had avoided accountability. Participants felt they had overestimated the threshold for regulatory intervention and possibly misunderstood the aim of regulation.
Sharpley 2003	Quantitative. Postal questionnaire	General practitioners.	105	Counselling.	93.3% agreed that counsellors should be state-registered although it was unclear by the authors' reporting whether this should be through a statutory mechanism or through a voluntary regulatory model with professional associations. 92.4% agreed that counsellors should be tertiary trained. 80.0% recommended counsellors be trained via a postgraduate university. 58.1% stated counsellors should possess a relevant undergraduate degree. 67.6% agreed counsellors were as professional as psychiatrists, psychologists, and social workers.
Sharpley 2004	Quantitative. Print-based questionnaire survey. Convenience sampling.	General public in small and large businesses, clubs, hospitals, community agencies, and learning institutions.	226	Counselling.	- When asked whether counsellors should be registered members of a government-approved association and/or state-registered, 83% of respondents indicated counsellors should be members of a professional organisation. 75.3% indicated counsellors should be tertiary trained. 67% indicated counsellors were as professional as psychologists. 45.1% preferred postgraduate qualifications and 41.6% preferred undergraduate university degree qualifications for counsellor training. 21.7% of respondents indicated counsellor competency as a potential drawback of counselling. - Questions regarding competency included the fear of choosing the wrong counsellor or the possibility that the counsellor might not be adequately trained or accredited.
Steel 2020a	Qualitative. Semi-structured telephone interviews.	Naturopaths.	10	Naturopathy.	Participants suggested that statutory registration may address the perceived GP concerns regarding naturopathic training and potentially improve patient access to naturopathic care.
Steel 2020b	Quantitative. Online survey.	Naturopaths.	153	Naturopathy.	Statutory registration was reported as 'definitely' needed by 65.4% of respondents, 24.2% indicated this was 'maybe' needed, 7.2% were unsure, and 3.3% indicated statutory regulation was not needed.
Steel 2023	Qualitative. Semi-structured telephone interviews.	Graduates, within five years of completing a bachelor's degree in naturopathy.	19	Naturopathy.	Reasons for supporting statutory registration were to: ensure minimum education standards, establish a recognised qualification, and have a standard of practice; promote respect and recognition, elevate the profession within healthcare, provide recognition of naturopathy as a distinct profession; promote public safety

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
					and remove unsafe practitioners; ensure future viability of the profession; and to protect the naturopath title and protect against co-option of title.
Tiralongo 2010	Quantitative. National postal questionnaire survey.	Community, hospital, consultant, industry, academia, public service and army pharmacists.	583	Naturopathy, Western herbal medicine.	92% strongly agreed/agreed that practitioners should be formally registered to safeguard the public, 3% disagreed/strongly disagreed, and 5% were unsure. 84% reported that factors they perceived as important in considering whether to employ a naturopath were that practitioners had the appropriate tertiary qualifications, and 63% indicated that the practitioner was a member of a professional association.
Ung 2017	Qualitative. Semi-structured interviews.	Practising pharmacists, regulatory authority (n=2 each). Pharmacy owner, pharmacist professional organisation, consumer advocate, medical professional organisation, complementary medicine professional organisation, pharmacy school, complementary medicine industry representative (n=1 each).	11	Naturopathy.	- One of 7 solutions suggested by participants to support pharmacists' extended role in complementary medicine products was employing naturopaths in pharmacies (8 participants). This was perceived to be hampered by a lack of statutory regulation of naturopaths and significant variation in education resulting in pharmacists being ultimately responsible, and therefore liable, for the advice provided. - There were two interrelated limitations to this proposed solution identified by some respondents. In Australia, Naturopathic practitioners are not governed by statutory regulation and this is associated with significant variations in education. The implication for pharmacists who employ naturopaths is that they are ultimately responsible for the advice given by the naturopaths.
Wardle 2013	Qualitative. Semi-structured interviews.	Naturopaths.	20	Naturopathy.	- Regulation/registration was considered positive by all but one practitioner. - Regulation was seen by many as the solution to many of the problems of the profession.

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
					- The primary reason for supporting regulation was to rid the profession of unethical, bogus, or fraudulent individuals co-opting the naturopath title without the required qualifications. - Regulation would overcome the challenges of increasing external influences on the profession, internal division/fragmentation, professional acceptance from conventional providers, problems with practitioner education, and co-option by undertrained/fraudulent practitioners that devalued the profession and hindered integration and communication with conventional providers.
West 2009	Quantitative. Questionnaire survey mailed to members of the AASW NT branch and to non-members using snowball sampling. Qualitative. Focus groups in Darwin, Katherine, and Alice Springs.	Social workers.	49 surveys, 14 focus group participants	Social workers.	14.3% of respondents gave unsolicited suggestions that registration should be an objective of the association. 93.5% of 46 valid responses indicated degree qualification was appropriate for the profession. - Focus groups placed a high priority on registration. Participants regarded the association was meeting member needs in lobbying for professional registration. They were pleased that progress was being made but remained frustrated at the pace of change in this area. Four participants felt registration and four others felt lobbying of government were areas of improvement for the association. - Registration was considered a priority to maintain professional identity (especially considering the multitude of position titles), manage ethical concerns (including unqualified workers in "social work" positions), for practitioner accountability, and a better understanding of social work labour force and worker needs.
Williams 2010	Quantitative. Paper-based questionnaire survey.	Participants at the National Association Paramedic Academics meeting, all directly involved in education of paramedics.	75 Outside Australia 12% of sample, (n=8)	Paramedicine.	- The majority of participants reported that the paramedic discipline would benefit from being recognised as a full profession (Mean = 4.62, SD = 0.771) and that the higher education sector had an important part to play in this process (Mean = 4.49, SD = 0.74). - A moderate mean score of 3.10 (SD=1.10) was reported on whether paramedicine exhibited traits of a professional body. - The majority of participants reported that national registration would not occur within the next 2 years (Mean = 2.52, SD = 1.12). - Respondents preferred an alliance with medicine (Mean = 3.29, SD = 1.30), compared with nursing (Mean = 2.05, SD = 1.14), to improve their chances of becoming a profession.
Williams 2012	Quantitative. Paper-based questionnaire	Members of the Australian College of Ambulance	872 Outside	Paramedicine.	The majority of participants indicated a strong belief that paramedics would benefit from being recognised as a full profession (Mean = 4.75, SD = 0.54) and

First author Year	Study design	Study population	Sample N	Profession examined	Main Findings
	survey of association members.	Professionals. Convenience sampling.	Australia 0.23% of sample, (n=2)		was dependent on higher education to improve its chances (Mean = 3.98, SD = 0.96). • The moderate mean score of 3.83 (SD = 0.94) was achieved on the item that respondents perceived the sector already exhibits the traits of a profession. • A minority of participants indicated that paramedicine would have national registration within the following two years (Mean = 2.90, SD = 1.03). • Participants preferred an alliance with medicine (Mean = 3.31, SD = 1.16) rather than nursing (Mean = 2.37, SD = 1.17) to improve their chances of becoming a profession.
Williams 2015	Quantitative. Paper-based questionnaire survey of association members	Students enrolled in undergraduate courses at three universities (2 in Australia, 1 in NZ). Convenience sampling.	479 Outside Australia 12.9% (n=62)	Paramedicine.	• 94.6% of participants agreed/strongly agreed that it was important for paramedics to be a regulated profession with a protected register. • 98.7% agreed/strongly agreed that members of the public expect paramedics to be professional.

Appendix 3: Scoping review critical appraisal summary tables.

Risk of bias assessment for qualitative studies (Lockwood et al., 2015).

First author Year	Domains										Overall risk appraisal
	1	2	3	4	5	6	7	8	9	10	
(Canaway, 2009)	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Moderate (include)
(Hill et al., 2005)	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Moderate (include)
(James, 2013)	Y	Y	Y	Y	Y	U	N	N	Y	Y	Moderate (include)
(Malhotra et al., 2020)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Low (include)
(Reed et al., 2022)	Y	Y	U	Y	Y	N	U	Y	Y	Y	Moderate (include)
(Reed et al., 2024)	Y	Y	U	Y	Y	Y	U	Y	Y	Y	Low (include)
(Steel et al., 2020a)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Low (include)
(Steel et al., 2023)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Low (include)
(Ung et al., 2017)	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	Low (include)
(Wardle et al., 2013)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Low (include)

Domains

1. Is there congruity between the stated philosophical perspective and the research methodology?
2. Is there congruity between the research methodology and the research question or objectives?
3. Is there congruity between the research methodology and the methods used to collect data?
4. Is there congruity between the research methodology and the representation and analysis of data?
5. Is there congruity between the research methodology and the interpretation of results?
6. Is there a statement locating the researcher culturally or theoretically?
7. Is the influence of the researcher on the research, and vice-versa, addressed?
8. Are participants, and their voices, adequately represented?
9. Is the research ethical according to current criteria or is there evidence of ethical approval by an appropriate body?
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Legend:

Y = criterion adequately met

N = criterion not adequately met

U = unclear if criterion met

Risk of bias assessment for population-based studies (Hoy et al., 2012).

First author Year	External validity domains				Internal validity domains						Overall risk appraisal
	1	2	3	4	5	6	7	8	9	10	
(Bensoussan et al., 2004)	Y	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Low (include)
(Braun et al., 2013)	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N	Low (include)
(Cohen et al., 2005)	Y	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Low (include)
(Dooley et al., 2010)	Y	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Low (include)
(Livingston et al., 2010)	Y	Y	Y	N	Y	Y	Y	Y	N/A	Y	Low (include)
(McCabe, 2005a)	Y	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Low (include)
(McCabe, 2005b)	Y	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Low (include)
(Reed et al., 2021)	Y	Y	Y	Y	Y	Y	N	Y	N/A	Y	Low (include)
(Reed et al., 2023)	Y	Y	Y	Y	Y	Y	N	Y	N/A	Y	Low (include)
(Sharpley & Agnew, 2003)	N	N	N	N	Y	Y	Y	Y	N/A	N	High (include)
(Sharpley et al., 2004)	Y	Y	N	N	Y	Y	Y	Y	N/A	N	Moderate (include)
(Steel et al., 2020b)	N	Y	Y	N	Y	Y	Y	Y	N/A	Y	Moderate (include)
(Tiralongo et al., 2010)	Y	Y	Y	N	Y	Y	Y	N	N/A	Y	Moderate (include)
(West et al., 2009)	Y	Y	Y	N	Y	Y	Y	Y	N/A	Y	Low (include)
(Williams et al., 2010)	N	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Low (include)
(Williams et al., 2012)	N	Y	Y	N	Y	Y	Y	Y	N/A	Y	Moderate (include)
(Williams & Webb, 2015)	N	Y	Y	N	Y	Y	Y	Y	N/A	Y	Moderate (include)

Domains

1. Was the study's target population a close representation of the national population in relation to relevant variables?
2. Was the sampling frame a true or close representation of the target population?
3. Was some form of random selection used to select the sample, OR was a census undertaken?
4. Was the likelihood of nonresponse bias minimal?
5. Were data collected directly from the subjects (as opposed to a proxy)?
6. Was an acceptable case definition used in the study?
7. Was the study instrument that measured the parameter of interest shown to have validity and reliability?
8. Was the same mode of data collection used for all subjects?
9. Was the length of the shortest prevalence period for the parameter of interest appropriate?
10. Were the numerator(s) and denominator(s) for the parameter of interest appropriate?

Legend:

Y = criterion adequately met

N = criterion not adequately met

M = criterion not applicable

Appendix 4: Eligibility criteria for assessing professions for study inclusion.

Domains and inclusion criteria

Eight criteria classified into four domains were used to identify which of the non-registered health professions would be included in this study. In the event there was more than one criterion in a domain, meeting at least one criterion was considered necessary to progress to the next assessment domain and criteria. Consumer utilisation and workforce numbers were used as additional information to support and validate decisions made regarding inclusion.

Domain 1. Registration status

Non-registered as of 1st July 2012

To be included in the present research, professions were required to be unregistered under *National Law* at the time of implementation of the second tranche of NRAS on 1 July 2012.

Included in the Options Report

Professions were considered for inclusion if they were listed in the Australian Health Ministers' Advisory Council report, *Options for the Regulation of Unregistered Health Practitioners* (AHMAC 2013).

Sixty-seven professions met these criteria and progressed to the next assessment domain.

Domain 2. Self-regulation status

a. Voluntary occupational certification scheme

Two main types of data formed the basis of this study: publicly available documents and stakeholder interviews. These data types required access to documents expressing opinions regarding regulation-related issues of a profession, as well as interviews with individuals willing to give their views regarding regulation. The most readily identifiable stakeholders were likely to be found in professional associations, and peak professional bodies, and the most readily accessible documents were to be found on websites of government and professional bodies.

These considerations necessitated the application of a criterion that professions within scope must have at least one professional representative body providing a voluntary occupational certification scheme (also known in Australia as self-regulation).

Applying this criterion saw the elimination of twelve professions; assistant in nursing, bioresonance practitioner, cardiac scientist/technician, electroencephalographic technician, hospital orderly, occupational health and safety adviser, operating theatre technician, optical mechanic, pharmacy assistant, pharmacy technician, therapy aide, and weight loss consultant none of which appear to have a professional representative body (see Appendix table 4.1).

Fifty-five professions met this criterion and progressed to the next domain (see Appendix table 4.1).

Domain 3. Healthcare provider status

Remaining professions were then assessed against their status in Australian healthcare.

b. Primary/hospital care

c. Allied health

In Australia, primary care providers are often the first person the patient has contact with in the healthcare system (AIHW, 2021). This is a key distinction because Australia has adopted principles for best practice regulation to ensure the right type and level of regulation is applied to designated activities, including regulation of professions. Therefore, even though a health profession may not be registered under the *National Law* they may still be identified as a primary care provider.

Professions providing clinical hospital care and those identified as allied health are also key providers within the health system. Together these classifications comprised the third assessment domain (see Appendix table 4.1).

Twenty-six professions were eliminated through the application of these criteria; anatomist/physiologist, art therapist, audiometrist, biomedical engineer, dental assistant, dental technician, dialysis technician, diversional therapist, environmental health officer, health practice manager, health information manager, health promotion officer, hypnotherapist, lactation consultant, medical laboratory scientist, medical laboratory technician, medical scientist, optical dispenser, orthotist, phlebotomist, prosthetist, reflexologist, rehabilitation counsellor, Reiki practitioner, respiratory scientist, Shiatsu therapist, sleep technologist.

Twenty-nine professions met at least one criterion and progressed to the final assessment domain (see Appendix table 4.1).

Domain 4. Government financial entitlements

Government support through financial entitlements establishes a form of co-regulation between government and industry. The final domain assessment criteria relate to co-

regulatory arrangements for professions that are acknowledged by government for some form of financial support or benefit.

d. Medicare rebate

e. GST-free status

f. Workers' compensation payments

The financial healthcare benefits most widely available to the Australian population are Medicare rebates, GST-free health service provision and, for employed Australians, workers compensation. The challenge is that these government benefits are applied in an inconsistent manner across the non-registered healthcare workforce. Furthermore, workers compensation schemes are the province of state and territory governments, that display lack of uniformity adding yet more complexity to decision-making. Given this variation, I considered it reasonable to assess any profession receiving at least one of these benefits (with workers compensation benefits provided in at least one Australian jurisdiction) as sufficient cause for inclusion in the research study.

When these criteria were applied, thirteen professions were eliminated: art therapy, aromatherapy, audiometry, Ayurveda, complementary and alternative medicine practice, homeopathy, music, dance and drama therapy.

Sixteen professions remained following application of the criteria (see Appendix table 4.1).

Case selection

Applying the above criteria resulted in the inclusion of 16 professions: audiology, clinical perfusion, counselling, dietetics, exercise physiology, massage therapy, myotherapy, naturopathy, nutrition, orthoptics, paramedicine, psychotherapy, social work, sonography, speech pathology, and Western herbal medicine. At this stage of the assessment, I used the available data on consumer utilisation and size of the professional workforce to validate and refine the selection of professions.

Utilisation rates for included professions range from approximately 70,000 patient contacts per annum for clinical perfusion, to an estimated 4 million contacts per annum for massage therapy/myotherapy. Workforce numbers range from around 120 clinical perfusionists to 33,000 counsellors. See Appendix table 4.1 for more information on consumer utilisation rates and workforce size. These data supported the decision to include 15 of the 16 professions in the study. One occupation, nutrition, met the required criteria but utilisation rates and workforce size were difficult to ascertain. Nutrition advice is provided by a number of professional groups including allied health professionals (predominantly dietitians), medical practitioners, naturopaths, and nurses (Nutrition Society of Australia, 2021). Furthermore, available data on utilisation rates

combines nutrition and dietetics (ABS 2017) making it impossible to distinguish between the two professions. This blurring of role boundaries between nutrition and other nutrition-prescribing professions led me to exclude nutrition as a discrete profession.

The final tally of fifteen professions included in the research study were: audiology, clinical perfusion, counselling, dietetics, exercise physiology, Western herbal medicine, massage therapy, myotherapy, naturopathy, orthoptics, paramedicine, psychotherapy, social work, sonography, and speech pathology.

Appendix Table 4.1

Profession	Criteria for inclusion in the research study							Supporting information		In/Out	Comment
	Domain 1 Registration status	Domain 2 Self- regulation	Domain 3 Healthcare provider status		Domain 4 Government financial benefits						
	i. Non- registered on 1 Jul 2012 & listed in 2013 Options Report	ii. Occupational certification	iii. Primary care provider	iv. Allied health provider	v. Medicare rebate	vi. GST- free	vii. Workers compensation (in 1 or more jurisdictions)	Consumer utilisation (2014–15) '000	Workforce size (approx.)	Included in research scope	
Anaesthetist technician	✓	✓	Hospital	✗	✗	✗	✗			✗	
Anatomist / physiologist	✓	✓	✗	✗						✗	
Aromatherapist	✓	✓	✓	✗	✗	✗	✗			✗	
Art therapist	✓	✓	✗	✓	✗	✗	✗			✗	
Assistant in nursing	✓	✗								✗	
Audiologist	✓	✓	✓	✓	✓	✓	NSW Qld Vic	246	1,885	✓	
Audiometrist	✓	✓	✗	✗						✗	
Ayurvedic practitioner	✓	✓	✓	✗	✗	✗	✗			✗	
Biomedical engineer	✓	✓	✗	✗						✗	
Bioresonance practitioner	✓	✗								✗	
Cardiac technician/scientist	✓	✗								✗	
Clinical perfusionist	✓	✓	Hospital	✓	✓	✓	✗	70	120	✓	
Complementary & alternative medicine practitioner	✓	✓	✓	✗	✗	✗	✗			✗	Generic term for a group of professions outside mainstream health provision
Counsellor	✓	✓	✗	✓	✗	✗	NSW Qld	359	33,000	✓	
Dance therapist	✓	✓	✗	✓	✗	✗	✗			✗	
Dental assistant	✓	✓	✗	✗						✗	

Profession	Criteria for inclusion in the research study							Supporting information		In/Out	Comment
	Domain 1 Registration status	Domain 2 Self- regulation	Domain 3 Healthcare provider status		Domain 4 Government financial benefits						
	i. Non- registered on 1 Jul 2012 & listed in 2013 Options Report	ii. Occupational certification	iii. Primary care provider	iv. Allied health provider	v. Medicare rebate	vi. GST- free	vii. Workers compensation (in 1 or more jurisdictions)	Consumer utilisation (2014–15) '000	Workforce size (approx.)	Included in research scope	
Dental technician	✓	✓	✗	✗						✗	
Diabetes educator	✓	✓	✗	✓	✓	✓				✗	
Dialysis technician	✓	✓	✗	✗						✗	
Dietitian	✓	✓	✓	✓	✓	✓	Qld Vic	566	4,025	✓	
Diversional therapist	✓	✓	✗	✗						✗	
Drama therapist	✓	✓	✗	✓	✗	✗	✗			✗	
Drug and alcohol counsellor	✓	✓	✓	✓	✗	✗	✗			✗	
Electroencephalographic technician	✓	✗	Hospital	✗	✓	✓	✗			✗	Works under the direction of the EEG technologist
Environmental health officer	✓	✓	✗	✗						✗	
Exercise physiologist	✓	✓	✗	✓	✓	✗	NSW Qld Vic WA	109	2,564	✓	
Family and marriage counsellor	✓	✓	✓	✓	✗	✗	✗			✗	
Health information manager	✓	✓	✗	✗						✗	
Health practice manager	✓	✓	✗	✗						✗	
Health promotion officer	✓	✓	✗	✗						✗	
Herbalist/ Western herbalist	✓	✓	✓	✗	✗	✓	✗	716	150	✓	
Homeopath	✓	✓	✓	✗	✗	✗	✗			✗	
Hospital orderly	✓	✗								✗	

Profession	Criteria for inclusion in the research study							Supporting information		In/Out	Comment
	Domain 1 Registration status	Domain 2 Self- regulation	Domain 3 Healthcare provider status		Domain 4 Government financial benefits						
	i. Non- registered on 1 Jul 2012 & listed in 2013 Options Report	ii. Occupational certification	iii. Primary care provider	iv. Allied health provider	v. Medicare rebate	vi. GST- free	vii. Workers compensation (in 1 or more jurisdictions)	Consumer utilisation (2014–15) '000	Workforce size (approx.)	Included in research scope	
Hypnotherapist	✓	✓	✗	✗						✗	
Lactation consultant	✓	✓	✗	✗						✗	
Massage therapist	✓	✓	✓	✓	✗	✗	NSW SA Vic	4147	18,900	✓	
Medical laboratory scientist	✓	✓	✗	✗						✗	
Medical laboratory technician	✓	✓	✗	✗						✗	
Medical scientist	✓	✓	✗	✗						✗	
Music therapist	✓	✓	✗	✓	✗	✗	✗			✗	
Myotherapist	✓	✓	✓	✓	✗	✗	Vic (6)	See massage	See massage	✓	-
Naturopath	✓	✓	✓	✗	✗	✓	Vic	1,242	2,800	✓	
Neurophysiology technician	✓	✓	✓	✗	✗	✗	✗			✗	
Nutritionist	✓	✓	✓	✗	✗	✓	✗	See dietitian		✗	
Occupational health and safety adviser	✓	✗								✗	
Operating theatre technician	✓	✗								✗	
Optical dispenser	✓	✓	✗	✗						✗	
Optical mechanic	✓	✗	✗	✗						✗	
Orthoptist	✓	✓	✓	✓	✓	✗	✗	1502.3	834	✓	
Orthotist/prosthetist	✓	✓	✗	✗						✗	
Orthotic and prosthetic technician	✓	✗	✗	✗						✗	

Profession	Criteria for inclusion in the research study							Supporting information		In/Out	Comment
	Domain 1 Registration status	Domain 2 Self- regulation	Domain 3 Healthcare provider status		Domain 4 Government financial benefits						
	i. Non- registered on 1 Jul 2012 & listed in 2013 Options Report	ii. Occupational certification	iii. Primary care provider	iv. Allied health provider	v. Medicare rebate	vi. GST- free	vii. Workers compensation (in 1 or more jurisdictions)	Consumer utilisation (2014–15) '000	Workforce size (approx.)	Included in research scope	
Paramedic	✓	✓	✓	✓	✗	✓	✗	3,938	21,492	✓	Registered December 2018
Pharmacy sales assistant	✓	✗								✗	
Pharmacy technician	✓	✗								✗	
Phlebotomist	✓	✓	✗	✗						✗	
Psychotherapist	✓	✓	✗	✓ ^(3b)	✗	✗	NSW	See counselling	2,300	✓	
Reflexologist	✓	✓	✗	✗						✗	
Rehabilitation counsellor	✓	✓	✗	✗						✗	
Reiki practitioner	✓	✓	✗	✗						✗	
Respiratory scientist	✓	✓	✗	✗						✗	
Shiatsu therapist	✓	✓	✗	✗						✗	
Sleep technologist/technician	✓	✓	✗	✗						✗	
Social worker	✓	✓	✗	✓	✓	✓	NSW Qld Vic	255.9	21,949	✓	
Sonographer	✓	✓	✗	✓	✓	✓	✗	273.4	4,773	✓	
Speech pathologist	✓	✓	✓	✓	✓	✓	Qld SA Vic WA	207.9	7,251	✓	
Therapy aide	✓	✗								✗	
Weight loss consultant	✓	✗								✗	

Appendix 5: Document sources for mapping events and decisions relating to HPR.

Documents and websites
Allied Health Professions Australia. (2024a). <i>About AHPA</i> . https://ahpa.com.au/about-ahpa/
Allied Health Professions Australia. (2024b). <i>Become a member</i> . https://www.ahpa.com.au/member-organisations
<i>Allied Professionals Registration Amendment Act 1993</i> (NT). (No. 5 of 1993). https://legislation.nt.gov.au/api/sitecore/Bill/APDF?id=17846
Australian Bureau of Statistics. (2017). Australian health survey: health service usage and health related actions 2014/15. Table 2 Type of health professions consulted, persons. Cat. no. 4364.0.55.002, ABS. https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0022014-15?OpenDocument
Australian Bureau of Statistics. (2021a). The Australian Census. https://www.abs.gov.au/census/about-census/australian-census
Australian Bureau of Statistics. (2022). Conceptual basis of OSCA. ABS. https://www.abs.gov.au/statistics/classifications/osca-occupation-standard-classification-australia/2024-version-1-0/osca-structure
Australian Competition and Consumer Commission. (n.d.). Private health insurance. https://www.accc.gov.au/consumers/specific-products-and-activities/private-health-insurance
Australian Government, Department of Health and Ageing. (2008). Report on the audit of health workforce in rural and regional Australia. April 2008. https://apo.org.au/node/3628
Australian Government, Department of Health. (2022). Allied health workforce data gap analysis. Issues paper, 10 June 2022. Health Policy Analysis Pty Ltd https://www.health.gov.au/sites/default/files/documents/2022/09/allied-health-workforce-data-gap-analysis-issues-paper_1.pdf
Australian Government, Department of Health and Aged Care. (2024a). <i>Health Ministers' Meeting (HMM)</i> . https://www.health.gov.au/committees-and-groups/health-ministers-meeting-hmm#:~:text=Role,agreed%20to%20in%20national%20agreements
Australian Government, Department of Health and Aged Care. (2024b). <i>Health Chief Executives Forum (HCEF)</i> . https://www.health.gov.au/committees-and-groups/health-chief-executives-forum-hcef
Australian Government, Department of Health and Aged Care. (2024d). Medicare Benefits Schedule, Chinese medicine practitioner. https://www9.health.gov.au/mbs/search.cfm?q=chinese+medicine+practitioner&sopt=5
Australian Government, Department of Health and Aged Care. (2024e). Unleashing the potential of our health workforce: scope of practice review. Issues Paper 1. 23 January 2024. https://www.health.gov.au/resources/collections/issues-papers?language=en
Australian Government, Department of the Prime Minister and Cabinet. (2016). <i>Regulation of Paramedics</i> . Office of Best Practice Regulation. 18 March 2016. Department of the Prime Minister and Cabinet. https://obpr.pmc.gov.au/published-impact-analyses-and-reports/regulation-paramedics

Documents and websites
Australian Government, Department of the Prime Minister and Cabinet. (2020). The Australian Government guide to regulatory impact analysis (2nd ed.). https://obpr.pmc.gov.au/sites/default/files/2021-06/australian-government-guide-to-regulatory-impact-analysis.pdf
Australian Government, Department of the Prime Minister and Cabinet. (2021). <i>Regulatory impact analysis guide for Ministers' Meetings and national standard setting bodies</i> . May 2021. https://obpr.pmc.gov.au/sites/default/files/2021-06/regulator-analysis-guide.pdf
Australian Government, Department of the Prime Minister and Cabinet. (2023). <i>Regulatory impact analysis guide for Ministers' Meetings and national standard setting bodies</i> . June 2023, Office of Impact Analysis. https://oia.pmc.gov.au/resources/guidance-impact-analysis/regulatory-impact-analysis-guide-ministers-meetings-and-national
Australian Government, Department of the Prime Minister and Cabinet. (n.d.). <i>Australia's Regulatory Impact Analysis (RIA) Framework</i> . https://oia.pmc.gov.au/about/ria-framework-key-changes-over-time
Australian Government, Department of Veterans' Affairs. (2021). Alternative funding models for allied health services for veterans. 1 August 2021. Nous Group. https://www.dva.gov.au/sites/default/files/2022-07/DVA_Nous_Report_Final.pdf
Australian Government, Department of Veterans' Affairs. (2023). Become a DVA health care provider. 5 May 2023. https://www.dva.gov.au/get-support/providers/become-dva-health-care-provider#rwu
Australian Government, Productivity Commission. (2005). <i>Australia's health workforce</i> . Research Report, 22 December 2005. Canberra: Productivity Commission. https://www.pc.gov.au/inquiries/completed/health-workforce/report/healthworkforce.pdf
Australian Government, Senate Community Affairs Legislation Committee. (2009). National registration and accreditation scheme for doctors and other health workers. August 2009. https://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/completed_inquiries/2008-10/registration_accreditation_scheme/report/index
Australian Government, Senate Community Affairs References Committee,. (2022). Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the <i>Health Practitioner Regulation National Law</i> . April 2022. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AHPRA/Report
Australian Government, Senate Standing Committee on Community Affairs. (2021). Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the <i>Health Practitioner Regulation National Law</i> . https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AHPRA
Australian Health Ministers' Advisory Council. (2008b). <i>National Registration and Accreditation Scheme. Calls for submissions and submissions received</i> . https://webarchive.nla.gov.au/awa/20091112011544/http://nhwt.gov.au/natreg-calls.asp
Australian Health Ministers' Advisory Council. (2009). <i>Regulatory impact statement for the decision to implement the Health Practitioner Regulation National Law</i> . Governance Committee, National Registration and Accreditation Implementation Project. 3 September.

Documents and websites
https://web.archive.org/web/20220314105948/https://agedcare.royalcommission.gov.au/system/files/2020-10/ATB.0001.0001.0104.pdf
Australian Health Ministers' Advisory Council. (2011b). <i>Options for regulation of unregistered health practitioners</i> . Consultation paper. February 2011. https://oia.pmc.gov.au/sites/default/files/posts/2011/06/unregistered_health_practitioners.pdf
Australian Health Ministers' Advisory Council. (2012). <i>Options for regulation of paramedics</i> . Consultation paper. July 2012. https://oia.pmc.gov.au/sites/default/files/posts/2012/07/options_for_regulation_of_paramedics_consultation_paper.pdf
Australian Health Ministers' Advisory Council. (2013). <i>Options for regulation of unregistered health practitioners</i> . Final report. April 2013. https://oia.pmc.gov.au/sites/default/files/posts/2013/08/unregistered-health-practitioners-final-report-decision-RIS.pdf
Australian Health Ministers' Advisory Council. (2014a). Review of the National Registration and Accreditation Scheme for health professions. Consultation paper. August 2014. https://www.nhaa.org.au/wp-content/uploads/Consultation_Paper_-_Review_of_NRAS_for_health_professions.pdf
Australian Health Ministers' Advisory Council. (2014b). <i>Independent review of the National Registration and Accreditation Scheme for health professions</i> . Final report. December 2014. https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31804&dbid=AP&chksu m=LDHcqSp8liqgxdxQ5zCmQ%3d%3d
Australian Health Ministers' Advisory Council. (2015b). <i>Options for regulation of paramedics</i> . Final report. September 2015. https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31806&dbid=AP&chksu m=xOJ6DDQ%2bS06BshRIGW4BjQ%3d%3d
Australian Health Ministers' Advisory Council. (2018a). AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions. September 2018. https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31798&dbid=AP&chksu m=W16VRFp6%2bKE9gQghhFI%2bKA%3d%3d
Australian Health Ministers' Advisory Council. (2018b). <i>Guide to the National Registration and Accreditation Scheme for health professions</i> . COAG Health Council. July 2018. https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31800&dbid=AP&chksu m=DJv2goMFt4mFaBiCKERVmg%3D%3D
Australian Health Practitioner Regulation Agency. (2011). Ahpra and National Boards Submission to the Senate Finance and Public Administration References Committee Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA). 14 April 2011. Submission 26. https://www.ahpra.gov.au/documents/default.aspx?record=WD11%2f5341&dbid=AP&chksu m=CWki8ZpM8qVFUS6EWkWIw%3d%3d
Australian Health Practitioner Regulation Agency. (2012). <i>Annual Report 2011-2012</i> . https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx
Australian Health Practitioner Regulation Agency. (2013). <i>Annual Report 2012-2013</i> . https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx

Documents and websites
Australian Health Practitioner Regulation Agency. (2018). <i>Paramedics: Welcome to the National Scheme!</i> 30 November 2018. https://www.paramedicineboard.gov.au/News/2018-11-30-Paramedics-Welcome-to-the-National-Scheme.aspx
Australian Health Practitioner Regulation Agency. (2020). <i>Annual Report 2019-20</i> . https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx
Australian Health Practitioner Regulation Agency. (2021). <i>Annual Report 2020-2021</i> . https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx
Australian Health Practitioner Regulation Agency. (2023a). <i>Annual Report 2022-2023</i> . https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx
Australian Health Practitioner Regulation Agency. (2023b). <i>Ministerial directives and communiqués</i> . https://www.ahpra.gov.au/About-Ahpra/Ministerial-Directives-and-Communiqués.aspx
Australian Health Practitioner Regulation Agency. (2023e). <i>What we do</i> . https://www.ahpra.gov.au/About-Ahpra/What-We-Do.aspx
Australian Health Workforce Ministerial Council. (2009). <i>Communiqué: Design of new National Registration and Accreditation Scheme</i> . Melbourne, 8 May 2009. https://web.archive.org/awa/20150622003328mp_/http://www.ahpra.gov.au/documents/default.aspx?record=WD11%2f4568&dbid=AP&chksum=kzPmDIlxyG4k04VD8R%2fJsA%3d%3d
Australian Health Workforce Ministerial Council. (2010). Australian Health Workforce Ministerial Council meeting. Final decisions and actions arising. Melbourne, 12 February 2010. https://www.ahpra.gov.au/documents/default.aspx?record=WD10%2F4060&dbid=AP&chksum=0NWg8A40kxkC2byk2XEnqw%3D%3D
Australian Health Workforce Ministerial Council. (2011). AHWMC submission to the Senate Finance and Public Administration References Committee Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA). April 2011. https://www.aph.gov.au/DocumentStore.ashx?id=de580e84-2507-4c6b-8513-3874f4d6f258
Australian Institute of Health and Welfare. (2022). Use of chronic disease management and allied health Medicare services - spending on Medicare-subsidised allied health services. 15 December 2022. https://www.aihw.gov.au/reports/chronic-disease/medicare-chronic-disease-allied-health-items/contents/allied-health-services/spending-on-medicare-subsidised-allied-health-serv
Australian Naturopathic Council. (2024). <i>Australian Naturopathic Council</i> . https://www.naturopathiccouncil.org.au/
Australian Register of Counsellors and Psychotherapists. (2011). <i>ARCAP response to consultation on options for regulation of unregistered health practitioners</i> . https://www.arcapregister.com.au/wp-content/uploads/2017/10/arcap_response_to_consultation_on_regulation_2.pdf
Australian Register of Naturopaths and Herbalists. (2014). <i>Alignment of complementary health qualifications to the Australian Qualifications Framework</i> . http://www.aronah.org/cshisc-support/

Documents and websites
Australian Taxation Office. (2024). Other health services. Listed health services. 12 June 2024. https://www.ato.gov.au/businesses-and-organisations/gst-excise-and-indirect-taxes/gst/in-detail/your-industry/gst-and-health/other-health-services#Eligiblehealthservices
Bismark, M.M., & Studdert, D.M. (2010). Realising the research power of complaints data. <i>The New Zealand Medical Journal</i> , 123(1314), 12-17.
Bupa HI Pty Ltd. (n.d.). Recognition criteria - Chinese herbal medicine. https://www.bupa.com.au/for-providers/ancillary/chinese-herbal-medicine#:~:text=Minimum%20educational%20qualifications,majoring%20in%20Chinese%20Herbal%20Medicine
Carlton, A.-L. (2006). National models for regulation of the health professions. <i>Law Context: A Socio-Legal Journal</i> , 23(2), 21-51. https://search.informit.org/doi/10.3316/ielapa.114642393174735
Carlton, A.-L., Leslie, K., Bourgeault, I.L., Balasubramanian, M., Mirshahi, R., Short, S., Carè, J., & Lin, V. (2024). Health practitioner regulation systems: a large-scale rapid review of the design, operation and strengthening of health practitioner regulation systems. Working Paper Series, January 2024. Canadian Health Workforce Network. https://www.hhr-rhs.ca/images/PDFs/HPRS_Report_Jan.2024.pdf
Christian Counsellors Association of Australia. (2022). <i>PACFA, ACA and ARCAP</i> . https://ccaa.net.au/about/pacfa-and-arcap/
Comcare. (2023). Allied health professionals. https://www.comcare.gov.au/service-providers/medical-allied-health/allied-health
Cormack, M. (2024). Unleashing the potential of our health workforce: scope of practice review. Final report, October 2024. https://www.health.gov.au/resources/publications/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report
Council of Ambulance Authorities. (2024). <i>The Council of Ambulance Authorities</i> . https://www.caa.net.au/about
Council of Australian Governments. (1992). <i>Intergovernmental Agreement on Mutual Recognition</i> . 5 November 1992. https://federation.gov.au/about/agreements/agreement-relating-mutual-recognition
Council of Australian Governments. (2007). <i>Best practice regulation: a guide for Ministerial Councils and national standard setting bodies</i> . October 2007.
Council of Australian Governments. (2008). <i>Intergovernmental Agreement for a National Registration and Accreditation Scheme for the health professions</i> . 26 March 2008. https://federation.gov.au/about/agreements/intergovernmental-agreement-health-workforce
Council of Australian Governments. (2012). <i>About COAG</i> . https://webarchive.nla.gov.au/awa/20210121023318/https://www.coag.gov.au/about-coag
Council of Australian Governments Health Council. (2015a) <i>Communiqué</i> . 6 November 2015. Adelaide. https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31805&dbid=AP&chksu m=p%2bOSKjOPfd%2fU6FzEffVjZQ%3d%3d

Documents and websites
Council of Australian Governments Health Council. (2015b). <i>Communiqué: A National Code of Conduct for health workers</i>. 17 April 2015. Sydney. https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31795&dbid=AP&chksu m=KBWAgQM3aVO2g8BSSM3%2fKw%3d%3d
Council of Australian Governments Health Council. (2015c). <i>Communiqué: The Independent Review of the National Registration and Accreditation Scheme for health professions</i>. Meeting as the Australian Health Workforce Ministerial Council. 7 August 2015. Darwin. https://www.ahpra.gov.au/documents/default.aspx?record=WD15%2f17740&dbid=AP&chk sum=FDOrpf%2fq0SfpDKC5lvVNsg%3d%3d&_gl=1*19lss1q*_ga*MTg2MDQ4NzE3LjE3MzY3MzUwNjE.*_ga_F1G6LRCHZB*MTczNzU4OTIzMy4zLjEuMTczNzU4OTI3Ny4wLjAuMA
Council of Australian Governments Health Council. (2015d). <i>A National Code of Conduct for health care workers</i>. Final report. 17 April 2015. Australian Health Ministers' Advisory Council. https://www.anpa.asn.au/files/Final%20Report%20-%20A%20National%20Code%20of%20Conduct%20for%20health%20care%20workers%20-%20April%2017%202015.pdf
Council of Australian Governments Health Council. (2016). <i>Communiqué</i>. 7 October 2016. Canberra. https://ahpra-search.clients.funnelback.com/s/redirect?collection=ahpra-websites-web&url=https%3A%2F%2Fwww.ahpra.gov.au%2Fdocuments%2Fdefault.aspx%3Frecord%3DWD16%252f21506%26dbid%3DAP%26chksu m%3DBPf8EmH25MWLAVHVx05BZA%253d%253d&auth=nn76%2F%2F2i8lgzauiz%2BCKSQw&profile=occupationaltherapy&rank=4&query=COAG+communiqué+%7C%5Bf%3A%22%24%2B%2B+web+page+%24%2B%2B%22+f%3A%22%24%2B%2B+pdf+%24%2B%2B%22%25D+%7C%5Bcontent%3A%22%24%2B%2B+comm unique+-+update+%24%2B%2B%22+content%3A%22%24%2B%2B+news+%24%2B%2B%22%25D+%7C d%3D2016
Council of Australian Governments Health Council. (2018). <i>Communiqué: Purpose of the National Registration and Accreditation Scheme</i>. 11 September 2018. https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31799&dbid=AP&chksu m=Do7bKOrNq5bLPPvgl6dqfw%3d%3d
Council of Australian Governments Health Council. (2019). <i>Communiqué</i>. 31 October - 1 November 2019. Perth. http://www.coaghealthcouncil.gov.au/Projects/Health-Practitioner-Regulation-National-Law https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31796&dbid=AP&chksu m=tHA6PF0%2b1BCQKwFYnUDTWw%3d%3d https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31797&dbid=AP&chksu m=5ac27DOLKeZ%2fSoZEf4XgQQ%3d%3d
Dawson, S. (2024). Regulating for results. Consultation paper 1: review of complexity in the National Registration and Accreditation Scheme. September 2024. https://www.health.gov.au/resources/publications/consultation-paper-1-review-of-complexity-in-the-national-registration-and-accreditation-scheme?language=en
Donato, R., & Onur, I. (2018). Private health insurance in Australia: policy reform approaches towards greater competition and efficiency to improve health system performance. October 2018, Monash University, Monash Business School, Australian Centre for Financial Studies. https://www.monash.edu/__data/assets/pdf_file/0005/2325884/Private-health-insurance-in-Australia.pdf

Documents and websites
Exercise and Sports Science Australia. (2021). Annual Report 2020-2021. https://www.essa.org.au/Common/Uploaded%20files/Reports/annual-report-2021.pdf
HBF Health Limited. (2024). Ancillary providers: information for ancillary providers and registration requirements with HBF. https://www.hbf.com.au/about-hbf/for-providers/ancillary
<i>Health and Community Services (Further Amendment) Act 1993</i> (Vic). (No. 124 of 1993). https://www.austlii.edu.au/au/legis/vic/hist_act/hacsaa1993470.pdf
<i>Health Practitioner Regulation National Law Act 2009</i> (Qld). (Act No. 45 of 2009). https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-045/lh
<i>Health Practitioner Regulation National Law Act (Administrative Arrangements) 2008</i> (Qld) (Act No. 62 of 2008). https://www.legislation.qld.gov.au/view/pdf/asmade/act-2008-062
<i>Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017</i> (Qld). (Act No. 32 of 2017). https://www.legislation.qld.gov.au/view/html/asmade/act-2017-032
<i>Health Professionals Act 2004</i> (ACT). (A2004-38). https://www.legislation.act.gov.au/DownloadFile/a/2004-38/20041118-14870/PDF/2004-38.PDF
<i>Health Professions Registration Act 2005</i> (Vic). (Act No. 97/2005). https://www.legislation.vic.gov.au/as-made/acts/health-professions-registration-act-2005
Health Workforce Principal Committee, Practitioner Regulation Subcommittee (2008). AHMAC agreed criteria for assessing the regulatory requirements for unregistered health occupations. https://webarchive.nla.gov.au/awa/20091112014211/http://nhwt.gov.au/hwpc-pracreg-sub.asp
Hospitals Contribution Fund of Australia Limited. (2023). Recognition requirements for providers of Chinese herbal medicine. https://www.hcf.com.au/pdf/Chinese_herbal_medicine_recognition_criteria.pdf
Medibank Private Limited. (2024). Ancillary provider recognition. https://www.medibank.com.au/providers/requirements/
<i>Medicare Agreements Act 1992</i> (Cth). (No. 226). https://www.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/num_act/maa1992168/s6.html
Morris, J., Moore, J., & Bismark, M. (2018). Health complaints entities in Australia and New Zealand: serving the public interest? In J.M. Chamberlain, M. Dent, & M. Saks (Eds.), <i>Professional Health Regulation in the Public Interest</i> (pp. 221-244). Polity Press. https://doi.org/10.51952/9781447332275.ch012
National Alliance of Self Regulating Health Professions. (2012). Harnessing self-regulation to support safety and quality in healthcare delivering: a comprehensive model for regulating all health practitioners. Proposal by the National Alliance of Self Regulating Health Professions, 1 March 2012. https://www.aopa.org.au/documents/item/123
National Alliance of Self Regulating Health Professions. (2024). About NASRHP. https://nasrhp.org.au/about/

Documents and websites
National Disability Insurance Agency. (2023). National Disability Insurance Scheme: 2022-23 annual pricing review report. June 2023. https://www.ndis.gov.au/media/6051/download?attachment
NDIS Quality and Safeguards Commission. (2018). Suitability assessment process guide. Information for NDIS Providers and their 'key personnel'. July 2018. Version 1. https://www.ndiscommission.gov.au/sites/default/files/2022-02/suit-assess-process-guide0-2_0.pdf
NIB Health Funds Limited. (2024). Ancillary providers. https://www.nib.com.au/providers/ancillary
NSW Health Care Complaints Commission. (2023). <i>Annual Report 2022-23. Protecting public health and safety</i> . https://www.hccc.nsw.gov.au/about-us/our-performance/annual-reports/default
Occupational Therapists Board of Queensland. (2012). <i>Occupational Therapists Board of Queensland: a history</i> . https://www.occupationaltherapyboard.gov.au/documents/default.aspx?record=WD12%2F8399&dbid=AP&chksun=SfMd1xjsN%2F1k47blbbm7MA%3D%3D
Oke, L. (2013). <i>Self-regulating health professions get proactive about standards of practice</i> . 24 October 2013. https://www.hospitalhealth.com.au/content/aged-allied-health/article/self-regulating-health-professionals-get-proactive-about-standards-of-practice-27581429
Professional Standards Councils. (2024). About us. https://www.psc.gov.au/about-us
Psychotherapy and Counselling Federation of Australia. (n.d.). <i>About PACFA</i> . https://www.pacfa.org.au/portal/portal/About/About.aspx?hkey=2afa9cff-85e0-4bfb-9415-c8ed5d60218c
Schofield, M. (2008). <i>Best practice self-regulation model for psychotherapy and counselling in Australia: final report</i> . February 2008. Psychotherapy and Counselling Federation of Australia. https://www.pacfa.org.au/common/Uploaded%20files/PCFA/Documents/Research/2008-self-regulation-report.pdf
Services Australia. (2024). Eligibility for health professionals. 24 June 2024. https://www.servicesaustralia.gov.au/eligibility-for-health-professionals?context=20
Social Workers Registration Bill 2018. (No. 45, 5 September 2018). https://www.legislation.sa.gov.au/__legislation/lz/b/archive/social%20workers%20registration%20bill%202018_%20hon%20tammy%20franks%20mlc/b_as%20introduced%20in%20lc/social%20workers%20registration%20bill%202018.un.pdf
<i>Social Workers Registration Act 2021 (SA) 2021</i> . https://www.legislation.sa.gov.au/lz/path=/v/a/2021/social%20workers%20registration%20act%202021_56
Standing Council on Health. (2014). National Registration and Accreditation Scheme for the health professions. Review Terms of Reference. Meeting as the Australian Health Workforce Ministerial Council. 29 April 2014. https://www.ahpra.gov.au/documents/default.aspx?record=WD14%2F13705&dbid=AP&chksun=wmkfvaZlILqu5d%2FsTv066g%3D%3D

Documents and websites
Victorian Government, Department of Human Services. (2003). <i>Regulation of the health professions in Victoria. A discussion paper</i> . October 2003. Policy and Strategic Projects Division. Melbourne. https://vgls.sdp.sirsidynix.net.au/client/search/asset/1160624
Victorian Health Complaints Commissioner. (2023). Annual Report 2022-23. Supporting safe and ethical care. https://hcc.vic.gov.au/resources/publications/annual-reports
Queensland Government, Queensland Health. (2024a). Audiology Decision RIS. Consultation paper. Brisbane. https://www.health.qld.gov.au/__data/assets/pdf_file/0035/1327976/audiology-ris-consultation-paper.pdf
Queensland Government, Queensland Health. (2024b). Audiology decision RIS. Consultation paper 2. Brisbane. https://www.deafnessforum.org.au/wp-content/uploads/2024/12/Audiology-Decision-RIS_Consultation-Paper-2.pdf
Australian Government, Department of Health and Aged Care. (2024c). Independent review of complexity in the National Registration and Accreditation Scheme. Terms of Reference. 29 May 2024. Commonwealth of Australia. Canberra. https://www.health.gov.au/resources/publications/independent-review-of-complexity-in-the-national-registration-and-accreditation-scheme-terms-of-reference?language=en
Dawson, S. (2024). Regulating for results. Review of complexity in the National Registration and Accreditation Scheme. Consultation paper 1. 12 September 2024. https://www.health.gov.au/resources/publications/consultation-paper-1-review-of-complexity-in-the-national-registration-and-accreditation-scheme?language=en
Cormack, M. (2024). Unleashing the potential of our health workforce: Scope of practice review. Final report. October 2024. https://www.health.gov.au/resources/publications/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report

Appendix 6: Data sources for documents included in document analysis.

Profession	Searches performed and date searched
Professional association	
Audiology	Search 1: Audiology Australia 13/05/2021 Australian College of Audiology 13/05/2021 Independent Audiologists Australia 13/05/2021 Search 2: audiology australia regulation/registration/statutory/ahpra australian college of audiology regulation/registration/statutory/ahpra 20/05/2021 independent audiologists australia regulation/registration/statutory/ahpra 20/05/2021 Search 3: audiology australia position statement/submission 09-10/07/2021 australian college of audiology position statement/submission 29/07/2021 independent audiologists australia position statement/submission 29/07/2021
Counselling	Search 1: Australian Counselling Association 15/05/2021 Australian Community Counselling Association 15/05/2021 Christian Counsellors Association of Australia 15/05/2021 Psychotherapy and Counselling Federation of Australia 15/05/2021 Search 2: australian counselling association regulation/registration/statutory/ahpra 20/05/2021 Australian Community Counselling Association regulation/registration/statutory/ahpra 20/05/2021 Christian Counsellors Association of Australia regulation/registration/statutory/ahpra 20/05/2021 psychotherapy and counselling federation of australia regulation/registration/statutory/ahpra 20/05/2021 Search 3: Australian Counselling Association position statement/submission 31/07/2021 Australian Community Counselling Association position statement/submission 31/07/2021 Christian Counsellors Association of Australia position statement/submission 31/07/2021 psychotherapy and counselling federation of australia position statement/submission 31/07/2021
Dietetics	Search 1: Dietitians Association of Australia 07/05/2021 Search 2: Dietitians Association of Australia regulation/registration/statutory/ahpra 20/05/2021

Profession	Searches performed and date searched
	Search 3: Dietitians Association of Australia position statement/submission 11/07/2021
Exercise Physiology	Search 1: Exercise and Sports Science Australia 24/04/2021 Search 2: Exercise and Sports Science Australia regulation/registration/statutory/ahpra 26/06/2021 Search 3: Exercise and Sports Science Australia position statement/submission 01/08/2021
Massage therapy/myotherapy	Search 1: Association of Massage Therapists 18/05/2021 Massage Association of Australia 18/05/2021 Massage Australia 03/07/2021 Massage and myotherapy Australia (previously Australian Association of Massage Therapists) 18/05/2021 Myotherapy Association Australia (Institute of Registered Myotherapists of Australia) 09/05/2021 Australian Natural therapists Association 18/05/2021 Australian Traditional Medicine Society 18/05/2021 Search 2: Association of Massage Therapists regulation/registration/statutory/ahpra 21/05/2021 Massage Association of Australia regulation/registration/statutory/ahpra 22/05/2021 Massage Australia regulation/registration/statutory/ahpra 03/07/2021 Massage and Myotherapy Australia regulation/registration/statutory/ahpra 22/05/2021 Australian Association of Massage Therapists regulation/registration/statutory/ahpra 22/05/2021 Myotherapy Association Australia regulation/registration/statutory/ahpra 22/05/2021 Institute of Registered Myotherapists of Australia regulation/registration/statutory/ahpra 22/05/2021 ANTA regulation/registration/statutory/ahpra 22/05/2021 ATMS regulation/registration/statutory/ahpra 22/05/2021 Search 3: Association of Massage Therapists position statement/submission 12/08/2021 Massage Association of Australia position statement/submission 12/08/2021 Massage Australia position statement/submission 12/08/2021 Massage and Myotherapy Australia position statement/submission 12/08/2021 Australian Association of Massage Therapists position statement/submission 13/08/2021 Myotherapy Association Australia position statement/submission

Profession	Searches performed and date searched
	13/08/2021 Institute of Registered Myotherapists of Australia position statement/submission 13/08/2021 Australian natural therapists association position statement/submission 13/07/2021 Australian traditional medicine society position statement/submission 13/07/2021
Naturopathy	Search 1: Australian Naturopathic Practitioners Association 18/05/2021 Australian Natural therapists Association 18/05/2021 Australian Traditional Medicine Society 18/05/2021 Complementary Medicine Association 18/05/2021 Naturopaths and Herbalists Association of Australia 22/05/2021 Society of Natural Therapists & Researchers 03/07/2021 Search 2: ANPA regulation/registration/statutory/ahpra 22/05/2021 ANTA regulation/registration/statutory/ahpra 22/05/2021 ATMS regulation/registration/statutory/ahpra 22/05/2021 Complementary Medicine Association regulation/registration/statutory/ahpra 22/05/2021 NHAA regulation/registration/statutory/ahpra 22/05/2021 Society of Natural Therapists & Researchers regulation/registration/statutory/ahpra 03/07/2021 Search 3: Australian naturopathic practitioners association position statement/submission 13/07/2021 Australian natural therapists association position statement/submission 13/07/2021 Australian traditional medicine society position statement/submission 13/07/2021 Complementary Medicine Association position statement position statement/submission 13/07/2021 Naturopaths and herbalists association of Australia position statement position statement/submission 13/07/2021 Society of Natural Therapists & Researchers position statement position statement/submission 03/08/2021
Orthoptics	Search 1: Orthoptics Australia 19/06/2021 Search 2: orthoptics australia regulation/registration/statutory/ahpra 20/05/2021 Search 3: orthoptics australia position statement/submission 07/08/2021
Paramedicine	Search 1: Council of Ambulance Authorities 19/05/2021 Australasian College of Paramedicine (previously Australian College of Ambulance Professionals, Journal of Emergency Primary Health Care now Australasian Journal of Paramedicine) 19/05/2021 Australasian College of Paramedic Practitioners 19/05/2021

Profession	Searches performed and date searched
	Search 2: Council of Ambulance Authorities regulation/registration/statutory/ahpra 23/05/2021 Australasian College of Paramedicine regulation/registration/statutory/ahpra 23/05/2021 Australasian College of Paramedic Practitioners regulation/registration/statutory/ahpra 23/05/2021 Search 3: Council of Ambulance Authorities position statement/submission 11 & 13/07/2021 Australasian College of Paramedicine position statement/submission 13/07/2021 Australasian College of Paramedic Practitioners position statement/submission 13/07/2021
Clinical perfusion	Search 1: Australian and New Zealand College of Perfusionists 21/06/2021 Search 2: Australian and New Zealand College of Perfusionists regulation/registration/statutory/ahpra 21/05/2021 Search 3: Australian and New Zealand College of Perfusionists position statement/submission 04/08/2021
Psychotherapy	Search 1: Australian Association of Clinical Hypnotherapy & Psychotherapy 15/05/2021 Psychotherapy and Counselling Federation of Australia 15/05/2021 Search 2: Australian Association of Clinical Hypnotherapy & Psychotherapy regulation/registration/statutory/ahpra 23/05/2021 Psychotherapy and Counselling Federation of Australia regulation/registration/statutory/ahpra 23/05/2021 Search 3: Australian Association of Clinical Hypnotherapy & Psychotherapy position statement/submission 03/08/2021
Social Work	Search 1: Australian Association of Social Workers 16/05/2021 Search 2: Australian Association of Social Workers regulation/registration/statutory/ahpra 23/05/2021 Search 3: Australian Association of Social Workers position statement/submission 11/07/2021
Sonography	Search 1: Australasian Sonographers Association 22-23/06/2021 Australasian Society for Ultrasound in Medicine 26/06/2021 Australian Society of Medical Imaging & Radiation Therapy 26/06/2021 Search 2:

Profession	Searches performed and date searched
	Australasian Sonographers Association regulation/registration/statutory/ahpra 23/06/2021 Australasian Society for Ultrasound in Medicine regulation/registration/statutory/ahpra 27/06/2021 Australian Society of Medical Imaging & Radiation Therapy regulation/registration/statutory/ahpra 27/06/2021 Search 3: Australasian Sonographers Association position statement/submission 07/08/2021 Australasian Society for Ultrasound in Medicine position statement/submission 11/08/2021 Australian Society of Medical Imaging & Radiation Therapy position statement/submission 11/08/2021
Speech pathology	Search 1: Speech Pathology Australia 16/05/2021 Search 2: Speech Pathology Australia regulation/registration/statutory/ahpra 23/05/2021 Search 3: Speech Pathology Australia position statement/submission 04/08/2021
Western herbal medicine	Search 1: Australian Natural Therapists Association 18/05/2021 Australian Traditional Medicine Society 18/05/2021 Complementary Medicine Association 18/05/2021 Naturopaths and Herbalists Association of Australia 22/05/2021 Society of Natural Therapists & Researchers 03/07/2021 Search 2: ANTA regulation/registration/statutory/ahpra 22/05/2021 ATMS regulation/registration/statutory/ahpra 22/05/2021 Complementary Medicine Association regulation/registration/statutory/ahpra 22/05/2021 NHAA regulation/registration/statutory/ahpra 22/05/2021 Society of Natural Therapists & Researchers regulation/registration/statutory/ahpra 03/07/2021 Search 3: Australian natural therapists association position statement/submission 13/07/2021 Australian traditional medicine society position statement/submission 13/07/2021 Complementary Medicine Association position statement position statement/submission 13/07/2021 Naturopaths and herbalists association of Australia position statement position statement/submission 13/07/2021 Society of Natural Therapists & Researchers position statement position statement/submission 03/08/2021
Peak body	
Allied health	Search 1:

Profession	Searches performed and date searched
	Allied Health Professions Australia 09/05/2021 Search 2: Allied Health Professions Australia regulation/registration/statutory/ahpra 23/05/2021 Search 3: Allied Health Professions Australia position statement/position submission/submission 10/07/2021
Allied health	Search 1: National Alliance of Self Regulating Health Professions 09/05/2021 Search 2: National Alliance of Self Regulating Health Professions regulation/registration/statutory/ahpra 23/05/2021 Search 3: National Alliance of Self Regulating Health Professions position statement/submission 10/07/2021
Naturopathy	Search 1: Australian Naturopathic Council 09/05/2021 Search 2: Australian Naturopathic Council regulation/registration/statutory/ahpra 23/05/2021 Search 3: Australian Naturopathic Council position statement/submission 10/07/2021
Registering organisation	
Counsellors and psychotherapists	Search 1: Australian Register of Counsellors & Psychotherapists 07/05/2021 Search 2: Australian Register of Counsellors and Psychotherapists regulation/registration/statutory/ahpra 23/05/2021 Search 3: Australian Register of Counsellors and Psychotherapists position statement position statement/submission 03/08/2021
Dietitians	Search 1: Dietitians Association of Australia 07/05/2021 Search 2: Register of Accredited Practising Dietitians regulation/registration/statutory/ahpra 23/05/2021 Search 3: Dietitians Association of Australia position statement/submission 11/07/2021
Naturopaths and herbalists	Search 1: Australian Register of Naturopaths & Herbalists 07/05/2021 Search 2: Australian Register of Naturopaths & Herbalists regulation/registration/statutory/ahpra 23/05/2021 Search 3:

Profession	Searches performed and date searched
	Australian Register of Naturopaths & Herbalists position statement/submission 11/07/2021
Orthoptics	Search 1: Australian Orthoptic Board 21/06/2021 Search 2: Australia Orthoptic Board regulation/registration/statutory/ahpra 21/05/2021 Search 3: Australian Orthoptic Board position statement/submission 07/08/2021
Sonography	Search 1: Australian Sonographer Accreditation Registry 24/06/2021 Search 2: Australian Sonographer Accreditation Agency regulation/registration/statutory/ahpra 21/05/2021 Search 3: Australian Sonographer Accreditation Agency position statement/submission 07/08/2021
	Additional search of Trove, Productivity Commission, AHMAC sites for consumer submissions expressing attitudes to registration
	2014 Victorian Government Inquiry into the performance of AHPRA https://www.parliament.vic.gov.au/4ae644/contentassets/cda8148c3c784647ad10057d4f131c41/final_version_ahpra_report_30314.pdf
	Senate Inquiry into National Registration and Accreditation Scheme for Doctors and Other Health Workers 2009 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/registration_accreditation_scheme/index
	Senate Inquiry into National Registration and Accreditation Scheme for Doctors and Other Health Workers 2009 - submissions https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/registration_accreditation_scheme/submissions/sublist

Search 1: Search of the professional body website.

Search 2: Google search of the professional body together with regulation-related terms.

Search 3: Google search of the professional body together with terms relating to document type.

Appendix 7: Professional bodies excluded from the interview recruitment schedule.

Organisation	Audiology	Clinical perfusion	Counselling	Dietetics	Exercise physiology	Massage therapy	Myotherapy	Naturopathy	Orthoptics	Paramedicine	Psychotherapy	Social work	Sonography	Speech pathology	Western herbal medicine	Comment
Peak professional bodies																
Australian Naturopathic Council (ANC)								•							•	
Registering organisations																
Australian Register of Counsellors & Psychotherapists (ARCAP)			•								•					ARCAP is the registering body for the Australian Counselling Association, and the Psychotherapy & Counselling Federation of Australia. Once accepted as a member of ACA or PACFA there is automatic membership entry to ARCAP. The ARCAP Board comprises four directors with equal standing. There is no president, vice president, or CEO. Two directors are appointed from each of ACA and PACFA. An interview with ARCAP must include all four directors at once (Personal email communication, 8 June 2022). ARCAP was excluded since separate interviews had been arranged with ACA and PACFA
Professional associations																
Australian College of Audiology (ACAud)	•															Preference was given to membership associations over colleges and two associations for audiology were included in recruitment schedule.
Hearing Aid Audiology Society of Australia (HAASA)																The association represents audiometrists which were excluded from study scope following assessment of professions.
Australasian Society of Cardiovascular Perfusionists (ASCVP)		•														No information found on internet search. Appears to no longer be in operation.

Organisation	Audiology	Clinical perfusion	Counselling	Dietetics	Exercise physiology	Massage therapy	Myotherapy	Naturopathy	Orthoptics	Paramedicine	Psychotherapy	Social work	Sonography	Speech pathology	Western herbal medicine	Comment
Australian Community Counselling Association (ACCA)			•													
Christian Counsellors Association of Australia (CCAA)			•													The association has around 400 members and is the smallest of the associations representing counsellors.
Australian Association of Clinical Hypnotherapy & Psychotherapy (AACHP)											•					No information found on internet search. Appears to no longer be in operation.
Massage Australia (MA)						•										No information found on internet search. Appears to no longer be in operation.
Australian Naturopathic Practitioners Association (ANPA)								•								The association has around 300 members and is the smallest of the associations representing naturopaths.
Complementary Healthcare Council of Australia (CHCA)																Represents complementary medicines industry not health professions or practitioners.
Complementary Medicine Association (CMA)								•							•	With fewer than 600 members, the association is smaller than others representing naturopaths and Western herbalists.
Australian & New Zealand College of Paramedicine (ANZPara)										•						No information on internet search. A perusal of the Australian Business Register suggests it may have merged with the Australasian College of Paramedicine.
Paramedics Australasia (PA)										•						No longer operating. May have merged with the Australasian College of Paramedicine – see https://www.facebook.com/ParamedicsAustralasia/ .
National Council of Ambulance Unions (NCAU)										•						Name changed to the Australasian Council of Ambulance Unions (ACAU, 2025).
Australian Society of Medical Imaging and Radiation Therapy (ASMIIRT)												•				

Appendix 8: Interview guides for stakeholder interviews.

Perspectives and experiences of healthcare stakeholders regarding the occupational regulation of non-registered healthcare professions

Interview guide for consumer advocates

Name of interviewee:

Job title:

Date and time of interview:

Interviewer:

Permission to audio record:

Introduction

Thank you for agreeing to be interviewed as part of this research project. The purpose of this interview is to explore your perceptions and experiences regarding the regulation of healthcare professions in Australia.

The interview will take about 90 minutes. You can withdraw from the interview and the study at any time. If you proceed with participating in the study, your responses in this interview will be de-identified, and no information will be reported that can be attributed to you.

During this interview, I would like to share my screen to show you government documents such as assessment criteria used for registering a health professional. Would that be okay with you?

As you are aware, this interview will be audio-recorded and transcribed. I will also be taking brief notes throughout.

Before we proceed with the interview, would you like to know anything more about the research or ask me any questions about your participation in this research project?

Topic 1 – Role and regulation

1. Can you tell me about your role?
2. From your perspective, what role does [the organisation] have in advocating for consumers on health-related matters?
3. a. Do you know about Australia's National Registration and Accreditation Scheme? b. If yes, what is your understanding of the Scheme and its purpose?
4. What do you think about the way health practitioners are currently regulated in Australia? Registered and non-registered. How it operates. How successful/unsuccessful it is. Does it fulfil its intended purpose?

Topic 2 – National Scheme, IGA criteria, regulation of health professions

5. a. Are you familiar with the criteria and process for assessing whether a health profession should be registered? (Show criteria)

	b. Do you have any views about the criteria? c. How effective do you think the criteria are in assessing professions eligible for registration?
6.	a. Has your organisation made any submission on behalf of a profession advocating for its statutory registration? b. How well did this work in your view?
7.	a. What do you think being a registered health profession means for consumers? b. What do you think it means for registered professions? c. What do you think it means for other health professions? d. What do you think it means for the health system generally?
8.	a. What's your perspective on the differences between registered and unregistered health professions? b. Based on your observation and experience, do you think consumers are aware of registered versus unregistered health professions? c. What do you think about how health practitioners are currently regulated?
9.	a. What's your view of the suitability of the self-regulatory mechanisms established by unregistered health professions? b. Do you see these mechanisms as equivalent to statutory regulation? c. What makes you say that?
10.	a. What do you think distinguishes a registered profession from an unregistered profession? (Show registered/ unregistered list) b. Ask for comments regarding the list.
11.	a. Where there are unregistered and registered health professions doing similar work with a similar scope of practice, do you think they should be registered in the same way? b. If yes, what do you think should be done about that? By whom? c. Do you think the registration scheme should be expanded to cover some of the unregistered health professions? Which ones? d. What is it about these professions that makes you say that? e. What do you think these professions could or should do about seeking registration? f. What if there are professions you think should be registered but don't appear to have any interest in pursuing registration. What do you think should happen in this case? g. Do you think there are some professions regulated under NRAS that shouldn't be? Which ones? h. What is it about these professions that makes you say that?
12.	a. Do you think it is up to government to identify a health profession for registration, or should the profession initiate registration with government? b. What role do you think your organisation plays in this?
13.	a. Legislation has recently been passed in South Australia to register social workers. Were you aware of that? What do you think about that decision? b. Research has found that consumers, GPs, pharmacists, and others believe some unregistered professions should be registered. c. What do you think about that?
14.	What do you think is the future for unregistered professions in relation to the National Scheme?

Final question

Is there anything we have not covered that you would like to mention?

Interview guide for government health policy stakeholders

Name of interviewee:

Job title:

Date and time of interview:

Interviewer:

Permission to audio record:

Introduction

Thank you for agreeing to be interviewed as part of this research project. The purpose of this interview is to explore your perceptions and experiences regarding the regulation of healthcare professions in Australia.

The interview will take about 90 minutes. You can withdraw from the interview and the study at any time. If you proceed with participating in the study, your responses in this interview will be de-identified, and no information will be reported that can be attributed to you.

During this interview, I would like to share my screen to show you government documents such as assessment criteria used for registering a health professional. Would that be okay with you?

As you are aware, this interview will be audio-recorded and transcribed. I will also be taking brief notes throughout.

Before we proceed with the interview, would you like to know anything more about the research or ask me any questions about your participation in this research project?

Topic 1 – Role and regulation

1. Can you tell me about your role in the department?
2. What do you think is the role of (the directorate) in regulating health practitioners?
3. What is your understanding of Australia's National Registration and Accreditation Scheme?
4. (If not answered above) What do you think is the purpose of statutory registration?
5. What do you think about the way health practitioners are regulated in Australia? Registered and non-registered. How it operates. How successful/unsuccessful it is. Does it fulfil its intended purpose?

Topic 2 – National Scheme, IGA criteria, regulation of health professions

6. a. Are you familiar with the criteria and process for assessing whether a health profession should be registered? (Show criteria) b. Do you have any views about the criteria? c. How effective do you think the criteria are in assessing professions eligible for registration?

7.	a. To your knowledge, how many health professions have been assessed against the criteria since 2012? Since Aboriginal & Torres Strait Islander health practice, Chinese medicine, medical radiation, and occupational therapy were registered. b. How well did this work in your view? c. Do you think the criteria were consistently applied?
8.	a. What do you think being a registered health profession means for the registered profession? b. What do you think it means for consumers? c. What do you think it means for other health professions? d. What do you think it means for the health system generally?
9.	a. What's your perspective on the differences between registered and unregistered health professions? b. Based on your observation and experience, do you think your department engages differently with registered and unregistered professions? c. (If yes) In what way do you think it engages differently? d. (If no) What makes you say that? e. How do you think this impacts the national registration scheme? A number of unregistered professions have said they have been disadvantaged by not being included in the National Scheme, and government reports have identified this as well. f. Have you seen any of those disadvantages? g. What do you think about that?
10.	a. What's your view of the suitability of the self-regulatory mechanisms established by unregistered health professions? b. Do you see these mechanisms as equivalent to statutory regulation? c. What makes you say that? d. Are there parts of these mechanisms that more appropriately belong in the statutory area than the self-regulatory area? e. Which parts and what makes you say that?
11.	What do you think distinguishes a registered profession from an unregistered profession?
12.	(Show registered/ unregistered list) Ask for comments regarding the list.
13.	a. Where there are unregistered and registered health professions doing similar work with a similar scope of practice, do you think they should be registered in the same way? b. If yes, what do you think should be done about that? By whom? c. Do you think the registration scheme should be expanded to cover some of the unregistered health professions? d. Which ones? e. What is it about these professions that makes you say that? f. What do you think these professions could or should do about seeking registration? g. What if there are professions you think should be registered, but they don't appear to have an interest in pursuing registration. What do you think should happen in this case? h. Do you think there are some professions regulated under NRAS that shouldn't be? i. Which ones? j. What is it about these professions that makes you say that?
14.	a. Do you think it is up to government to identify a health profession for registration, or should the profession initiate registration with government? b. What role do you think your department has in this?
15.	a. In the past ten years, one health profession has been registered under the National Scheme, and that is paramedicine, in 2018.

b. Do you think that was a good decision? c. What do you think about the process that led to paramedicine registration? d. Both social workers and paramedicine were considered for registration at that time. Why do you think paramedicine was registered and not social work? e. Legislation has recently been passed in South Australia to register social workers. Were you aware of that? What do you think about that decision? f. Research has found that consumers, GPs, pharmacists, and others believe some unregistered professions should be registered. What do you think about that? g. Some health professions such as counsellors, dietitians, naturopaths, and sonographers have established interim arrangements for voluntary registering schemes or have formed national alliances to strengthen regulatory oversight because of a lack of progress by government in registering them. What do you think about that? h. Do you think these non-statutory arrangements are better than bringing these professions into the National Scheme? Can you elaborate on that? i. Do you think these non-statutory arrangements should be encouraged or discouraged? What makes you say that?
16. What do you think is the future for unregistered professions in relation to the National Scheme?
17. a. Do you think that the COVID pandemic has impacted unregistered health occupations? b. How do you think they were impacted? c. Did they need to modify their practice? e. Were they prevented from working because they were not Ahpra registered? f. What do you think this means, or what should be done about this?

Final question

Is there anything we have not covered that you would like to mention?

Interview guiding questions for profession representatives

Name of interviewee:

Job title:

Date and time of interview:

Interviewer:

Permission to audio record:

Introduction

Thank you for agreeing to be interviewed as part of this research project. The purpose of this interview is to explore your perceptions and experiences regarding the regulation of healthcare professions in Australia.

The interview will take about 90 minutes. You can withdraw from the interview and the study at any time. If you proceed with participating in the study, your responses in this interview will be de-identified, and no information will be reported that can be attributed to you.

During this interview, I would like to share my screen to show you government documents such as assessment criteria used for registering a health professional. Would that be okay with you?

As you are aware, this interview will be audio-recorded and transcribed. I will also be taking brief notes throughout.

Before we proceed with the interview, would you like to know anything more about the research or ask me any questions about your participation in this research project?

Topic 1 – Occupation

1. Can you tell me about your role with [the professional body]?
2. From your perspective, what is the role of [the profession] in Australian healthcare?

Topic 2 – Regulation

1. What do you think about the way health professions are regulated in Australia? Registered and non-registered. How it operates. How successful/unsuccessful it is. Does it fulfil its intended purpose?
2. What do you think is the purpose of statutory registration?
3. a. Are you aware of the criteria used to assess whether a profession should be registered? (Show criteria) b. What do you think of the criteria?
4. What do you think should be considered when decision-makers are thinking about registering a health profession?
5. What is your understanding of the process for deciding which healthcare professions are registered? If there is an understanding, go to Q6; if not, go to Q7b.
6. What do you think of that process?

7.	a. What has been your experience of the assessment process? OR b. Have you had any experience with the assessment process c. Can you tell me more about that? d. How successful do you think you were with that? e. Do you think your claim was genuinely considered? f. Why do you think that is?
8.	a. What is your understanding of who the key decision-makers are in registering a health profession? b. Can you tell me more about that? Who do you mean by that? c. Who do you think should decide?
9.	a. What has been your experience engaging with decision-makers/government officers? b. Can you tell me more about that?
10.	a. In some instances, decision-makers identify a profession for registration, and in others, the profession actively pursues registration themselves. b. Who do you think should have the responsibility for identifying which professions should be registered?
11.	a. Has the association made any submissions for/against statutory registration? b. What kind of submissions have been put forward by the association? c. When were these submissions to your knowledge?
12.	Some participants I've interviewed have said that getting the ear of decision-makers to discuss registration has been challenging. What do you say to that?
13.	a. From your perspective, how did (paramedicine/social work) manage to gain the ear of decision-makers to achieve registration? b. (for social work representatives) Now that registration has been enacted for social workers in South Australia, where to next for the social work profession?
14.	a. In the past ten years, one health profession has been registered under the National Scheme, and that is paramedicine in 2018. What do you think about that? (Show registered/ unregistered list b. Do you think there are others that should be registered as health professions? c. Which ones? d. What is it about these professions that makes you say that?
15.	a. Do you think [your profession] should be registered with Ahpra? b. What makes you say that?
16.	a. What do you think the majority of your members want in relation to statutory registration? b. Why do you think that is?
17.	a. What concerns would the majority of your members have about statutory registration? b. Why do you think that is?
18.	a. Have you conducted any membership surveys or other surveys seeking opinions about regulation? b. What did the results of the survey/s tell you? c. What were these? Were they published, and are they available?
19.	I've been hearing from some participants about a certification scheme for non-registered health professions. Have you heard anything about that? Can you tell me more about that?
20.	a. Do you think the COVID pandemic impacted your members? b. How do you think they were impacted? Can you tell me more? c. Did they need to modify their practice? d. Were they prevented from working because they were not Ahpra registered? e. What was the reaction of your members?

f. Do you think this made a difference in what practitioners thought about registration? g. What do you think this means, or what should be done about this?
21. a. Do you have any plans to pursue registration? b. Can you tell me more about that?
22. a. What do you think are the challenges [your profession] faces in trying to gain registration? b. Why do you think that is? c. How do you think these can be overcome?
23. a. What is it about statutory registration/self-regulation that is important to you? b. What do you think you have with statutory registration/self-registration that you don't have with self-registration/statutory registration?
24. If you had a chance to have a conversation with a decision-maker what would you say?

Final question

Is there anything we have not covered that you would like to mention?

Appendix 9: Events and policy decisions regarding health practitioner regulation.

Date	Key event/decision
1992	Passing of the <i>Commonwealth Mutual Recognition Act 1992</i> (Cth). Legislation allowing the mutual recognition of professional qualifications between the states and territories and hence the movement of registered health practitioners across jurisdictional boundaries without the need to register in each jurisdiction (COAG, Council of Australian Governments, 1992: 1).
1995	Australian Health Ministers' Advisory Council establishes Intergovernmental Agreement assessment criteria and process for regulating health professions (COAG, 2008a: 22).
2000	Establishment of the Australian Health Workforce Advisory Committee to monitor the health workforce (DOHAC, 2008).
Jun 2004	Council of Australian Governments (COAG) commissions a whole-of-government report on issues relating to supply and demand of the health workforce over the ensuing ten years (Productivity Commission, 2005: IV). Scope included the entire health workforce. Review encompassed regulatory, institutional, structural, educational, distribution and strategic components relating to health professions and healthcare provision (Productivity Commission, 2005: V-VII, 2-3).
22 Dec 2005	Productivity Commission report <i>Australia's Health Workforce</i> released. Recommendations include the statutory establishment of a single national entity for the registration of health workers (Productivity Commission, 2005: 144-145), and a single national accreditation board for the education and training (Productivity Commission, 2005: 127). The new arrangements are suggested to be reviewed after five years of operation (Productivity Commission, 2005: XXXVIII, XLII).
14 Jul 2006	COAG response to the Productivity Commission report. COAG agrees to establish "a single national registration scheme for health professionals, beginning with the nine professions currently registered in all jurisdictions" (COAG, 2006: 4). The nine occupations identified for the first tranche of registration were: chiropractic, dental (dentists, dental hygienists, dental prosthetists, and dental therapists), medicine, nursing and midwifery, pharmacy, physiotherapy, optometry, osteopathy, and psychology.
26 Mar 2008	COAG members sign The National Partnership Agreement to Deliver a Seamless National Economy and an Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions to implement the National Registration and Accreditation Scheme by 1 July 2010. The agreement includes podiatry as a special case occupation to be added to the Scheme. (COAG, 2008a; COAG, 2008b).
28 Jul 2008	Call for submissions on partially regulated health occupations (NHWT, 2008b).
25 Nov 2008	The Queensland Government, as host jurisdiction for the legislation underpinning the NRAS passes the first of two acts to establish the structure and governance arrangements for the Scheme (<i>Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008</i> (Qld)).

Date	Key event/decision
8 May 2009	Ministerial Council agrees to register three additional occupations under the <i>National Law</i> from 1 July 2012; Aboriginal and Torres Strait Islander practice, Chinese medicine practice, and medical radiation practice. Inclusion of mandatory reporting requirements, criminal history and identity checks for new registrants, and annual declarations when reregistering (AHWMC 2009: 2, 3).
6 Aug 2009	Senate Community Affairs Committee inquiry report into national registration and accreditation scheme for doctors and other health workers (Senate Community Affairs Legislation Committee, 2009).
6 Aug 2009	Senate Community Affairs Legislation Committee inquiry report into national registration and accreditation scheme for doctors and other health workers (Senate Community Affairs Legislation Committee, 2009).
27 Aug 2009	Health Ministers agree to include occupational therapy in the Scheme from 1 July 2012 (OTBOQ, 2009: 1).
3 Sep 2009	Regulatory Impact Statement for the decision to implement health practitioner legislation concludes that the preferred option for the implementation of the Scheme was that 'four partially regulated professions be included in the Scheme, being Aboriginal and Torres Strait Islander clinical health workers, Chinese medicine practitioners, medical radiation therapists and occupational therapists.' (AHMAC, 2009: 2).
6 Oct 2009	Queensland Parliament introduces the <i>Health Practitioner Regulation National Law Act 2009</i> (Qld).
3 Nov 2009	<i>Health Practitioners Regulation National Law Act 2009 (Qld)</i> receives Royal Assent in Queensland, replacing Act A (Senate Finance and Public Administration Reference Committee, 2011: 8).
16 Mar 2010 to 30 Aug 2010	<i>National Law</i> is passed in other jurisdictions: • Australian Capital Territory (16 March 2010) • Northern Territory (17 March 2010) • Victoria (30 March 2010) • New South Wales (15 June 2010) • Tasmania (25 June 2010) • South Australia (1 July 2010) • Western Australia (30 August 2010) (AHWMC, 2011: 7).
May 2010	Senate Community Affairs Committee inquiry report into the Health Practitioner Regulation (Consequential Amendments) Bill 2010
1 July 2010	Introduction of the National Registration and Accreditation Scheme for Health Practitioners for ten healthcare professions in all jurisdictions except Western Australia (AHWMC, 2011: 3).
18 Oct 2010	<i>National Law</i> commences for ten healthcare occupations in Western Australia. (AHWMC, 2011: 3)
Nov 2010	Ministerial Council agrees to a national consultation "to consider whether there is a need for strengthened regulatory protections for consumers who use the services of unregistered health practitioners." (AHMAC, 2011b: 1).
Feb 2011	Consultation paper issued on options for regulation of unregistered health practitioners (AHMAC, 2011b).

Date	Key event/decision
Nov 2011	Commonwealth Government response to the Senate Community Affairs Committee inquiry report into the Health Practitioner Regulation (Consequential Amendments) Bill 2010
1 Jul 2012	<i>National Law</i> commences for four healthcare occupations (AHMAC, 2018b: 2); Aboriginal and Torres Strait Islander practice, Chinese medicine practice, medical radiation practice, occupational therapy.
Jul 2012	Consultation paper issued on options for regulation of paramedics. (AHMAC, 2012).
Apr 2013	Final report released on options for regulation of unregistered health practitioners. Recommendation: "Option 3, a single National Code of Conduct with enforcement powers for breach of the Code is considered likely to deliver the greatest net public benefit to the community [...]. On balance, Option 3 is the recommended option because it is the least cost option while effective in reducing harm and achieving the objective of protecting the public." (AHMAC, 2013: 7).
1 Aug 2013	Health Ministers agree to strengthen state and territory health complaint mechanisms through a National Code of Conduct for unregistered health practitioners in each state and territory. State and territory entities will have statutory powers of investigation for breaches and issuance of prohibition orders that will be accessible nationally on a web based register with mutual recognition across all states and territories (Standing Council on Health, 2013). The code has been introduced in: The code has been introduced in: • New South Wales (2008) • South Australia (2013) • Queensland (2015) • Victoria (2017) • Western Australia (2023) • Australian Capital Territory (2024) The code has not yet been introduced in: • Tasmania • Northern Territory
11 Apr 2014	Health Ministers appoint Mr Kim Snowball to lead an independent review of the NRAS (Standing Council on Health, 2014).
Aug 2014	Consultation paper issued for the review of the National Registration and Accreditation Scheme for health professions. (AHMAC, 2014a)
Dec 2014	Final report released for the Independent review of the National Registration and Accreditation Scheme for health professions. Recommendations include consolidation of nine "low-regulatory-workload" professions, and taking steps to "ensure that health professionals not included in the National Scheme should not be excluded or disadvantaged professionally." (AHMAC, 2014b: 5-6).
17 Apr 2015	COAG Health Council agree to the terms of the National Code of Conduct for health care workers. (CHC 2015b)
7 Aug 2015	Health Ministers agree to several recommendations of the independent review of the NRAS. Decision regarding consolidation of low regulatory load

Date	Key event/decision
	professions is deferred with Ministers seeking further advice from the Australian Health Minister's advisory Council. Ministers agree to issue a communiqué to clarify the intent of the Scheme and propose a process for non-registered professions to raise concerns regarding disadvantage resulting from exclusion from the Scheme (CHC 2015c: 2-3)
Sep 2015	Final report released on options for regulation of paramedics. Recommendation: "Extend regulation to the paramedic profession under the National Registration and Accreditation Scheme, is likely to deliver the greatest net public benefit to the community compared with all other options." (AHMAC, 2015: 12).
6 Nov 2015	COAG Health Council, on a majority vote, agree to the national registration of paramedics under the NRAS with only those jurisdictions that wish to register paramedics adopting the necessary amendments. (CHC, 2015a)
2016	The Australian Health Ministers' Advisory Council commissioned the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions in 2016. See p. 16 of 2018 Guide to the NRAS for health professions.
8 Apr 2016	Health Ministers agreed not to consolidate nine National Boards of the National Registration and Accreditation Scheme but did not rule out the possibility of future changes to ensure the Scheme's governance arrangements remain fit for purpose. It was agreed that the <i>Health Practitioner Regulation National Law 2009</i> be amended to allow for changes to the governance arrangements to the Scheme. (COAG, 2016: 4)
7 Oct 2016	COAG Health Council decides against inclusion of social work in the National Scheme, and agrees to amend the <i>Health Practitioner Regulation National Law</i> to include paramedics. (CHC, 2016: 2, 5)
13 Sep 2017	Tranche 1 amendments to the <i>National Law</i> receives Royal Assent in Queensland Parliament. Amendments include national regulation of paramedics, improvements to notifications management and disciplinary powers, and recognition of nursing and midwifery as separate professions. (<i>Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017</i> (Qld)).
30 Mar 2020	The Office of Best Practice Regulation releases The Australian Government guide to regulatory impact analysis which states, 'The Government has a renewed deregulation agenda aimed at regulatory barriers that prevent Australians from investing and creating jobs, while ensuring that the regulatory burden for individuals, businesses and community organisations is as light and efficient as possible.' (DPMC, 2020: 11)
11 May 2022	Tranche 2 <i>National Law</i> Amendments passed by the Queensland Parliament (<i>Health Practitioner Regulation National Law and Other Legislation Amendment Act 2022</i> (Qld)). "Guiding principles (1) The main guiding principle of the national registration and accreditation scheme is that the following are paramount— (a) protection of the public;

Date	Key event/decision
	(b) public confidence in the safety of services provided by registered health practitioners and students. (2) The other guiding principles of the national registration and accreditation scheme are as follows— (a) the Scheme is to operate in a transparent, accountable, efficient, effective and fair way; (b) fees required to be paid under the Scheme are to be reasonable having regard to the efficient and effective operation of the Scheme; (c) restrictions on the practice of a health profession are to be imposed under the Scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.”
Apr 2023	National Cabinet commissions ‘Scope of Practice Review’ for governments to work together to review the barriers and incentives for primary health care professionals working to their full scope of practice (DOHAC, 2024d: 4, 5).
13 Dec 2023	State and Territory Health Ministers, meeting as the Health Ministers’ Meeting agree to develop a Decision Regulatory Impact Statement (Decision RIS) to consider options for the future regulation of audiology including registration under the NRAS (Queensland Government, 2024a: 3).
May 2024	Health Ministers commission an independent review into the complexity of the NRAS. The review aims were to identify areas of unproductive and unnecessary complexity in health practitioner regulation, propose reforms to enable the National Scheme to work, and ensure the National Scheme remains ‘fit for purpose’ and meets community expectations (Dawson, 2024: 4-5).
Jul 2024	Decision RIS for regulating audiology finalised and assessed as compliant by the Office of Impact Analysis (Queensland Government, 2024b: 3).
16 Aug 2024	Ministerial Council considers the Decision RIS for audiology and agree in-principle to include audiology in the NRAS. The Council request further work to inform a final decision. This includes targeted consultation with stakeholders to consider issues including costs, implementation, risks, and impacts on First Nations communities (Queensland Government, 2024b: 3-4).
5 Sep 2024	The Health Workforce Taskforce discuss steps for progressing the targeted consultation for audiology registration. Queensland Health charged with progressing the consultation on behalf of the Taskforce, with a update to the Ministerial Council planned in early 2025 (Queensland Government, 2024b: 3).
16 Sep 2024	Complexity Review Consultation Paper issued in which a new “middle tier” of regulation is proposed, where Ahpra accredits a professional membership body to establish and maintain a statutory register of practitioners, who voluntarily sign up to the register (Dawson, 2024: 88-89). No non-registered professions identified for inclusion in this regulation tier.
Oct 2024	Scope of practice review identifies three possible mechanisms to support self-regulated professions: A. Targeted legislative amendments to introduce a pathway into the NRAS by introducing an additional criterion, such as a ‘public interest’ criterion, to the NRAS criteria for regulatory assessment of the need to statutory regulation of a health profession.

Date	Key event/decision
	B. Amendment to the definition of a 'health profession' by amending the <i>National Law</i> to include additional specified professions in the definition of a 'health profession'. C. Accreditation by Ahpra (or another body) of relevant professions bodies to perform consistent, quality self-regulation functions for professions which are not nationally registered in the NRAS. (Cormack, 2024: 123-128) Self-regulated professions proposed by the Review as a starting point for Options A, B and C (subject to final decision through the RIA process): • audiology; • dietetics; • counselling; • exercise physiology; • social work; • sonography (cardiac and medical); and • speech pathology (Cormack, 2024: 129).

Appendix 10: Workers' compensation arrangements for naturopaths in Australia.

State/territory legislation	Regulator	Eligible providers	Status of naturopath
<i>Workers Compensation Act 1951, No. 2 (ACT)</i>	WorkSafe ACT	Must be recommended by doctor in personal injury plan and agreed by insurer.	Nothing found on website about approved allied health providers or naturopaths.
<i>Workplace Injury Management and Workers Compensation Act 1998 (NSW)</i>	NSW icare State Insurance Regulatory Authority (SIRA)	Treating allied health practitioner disciplines require approval by SIRA in order to be deemed appropriately qualified to provide specified treatment or services in the workers compensation system. Includes chiropractors, osteopaths and exercise physiologists.	Naturopaths are not included as treating allied health practitioner discipline. There is provision for compensation payments for complementary and alternative therapies for <i>work-related dust diseases</i> , on referral from treating medical practitioner.
<i>Return to Work Act 1986 (NT)</i>	NT WorkSafe	If liability for a claim has been accepted, all reasonable medical and rehabilitation services are paid for by the insurer through the workers compensation scheme. No guidelines available about what are reasonable medical and rehabilitation services.	No evidence to suggest naturopaths are included. However, no guidance on website about what are 'reasonable medical and rehabilitation services' and whether the services of naturopaths may be reimbursed.
<i>Workers' Compensation And Rehabilitation Act 2003 (QLD)</i>	WorkSafe Queensland	Costs covered for approved registered providers and approved non-board registered providers. Includes chiropractors, osteopaths and acupuncture provided by registered Chinese medicine practitioners.	Website lists 'Services we don't cover' and this includes natural therapists and naturopaths.
<i>Workers Rehabilitation and Compensation Act 1986 (SA)</i>	ReturntoWorkSA	Pays for reasonable and necessary health and return to work services. The website lists a range of registered and unregistered health services including chiropractic, osteopathy and remedial massage, subject to an 'allied health management plan'.	No reference to naturopaths in list of service providers.
<i>Workers Rehabilitation and Compensation Act 1988 (TAS)</i>	WorkCover Tasmania	A worker is entitled to payment of expenses for medical or other services if the expense is reasonable and necessarily incurred. This largely depends on the individual circumstances of each case.	No mechanism for approval of allied health providers. General guidelines about reimbursement for medical and other services. No mention of naturopaths or naturopathic services.

State/territory legislation	Regulator	Eligible providers	Status of naturopath
<i>Accident Compensation (WorkCover Insurance) Act 1993 (VIC)</i>	WorkSafe Victoria	Naturopathy is listed as an allied health profession and naturopaths may be registered as healthcare providers with WorkSafe Victoria.	Naturopaths must be eligible for full membership of specified professional associations and have a minimum of \$1 million professional indemnity insurance. Three associations specified: Australian Natural Therapists Association Australian Natural Practitioners Association Complementary Medicine Association
<i>Workers Compensation and Rehabilitation Act 1981 (WA)</i>	WorkCover WA	Act and regulations recognise certain forms of treatment.	Naturopaths are not approved health providers; however naturopathy may be deemed as 'reasonable' therapy. The website states: If a worker requires treatment from a non-approved health provider for example a naturopath, they should check with their employer's insurer to ensure that their cost will be reimbursed prior to commencing treatment.

(Carlton et al., 2025: 233, reproduced with permission from the ANC)

Appendix 11: Table of documents meeting inclusion criteria for document analysis.

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
ALLH 200810 Consumers Health Forum Aust Submission NRAS Trove NATREG 20080919 Call for submissions on proposed registration arrangements	Submission	Allied health	Other	Consumer body	Statutory registration	ALLH_CONSUMER_2008_Doc1
ALLH 20130201 Consumers Health Forum of Australia Inquiry into the performance of AHPRA	Submission	Allied health	Other	Consumer body	Not stated	ALLH_CONSUMER_2013_Doc2
ALLH AHPA 20120925 PHI submission	Submission	Allied health	AHPA	Peak body	Not stated	ALLH_AHPA_2012_Doc1
ALLH AHPA 2013 Oct Self-regulating health professionals get proactive about standards of practice	General communication	Allied health	AHPA	Peak body	Co-regulation	ALLH_AHPA_2013_Doc2
ALLH AHPA 20141009 Submission into the review of NRAS	Submission	Allied health	AHPA	Peak body	Co-regulation	ALLH_AHPA_2014_Doc3
ALLH AHPA 20150624 Submission in response to electronic health records and healthcare identifiers legislation discussion paper	Submission	Allied health	AHPA	Peak body	Not stated	ALLH_AHPA_2015_Doc4
ALLH AHPA 201706 Response to the NDIS Code of Conduct discussion paper	Submission	Allied health	AHPA	Peak body	Not stated	ALLH_AHPA_2017_Doc5
ALLH AHPA 2018 Consultation Response Senate Community Affairs Ref Comm Inquiry into effectiveness of age care quality ass & acc	Submission	Allied health	AHPA	Peak body	Not stated	ALLH_AHPA_2018_Doc6
ALLH AHPA 201807 Position statement improving the efficiency of referrals to other health professionals for allied health patients	Position statement	Allied health	AHPA	Peak body	Not stated	ALLH_AHPA_2018_Doc7
ALLH AHPA 201912 Royal Commission into Aged Care Quality and Safety Supplementary Submission Workforce Issues	Submission	Allied health	AHPA	Peak body	Unclear/ambiguous	ALLH_AHPA_2019_Doc8
ALLH AHPA 202001 Submission Royal Commission into Aged Care Quality and Safety Supplementary submission aged care program redesign	Submission	Allied health	AHPA	Peak body	Unclear/ambiguous	ALLH_AHPA_2020_Doc9
ALLH AHPA 202005 Submission Select committee on COVID-19 Inquiry into the Australian Government's response to the COVID-19 pandemic	Submission	Allied health	AHPA	Peak body	Not stated	ALLH_AHPA_2020_Doc10
ALLH NARSHP 20120301 Att 1 - Review of NRAS COAG Harnessing self-reg to support safety & quality in	Submission	Allied health	NARSHP	Peak body	Co-regulation	ALLH_NARSHP_2012_Doc1

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
healthcare a comprehensive model for regulating all health care practitioners						
ALLH NARSHP 20141009 Submission Review of NRAS COAG	Submission	Allied health	NARSHP	Peak body	Co-regulation	ALLH_NARSHP_2014_Doc2
ALLH NASRHP 20161202 Self regulating health professions peak bodies membership standards	Policy Statement	Allied health	NARSHP	Peak body	Self-regulation	ALLH_NARSHP_2016_Doc3
ALLH NASRHP 2017 About NASRHP	General communication	Allied health	NARSHP	Peak body	Not stated	ALLH_NARSHP_2017_Doc4
ALLH NASRHP 2017 Submission to the Independent Review of Accreditation Systems within the NRAS COAG	Submission	Allied health	NARSHP	Peak body	Self-regulation	ALLH_NARSHP_2017_Doc5
ALLH NASRHP 2019 2020 Pre-budget submission	Submission	Allied health	NARSHP	Peak body	Self-regulation	ALLH_NARSHP_2019_Doc6
AUDIO 201701 Parents of deaf children and Aussie deaf kids Submission on hearing services under the NDIS	Submission	Audiology	Other	Consumer body	Statutory registration	AUDIO_CONSUMER_2017_Doc1
AUDIO AA 201307 Professional Practice Standards Part A Practice Operations July 2013	Codes/ Standards/ Guidelines	Audiology	AA	Professional association	Self-regulation	AUDIO_AA_2013_Doc1
AUDIO AA 20160920 Scope of Practice for audiologists and audiometrists	Codes/ Standards/ Guidelines	Audiology	AA	Professional association	Not stated	AUDIO_AA_2016_Doc2
AUDIO AA 20161223 Submission to the house of reps standing committee on health aged care and sport inquiry into the hearing health and wellbeing of Australia	Submission	Audiology	AA	Professional association	Co-regulation to statutory registration	AUDIO_AA_2016_Doc3
AUDIO AA 20170317 Consultation Paper - National Code of Conduct for Health Care Workers in Tasmania	Submission	Audiology	AA	Professional association	Not stated	AUDIO_AA_2017_Doc4
AUDIO AA 20170714 Position statement Remuneration	Position statement	Audiology	AA	Professional association	Not stated	AUDIO_AA_2017_Doc5
AUDIO AA 20191201 Ethics Review Committee Background Information on the regulation of audiologists and audiometrists in Australia	General communication	Audiology	AA	Professional association	Not stated	AUDIO_AA_2019_Doc6
AUDIO AA 2020 DRAFT Position statement Role of the Audiologist	Position statement	Audiology	AA	Professional association	Not stated	AUDIO_AA_2020_Doc7

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
AUDIO AA 20200113 Submission to NSW Health concerning Code of Conduct for unregulated health professionals	Submission	Audiology	AA	Professional association	Not stated	AUDIO_AA_2020_Doc8
AUDIO ACAud 2019 Roadmap for Hearing Health	Strategic plan	Audiology	ACAud	Professional association	Self-regulation	AUDIO_ACAud_2019_Doc1
AUDIO ACAud 20190211 Media Release - ACAud Members abide by a Code of Conduct	Media release/ reports	Audiology	ACAud	Professional association	Self-regulation	AUDIO_ACAud_2019_Doc2
AUDIO ACAud 2020 Strategic Plan 2020-2023	Strategic plan	Audiology	ACAud	Professional association	Not stated	AUDIO_ACAud_2020_Doc3
AUDIO IAA 2014 Annual Report 2013-2014 Independent Audiologists Australia	Annual Report	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2014_Doc1
AUDIO IAA 20141010 Review of NRAS Independent Audiologists Australia COAG	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2014_Doc2
AUDIO IAA 2015 Annual Report 2014-2015 Independent Audiologists Australia	Annual Report	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2015_Doc3
AUDIO IAA 2015 Jul Senate select comm on health Submission from Independent Audiologists Australia Inc	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2015_Doc4
AUDIO IAA 2016 Annual Report 2015-2016 Independent Audiologists Australia	Annual Report	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2016_Doc5
AUDIO IAA 20160527 Service Delivery Framework for Hearing Services, practice standards, the quality principles within the framework	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2016_Doc6
AUDIO IAA 201608 Mandatory national registration for audiologists Independent Audiologists Australia	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2016_Doc7
AUDIO IAA 20161222 Inquiry into the Hearing Health and Wellbeing of Australia	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2016_Doc8
AUDIO IAA 20170127 Joint Standing Committee on the NDIS Hearing Services	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2017_Doc9
AUDIO IAA 20170306 Supplementary statement to the Joint Standing Committee on the NDIS – Hearing Services	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2017_Doc10
AUDIO IAA 20170620 Review of Services and technology supply in the Hearing Services Program Public Discussion Paper	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2017_Doc11

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
AUDIO IAA 20171221 Patient safety and quality improvement in primary care - Consultation paper	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2017_Doc12
AUDIO IAA 20180524 Thematic review of Commonwealth hearing services legislation	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2018_Doc13
AUDIO IAA 20180809 Implementation of the National Disability Insurance Scheme and the provision of disability services in NSW	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2018_Doc14
AUDIO IAA 2019 Annual Report 2018-2019 Independent Audiologists Australia	Annual Report	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2019_Doc15
AUDIO IAA 20190220 Regulation of Audiology in Australia to COAG Members and Opposition Amended 26 February 2020	Submission	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2019_Doc16
AUDIO IAA 2021 Quick Facts about Hearing Services in Australia Independent Audiologists Australia	General communication	Audiology	IAA	Professional association	Statutory registration	AUDIO_IAA_2021_Doc17
COUNS ACA 20080519 p40 HealthWFCComm PracReg Sub for psychotherapy & counselling in Aust	Submission	Counselling	ACA	Professional association	Self-regulation to statutory registration	COUNS_ACA_2008_Doc1
COUNS ACA 20080827 p7 Vic DOHS Combined Multiple Ass Sub Best practice self reg for psychotherapy & counselling in Aust	Submission	Counselling	ACA	Professional association	Self-regulation to statutory registration	COUNS_ACA_2008_Doc2
COUNS ACA 20110804 Submission to the inquiry into Commonwealth funding and administration of mental health services	Submission	Counselling	ACA	Professional association	Unclear/ambiguous	COUNS_ACA_2011_Doc3
COUNS ACA 20141015 Review of NRAS COAG	Submission	Counselling	ACA	Professional association	Co-regulation	COUNS_ACA_2014_Doc4
COUNS ACA 2016 Scope of Practice for Registered Counsellors	Codes/Standards/Guidelines	Counselling	ACA	Professional association	Not stated	COUNS_ACA_2016_Doc5
COUNS ACA 2021 Aims and Objectives	General communication	Counselling	ACA	Professional association	Self-regulation	COUNS_ACA_2021_Doc6
COUNS ACA 202103 Submission to the House Select Committee on Mental Health and Suicide Prevention	Submission	Counselling	ACA	Professional association	Self-regulation	COUNS_ACA_2021_Doc7
COUNS ACA 202106 Care Workforce Labour Market Study Submission	Submission	Counselling	ACA	Professional association	Self-regulation	COUNS_ACA_2021_Doc8

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
COUNS ACA Questions to Ask Before You See a Counsellor	General communication	Counselling	ACA	Professional association	Not stated	COUNS_ACA_Undated_Doc9
COUNS ACCA 20141104 Review of NRAS COAG	Submission	Counselling	ACCA	Professional association	Statutory registration	COUNS_ACCA_2014_Doc1
COUNS ANTA 20080925 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Counselling	ANTA	Professional association	Unclear/ambiguous	COUNS_ANTA_2008_Doc1
COUNS ANTA 2013 Submission to the PHI Rebate review	Submission	Counselling	ANTA	Professional association	Not stated	COUNS_ANTA_2013_Doc2
COUNS ANTA 2014 Review of NRAS COAG	Submission	Counselling	ANTA	Professional association	Statutory registration	COUNS_ANTA_2014_Doc3
COUNS ANTA 2017 Review of accreditation systems within the NRAS COAG	Submission	Counselling	ANTA	Professional association	Statutory registration	COUNS_ANTA_2017_Doc4
COUNS ANTA 20170328 Submissions Reforms to the regulatory framework for complementary medicines Assessment pathways	Submission	Counselling	ANTA	Professional association	Statutory registration	COUNS_ANTA_2017_Doc5
COUNS ANTA 2021 FAQ part 2	General communication	Counselling	ANTA	Professional association	Not stated	COUNS_ANTA_2021_Doc6
COUNS ARCAP 2011 Response_to_consultation_on_options for regulation of unregistered health practitioners	Submission	Counselling	ARCAP	Registering organisation	Self-regulation	COUNS_ARCAP_2011_Doc1
COUNS ARCAP 2012 General ARCAP - background to ARCAP ACA PACFA	Submission	Counselling	ARCAP	Registering organisation	Not stated	COUNS_ARCAP_2012_Doc2
COUNS ARCAP 201904 Productivity Commission Submission FINAL	Submission	Counselling	ARCAP	Registering organisation	Not stated	COUNS_ARCAP_2019_Doc3
COUNS ARCAP 202004 Submission-Medicare-provider-numbers-for-Counsellors-and-Psychotherapists-April-2020	Submission	Counselling	ARCAP	Registering organisation	Self-regulation	COUNS_ARCAP_2020_Doc4
COUNS ATMS 20110905 Submission to ACCC on private health insurance report	Submission	Counselling	ATMS	Professional association	Not stated	COUNS_ATMS_2011_Doc1
COUNS ATMS 2017 Strategic-Plan-2017-2020	Strategic plan	Counselling	ATMS	Professional association	Not stated	COUNS_ATMS_2017_Doc2
COUNS CCAA Christian Counsellors Association of Australia What is PACFA, ACA and ARCAP	General communication	Counselling	CCAA	Professional association	Not stated	COUNS_CCAA_Undated_Doc1
COUNS PACFA 200802 Best Practice Self-Regulation Model for Psychotherapy and Counselling in Australia	Submission	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_2008_Doc1

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
COUNS PACFA 20080519 p10 HealthWFFComm PracReg Sub for psychotherapy & counselling in Aust	Submission	Counselling	PACFA	Professional association	Self-regulation to statutory registration	COUNS_PACFA_2008_Doc2
COUNS PACFA 20080827 p37 Vic DOHS Combined Multiple Ass Sub Best practice self reg for psychotherapy & counselling in Aust	Submission	Counselling	PACFA	Professional association	Self-regulation to statutory registration	COUNS_PACFA_2008_Doc3
COUNS PACFA 201104 Enews-April2011 PACFA Submission on Options for Regulation of unregistered health practitioners	Submission	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_2011_Doc4
COUNS PACFA 20110909 Response-to-consultation-on-NSW-Draft-Public-Health-Regulation Sep 2011	Submission	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_2011_Doc5
COUNS PACFA 20111208 Response-to-consultation-on-SA-Draft-Code-of-Conduct-FINAL	Submission	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_2011_Doc6
COUNS PACFA 20120921 Submission-to-the-ACCC-on-private-health-insurance- September-2012	Submission	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_2012_Doc7
COUNS PACFA 20121221 Submission-to-CoA-DOHAC-on-Natural-Therapies_Dec2012	Submission	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_2012_Doc8
COUNS PACFA 201404 Submission-to-AHMAC-on-National-Code-of-Conduct-April-2014	Submission	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA2014_Doc9
COUNS PACFA 20150125 Submission-to-the-ACCC-on-private-health-insurance-January-2015	Submission	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_2015_Doc10
COUNS PACFA 2018 Scope-of-Practice-for-Registered-Counsellors - Copy	Codes/ Standards/ Guidelines	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_2018_Doc11
COUNS PACFA 202001 Response-to-Productivity-Commission-Mental-Health-Draft-Report-Jan2020-1	Submission	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_2020_Doc12
COUNS PACFA 202009 PACFA Response to the Higher Education Support Amendment (Job-Ready graduates and supporting regional and remote students) Bill 2020	Submission	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_2020_Doc13
COUNS PACFA 2021 Campaigns Government Recognition - Copy	General communication	Counselling	PACFA	Professional association	Unclear/ ambiguous	COUNS_PACFA_2021_Doc14
COUNS PACFA 2021 Professional Recognition - Copy	General communication	Counselling	PACFA	Professional association	Unclear/ ambiguous	COUNS_PACFA_2021_Doc15

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
COUNS PACFA FACTSHEET-Self-Regulating-profession-of-Counselling-and-psychotherapy - Copy	General communication	Counselling	PACFA	Professional association	Self-regulation	COUNS_PACFA_Undated_Doc16
DIET Aust GP Network 20081003 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Dietetics	Other	Other organisation	Statutory registration	DIET_AUSTGPNETWORK_2008_Doc1
DIET DA 20050729 Response to The Health Workforce issues paper	Submission	Dietetics	DA	Professional association	Self-regulation	DIET_DA_2005_Doc1
DIET DA 201207 International criminal history checks	Submission	Dietetics	DA	Professional association	Unclear/ambiguous	DIET_DA_2012_Doc2
DIET DA 201307 Regulating the advertising of therapeutic goods to the general public	Submission	Dietetics	DA	Professional association	Not stated	DIET_DA_2013_Doc3
DIET DA 2014 Att 1 Review of NRAS COAG	Submission	Dietetics	DA	Professional association	Not stated	DIET_DA_2014_Doc4
DIET DA 2014 Att 2a Review of NRAS COAG	Submission	Dietetics	DA	Professional association	Not stated	DIET_DA_2014_Doc5
DIET DA 2014 Att 2b Review of NRAS COAG	Submission	Dietetics	DA	Professional association	Not stated	DIET_DA_2014_Doc6
DIET DA 2014 Att 3a Review of NRAS COAG	Submission	Dietetics	DA	Professional association	Not stated	DIET_DA_2014_Doc7
DIET DA 2014 Att 3b Review of NRAS COAG	Submission	Dietetics	DA	Professional association	Not stated	DIET_DA_2014_Doc8
DIET DA 2014 Att 3c Review of NRAS COAG	Submission	Dietetics	DA	Professional association	Not stated	DIET_DA_2014_Doc9
DIET DA 2014 Submission Review of NRAS COAG	Submission	Dietetics	DA	Professional association	Co-regulation	DIET_DA_2014_Doc10
DIET DA 201502 Mutual recognition schemes	Submission	Dietetics	DA	Professional association	Unclear/ambiguous	DIET_DA_2015_Doc11
DIET DA 201701 Accreditation Standards for dietetics education programs V2.0	Codes/ Standards/ Guidelines	Dietetics	DA	Professional association	Not stated	DIET_DA_2017_Doc12
DIET DA 2018 Strategic_Plan_2018-2021	Strategic plan	Dietetics	DA	Professional association	Not stated	DIET_DA_2018_Doc13
DIET DA 201803 Submission-52-Inquiry into the implementation, performance and governance of the NDIS	Submission	Dietetics	DA	Professional association	Not stated	DIET_DA_2018_Doc14

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
DIET DA 2019 Australia's Health Workforce strengthening the education foundation	Submission	Dietetics	DA	Professional association	Statutory registration	DIET_DA_2019_Doc15
DIET DA 2020 Annual Report 2019-20	Annual Report	Dietetics	DA	Professional association	Not stated	DIET_DA_2020_Doc16
DIET DA 2020 Maintaining Professional Standards	General communication	Dietetics	DA	Professional association	Unclear/ambiguous	DIET_DA_2020_Doc17
DIET DA 2020 Preventive_Health_Strategy_Consultation_DA_Sep_2020	Submission	Dietetics	DA	Professional association	Unclear/ambiguous	DIET_DA_2020_Doc18
DIET DA 2021 Our-Healthcare-Future-Allied-Health-Workforce-2040	Submission	Dietetics	DA	Professional association	Not stated	DIET_DA_2021_Doc19
DIET DA 2021 Private health insurance reforms – second wave	Submission	Dietetics	DA	Professional association	Unclear/ambiguous	DIET_DA_2021_Doc20
DIET DA 2021 SA-Rural-Allied-Health-Workforce-Plan	Submission	Dietetics	DA	Professional association	Unclear/ambiguous	DIET_DA_2021_Doc21
DIET DA 202104 Response to Draft national preventive health strategy	Submission	Dietetics	DA	Professional association	Not stated	DIET_DA_2021_Doc22
EXEPHY 20130201 DeptRegAust, LocalGovt, Arts&Sport Submission to inquiry by senate committee The practice of sports science in Australia	Submission	Exercise physiology	Other	Professional association	Self-regulation to statutory registration	EXEPHY_GOVT_2013_Doc1
EXEPHY ESSA 20080919 Submission NRAS Trove NATREG Call for submissions on proposed registration arrangements	Submission	Exercise physiology	ESSA	Professional association	Unclear/ambiguous	EXEPHY_ESSA_2008_Doc1
EXEPHY ESSA 2012 Annual Report	Annual Report	Exercise physiology	ESSA	Professional association	Not stated	EXEPHY_ESSA_2012_Doc2
EXEPHY ESSA 2013 Annual Report	Annual Report	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2013_Doc3
EXEPHY ESSA 2014 National-Hospital-Workforce-Support-Doc-FINAL-with-APPENDICES	Strategic plan	Exercise physiology	ESSA	Professional association	Not stated	EXEPHY_ESSA_2014_Doc4
EXEPHY ESSA 2014 Submission Review of NRAS COAG	Submission	Exercise physiology	ESSA	Professional association	Co-regulation	EXEPHY_ESSA_2014_Doc5
EXEPHY ESSA 2015 Annual Report	Annual Report	Exercise physiology	ESSA	Professional association	Unclear/ambiguous	EXEPHY_ESSA_2015_Doc6
EXEPHY ESSA 201510 Deloitte Value of accredited exercise physiologists in Australia - full report	Report	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2015_Doc7

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
EXEPHY ESSA 2016 Annual Report	Annual Report	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2016_Doc8
EXEPHY ESSA 2017 Annual Report	Annual Report	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2017_Doc9
EXEPHY ESSA 20171222 Submission to Australian Commission on Safety and Quality in Health Care Patient safety and quality improvement in primary care	Submission	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2017_Doc10
EXEPHY ESSA 2018 Annual Report	Annual Report	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2018_Doc11
EXEPHY ESSA 20190603 Future Workforce Report	Report	Exercise physiology	ESSA	Professional association	Not stated	EXEPHY_ESSA_2019_Doc12
EXEPHY ESSA 2020 Sports Science Industry Development Plan 2020-2025	Strategic plan	Exercise physiology	ESSA	Professional association	Not stated	EXEPHY_ESSA_2020_Doc13
EXEPHY ESSA 20200521 Submission to ACCC on the private healthcare Australia Limited's application for authorisation	Submission	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2020_Doc14
EXEPHY ESSA 2020-2021 Pre-budget submission	Submission	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2020_Doc15
EXEPHY ESSA 2021 Strategic Plan 2021-2023	Strategic plan	Exercise physiology	ESSA	Professional association	Not stated	EXEPHY_ESSA_2021_Doc16
EXEPHY ESSA 20210113 Submission Health outcomes and access to health and hospital services in rural, regional and remote NSW	Submission	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2021_Doc17
EXEPHY ESSA 202101 Membership and Accreditation Standards	Codes/ Standards/ Guidelines	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2021_Doc18
EXEPHY ESSA 20210312 Submission to Inquiry into rural health services in Tasmania	Submission	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2021_Doc19
EXEPHY ESSA 2021-2022 Pre-budget submission	Submission	Exercise physiology	ESSA	Professional association	Self-regulation	EXEPHY_ESSA_2021_Doc20
MASS AMT 2007-08 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Unclear/ ambiguous	MASS_AMT_2008_Doc1
MASS AMT 2008-09 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Unclear/ ambiguous	MASS_AMT_2009_Doc2

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
MASS AMT 2009-10 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Unclear/ambiguous	MASS_AMT_2010_Doc3
MASS AMT 2010-11 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Unclear/ambiguous	MASS_AMT_2011_Doc4
MASS AMT 2011 Association of Massage Therapists 2011 Apr Submission to AHMAC on options for regulation of unregistered health practitioners	Submission	Massage therapy	AMT	Professional association	Self-regulation and co-regulation	MASS_AMT_2011_Doc5
MASS AMT 2011-12 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Unclear/ambiguous	MASS_AMT_2012_Doc6
MASS AMT 201209 Association of Massage Therapists 2012 Sept Submission to CMO Review of the Aust Govt Rebate on Private Health Insurance for natural therapies.	Submission	Massage therapy	AMT	Professional association	Not stated	MASS_AMT_2012_Doc7
MASS AMT 2012-13 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Unclear/ambiguous	MASS_AMT_2013_Doc8
MASS AMT 2013-14 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Self- and co-regulation	MASS_AMT_2014_Doc9
MASS AMT 201405 Association of Massage Therapists 2014 Submission to AHMAC on the terms of a National Code of Conduct for Health Care Workers	Submission	Massage therapy	AMT	Professional association	Self- and co-regulation	MASS_AMT_2014_Doc10
MASS AMT 2014-15 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Self- and co-regulation	MASS_AMT_2015_Doc11
MASS AMT 20150703 Association of Massage Therapists 2015 Media-Release AMT calls for regulatory reform in light of David Wang rape conviction	Media release/ reports	Massage therapy	AMT	Professional association	Self- and co-regulation	MASS_AMT_2015_Doc12
MASS AMT 2015-16 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Self- and co-regulation	MASS_AMT_2016_Doc13
MASS AMT 201607 Association of Massage Therapists e-newsletter 2016 July	General communication	Massage therapy	AMT	Professional association	Self- and co-regulation	MASS_AMT_2016_Doc14
MASS AMT 2016-17 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Self- and co-regulation	MASS_AMT_2017_Doc15
MASS AMT 2017-18 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Unclear/ambiguous	MASS_AMT_2018_Doc16

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
MASS AMT 2018 Association of Massage Therapists 2018 Submission to the NT Dept of Health on a National Code of Conducts for Health Care Workers	Submission	Massage therapy	AMT	Professional association	Self- and co-regulation	MASS_AMT_2018_Doc17
MASS AMT 2018-2019 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Unclear/ ambiguous	MASS_AMT_2019_Doc18
MASS AMT 2019 Association of Massage Therapists AMT-strategic-plan-2019-2024	Strategic plan	Massage therapy	AMT	Professional association	Self- and co-regulation	MASS_AMT_2019_Doc19
MASS AMT 2019-20 Annual Report	Annual Report	Massage therapy	AMT	Professional association	Unclear/ ambiguous	MASS_AMT_2020_Doc20
MASS AMT Association of Massage Therapists AMT Position statement on Regulation of the massage therapy industry	Position statement	Massage therapy	AMT	Professional association	Self- and co-regulation	MASS_AMT_Undated_Doc21
MASS ANTA 20080925 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Massage therapy	ANTA	Professional association	Unclear/ ambiguous	MASS_ANTA_2008_Doc1
MASS ANTA 2013 Submission to the PHI Rebate review	Submission	Massage therapy	ANTA	Professional association	Not stated	MASS_ANTA_2013_Doc2
MASS ANTA 2014 Review of NRAS COAG	Submission	Massage therapy	ANTA	Professional association	Statutory registration	MASS_ANTA_2014_Doc3
MASS ANTA 2017 Review of accreditation systems within the NRAS COAG	Submission	Massage therapy	ANTA	Professional association	Statutory registration	MASS_ANTA_2017_Doc4
MASS ANTA 20170328 Submissions Reforms to the regulatory framework for complementary medicines Assessment pathways	Submission	Massage therapy	ANTA	Professional association	Statutory registration	MASS_ANTA_2017_Doc5
MASS ANTA 2018 About Us	General communication	Massage therapy	ANTA	Professional association	Statutory registration	MASS_ANTA_2018_Doc6
MASS ANTA 2018 Benefits of joining ANTA	General communication	Massage therapy	ANTA	Professional association	Statutory registration	MASS_ANTA_2018_Doc7
MASS ANTA 2018 FAQ	General communication	Massage therapy	ANTA	Professional association	Statutory registration	MASS_ANTA_2018_Doc8
MASS ANTA 2018 Statutory Registration - NRAS	General communication	Massage therapy	ANTA	Professional association	Statutory registration	MASS_ANTA_2018_Doc9
MASS ANTA 201804 Weir Submission to Chair HWPC Registration of Remedial Massage and Myotherapy	Submission	Massage therapy	ANTA	Professional association	Statutory registration	MASS_ANTA_2018_Doc10
MASS ANTA 2021 FAQ part 2	General communication	Massage therapy	ANTA	Professional association	Not stated	MASS_ANTA_2021Doc11

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
MASS ATMS 200503 Submission to Senate Community Affairs References Committee on the Inquiry Into Services and Treatment Options for Persons with Cancer	Submission	Massage therapy	ATMS	Professional association	Not supportive of statutory registration	MASS_ATMS_2005_Doc1
MASS ATMS 20110905 Submission to ACCC on private health insurance report	Submission	Massage therapy	ATMS	Professional association	Not stated	MASS_ATMS_2011_Doc2
MASS ATMS 201301 Submission to the CMO natural therapies review of PHI rebate	Submission	Massage therapy	ATMS	Professional association	Not stated	MASS_ATMS_2013_Doc3
MASS ATMS 20131217 Submission to the HCCC on the promotion of false or misleading health related information or practices	Submission	Massage therapy	ATMS	Professional association	Not stated	MASS_ATMS_2013_Doc4
MASS ATMS 2017 Strategic-Plan-2017-2020	Strategic plan	Massage therapy	ATMS	Professional association	Not stated	MASS_ATMS_2017_Doc5
MASS MMA 201307 Submission Consultation RIS Regulating the advertising of therapeutic goods to the general public	Submission	Massage therapy	MMA	Professional association	Self-regulation	MASS_MMA_2013_Doc1
MASS MMA 2016 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2015-2016	Annual Report	Massage therapy	MMA	Professional association	Self-regulation	MASS_MMA_2016_Doc2
MASS MMA 20160829 Submission to Inquiry into the performance of the Qld Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013	Submission	Massage therapy	MMA	Professional association	Self-regulation	MASS_MMA_2016_Doc3
MASS MMA 2017 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2016-2017	Annual Report	Massage therapy	MMA	Professional association	Self- and co-regulation	MASS_MMA_2017_Doc4
MASS MMA 2017 Massage and Myotherapy Review of accreditation systems within the NRAS COAG b	Submission	Massage therapy	MMA	Professional association	Not stated	MASS_MMA_2017_Doc5
MASS MMA 201702 Massage and Myotherapy Australia 2017 Feb Opportunities in palliative care and end of life care submission to Productivity Commission Public Enquiry	Submission	Massage therapy	MMA	Professional association	Unclear/ambiguous	MASS_MMA_2017_Doc6
MASS MMA 2018 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2017-2018	Annual Report	Massage therapy	MMA	Professional association	Self- and co-regulation	MASS_MMA_2018_Doc7
MASS MMA 2019 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2018-2019	Annual Report	Massage therapy	MMA	Professional association	Self- and co-regulation	MASS_MMA_2019_Doc8
MASS MMA 2020 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2019-2-20	Annual Report	Massage therapy	MMA	Professional association	Self- and co-regulation	MASS_MMA_2020_Doc9

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
MASS MMA 2020 Massage and Myotherapy Australia 2020 Code of ethics report 2016-2019 Complaints in Massage Therapy our problem our solution	Codes/ Standards/ Guidelines	Massage therapy	MMA	Professional association	Not stated	MASS_MMA_2020_Doc10
MASS MMA AAMT 2011 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2010-2011	Annual Report	Massage therapy	MMA	Professional association	Unclear/ ambiguous	MASS_MMA_2011_Doc11
MASS MMA AAMT 2012 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2011-2012	Annual Report	Massage therapy	MMA	Professional association	Unclear/ ambiguous	MASS_MMA_2012_Doc12
MASS MMA AAMT 2013 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2012-2013	Annual Report	Massage therapy	MMA	Professional association	Not stated	MASS_MMA_2013_Doc13
MASS MMA AAMT 2014 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2013-2014	Annual Report	Massage therapy	MMA	Professional association	Not stated	MASS_MMA_2014_Doc14
MASS MMA AAMT 2015 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2014-2015	Annual Report	Massage therapy	MMA	Professional association	Not stated	MASS_MMA_2015_Doc15
MASS MMA AAMT 201607 Australian Association of Massage Therapists A submission First Stage of Human Services – Productivity Commission Inquiry Identifying Sectors for Reform	Submission	Massage therapy	MMA	Professional association	Self-regulation	MASS_MMA_2016_Doc16
MYOTH ANTA 20080925 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Myotherapy	ANTA	Professional association	Unclear/ ambiguous	MYOTH_ANTA_2008_Doc1
MYOTH ANTA 2013 Submission to the PHI Rebate review	Submission	Myotherapy	ANTA	Professional association	Not stated	MYOTH_ANTA_2013_Doc2
MYOTH ANTA 2014 Review of NRAS COAG	Submission	Myotherapy	ANTA	Professional association	Statutory registration	MYOTH_ANTA_2014_Doc3
MYOTH ANTA 2017 Review of accreditation systems within the NRAS COAG	Submission	Myotherapy	ANTA	Professional association	Statutory registration	MYOTH_ANTA_2017_Doc4
MYOTH ANTA 20170328 Submissions Reforms to the regulatory framework for complementary medicines Assessment pathways	Submission	Myotherapy	ANTA	Professional association	Statutory registration	MYOTH_ANTA_2017_Doc5
MYOTH ANTA 2018 About Us	General communication	Myotherapy	ANTA	Professional association	Statutory registration	MYOTH_ANTA_2018_Doc6
MYOTH ANTA 2018 Benefits of joining ANTA	General communication	Myotherapy	ANTA	Professional association	Statutory registration	MYOTH_ANTA_2018_Doc7
MYOTH ANTA 2018 FAQ	General communication	Myotherapy	ANTA	Professional association	Statutory registration	MYOTH_ANTA_2018_Doc8

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
MYOTH ANTA 2018 Statutory Registration - NRAS	General communication	Myotherapy	ANTA	Professional association	Statutory registration	MYOTH_ANTA_2018_Doc9
MYOTH ANTA 201804 Weir Submission to Chair HWPC Registration of Remedial Massage and Myotherapy	Submission	Myotherapy	ANTA	Professional association	Statutory registration	MYOTH_ANTA_2018_Doc10
MYOTH ANTA 2021 FAQ part 2	General communication	Myotherapy	ANTA	Professional association	Not stated	MYOTH_ANTA_2021_Doc11
MYOTH MAA 20130131 Myotherapy Association Australia Institute of Registered Myotherapists of Australia Review of the Aust Govt Rebate on PHI for natural therapies	Submission	Myotherapy	MAA	Professional association	Not stated	MYOTH_MAA_2013_Doc1
MYOTH MAA 2019 Annual Report Myotherapy Association Australia Annual_Report_2019	Annual Report	Myotherapy	MAA	Professional association	Self-regulation	MYOTH_MAA_2019_Doc2
MYOTH MAA 2019 Myotherapy Association Australia Strategic Plan	Strategic plan	Myotherapy	MAA	Professional association	Self-regulation	MYOTH_MAA_2019_Doc3
MYOTH MAA 2020 Annual Report Myotherapy Association Australia Annual Report 2020	Annual Report	Myotherapy	MAA	Professional association	Self-regulation	MYOTH_MAA_2020_Doc4
MYOTH MAA 20201019 Myotherapy Association Australia 2020 Oct Patients 'out in the cold' as new rules exclude myotherapy	Media release/ reports	Myotherapy	MAA	Professional association	Not stated	MYOTH_MAA_2020_Doc5
MYOTH MMA 201307 Submission Consultation RIS Regulating the advertising of therapeutic goods to the general public	Submission	Myotherapy	MMA	Professional association	Self-regulation	MYOTH_MMA_2013_Doc1
MYOTH MMA 2016 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2015-16	Annual Report	Myotherapy	MMA	Professional association	Self-regulation	MYOTH_MMA_2016_Doc2
MYOTH MMA 20160829 Submission to Inquiry into the performance of the Qld Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013	Submission	Myotherapy	MMA	Professional association	Self-regulation	MYOTH_MMA_2016_Doc3
MYOTH MMA 2017 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2016-17	Annual Report	Myotherapy	MMA	Professional association	Self- and co-regulation	MYOTH_MMA_2017_Doc4
MYOTH MMA 2017 Massage and Myotherapy Review of accreditation systems within the NRAS COAG b	Submission	Myotherapy	MMA	Professional association	Not stated	MYOTH_MMA_2017_Doc5
MYOTH MMA 201702 Massage and Myotherapy Australia 2017 Feb Opportunities in palliative care and end of life care submission to Productivity Commission Public Enquiry	Submission	Myotherapy	MMA	Professional association	Unclear/ ambiguous	MYOTH_MMA_2017_Doc6

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
MYOTH MMA 2018 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2017-2018	Annual Report	Myotherapy	MMA	Professional association	Self- and co-regulation	MYOTH_MMA_2018_Doc7
MYOTH MMA 2019 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2018-2019	Annual Report	Myotherapy	MMA	Professional association	Self- and co-regulation	MYOTH_MMA_2019_Doc8
MYOTH MMA 2020 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2019-2020	Annual Report	Myotherapy	MMA	Professional association	Self- and co-regulation	MYOTH_MMA_2020_Doc9
MYOTH MMA 2020 Massage and Myotherapy Australia 2020 Code of ethics report 2016-2019 Complaints in Massage Therapy our problem our solution	Codes/ Standards/ Guidelines	Myotherapy	MMA	Professional association	Not stated	MYOTH_MMA_2020_Doc10
MYOTH MMA AAMT 2015 Annual Report Massage and Myotherapy Australia Annual Report AAMT 2014-2015	Annual Report	Myotherapy	MMA	Professional association	Not stated	MYOTH_MMA_2015_Doc11
MYOTH MMA AAMT 201607 Australian Association of Massage Therapists A submission First Stage of Human Services – Productivity Commission Inquiry Identifying Sectors for Reform	Submission	Myotherapy	MMA	Professional association	Self-regulation	MYOTH_MMA_2016_Doc12
NAT 20081003 Wardle UQ NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Naturopathy	Other	Individual	Statutory registration	NAT_INDIVIDUAL_2008_Doc1
NAT 20090509 Wardle Submission to the Senate Inquiry into the NRAS for Doctors and Other Health Workers	Submission	Naturopathy	Other	Individual	Statutory registration	NAT_INDIVIDUAL_2009_Doc2
NAT 20100827 Wardle Consultation submission TGA advertising arrangements	Submission	Naturopathy	Other	Individual	Statutory registration	NAT_INDIVIDUAL_2010_Doc3
NAT 20101021 Wardle Unregulated naturopaths putting lives at risk - ABC News	Media release/ reports	Naturopathy	Other	Individual	Statutory registration	NAT_INDIVIDUAL_2010_Doc4
NAT 20130131 Wardle Submission to PHI review Individual Naturopathy Western Herbalism (1) - transcript	Submission	Naturopathy	Other	Individual	Statutory registration	NAT_INDIVIDUAL_2013_Doc5
NAT ANC 20200609 Why do we need Registration Regulation of the Naturopathic profession in Australia_ (June 2020) – Australian Naturopathic Council	Position statement	Naturopathy	ANC	Peak professional body	Statutory registration	NAT_ANC_2020_Doc1
NAT ANC 202010 E-bulletin 1 (October 2020) – Australian Naturopathic Council	General communication	Naturopathy	ANC	Peak professional body	Statutory registration	NAT_ANC_2020_Doc2

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
NAT ANC 2021 Australian Naturopathic Council – Official Site of the ANC	General communication	Naturopathy	ANC	Peak professional body	Statutory registration	NAT_ANC_2021_Doc3
NAT ANC 2021 Frequently Asked Questions – Australian Naturopathic Council	General communication	Naturopathy	ANC	Peak professional body	Statutory registration	NAT_ANC_2021_Doc4
NAT ANC 2021 Pre-Budget-submission-2021-22	Submission	Naturopathy	ANC	Peak professional body	Statutory registration	NAT_ANC_2021_Doc5
NAT ANPA 201301 Submission to DOHAC Evidence in support of PHI Rebates for naturopathy	Submission	Naturopathy	ANPA	Professional association	Statutory registration	NAT_ANPA_2013_Doc1
NAT ANPA 20170328 TGA CAM Submission Reforms to the regulatory framework for complementary medicines assessment pathways	Submission	Naturopathy	ANPA	Professional association	Statutory registration	NAT_ANPA_2017_Doc2
NAT ANPA 20170512 TGA Submission - Regulation of _low risk_ products	Submission	Naturopathy	ANPA	Professional association	Statutory registration	NAT_ANPA_2017_Doc3
NAT ANPA 20170731 Regulation for Naturopaths (continued)	General communication	Naturopathy	ANPA	Professional association	Statutory registration	NAT_ANPA_2017_Doc4
NAT ANPA 2019 Submission for the Terms of Reference to The Natural Therapies Review 2019	General communication	Naturopathy	ANPA	Professional association	Statutory registration	NAT_ANPA_2019_Doc5
NAT ANPA 2020 DOHAC Natural Therapies Review 2019-20	General communication	Naturopathy	ANPA	Professional association	Statutory registration	NAT_ANPA_2020_Doc6
NAT ANPA 2021 Professional Regulation	Position statement	Naturopathy	ANPA	Professional association	Statutory registration	NAT_ANPA_2021_Doc7
NAT ANTA 20080925 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Naturopathy	ANTA	Professional association	Unclear/ambiguous	NAT_ANTA_2008_Doc1
NAT ANTA 2013 Submission to the PHI Rebate review	Submission	Naturopathy	ANTA	Professional association	Not stated	NAT_ANTA_2013_Doc2
NAT ANTA 2014 Review of NRAS COAG	Submission	Naturopathy	ANTA	Professional association	Statutory registration	NAT_ANTA_2014_Doc3
NAT ANTA 201609 Weir Submission to Chair HWPC Registration of naturopathy, WHM and nutritional medicine	Submission	Naturopathy	ANTA	Professional association	Statutory registration	NAT_ANTA_2016_Doc4
NAT ANTA 2017 Review of accreditation systems within the NRAS COAG	Submission	Naturopathy	ANTA	Professional association	Statutory registration	NAT_ANTA_2017_Doc5

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
NAT ANTA 20170328 Submissions Reforms to the regulatory framework for complementary medicines Assessment pathways	Submission	Naturopathy	ANTA	Professional association	Statutory registration	NAT_ANTA_2017_Doc6
NAT ANTA 2018 About Us	General communication	Naturopathy	ANTA	Professional association	Statutory registration	NAT_ANTA_2018_Doc7
NAT ANTA 2018 Benefits of joining ANTA	General communication	Naturopathy	ANTA	Professional association	Statutory registration	NAT_ANTA_2018_Doc8
NAT ANTA 2018 FAQ	General communication	Naturopathy	ANTA	Professional association	Statutory registration	NAT_ANTA_2018_Doc9
NAT ANTA 2018 Statutory Registration - NRAS	General communication	Naturopathy	ANTA	Professional association	Statutory registration	NAT_ANTA_2018_Doc10
NAT ANTA 2018 Statutory Registration is the Key Ingredient	General communication	Naturopathy	ANTA	Professional association	Statutory registration	NAT_ANTA_2018_Doc11
NAT ANTA 2021 FAQ part 2	General communication	Naturopathy	ANTA	Professional association	Not stated	NAT_ANTA_2021_Doc12
NAT ARONAH 2010 National register of naturopaths and herbalists to improve public safety – Australian Register of Naturopaths and Herbalists	General communication	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2010_Doc1
NAT ARONAH 2011 Submission to AHMAC on options for the regulation of unregistered health practitioners	Submission	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2011_Doc2
NAT ARONAH 2013 Submission to TGA Consultation Regulating the advertising of therapeutic goods to the general public	Submission	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2013_Doc3
NAT ARONAH 2014 CSHISC Alignment of comp health quals to the Aust Qual Framework	Submission	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2014_Doc4
NAT ARONAH 2015 Dodgy naturopathy courses putting public at risk	General communication	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2015_Doc5
NAT ARONAH 2015 Education the key to effective practice. A response to the recent NHMRC review	General communication	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2015_Doc6
NAT ARONAH 2016 Naturopathy can be safe and effective, but registration is the key	General communication	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2016_Doc7
NAT ARONAH 2017 MEDIA-RELEASE_Delays-in-pathways-for-statutory-registration-of-naturopaths	Media release/ reports	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2017_Doc8
NAT ARONAH 2017 Scope of Practice	Codes/ Standards/ Guidelines	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2017_Doc9

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
NAT ARONAH 2017 Submission Reforms to the subsidisation of private health insurance rebates	Submission	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2017_Doc10
NAT ARONAH 2018 MEDIA-RELEASE_Delays-in-pathways-for-statutory-registration-of-naturopaths_Bodnar-sentenced_final	Media release/reports	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2018_Doc11
NAT ARONAH 20180919 Registration – the next best thing for naturopathy, or is it The Naturopathic Insider	General communication	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_2018_Doc12
NAT ARONAH About ARONAH	General communication	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_Undated_Doc13
NAT ARONAH Protecting the public, advancing the profession	General communication	Naturopathy	ARONAH	Registering organisation	Statutory registration	NAT_ARONAH_Undated_Doc14
NAT ATMS 200503 Submission to Senate Community Affairs References Committee on the Inquiry Into Services and Treatment Options for Persons with Cancer	Submission	Naturopathy	ATMS	Professional association	Not supportive of statutory registration	NAT_ATMS_2005_Doc1
NAT ATMS 20110905 Submission to ACCC on private health insurance report	Submission	Naturopathy	ATMS	Professional association	Not stated	NAT_ATMS_2011_Doc2
NAT ATMS 201301 Submission to the CMO natural therapies review of PHI rebate	Submission	Naturopathy	ATMS	Professional association	Not stated	NAT_ATMS_2013_Doc3
NAT ATMS 201305 Submission to the TGA re the consultation regulation impact statement	Submission	Naturopathy	ATMS	Professional association	Self-regulation	NAT_ATMS_2013_Doc4
NAT ATMS 201307 The facts on what is happening to POPs	General communication	Naturopathy	ATMS	Professional association	Unclear/ambiguous	NAT_ATMS_2013_Doc5
NAT ATMS 20131217 Submission to the HCCC on the promotion of false or misleading health related information or practices	Submission	Naturopathy	ATMS	Professional association	Not stated	NAT_ATMS_2013_Doc6
NAT ATMS 20131219 Response to the proposed Australian Register of Naturopaths and Herbalists - ARONAH	Submission	Naturopathy	ATMS	Professional association	Self-regulation	NAT_ATMS_2013_Doc7
NAT ATMS 20140830 Le Breton Letter Edited-Additional-Information-to-CSHISC-August-2014-V3	Submission	Naturopathy	ATMS	Professional association	Self-regulation	NAT_ATMS_2014_Doc8
NAT ATMS 2017 Strategic-Plan-2017-2020	Strategic plan	Naturopathy	ATMS	Professional association	Not stated	NAT_ATMS_2017_Doc9
NAT ATMS 20170707 Position-Statement-Registration 2017 July	Position statement	Naturopathy	ATMS	Professional association	Not supportive	NAT_ATMS_2017_Doc10

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
					of statutory registration	
NAT ATMS 20180530 Berryman interview Fx Medicine Naturopathy What is Co-Regulation with Peter Berryman	General communication	Naturopathy	ATMS	Professional association	Self-regulation	NAT_ATMS_2018_Doc11
NAT ATMS 202001 Position-Statement-Registration 2020 January	Position statement	Naturopathy	ATMS	Professional association	Unclear/ambiguous	NAT_ATMS_2020_Doc12
NAT CHCA 20110131 Submission to ARONAH practice and standards for naturopaths and Western herbalists	Submission	Naturopathy	Other	Other organisation	Unclear/ambiguous	NAT_CHCA_2011_Doc1
NAT CHCA 201305 Complementary Healthcare Council 2013 May White Paper Registration of Nats and WHM protecting public health and rights	Position statement	Naturopathy	Other	Other organisation	Statutory registration	NAT_CHCA_2013_Doc2
NAT CMAss 201101 Submission to ARONAH practice and standards for naturopaths and Western herbalists	Submission	Naturopathy	CMAss	Professional association	Statutory registration	NAT_CMAss_2011_Doc1
NAT CMAss 2021 FAQ	General communication	Naturopathy	CMAss	Professional association	Statutory registration	NAT_CMAss_2021_Doc2
NAT CMAss 2021 History Aim Mission	General communication	Naturopathy	CMAss	Professional association	Statutory registration	NAT_CMAss_2021_Doc3
NAT CMAust 20141022 Review of NRAS COAG	Submission	Naturopathy	Other	Other organisation	Statutory registration	NAT_CMAust_2014_Doc4
NAT Doolan 200810 Naturopaths for registration Submission	Submission	Naturopathy	Other	Other organisation	Statutory registration	NAT_NAT4REG_2008_Doc1
NAT NHAA 2006 Oct Submission to Vic DOHS re Lin, La Trobe Report submission Oct06	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2006_Doc1
NAT NHAA 2008 Apr Submission to SA SDC Bogus, Unregistered and Deregistered Health Practitioners	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2008_Doc2
NAT NHAA 2008 Feb Submission to Inquiry of Natl Higher Education Accred. Body Feb08	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2008_Doc3
NAT NHAA 2008 Jan Prebudget submission January 2008	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2008_Doc4
NAT NHAA 2008 Jan Submission to NSW Health re Unregistered Health Practitioners Code of Conduct	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2008_Doc5
NAT NHAA 2008 Mar Submission to Aust Govt Private Health Insurance accreditation Rules submission March 2008	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2008_Doc6

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
NAT NHAA 2009 Mar 1 Submission to NHHRC National Health and Hospitals Reform Commission interim report	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2009_Doc7
NAT NHAA 20090809 Submission to ARONAH	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2009_Doc8
NAT NHAA 2011 Apr Submission to AHMAC regarding options for regulation of unregistered health practitioners	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2011_Doc9
NAT NHAA 2012 Aug Review of the Australian Government rebate on PHI for natural therapies	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2012_Doc10
NAT NHAA 2013b May ARONAH_Standards_and_Guidelines	Codes/ Standards/ Guidelines	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2013_Doc11
NAT NHAA 2013 Submission to parliamentary inquiry Promotion of false or misleading health related information or practices	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2013_Doc12
NAT NHAA 2014 Apr Submission to AHMAC National_Code_of_Conduct_for_health_care_workers	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2014_Doc13
NAT NHAA 2014 Oct Submission Independent AHMAC review of the NRAS for health professions	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2014_Doc14
NAT NHAA 2015 Jul 10 MEDIA RELEASE Peak naturopathic association calls for government regulation	Media release/ reports	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2015_Doc15
NAT NHAA 2018 Welcome to the NHAA	General communication	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2018_Doc16
NAT NHAA 20180406 News Naturopaths call for government regulation in the name of public safety	General communication	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2018_Doc17
NAT NHAA 201808 NHAA submission on Exposure draft subordinate legislation PHI reforms Amendment Rules 2018	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2018_Doc18
NAT NHAA 2020 Submission to 2020 Summit	Submission	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_2020_Doc19
NAT NHAA About the Naturopaths and Herbalists Association of Australia	General communication	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_Undated_Doc20
NAT NHAA Regulation FAQs	General communication	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_Undated_Doc21

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
NAT NHAA Regulation of herbalists and naturopaths in Australia	General communication	Naturopathy	NHAA	Professional association	Statutory registration	NAT_NHAA_Undated_Doc22
NAT SSNT 2013 Submission to TGA consultation RIS re regulation of therapeutic goods to the general public	Submission	Naturopathy	Other	Other organisation	Statutory registration	NAT_SSNT_2013_Doc1
ORTHOP AOB 20140925 Australian Orthoptic Board - FAQs	General communication	Orthoptics	AOB	Registering organisation	Not stated	ORTHOP_AOB_2014_Doc1
ORTHOP AOB 202004 Australian Orthoptic Board - AOB Registration	Position statement	Orthoptics	AOB	Registering organisation	Not stated	ORTHOP_AOB_2020_Doc2
ORTHOP OA 200812 Orthoptic Association of Australia Submission NRAS Trove NATREG 20080919 Call for submissions on proposed registration arrangements	Submission	Orthoptics	OA	Professional association	Not stated	ORTHOP_OA_2008_Doc1
ORTHOP OA 2018 Orthoptics Australia 2018-2019 Annual Report	Annual Report	Orthoptics	OA	Professional association	Not stated	ORTHOP_OA_2018_Doc2
ORTHOP OA 201806 Submission to Patient Safety and Quality Improvement in Primary Care Discussion Paper	Submission	Orthoptics	OA	Professional association	Not stated	ORTHOP_OA_2018_Doc3
ORTHOP OA 2019 Orthoptics Australia 2019-20 Annual Report	Annual Report	Orthoptics	OA	Professional association	Not stated	ORTHOP_OA_2019_Doc4
ORTHOP OA 20190913 Submission to Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning	Submission	Orthoptics	OA	Professional association	Not stated	ORTHOP_OA_2019_Doc5
ORTHOP OA 2021 Orthoptics Australia 2021 Professional registration	General communication	Orthoptics	OA	Professional association	Not stated	ORTHOP_OA_2021_Doc6
PARA ACAP 200507 Submission Productivity Commission health WF study	Submission	Paramedicine	ACAP	Professional association	Statutory registration	PARA_ACAP_2005_Doc1
PARA ACAP 20051110 Submission Productivity commission health WF study	Submission	Paramedicine	ACAP	Professional association	Statutory registration	PARA_ACAP_2005_Doc2
PARA AMA 201501 Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	Other	Other organisation	Statutory registration	PARA_AMA_2015_Doc1
PARA Ambulance Employees Australia Vic Submission Senate inquiry into the establishment of a national registration system for Aust paramedics	Submission	Paramedicine	Other	Other organisation	Statutory registration	PARA_AEA_Undated_Doc1
PARA ANZCP 20120903 see appendix Submission to Health Workforce Principal Committee on Options for the Regulation of Paramedics	Submission	Paramedicine	ACP	Professional association	Statutory registration	PARA_ANZCPara_2012_Doc1

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
PARA ANZCP 201601 Australian and NZ College of Paramedicine Submission for the establishment of a national registration system for Aust paramedics to ensure patient community safety	Submission	Paramedicine	ACP	Professional association	Statutory registration	PARA_ANZCPara_2016_Doc2
PARA Aust Paramedics Ass Qld Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	Other	Other organisation	Statutory registration	PARA_APAQld_Undated_Doc1
PARA Bange, Brightwell, Maguire 201601 Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	Other	Individual	Statutory registration	PARA_INDIVIDUAL_2016_Doc1
PARA Bange, Brightwell, Maguire 20160216 Submission Supplement Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	Other	Individual	Statutory registration	PARA_INDIVIDUAL_2016_Doc2
PARA CAA 201112 Council of Ambulance Authorities 2011 Dec Factors affecting the supply of health services and medical professionals in rural areas	Submission	Paramedicine	CAA	Peak professional body	Not stated	PARA_CAA_2011_Doc1
PARA CAA 2013 Annual Report Council of Ambulance Authorities 2012-13 Annual_Report	Annual Report	Paramedicine	CAA	Peak professional body	Statutory registration	PARA_CAA_2013_Doc2
PARA CAA 2015 Annual Report Council of Ambulance Authorities 2014-15 Annual_Report	Annual Report	Paramedicine	CAA	Peak professional body	Statutory registration	PARA_CAA_2015_Doc3
PARA CAA 201510 Submission to Public safety mobile broadband productivity commission	Submission	Paramedicine	CAA	Peak professional body	Statutory registration	PARA_CAA_2015_Doc4
PARA CAA 2016 Annual Report Council of Ambulance Authorities 2015-16 Annual_Report	Annual Report	Paramedicine	CAA	Peak professional body	Statutory registration	PARA_CAA_2016_Doc5
PARA CAA 201601 Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	CAA	Peak professional body	Statutory registration	PARA_CAA_2016_Doc6
PARA CAA 2017 Council of Ambulance Authorities COAG 2017 Review of accreditation systems within the NRAS	Submission	Paramedicine	CAA	Peak professional body	Statutory registration	PARA_CAA_2017_Doc7

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
PARA CAA 2018 Annual Report Council of Ambulance Authorities 2017-18 Annual_Report	Annual Report	Paramedicine	CAA	Peak professional body	Statutory registration	PARA_CAA_2018_Doc8
PARA Eburn 20120905 Submission Attachment 1 Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	Other	Individual	Statutory registration	PARA_INDIVIDUAL_2012_Doc3
PARA Eburn 20160129 Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	Other	Individual	Statutory registration	PARA_INDIVIDUAL_2016_Doc4
PARA NCAU 201601 National Council of Ambulance Unions Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	NCAU	Peak professional body	Statutory registration	PARA_NCAU_2016_Doc1
PARA NSW Health 20160129 Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	Other	Government	Not supportive of statutory registration	PARA_NSWHealth_2016_Doc1
PARA PA 201410 Paramedics Australasia COAG 2014 - Review of NRAS	Submission	Paramedicine	PA	Professional association	Statutory registration	PARA_PA_2014_Doc1
PARA PA 2016 Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	PA	Professional association	Statutory registration	PARA_PA_2016_Doc2
PARA PA 2018 Paramedics Australasia COAG 2018 - Stage 2 submissions to the <i>Health Practitioner Regulation National Law</i>	Submission	Paramedicine	PA	Professional association	Statutory registration	PARA_PA_2018_Doc3
PARA PA Paramedics Australasia Paramedicine role descriptions	Codes/ Standards/ Guidelines	Paramedicine	PA	Professional association	Statutory registration	PARA_PA_Undated_Doc4
PARA Royal Flying Doctor Service 20160129 Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	Other	Other organisation	Statutory registration	PARA_RFDS_2016_Doc1
PARA Townsend 20160129 Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	Other	Individual	Statutory registration	PARA_INDIVIDUAL_2016_Doc5

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
PARA Vic DHHS 2016 Submission Senate inquiry into the establishment of a national registration system for Australian paramedics	Submission	Paramedicine	Other	Government	Statutory registration	PARA_VicDHHS_Undated_Doc1
PERF ANZCP 2014 Australian and NZ College of Perfusionists COAG 2014 - Review of NRAS	Submission	Clinical Perfusion	ANZCP	Professional association	Statutory registration	PERF_ANZCPerf_2014_Doc1
PERF ANZCP 20201120 Australian and NZ College of Perfusionists - Rules	Codes/ Standards/ Guidelines	Clinical Perfusion	ANZCP	Professional association	Not stated	PERF_ANZCPerf_2020_Doc2
PERF ANZCP 2021 Australian and NZ College of Perfusionists - Advocacy	General communication	Clinical Perfusion	ANZCP	Professional association	Not stated	PERF_ANZCPerf_2021_Doc3
PERF ANZCP 2021 Australian and NZ College of Perfusionists - The College objectives, advocacy and regulation	General communication	Clinical Perfusion	ANZCP	Professional association	Unclear/ ambiguous	PERF_ANZCPerf_2021_Doc4
PERF ANZCP 2021 Australian and NZ College of Perfusionists - Welcome	General communication	Clinical Perfusion	ANZCP	Professional association	Not stated	PERF_ANZCPerf_2021_Doc5
PERF ANZCP Australian and NZ College of Perfusionists - Australasian Board of Cardiovascular Perfusion	General communication	Clinical Perfusion	ANZCP	Professional association	Not stated	PERF_ANZCPerf_Undated_Doc6
PERF ASCVP 20050725 Australasian Society of Cardio-Vascular Perfusionists 2005 A Case for Registration	Submission	Clinical Perfusion	ASCVP	Professional association	Statutory registration	PERF_ASCVP_2005_Doc1
PERF ASCVP 20051108 Submission Productivity commission position paper	Submission	Clinical Perfusion	ASCVP	Professional association	Statutory registration	PERF_ASCVP_2005_Doc2
PSYC ACA 20080519 p40 HealthWFCOMM PracReg Sub for psychotherapy & counselling in Aust	Submission	Psychotherapy	ACA	Professional association	Self-regulation to statutory registration	PSYC_ACA_2008_Doc1
PSYC ACA 20080827 p7 Vic DOHS Combined Multiple Ass Sub Best practice self reg for psychotherapy & counselling in Aust	Submission	Psychotherapy	ACA	Professional association	Self-regulation to statutory registration	PSYC_ACA_2008_Doc2
PSYC ACA 20110804 Submission to the inquiry into Commonwealth funding and administration of mental health services	Submission	Psychotherapy	ACA	Professional association	Unclear/ ambiguous	PSYC_ACA_2011_Doc3
PSYC ACA 20141015 Review of NRAS COAG	Submission	Psychotherapy	ACA	Professional association	Co-regulation	PSYC_ACA_2014_Doc4

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
PSYC ACA 2016 Scope of Practice for Registered Counsellors	Codes/ Standards/ Guidelines	Psychotherapy	ACA	Professional association	Not stated	PSYC_ACA_2016_Doc5
PSYC ACA 2021 Aims and Objectives	General communication	Psychotherapy	ACA	Professional association	Self-regulation	PSYC_ACA_2021_Doc6
PSYC ACA 202103 Submission to The House Select Committee on Mental Health and Suicide Prevention	Submission	Psychotherapy	ACA	Professional association	Self-regulation	PSYC_ACA_2021_Doc7
PSYC ACA 202106 Care Workforce Labour Market Study Submission	Submission	Psychotherapy	ACA	Professional association	Self-regulation	PSYC_ACA_2016_Doc8
PSYC ARCAP 2011 Response_to_consultation_on_options for regulation of unregistered health practitioners	Submission	Psychotherapy	ARCAP	Registering organisation	Self-regulation	PSYC_ARCAP_2011_Doc1
PSYC ARCAP 2012 General ARCAP - background to ARCAP ACA PACFA	Submission	Psychotherapy	ARCAP	Registering organisation	Not stated	PSYC_ARCAP_2012_Doc2
PSYC ARCAP 201904 Productivity Commission Submission	Submission	Psychotherapy	ARCAP	Registering organisation	Not stated	PSYC_ARCAP_2019_Doc3
PSYC ARCAP 202004 Submission-Medicare-provider-numbers-for-Counsellors-and-Psychotherapists-April-2020	Submission	Psychotherapy	ARCAP	Registering organisation	Self-regulation	PSYC_ARCAP_2020_Doc4
PSYC PACFA 200802 Best Practice Self-Regulation Model for Psychotherapy and Counselling in Australia	Submission	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2008_Doc1
PSYC PACFA 20080519 p10 Health WF Comm Prac Reg Sub for psychotherapy & counselling in Aust	Submission	Psychotherapy	PACFA	Professional association	Self-regulation to statutory registration	PSYC_PACFA_2008_Doc2
PSYC PACFA 20080827 p37 Vic DOHS Combined Multiple Ass Sub Best practice self reg for psychotherapy & counselling in Aust	Submission	Psychotherapy	PACFA	Professional association	Self-regulation to statutory registration	PSYC_PACFA_2008_Doc3
PSYC PACFA 201104 Enews-April2011 PACFA Submission on Options for Regulation of unregistered health practitioners	Submission	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2011_Doc4
PSYC PACFA 20110909 Response-to-consultation-on-NSW-Draft-Public-Health-Regulation Sep 2011	Submission	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2011_Doc5
PSYC PACFA 20111208 Response-to-consultation-on-SA-Draft-Code-of-Conduct-FINAL	Submission	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2011_Doc6

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
PSYC PACFA 20120921 Submission-to-the-ACCC-on-private-health-insurance- September-2012	Submission	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2012_Doc7
PSYC PACFA 20121221 Submission-to-DOHAC-on-Natural-Therapies_Dec2012	Submission	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2012_Doc8
PSYC PACFA 201404 Submission-to-AHMAC-on-National-Code-of-Conduct-April-2014	Submission	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2014_Doc9
PSYC PACFA 20150125 Submission-to-the-ACCC-on-private-health-insurance-January-2015	Submission	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2015_Doc10
PSYC PACFA 2018 Scope-of-Practice-for-Registered-Counsellors	Codes/ Standards/ Guidelines	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2018_Doc11
PSYC PACFA 202001 Response-to-Productivity-Commission-Mental-Health-Draft-Report-Jan2020-1	Submission	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2020_Doc12
PSYC PACFA 202009 PACFA Response to the Higher Education Support Amendment (Job-Ready graduates & supporting regional and remote students) Bill 2020	Submission	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_2020_Doc13
PSYC PACFA 2021 Campaigns Government Recognition	General communication	Psychotherapy	PACFA	Professional association	Unclear/ ambiguous	PSYC_PACFA_2021_Doc14
PSYC PACFA 2021 Professional Recognition	General communication	Psychotherapy	PACFA	Professional association	Unclear/ ambiguous	PSYC_PACFA_2021_Doc15
PSYC PACFA FACTSHEET-Self-Regulating-profession-of-Counselling-and-psychotherapy	General communication	Psychotherapy	PACFA	Professional association	Self-regulation	PSYC_PACFA_Undated_Doc16
SOCWK AASW 20050731 Submission Productivity commission health WF study	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2005_Doc1
SOCWK AASW 20051111 Submission Productivity commission health WF position paper	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2005_Doc2
SOCWK AASW 2011 NRC Roy Morgan The views of Australians regarding regulatory requirements of counsellors and qualified therapists	Report	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2011_Doc3
SOCWK AASW 2011 Oct Submission Senate Community Affairs References Committee Inquiry into the Commonwealth contribution to former forced adoption policies and practices	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2011_Doc4
SOCWK AASW 2011 Protecting the health & wellbeing of Aust A submission to Health Ministers on the national regulation of social work	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2011_Doc5

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
SOCWK AASW 2012 Registration and Title Protection for AASW members - Directions Paper for 2013	Strategic plan	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2012_Doc6
SOCWK AASW 2013 Nov 11 Healy Professional Registration and Title Protection for Social Workers in Australia Past, Present and Future	Position statement	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2013_Doc7
SOCWK AASW 2013 Position paper National-Code-of-Conduct-for-Unregistered-Professionals_08-13	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2013_Doc8
SOCWK AASW 2013 Risk to the public and unintended consequences of excluding social workers from the NRAS	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2013_Doc9
SOCWK AASW 2014 Addendum Review of NRAS COAG	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2014_Doc10
SOCWK AASW 2014 NRAS and the National Regulation of Social Work implications for social workers in non health settings	Position statement	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2014_Doc11
SOCWK AASW 2014 The profession of social work and the unintended consequences of a two tiered system on WF and service sustainability	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2014_Doc12
SOCWK AASW 20140430 Submission to the AHMAC re a national code of conduct for health care workers	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2014_Doc13
SOCWK AASW 201406 NRAS and the National Regulation of Social Work implications for social workers in non health settings	Position statement	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2014_Doc14
SOCWK AASW 201409 Evidence of harm caused by social workers	Report	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2014_Doc15
SOCWK AASW 201410 Submission Review of NRAS COAG	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2014_Doc16
SOCWK AASW 2015 Healy Being a Self-regulating Profession in the 21st Century Problems and Prospects NPA	General communication	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2015_Doc17
SOCWK AASW 2016 Not all people who call themselves social workers are qualified -transcript	Media release/ reports	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2016_Doc18
SOCWK AASW 20160315 SA pushes for national registration scheme	General communication	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2016_Doc19
SOCWK AASW 2018 Annual Report 2017-18	Annual Report	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2018_Doc20

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
SOCWK AASW 2018 Calls for registration of the social work profession - transcript	Media release/ reports	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2018_Doc21
SOCWK AASW 2018 SA Election Policy Statement 2017-18	Policy Statement	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2018_Doc22
SOCWK AASW 2018 Strategic Plan 2018-2021	Strategic plan	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2018_Doc23
SOCWK AASW 2018 welcomes historic step taken to protect vulnerable in society, introduction of a Bill to register SOWO in Sth Aust	Media release/ reports	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2018_Doc24
SOCWK AASW 2019 Annual Report 2018-2019	Annual Report	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2019_Doc25
SOCWK AASW 2019 Audited Financial Report 2018-2019	Annual Report	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2019_Doc26
SOCWK AASW 2019 Federal Election Policy Platform	Policy Statement	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2019_Doc27
SOCWK AASW 2020 AASW Renews call for Social Work Registration - National Child Protection Week 2020	Media release/ reports	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2020_Doc28
SOCWK AASW 2020 AASW WELCOMES GROUNDBREAKING SOUTH AUSTRALIAN LEGISLATION	Media release/ reports	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2020_Doc29
SOCWK AASW 2020 Annual Report 2019-20	Annual Report	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2020_Doc30
SOCWK AASW 2020 QUEENSLAND ELECTION 2020 CHILD SAFETY AASW RENEWS CALL FOR SOCIAL WORK REGISTRATION	Media release/ reports	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2020_Doc31
SOCWK AASW 202008 Submission to Job-ready graduates package draft legislation DESE	Submission	Social work	AASW	Professional association	Not stated	SOCWK_AASW_2020_Doc32
SOCWK AASW 2021 Latest campaign actions - Registration of social work	General communication	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2021_Doc33
SOCWK AASW 2021 National Registration and Accreditation Scheme	General communication	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2021_Doc34
SOCWK AASW 2021 Social Policy & Advocacy	General communication	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2021_Doc35
SOCWK AASW 2021 Social work milestones - AASW	General communication	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2021_Doc36
SOCWK AASW 2021 South Australian registration campaign	General communication	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2021_Doc37

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
SOCWK AASW 2021 Tasmanian election - AASW renews calls for social work registration	Media release/ reports	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2021_Doc38
SOCWK AASW FAQs About regulation impact statements	General communication	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_Undated_Doc39
SOCWK AASW QLD 202001 Submission to the Queensland Govt Health legislation Amendment Bill 2019 Prohibition of conversion therapy	Submission	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_2020_Doc40
SOCWK AASW Registration FAQs	General communication	Social work	AASW	Professional association	Statutory registration	SOCWK_AASW_Undated_Doc41
SOCWK AASW Submission to the Royal Commission into Victoria's Mental Health System	Submission	Social work	AASW	Professional association	Not stated	SOCWK_AASW_Undated_Doc42
SOCWK Aust GP Network 20081003 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Social work	Other	Other organisation	Statutory registration	SOCWK_AUSTGPNETWORK_2008_Doc1
SOCWK Morrison Submission NRAS Trove NATREG Call for submissions on proposed registration arrangements	Submission	Social work	Other	Individual	Statutory registration	SOCWK_INDIVIDUAL_2008_Doc1
SONO ASA 20051111 Submission to Productivity Commission health WF study	Submission	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2005_Doc1
SONO ASA 20081003 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2008_Doc2
SONO ASA 20100304 Position statement registration of sonographers	Position statement	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2010_Doc3
SONO ASA 20110414 Submission to Senate Fin and Public Admin Committees Inquiry into the Admin of health pracs registration by AHPRA	Submission	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2011_Doc4
SONO ASA 2014 Australasian sonographers association submission review of NRAS COAG	Submission	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2014_Doc5
SONO ASA 2015 Annual Report 2014-15	Annual Report	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2015_Doc6
SONO ASA 2015 Intimate examinations consent and chaperones	Codes/ Standards/ Guidelines	Sonography	ASA	Professional association	Not stated	SONO_ASA_2015_Doc7
SONO ASA 20150708 Media Release PM - Fake ultrasound pictures spark calls for industry regulation 08_07_2015	Media release/ reports	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2015_Doc8

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
SONO ASA 20150708 Media Release Ultrasound scam prompts call for sonographers to be regulated - ABC News	Media release/ reports	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2015_Doc9
SONO ASA 2016 Annual Report 2015-2016	Annual Report	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2016_Doc10
SONO ASA 20161215 Media Release The urgent need to regulate sonographers in Australia	Media release/ reports	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2016_Doc11
SONO ASA 2017 Annual Report 2016-2017	Annual Report	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2017_Doc12
SONO ASA 2018 Annual Report 2017-2018	Annual Report	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2018_Doc13
SONO ASA 20180117 - Submission to Parliament of Australia Senate inquiry into the availability accessibility of diagnostic image equipment	Submission	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2018_Doc14
SONO ASA 2019 Annual Report 2018-2019	Annual Report	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2019_Doc15
SONO ASA 2019 Submission feedback on draft revised professional capabilities for medical radiation practice	Submission	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2019_Doc16
SONO ASA 20190816 - Response to the Office of the National Rural Health Commissioner on Rural Allied Health	Submission	Sonography	ASA	Professional association	Not stated	SONO_ASA_2019_Doc17
SONO ASA 2019-2020_Pre-Budget-Submission	Submission	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2020_Doc18
SONO ASA 2020 Annual Report 2019-2020	Annual Report	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2020_Doc19
SONO ASA 20200527 - COVID19_Senate_Inquiry-ASA_sub-200527	Submission	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2020_Doc20
SONO ASA 2020-2021_Pre-Budget-Submission	Submission	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2020_Doc21
SONO ASA 2021 Case examples supporting regulation	General communication	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2021_Doc22
SONO ASA 2021 History of the ASA	General communication	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2021_Doc23
SONO ASA 2021 Sonographer regulation in Australia	General communication	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2021_Doc24

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
SONO ASA 2021 Strategic Intent 2021–2023, 2018-2020	Strategic plan	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2021_Doc25
SONO ASA 202104 National Regulation of Australian Sonographers FAQs - Employers of Sonographers	Position statement	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2021_Doc26
SONO ASA 202104 National Regulation of Australian Sonographers FAQs - Other practitioners	Position statement	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2021_Doc27
SONO ASA 202104 National Regulation of Australian Sonographers FAQs - Radiologists	Position statement	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2021_Doc28
SONO ASA 202104 National Regulation of Australian Sonographers FAQs - Sonographers	Position statement	Sonography	ASA	Professional association	Statutory registration	SONO_ASA_2021_Doc29
SONO ASA Consultation RIS improving the quality and safety of Medicare funded diagnostic imaging services through enhancement of regulatory and accreditation	Submission	Sonography	ASA	Professional association	Not stated	SONO_ASA_Undated_Doc30
SONO ASAR 201809 POL_11 Position statement on Sonographer qualifications and areas of practice	Position statement	Sonography	ASAR	Registering organisation	Not stated	SONO_ASAR_2018_Doc1
SONO ASAR 2019 Draft revised professional capabilities for medical radiation practice	Submission	Sonography	ASAR	Registering organisation	Not stated	SONO_ASAR_2019_Doc2
SONO ASAR 20210206 ASAR Position statement on Sonographer Regulation	Position statement	Sonography	ASAR	Registering organisation	Not stated	SONO_ASAR_2021_Doc3
SONO ASMIRT 2019 MRPBA Submission feedback on draft revised professional capabilities for medical radiation practice	Submission	Sonography	ASMIRT	Professional association	Statutory registration	SONO_ASMIRT_2019_Doc1
SONO ASUM 20150709 ASUM REALTIME News AHPRA Registration for Sonographers	General communication	Sonography	ASUM	Professional association	Statutory registration	SONO_ASUM_2015_Doc1
SONO ASUM 20151105 National Registration for Sonographer - Submission update	Media release/ reports	Sonography	ASUM	Professional association	Statutory registration	SONO_ASUM_2015_Doc2
SONO ASUM 20161215 Media Release The urgent need to regulate sonographers in Australia with ASA	Media release/ reports	Sonography	ASUM	Professional association	Statutory registration	SONO_ASUM_2016_Doc3
SONO ASUM 20170501 Review of accreditation systems within the NRAS COAG	Submission	Sonography	ASUM	Professional association	Statutory registration	SONO_ASUM_2017_Doc4
SONO ASUM 20180122 Submission to Family and Community Devt Committee - S101	Submission	Sonography	ASUM	Professional association	Statutory registration	SONO_ASUM_2018_Doc5
SONO ASUM 20190420 Draft revised professional capabilities for medical radiation practice ASUM response	Submission	Sonography	ASUM	Professional association	Not stated	SONO_ASUM2019_Doc6

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
SONO ASUM 2020 Annual_Report	Annual Report	Sonography	ASUM	Professional association	Statutory registration	SONO_ASUM_2020_Doc7
SONO ASUM 2020103 ASUM REALTIME News Sonographer regulation update	General communication	Sonography	ASUM	Professional association	Statutory registration	SONO_ASUM_2020_Doc8
SONO ASUM 202011 Process for Regulation	General communication	Sonography	ASUM	Professional association	Statutory registration	SONO_ASUM_2020_Doc9
SONO ASUM Submission Consultation RIS on improving the quality and safety of Medicare-funded diagnostic imaging	Submission	Sonography	ASUM	Professional association	Statutory registration	SONO_ASUM_Undated_Doc10
SONO Lewis 20051107 Australia's health workforce position paper 2005	Submission	Sonography	Other	Individual	Not stated	SONO_INDIVIDUAL_2005_Doc1
SONO RANZCOG 201503 Position statement on the appropriate use of diagnostic ultrasound-(C-Gen-10)-Review-March-2015	Position statement	Sonography	Other	Other organisation	Unclear/ambiguous	SONO_RANZCOG_2015_Doc1
SPPATH Aust GP Network 20081003 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Speech pathology	Other	Other organisation	Statutory registration	SPPATH_AUSTGPNETWORK_2008_Doc1
SPPATH HQCC 20081029 Qld Submission NRAS for health professions consultation paper	Submission	Speech pathology	Other	Government	Statutory registration	SPPATH_HQCC_Qld_2008_Doc1
SPPATH HQCC QLD 20081010 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Speech pathology	Other	Government	Statutory registration	SPPATH_HQCC_Qld_2008_Doc1
SPPATH Office of Health Review WA 20081015 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Speech pathology	Other	Government	Statutory registration	SPPATH_OHR_WA_2008_Doc1
SPPATH SPA 200507 Submission Productivity commission health WF study	Submission	Speech pathology	SPA	Professional association	Not stated	SPPATH_SPA_2005_Doc1
SPPATH SPA 200511 Submission Productivity commission health WF study	Submission	Speech pathology	SPA	Professional association	Self-regulation	SPPATH_SPA_2005_Doc2
SPPATH SPA 20081003 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Speech pathology	SPA	Professional association	Statutory registration	SPPATH_SPA_2008_Doc3
SPPATH SPA 20081217 Submission proposed arrangements for accreditation	Submission	Speech pathology	SPA	Professional association	Statutory registration	SPPATH_SPA_2008_Doc4
SPPATH SPA 201402 Submission to the inquiry into the prevalence of different types of speech, language and comm disorders.	Submission	Speech pathology	SPA	Professional association	Statutory registration	SPPATH_SPA_2014_Doc5

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
SPPATH SPA 20141010 Review of NRAS COAG	Submission	Speech pathology	SPA	Professional association	Statutory registration	SPPATH_SPA_2014_Doc6
SPPATH SPA 20151109 Submission to the Medicare benefits schedule review taskforce	Submission	Speech pathology	SPA	Professional association	Statutory registration	SPPATH_SPA_2015_Doc7
SPPATH SPA 20151204 Submission to the Australian Government DOHAC Private Health Insurance consultations	Submission	Speech pathology	SPA	Professional association	Statutory registration	SPPATH_SPA_2015_Doc8
SPPATH SPA 2016 Professional Self Regulation	General communication	Speech pathology	SPA	Professional association	Self-regulation	SPPATH_SPA_2016_Doc9
SPPATH SPA 2016 Speech Pathology 2030 making futures happen	Strategic plan	Speech pathology	SPA	Professional association	Statutory registration	SPPATH_SPA_2016_Doc10
SPPATH SPA 20160812 Review of the National Safety and Quality Health Service Standards RIS	Submission	Speech pathology	SPA	Professional association	Statutory registration	SPPATH_SPA_2016_Doc11
SPPATH SPA 2017 Submission to the Independent Review of Accreditation Systems with the NRAS COAG	Submission	Speech pathology	SPA	Professional association	Self-regulation	SPPATH_SPA_2017_Doc12
SPPATH SPA 20170227 Submission to the Aust Law Reform Commission Elder Abuse Discussion Paper	Submission	Speech pathology	SPA	Professional association	Statutory registration	SPPATH_SPA_2017_Doc13
SPPATH SPA 20170621 Submission to the Aus Govt DSS National Disability Insurance Scheme (NDIS) – Code of Conduct	Submission	Speech pathology	SPA	Professional association	Self-regulation	SPPATH_SPA_2017_Doc2017_Doc14
SPPATH SPA 201709 Speech pathology is a Self-Regulated profession	General communication	Speech pathology	SPA	Professional association	Self-regulation	SPPATH_SPA_2017_Doc15
SPPATH SPA 20171221 Australian Commission on Safety and Quality in Health Care's consultation patient safety and quality improvement in primary care	Submission	Speech pathology	SPA	Professional association	Self-regulation	SPPATH_SPA_2017_Doc16
SPPATH SPA 2018 Professional Self Regulation Booklet	General communication	Speech pathology	SPA	Professional association	Not stated	SPPATH_SPA_2018_Doc17
SPPATH SPA 2018 Stage 2 Submission to the <i>Health Practitioner Regulation National Law</i> COAG	Submission	Speech pathology	SPA	Professional association	Statutory registration	SPPATH_SPA_2018_Doc18
SPPATH SPA 20190405 Submission to the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health	Submission	Speech pathology	SPA	Professional association	Not stated	SPPATH_SPA_2019_Doc19
SPPATH SPA 20190409 Submission to The Royal Commission into Aged Care Quality and Safety	Submission	Speech pathology	SPA	Professional association	Co-regulation	SPPATH_SPA_2019_Doc20

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
SPPATH SPA 20190603 Submission to the Medicare Benefits Schedule Review Taskforce Primary Care	Submission	Speech pathology	SPA	Professional association	Not stated	SPPATH_SPA_2019_Doc21
SPPATH SPA 201909 Speech Pathology Australia is a self-regulated profession FAQs September 2019_RM edits	General communication	Speech pathology	SPA	Professional association	Self-regulation	SPPATH_SPA_2019_Doc22
SPPATH SPA 20191206 Submission to The Royal Commission into Aged Care Quality and Safety	Submission	Speech pathology	SPA	Professional association	Co-regulation	SPPATH_SPA_2019_Doc23
SPPATH SPA 2020 Strategic_Plan_2020-2022	Strategic plan	Speech pathology	SPA	Professional association	Not stated	SPPATH_SPA_2020_Doc24
SPPATH SPA 20200629 Submission to the Australian Govt DOH consultation aged care worker regulation scheme	Submission	Speech pathology	SPA	Professional association	Co-regulation	SPPATH_SPA_2020_Doc25
SPPATH SPA 20210129 Statement to the Royal Commission into violence, abuse, neglect and exploitation of people with disability	Submission	Speech pathology	SPA	Professional association	Co-regulation	SPPATH_SPA_2021_Doc26
WHM 20081003 Wardle UQ NRAS Trove NATREG 20080728 Call For Submissions on partially-regulated professions	Submission	Western herbal medicine	Other	Individual	Statutory registration	WHM_INDIVIDUAL_2008_Doc1
WHM 20090509 Wardle Submission to the Senate Inquiry into the NRAS for Doctors and Other Health Workers	Submission	Western herbal medicine	Other	Individual	Statutory registration	WHM_INDIVIDUAL_2009_Doc2
WHM 20100827 Wardle Consultation submission TGA advertising arrangements	Submission	Western herbal medicine	Other	Individual	Statutory registration	WHM_INDIVIDUAL_2010_Doc3
WHM 20130131 Wardle Submission to PHI review Individual Naturopathy Western Herbalism	Submission	Western herbal medicine	Other	Individual	Statutory registration	WHM_INDIVIDUAL_2013_Doc4
WHM ANTA 20080925 NRAS Trove NATREG 20080728 Call For Submissions on partially regulated professions	Submission	Western herbal medicine	ANTA	Professional association	Unclear/ambiguous	WHM_ANTA_2008_Doc1
WHM ANTA 2013 Submission to the PHI Rebate review	Submission	Western herbal medicine	ANTA	Professional association	Not stated	WHM_ANTA_2013_Doc2
WHM ANTA 2014 Review of NRAS COAG	Submission	Western herbal medicine	ANTA	Professional association	Statutory registration	WHM_ANTA_2014_Doc3
WHM ANTA 201609 Weir Submission to Chair HWPC Registration of naturopathy, WHM and nutritional medicine	Submission	Western herbal medicine	ANTA	Professional association	Statutory registration	WHM_ANTA_2016_Doc4
WHM ANTA 2017 Review of accreditation systems within the NRAS COAG	Submission	Western herbal medicine	ANTA	Professional association	Statutory registration	WHM_ANTA_2017_Doc5

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
WHM ANTA 20170328 Submissions Reforms to the regulatory framework for complementary medicines Assessment pathways	Submission	Western herbal medicine	ANTA	Professional association	Statutory registration	WHM_ANTA_2017_Doc6
WHM ANTA 2018 About Us	General communication	Western herbal medicine	ANTA	Professional association	Statutory registration	WHM_ANTA_2018_Doc7
WHM ANTA 2018 Benefits of joining ANTA	General communication	Western herbal medicine	ANTA	Professional association	Statutory registration	WHM_ANTA_2018_Doc8
WHM ANTA 2018 FAQ	General communication	Western herbal medicine	ANTA	Professional association	Statutory registration	WHM_ANTA_2018_Doc9
WHM ANTA 2018 Statutory Registration - NRAS	General communication	Western herbal medicine	ANTA	Professional association	Statutory registration	WHM_ANTA_2018_Doc10
WHM ANTA 2018 Statutory Registration is the Key Ingredient	General communication	Western herbal medicine	ANTA	Professional association	Statutory registration	WHM_ANTA_2018_Doc11
WHM ANTA 2021 FAQ part 2	General communication	Western herbal medicine	ANTA	Professional association	Not stated	WHM_ANTA_2021_Doc12
WHM ARONAH 2010 National register of naturopaths and herbalists to improve public safety – Australian Register of Naturopaths and Herbalists	General communication	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2010_Doc1
WHM ARONAH 2011 Submission to AHMAC on options for the regulation of unregistered health practitioners	Submission	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2011_Doc2
WHM ARONAH 2013 Submission to TGA Consultation Regulating the advertising of therapeutic goods to the general public	Submission	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2013_Doc3
WHM ARONAH 2014 CSHISC Alignment of comp health quals to the Aust Qual Framework	Submission	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2014_Doc4
WHM ARONAH 2015 Dodgy naturopathy courses putting public at risk	General communication	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2015_Doc5
WHM ARONAH 2015 Education is the key to effective practice. A response to the recent NHMRC review	General communication	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2015_Doc6
WHM ARONAH 2016 Naturopathy can be safe and effective, but registration is the key	General communication	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2016_Doc7
WHM ARONAH 2017 MEDIA-RELEASE_Delays-in-pathways-for-statutory-registration-of-naturopaths	Media release/ reports	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2017_Doc8
WHM ARONAH 2017 Scope of Practice	Codes/ Standards/ Guidelines	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2017_Doc9

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
WHM ARONAH 2017 Submission Reforms to the subsidisation of private health insurance rebates	Submission	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2017_Doc10
WHM ARONAH 2018 MEDIA-RELEASE_Delays-in-pathways-for-statutory-registration-of-naturopaths_Bodnar-sentenced_final	Media release/reports	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2018_Doc11
WHM ARONAH 20180919 Registration – the next best thing for naturopathy, or is it The Naturopathic Insider	General communication	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_2018_Doc12
WHM ARONAH About ARONAH	General communication	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_Undated_Doc13
WHM ARONAH Protecting the public, advancing the profession	General communication	Western herbal medicine	ARONAH	Registering organisation	Statutory registration	WHM_ARONAH_Undated_Doc14
WHM ATMS 200503 Submission to Senate Community Affairs References Committee on the Inquiry Into Services and Treatment Options for Persons with Cancer	Submission	Western herbal medicine	ATMS	Professional association	Not supportive of statutory registration	WHM_ATMS_2005_Doc1
WHM ATMS 20110905 Submission to ACCC on private health insurance report	Submission	Western herbal medicine	ATMS	Professional association	Not stated	WHM_ATMS_2011_Doc2
WHM ATMS 201301 Submission to the CMO natural therapies review of PHI rebate	Submission	Western herbal medicine	ATMS	Professional association	Not stated	WHM_ATMS_2013_Doc3
WHM ATMS 201305 Submission to the TGA re the consultation regulation impact statement	Submission	Western herbal medicine	ATMS	Professional association	Self-regulation	WHM_ATMS_2013Doc4
WHM ATMS 201307 The facts on what is happening to POPs	General communication	Western herbal medicine	ATMS	Professional association	Unclear/ambiguous	WHM_ATMS_2013_Doc5
WHM ATMS 20131217 Submission to the HCCC on the promotion of false or misleading health-related information or practices	Submission	Western herbal medicine	ATMS	Professional association	Not stated	WHM_ATMS_2013_Doc6
WHM ATMS 20131219 Response to the proposed Australian Register of Naturopaths and Herbalists - ARONAH	Submission	Western herbal medicine	ATMS	Professional association	Self-regulation	WHM_ATMS_2013_Doc7
WHM ATMS 20140830 Le Breton Letter Edited-Additional-Information-to-CSHISC-August-2014-V3	Submission	Western herbal medicine	ATMS	Professional association	Self-regulation	WHM_ATMS_2014_Doc8
WHM ATMS 2017 Strategic-Plan-2017-2020	Strategic plan	Western herbal medicine	ATMS	Professional association	Not stated	WHM_ATMS_2017_Doc9
WHM ATMS 20170707 WHM Position-Statement-Registration 2017 July	Position statement	Western herbal medicine	ATMS	Professional association	Not supportive	WHM_ATMS_2017_Doc10

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
					of statutory registration	
WHM ATMS 20180530 Berryman interview Fx Medicine Naturopathy What is Co-Regulation with Peter Berryman	General communication	Western herbal medicine	ATMS	Professional association	Self-regulation	WHM_ATMS_2018_Doc11
WHM ATMS 202001 Position-Statement-Registration 2020 January	Position statement	Western herbal medicine	ATMS	Professional association	Unclear/ambiguous	WHM_ATMS_2020_Doc12
WHM CHCA 20110131 Submission to ARONAH practice and standards for naturopaths and Western herbalists	Submission	Western herbal medicine	Other	Other organisation	Unclear/ambiguous	WHM_CHCA_2011_Doc1
WHM CHCA 201305 Complementary Healthcare Council 2013 May White Paper Registration of Nats and WHM protecting public health and rights	Position statement	Western herbal medicine	Other	Other organisation	Statutory registration	WHM_CHCA_2013_Doc2
WHM CMAss 201101 Submission to ARONAH practice and standards for naturopaths and Western herbalists	Submission	Western herbal medicine	CMAss	Professional association	Statutory registration	WHM_CMAss_2011_Doc1
WHM CMAss 2021 FAQ	General communication	Western herbal medicine	CMAss	Professional association	Statutory registration	WHM_CMAss_2021_Doc2
WHM CMAss 2021 History Aim Mission	General communication	Western herbal medicine	CMAss	Professional association	Statutory registration	WHM_CMAss_2021_Doc3
WHM CMAust 20141022 Review of NRAS COAG	Submission	Western herbal medicine	Other	Other organisation	Statutory registration	WHM_CMAust_2014_Doc4
WHM Doolan 2008 Naturopaths for registration Submission	Submission	Western herbal medicine	Other	Other organisation	Statutory registration	WHM_NAT4REG_2008_Doc1
WHM NHAA 2006 Oct Submission to Vic DOHS re Lin, La Trobe Report submission Oct06	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2006_Doc1
WHM NHAA 2008 Apr Submission to SA SDC Bogus, Unregistered and Deregistered Health Practitioners	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2008_Doc2
WHM NHAA 2008 Feb Submission to Inquiry of Natl Higher Education Accred. Body Feb08	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2008_Doc3
WHM NHAA 2008 Jan Prebudget submission January 2008	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2008_Doc4
WHM NHAA 2008 Jan Submission to NSW Health re Unregistered Health Practitioners Code of Conduct	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2008_Doc5
WHM NHAA 2008 Mar Submission to Aust Govt Private Health Insurance accreditation Rules submission March 2008	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2008_Doc6

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
WHM NHAA 2009 Mar 1 Submission to NHHRC National Health and Hospitals Reform Commission interim report	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2009_Doc7
WHM NHAA 20090809 Submission to ARONAH	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2009_Doc8
WHM NHAA 2011 Apr Submission to AHMAC regarding options for regulation of unregistered health practitioners	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2011_Doc9
WHM NHAA 2012 Aug Review of the Australian Government rebate on PHI for natural therapies	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2012_Doc10
WHM NHAA 2013b May ARONAH_Standards_and_Guidelines	Codes/ Standards/ Guidelines	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2013_Doc11
WHM NHAA 2013 Submission to parliamentary inquiry Promotion of false or misleading health related information or practices	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2013_Doc12
WHM NHAA 2014 Apr Submission to AHMAC National_Code_of_Conduct_for_health_care_workers	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2014_Doc13
WHM NHAA 2014 Oct Submission Independent AHMAC review of the NRAS for health professions	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2014_Doc14
WHM NHAA 20150710 MEDIA RELEASE Peak naturopathic association calls for government regulation	Media release/ reports	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2015_Doc15
WHM NHAA 2018 Welcome to the NHAA	General communication	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2018_Doc16
WHM NHAA 20180406 News Naturopaths call for government regulation in the name of public safety	General communication	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2018_Doc17
WHM NHAA 201808 NHAA submission on Exposure draft subordinate legislation PHI reforms Amendment Rules 2018	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2018_Doc18
WHM NHAA 2020 Submission to 2020 Summit	Submission	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_2020_Doc19
WHM NHAA About the Naturopaths and Herbalists Association of Australia	General communication	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_Undated_Doc20
WHM NHAA Regulation FAQs	General communication	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_Undated_Doc21

Documents	Document Type	Occupation	Organisation	Organisation Type	Position on regulation	Document identification code
WHM NHAA Regulation of herbalists and naturopaths in Australia	General communication	Western herbal medicine	NHAA	Professional association	Statutory registration	WHM_NHAA_Undated_Doc22
WHM SSNT 2013 submission to TGA consultation RIS re regulation of therapeutic goods to the general public	Submission	Western herbal medicine	Other	Other organisation	Statutory registration	WHM_SSNT_2013_Doc1

Appendix 12: Documents retrieved for the Australian Association of Social Workers.

Date and document details	Document type	Position on regulation
20050731 Submission to the Productivity Commission on Australia's health workforce	Submission	Registration
20051111 Submission to the Productivity Commission on Australia's health workforce. Position paper	Submission	Registration
2011 NRC Roy Morgan. The views of Australians regarding regulatory requirements of counsellors and qualified therapists	Report	Registration
2011 Oct Submission Senate Community Affairs References Committee Inquiry into the Commonwealth contribution to former forced adoption policies and practices	Submission	Registration
2011 Protecting the health & wellbeing of Australians. A submission to Health Ministers on the national regulation of social work	Submission	Registration
2012 Registration and Title Protection for AASW members. Directions Paper for 2013	Strategic plan	Registration
2013 Nov 11 Healy, K. 2014. Professional Registration and Title Protection for Social Workers in Australia Past, Present and Future	Position statement	Registration
2013 Position paper National Code of Conduct for Unregistered Professionals. August 2013	Submission	Registration
2013 Risk to the public and unintended consequences of excluding social workers from the NRAS	Submission	Registration
2014 Addendum Review of NRAS COAG	Submission	Registration
2014 NRAS and the National Regulation of Social Work implications for social workers in non-health settings	Position statement	Registration
2014 The profession of social work and the unintended consequences of a two-tiered system on WF and service sustainability	Submission	Registration
2014 Apr 30 Submission to the AHMAC regarding a national code of conduct for health care workers	Submission	Registration
2014 Jun NRAS and the National Regulation of Social Work. Implications for social workers in non-health settings	Position statement	Registration
2014 Sep Evidence of harm caused by social workers	Report	Registration
2014 Oct Submission to the Review of National Registration and Accreditation Scheme COAG	Submission	Registration
2015 Healy, K. 2015. Being a Self-regulating Profession in the 21st Century. Problems and Prospects	General communication	Registration

2016 Not all people who call themselves social workers are qualified	Media release/ reports	Registration
2016 Mar 15 South Australia pushes for national registration scheme	General communication	Registration
2018 Annual Report 2017-18	Annual Report	Registration
2018 Calls for registration of the social work profession	Media release/ reports	Registration
2018 SA Election Policy Statement 2017-18	Policy Statement	Registration
2018 Strategic Plan 2018-2021	Strategic plan	Registration
2018 Historic step taken to protect vulnerable in society. Introduction of a Bill to register social workers in South Aust	Media release/ reports	Registration
2019 Annual Report 2018-2019	Annual Report	Registration
2019 Audited Financial Report 2018-2019	Annual Report	Registration
2019 Federal Election Policy Platform	Policy Statement	Registration
2020 AASW renews call for Social Work Registration - National Child Protection Week 2020	Media release/ reports	Registration
2020 AASW welcomes groundbreaking South Australian legislation	Media release/ reports	Registration
2020 Annual Report 2019-2020	Annual Report	Registration
2020 Queensland election 2020 child safety AASW renews call for social work registration	Media release/ reports	Registration
2020 Jan Queensland submission to the Queensland Government Health legislation Amendment Bill 2019 Prohibition of conversion therapy	Submission	Registration
2020 Aug Submission to Job-ready graduates package draft legislation	Submission	Not stated
2021 Latest campaign actions - Registration of social work	General communication	Registration
2021 National Registration and Accreditation Scheme	General communication	Registration
2021 Social Policy & Advocacy	General communication	Registration
2021 Social work milestones - AASW	General communication	Registration
2021 South Australian registration campaign	General communication	Registration
2021 Tasmanian election - AASW renews calls for social work registration	Media release/ reports	Registration
FAQs About regulation impact statements	General communication	Registration
Registration FAQs	General communication	Registration
Submission to the Royal Commission into Victoria's Mental Health System	Submission	Not stated

References

- AASW See Australian Association of Social Workers
- Abbott, A. (1988). *The system of professions: An essay on the division of expert labor*. University of Chicago Press.
- ABC Four Corners. (2021). *Cosmetic cowboys: The unregulated world of cosmetic surgery*. Adele Ferguson, 25 October 2021. Australian Broadcasting Corporation. <https://www.abc.net.au/news/2021-10-26/cosmetic-cowboys/13603636>
- ABS See Australian Bureau of Statistics
- ACAU See Australasian Council of Ambulance Unions
- ACCC See Australian Competition and Consumer Commission
- ACMA See Australian Communications and Media Authority
- ACT See Parliament of the Australian Capital Territory
- Adams, T.L., & Saks, M. (2018). Neo-Weberianism and changing state-profession relations: The case of Canadian health care. *Sociologia, Problemas e Práticas*, (88), 61-77. <https://doi.org/10.7458/SPP20188814798>
- Ahern, K.J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research*, 9(3), 407-411. <https://journals.sagepub.com/doi/10.1177/104973239900900309>
- AHMAC See Australian Health Ministers' Advisory Council
- AHPA See Allied Health Professions Australia
- Ahpra See Australian Health Practitioner Regulation Agency
- AHWMC See Australian Health Workforce Ministerial Council
- AIHW See Australian Institute of Health and Welfare
- Alaszewski, A. (2013). Using documents in health research. In M. Saks & J. Allsop (Eds.), *Researching health: Qualitative, quantitative and mixed methods* (pp. 67-86). SAGE.
- Alderson, D., & Montesano, D. (2003). *Regulating, de-regulating and changing scopes of practice in the health professions: A jurisdictional review*. A report prepared for the Health Professions Regulatory Advisory Council (HPRAC). April 2003. Government of Ontario. https://www.ramblemuse.com/mps/documents/HPRAC_2003_WhyRegulate_Ontario.pdf

- Aldridge, S. (2008). The regulation of health professionals: An overview of the British Columbia experience. *Journal of Medical Imaging and Radiation Sciences*, 39(1), 4-10. <https://doi.org/10.1016/j.jmir.2008.01.001>
- Alford, R.A. (1975). *Health care politics: Ideological and interest group barriers to reform*. University of Chicago Press.
- Allied Health Professions Australia. (2025a). *About AHPA*. <https://ahpa.com.au/about-ahpa/>
- Allied Health Professions Australia. (2025b). *Member organisations*. <https://www.ahpa.com.au/member-organisations>
- Allied Health Professions Australia. (2025c). *What is allied health?* <https://www.ahpa.com.au/what-is-allied-health>
- Allied Professionals Registration Amendment Act 1993* (NT) (No. 5, 1993). <https://legislation.nt.gov.au/api/sitecore/Bill/APDF?id=17846>
- Alvesson, M., & Ashcraft, K.L. (2009). Critical methodology in management and organization research. In D.A. Buchanan & A. Bryman (Eds.), *The SAGE Handbook of organizational research methods* (pp. 61-77). SAGE.
- Alvesson, M., & Deetz, S. (2006). *Doing critical management research*. SAGE.
- ANC See Australian Naturopathic Council
- AOB See Australian Orthoptic Board
- ARCAP See Australian Register of Counsellors and Psychotherapists
- Archer, M. (1995). *Realist social theory: The morphogenetic approach*. Cambridge University Press.
- Archer, M., Bhaskar, R., Collier, A., Lawson, T., & Norrie, A. (1998). *Critical realism: essential readings*. Routledge.
- Archer, M., Decoteau, C., Gorski, P., Little, D., Porpora, D., Rutzou, T., Smith, C., Steinmetz, G., & Vandenberghe, F. (2016). What is critical realism? *Perspectives*, 38(2), 4-9.
- Arksey, H., & Knight, P. (1999). *Interviewing for social scientists: An introductory resource with examples*. SAGE.
- ARONAH See Australian Register of Naturopaths and Herbalists
- ASA See Australasian Sonographers Association
- ATO See Australian Taxation Office
- Australasian Council of Ambulance Unions. (2025). *Australasian Council of Ambulance Unions*. <https://www.cwaustral.com.au/portfolio-item/national-council-of-ambulance-unions/>

- Australasian Sonographers Association. (2019). *Understanding public awareness and perceptions of sonographers*. Perception of sonographers research report. Survey Matters. <https://www.sonographers.org/publicassets/eab3a96c-e2a6-ea11-90fb-0050568796d8/ASA-Public-Perception-of-Sonographers-2019-Report.pdf>
- Australian Bureau of Statistics. (2008). *Australian social trends, 2008: Complementary therapies*. Cat. no. 4102.0. ABS. [https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/605130A47359FC89CA25748E00129DC0/\\$File/41020_2008_9.pdf](https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/605130A47359FC89CA25748E00129DC0/$File/41020_2008_9.pdf)
- Australian Bureau of Statistics. (2017). *Australian health survey: Health service usage and health related actions 2014/15*. Cat. no. 4364.0.55.002, ABS. <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0022014-15?OpenDocument>
- Australian Bureau of Statistics. (2021a). *The Australian Census*. ABS. <https://www.abs.gov.au/census/about-census/australian-census>
- Australian Bureau of Statistics. (2021b). *Table Builder*. 8 November 2021. ABS. <https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder>.
- Australian Bureau of Statistics. (2024). *Conceptual model. OSCA - Occupation Standard Classification for Australia*. 6 December 2024, Version 1.0. ABS. <https://www.abs.gov.au/statistics/classifications/osca-occupation-standard-classification-australia/2024-version-1-0/conceptual-model>
- Australian Capital Territory Human Rights Commission. (2024). *Annual Report 2023-24*. <https://www.hrc.act.gov.au/resources>
- Australian Communications and Media Authority. (2015). *Optimal conditions for effective self- and co-regulatory arrangements*. Occasional paper. June 2015 edition. Commonwealth of Australia. Canberra. <https://www.acma.gov.au/sites/default/files/2019-08/Optimal%20conditions%20for%20effective%20self%20and%20co%20regulatory%20.pdf>
- Australian Competition and Consumer Commission. (n.d.). *Private health insurance*. <https://www.accc.gov.au/consumers/specific-products-and-activities/private-health-insurance>
- Australian Government, Department of Health and Aged Care. (2019a). *Private health insurance reforms – changing coverage for some natural therapies*. 17 February 2019. https://www.health.gov.au/resources/publications/private-health-insurance-reforms-changing-coverage-for-some-natural-therapies?utm_source=health.gov.au&utm_medium=callout-auto-custom&utm_campaign=digital_transformation

- Australian Government, Department of Health and Aged Care. (2019b). *Review of natural therapies for private health insurance*. 7 April 2019.
<https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/review-of-natural-therapies-for-private-health-insurance>
- Australian Government, Department of Health and Aged Care. (2020). *Health regulatory policy framework*. December 2020.
<https://www.health.gov.au/resources/publications/health-regulatory-policy-framework?language=en>
- Australian Government, Department of Health and Aged Care. (2022a). *What private health insurance covers*. 29 November 2022.
<https://www.health.gov.au/topics/private-health-insurance/what-private-health-insurance-covers#:~:text=By%20law%2C%20private%20health%20insurance,hospital%20diagnostic%20imaging%20and%20tests>
- Australian Government, Department of Health and Aged Care. (2022b). *Allied health workforce data gap analysis*. Issues paper. 10 June 2022. Health Policy Analysis Pty Ltd. Commonwealth of Australia. Canberra.
<https://www.health.gov.au/resources/publications/allied-health-workforce-data-gap-analysis-issues-paper?language=en>
- Australian Government, Department of Health and Aged Care. (2023a). *Best practice regulation*. 6 July 2023. <https://www.health.gov.au/about-us/what-we-do/regulation-and-compliance/best-practice-regulation>
- Australian Government, Department of Health and Aged Care. (2023b). *Cosmetic surgery reforms. Find out what we're doing to make cosmetic surgery safer in Australia*. 15 November 2023. <https://www.health.gov.au/our-work/cosmetic-surgery-reforms>
- Australian Government, Department of Health and Aged Care. (2024a). *Health Chief Executives Forum (HCEF)*. 17 March 2025.
<https://www.health.gov.au/committees-and-groups/health-chief-executives-forum-hcef>
- Australian Government, Department of Health and Aged Care. (2024b). *Independent review of complexity in the National Registration and Accreditation Scheme – Terms of Reference*. 29 May 2024. Commonwealth of Australia. Canberra.
<https://www.health.gov.au/resources/publications/independent-review-of-complexity-in-the-national-registration-and-accreditation-scheme-terms-of-reference?language=en>
- Australian Government, Department of Health and Aged Care. (2024c). *Medicare Benefits Schedule - Chinese medicine practitioner*. MBS Online, Medicare Benefits Schedule.
<https://www9.health.gov.au/mbs/search.cfm?q=Chinese+medicine+practitioner&sopt=S>

- Australian Government, Department of Health and Aged Care. (2024d). *Medicare Benefits Schedule - Chinese medicine practitioner*.
<https://www9.health.gov.au/mbs/search.cfm?q=chinese+medicine+practitioner&sopt=S>
- Australian Government, Department of Health and Aged Care. (2024e). *Unleashing the potential of our health workforce: Scope of practice review. Issues Paper 1*. 23 January 2024. Commonwealth of Australia. Canberra.
<https://www.health.gov.au/resources/collections/issues-papers?language=en>
- Australian Government, Department of Health and Aged Care. (2024f). *Medicare Benefits Schedule - Item 22060*. MBS Online, Medicare Benefits Schedule.
<https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=22060&qt=item#:~:text=Medicare%20benefits%20are%20not%20payable,the%20RVG%20in%20Group%20T10.>
- Australian Government, Department of Health and Aged Care. (2025a). *Health Ministers' Meeting (HMM)*. 11 February 2025.
<https://www.health.gov.au/committees-and-groups/health-ministers-meeting-hmm>
- Australian Government, Department of Health and Aged Care. (2025b). *Natural Therapies Review 2024 – Report and recommendations*. 27 March 2025.
<https://www.health.gov.au/resources/publications/natural-therapies-review-2024-report-and-recommendations>
- Australian Government, Department of Health and Ageing. (2008). *Report on the audit of health workforce in rural and regional Australia*. 7 April 2008. Commonwealth of Australia. Canberra. <https://apo.org.au/node/3628>
- Australian Government, Department of Industry, Science, Energy and Resources. (2020). *The Australian Public Service framework for engagement and participation*. Commonwealth of Australia. Canberra.
<https://www.industry.gov.au/sites/default/files/2019-11/aps-framework-for-engagement-and-participation.pdf>
- Australian Government, Department of the Prime Minister and Cabinet. (2007). *Best practice regulation: A guide for Ministerial Councils and national standard setting bodies*. October 2007. Commonwealth of Australia. Canberra.
- Australian Government, Department of the Prime Minister and Cabinet. (2016). *Regulation of paramedics*. 18 March 2016.
<https://obpr.pmc.gov.au/published-impact-analyses-and-reports/regulation-paramedics>

- Australian Government, Department of the Prime Minister and Cabinet. (2020). *The Australian Government guide to regulatory impact analysis* (2nd ed.). Commonwealth of Australia. Canberra.
<https://obpr.pmc.gov.au/sites/default/files/2021-06/australian-government-guide-to-regulatory-impact-analysis.pdf>
- Australian Government, Department of the Prime Minister and Cabinet. (2021). *Regulatory impact analysis guide for Ministers' Meetings and national standard setting bodies*. May 2021. Commonwealth of Australia. Canberra.
<https://obpr.pmc.gov.au/sites/default/files/2021-06/regulator-analysis-guide.pdf>
- Australian Government, Department of the Prime Minister and Cabinet. (2022). *A new name for a renewed focus*. 18 November 2022. The Office of Impact Analysis. <https://oia.pmc.gov.au/>
- Australian Government, Department of the Prime Minister and Cabinet. (2023). *Regulatory impact analysis guide for Ministers' Meetings and national standard setting bodies*. June 2023. The Office of Impact Analysis. Commonwealth of Australia. Canberra.
<https://oia.pmc.gov.au/resources/guidance-impact-analysis/regulatory-impact-analysis-guide-ministers-meetings-and-national>
- Australian Government, Department of the Prime Minister and Cabinet. (n.d.). *Australia's Regulatory Impact Analysis (RIA) Framework*. The Office of Impact Analysis. Commonwealth of Australia. Canberra.
<https://oia.pmc.gov.au/about/ria-framework-key-changes-over-time>
- Australian Government, Department of Veterans' Affairs. (2021). *Alternative funding models for allied health services for veterans*. 1 August 2021. Nous Group. Commonwealth of Australia. Canberra.
https://www.dva.gov.au/sites/default/files/2022-07/DVA_Nous_Report_Final.pdf
- Australian Government, Department of Veterans' Affairs. (2023). *Become a DVA health care provider*. 5 May 2023. <https://www.dva.gov.au/get-support/providers/become-dva-health-care-provider#rwu>
- Australian Government, Expert Committee on Complementary Medicines in the Health System. (2003). *Complementary medicines in the Australian health system*. Report to the Parliamentary Secretary to the Minister for Health and Ageing. September 2003. Canberra.
<https://www.tga.gov.au/sites/default/files/committees-eccmhs-report-031031.pdf>

- Australian Government, Jobs and Skills Australia. (n.d.). *Employment projections (May 2024 - May 2034)*. Victoria University.
<https://www.jobsandskills.gov.au/data/employment-projections>,
https://www.jobsandskills.gov.au/sites/default/files/2024-11/employment_projections_-_may_2024_to_may_2034.xlsx
- Australian Government, Productivity Commission. (2005). *Australia's health workforce*. Research Report. 22 December 2005. Canberra.
<https://www.pc.gov.au/inquiries/completed/health-workforce/report/healthworkforce.pdf>
- Australian Government, Productivity Commission. (2013). *Regulator engagement with small business*. Research Report. September 2013. Commonwealth of Australia. Canberra. <https://www.pc.gov.au/inquiries/completed/small-business/report>
- Australian Government, Productivity Commission. (n.d.). *About the Productivity Commission*. <https://www.pc.gov.au/about>
- Australian Government, Senate Community Affairs Legislation Committee. (2009). *National registration and accreditation scheme for doctors and other health workers*. August 2009. Canberra: Commonwealth Government.
https://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/completed_inquiries/2008-10/registration_accreditation_scheme/report/index
- Australian Government, Senate Community Affairs References Committee. (2022). *Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law*. April 2022. Canberra: Commonwealth Government.
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AHPRA/Report
- Australian Government, Senate Finance and Public Administration References Committee. (2011). *The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*. June 2011. Canberra.
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Completed_inquiries/2010-13/healthpractitionerregistration/report/index
- Australian Government, Senate Standing Committees on Community Affairs. (n.d.). *Completed inquiries and reports*.
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2019-22

- Australian Government, Services Australia. (2024). *Eligibility for health professionals*. 1 November 2024. <https://www.servicesaustralia.gov.au/eligibility-for-health-professionals?context=20>
- Australian Government, Taskforce on Industry Self-Regulation. (2000). *Industry self-regulation in consumer markets*. August 2000. Canberra: Commonwealth Government. <https://treasury.gov.au/publication/taskforce-on-industry-self-regulation-final-report>
- Australian Government, Therapeutic Goods Administration. (2022). *Listed medicines evidence guidelines. How to demonstrate the efficacy of listed medicines is acceptable*. Version 4.0. June 2022. Canberra. <https://www.tga.gov.au/sites/default/files/evidence-guidelines.pdf>
- Australian Government, Therapeutic Goods Administration. (2023). *Evidence guidelines. How to demonstrate the efficacy of listed medicines is acceptable*. 24 January 2023. <https://www.tga.gov.au/resources/resource/guidance/evidence-guidelines>
- Australian Health Ministers' Advisory Council. (2008a). National Registration and Accreditation Scheme. <https://webarchive.nla.gov.au/awa/20091112010807/http://nhwt.gov.au/natreg.asp>
- Australian Health Ministers' Advisory Council. (2008b). *National Registration and Accreditation Scheme*. Calls for submissions and submissions received. <https://webarchive.nla.gov.au/awa/20091112011544/http://nhwt.gov.au/natreg-calls.asp>
- Australian Health Ministers' Advisory Council. (2009). *Regulatory impact statement for the decision to implement the Health Practitioner Regulation National Law*. 3 September 2009. Governance Committee, National Registration and Accreditation Implementation Project. <https://web.archive.org/web/20220314105948/https://agedcare.royalcommission.gov.au/system/files/2020-10/ATB.0001.0001.0104.pdf>
- Australian Health Ministers' Advisory Council. (2011a). *Cosmetic medical and surgical procedures: A national framework*. Final report. Inter-jurisdictional Cosmetic Surgery Working Group, Clinical, Technical and Ethical Principal Committee. Prepared under the auspices of the Australian Health Ministers' Conference. <https://www.health.nsw.gov.au/publications/documents/cosmetic-surgery.pdf>
- Australian Health Ministers' Advisory Council. (2011b). *Options for regulation of unregistered health practitioners*. Consultation paper. February 2011. https://oia.pmc.gov.au/sites/default/files/posts/2011/06/unregistered_health_practitioners.pdf

- Australian Health Ministers' Advisory Council. (2012). *Options for regulation of paramedics*. Consultation paper. July 2012.
<https://oia.pmc.gov.au/published-impact-analyses-and-reports/options-regulation-paramedics-coag-consultation-regulation>
- Australian Health Ministers' Advisory Council. (2013). *Options for regulation of unregistered health practitioners*. Final report. April 2013.
<https://oia.pmc.gov.au/sites/default/files/posts/2013/08/unregistered-health-practitioners-final-report-decision-RIS.pdf>
- Australian Health Ministers' Advisory Council. (2014a). *Review of the National Registration and Accreditation Scheme for health professions*. Consultation paper. August 2014.
<https://web.archive.org/web/20210426210200/https://www.coaghealthcouncil.gov.au/DesktopModules/EasyDNNNews/DocumentDownload.ashx?portalid=0&moduleid=524&articleid=64&documentid=67>
- Australian Health Ministers' Advisory Council. (2014b). *Independent review of the National Registration and Accreditation Scheme for health professions*. Final report. December 2014.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31804&dbid=AP&chksum=LDHcqSp8liqgxgdxQ5zCmQ%3d%3d>
- Australian Health Ministers' Advisory Council. (2015). *Options for regulation of paramedics*. Final report. September 2015.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31806&dbid=AP&chksum=xOJ6DDQ%2BS06BshRIGW4BjQ%3D%3D>
- Australian Health Ministers' Advisory Council. (2018a). *AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions*. September 2018.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31798&dbid=AP&chksum=W16VRFp6%2bKE9gQghhFI%2bKA%3d%3d>
- Australian Health Ministers' Advisory Council. (2018b). *Guide to the National Registration and Accreditation Scheme for health professions*. July 2018. COAG Health Council.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31800&dbid=AP&chksum=DJv2goMFt4mFaBiCKERVmg%3D%3D>
- Australian Health Practitioner Regulation Agency. (2011). *Ahpra and National Boards Submission to the Senate Finance and Public Administration References Committee Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*. 14 April 2011. Submission 26.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD11%2f5341&dbid=AP&chksum=CWkl8ZpM8qVFUS6EWkWllw%3d%3d>

- Australian Health Practitioner Regulation Agency. (2013). *Annual Report 2012-13*. <https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx>
- Australian Health Practitioner Regulation Agency. (2014). *Annual report 2013-14*. <https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx>
- Australian Health Practitioner Regulation Agency. (2020). *Annual Report 2019-20*. <https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx>
- Australian Health Practitioner Regulation Agency. (2021a). *Annual Report 2020-21*. <https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx>
- Australian Health Practitioner Regulation Agency. (2021b). *Reputational insights 2021: Practitioner perceptions of the Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards*. 26 June 2023. <https://www.ahpra.gov.au/News/20230626-Ahpra-and-National-Boards-release-social-research-results.aspx>
- Australian Health Practitioner Regulation Agency. (2023a). *Core functions*. <https://www.ahpra.gov.au/About-Ahpra/What-We-Do/Core-functions.aspx>
- Australian Health Practitioner Regulation Agency. (2023b). *Ministerial directives and communiqués*. <https://www.ahpra.gov.au/About-Ahpra/Ministerial-Directives-and-Communiques.aspx>
- Australian Health Practitioner Regulation Agency. (2023c). *Regulatory principles for the National Scheme*. <https://www.ahpra.gov.au/about-ahpra/what-we-do/regulatory-principles.aspx>
- Australian Health Practitioner Regulation Agency. (2024a). *Annual report 2023-24. Leadership and collaboration for safer healthcare*. June 2024. <https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx>
- Australian Health Practitioner Regulation Agency. (2024b). *National Law amendments*. <https://web.archive.org/web/20221017182037/https://www.ahpra.gov.au/About-Ahpra/Ministerial-Directives-and-Communiques/National-Law-amendments.aspx>
- Australian Health Practitioner Regulation Agency. (2024c). *National Scheme reports and reviews*. <https://www.ahpra.gov.au/About-Ahpra/Ministerial-Directives-and-Communiques/National-Scheme-reports-and-reviews.aspx>

- Australian Health Practitioner Regulation Agency and the Medical Board of Australia. (2022). *Independent review of the regulation of medical practitioners who perform cosmetic surgery*. Final report. August 2022.
<https://www.ahpra.gov.au/Resources/Cosmetic-surgery-hub/Cosmetic-surgery-review.aspx>
- Australian Health Practitioner Regulation Agency and the Paramedicine Board of Australia. (2018). *Paramedics: Welcome to the National Scheme!* 30 November 2018. <https://www.paramedicineboard.gov.au/News/2018-11-30-Paramedics-Welcome-to-the-National-Scheme.aspx>
- Australian Health Workforce Ministerial Council. (2009). *Communiqué: Council of Australian Governments meeting. Design of new National Registration and Accreditation Scheme*. 8 May 2009. Melbourne.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD11%2F4568&dbid=AP&checksum=kzPmDIIxyG4k04VD8R%2FJsA%3D%3D>
- Australian Health Workforce Ministerial Council. (2010). *Australian Health Workforce Ministerial Council meeting. Final decisions and actions arising*. 12 February 2010. Melbourne.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD10%2F4060&dbid=AP&checksum=0NWg8A40kxkC2byk2XEnqw%3D%3D>
- Australian Health Workforce Ministerial Council. (2011). *AHWMC Submission to the Senate Finance and Public Administration References Committee Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*. April 2011.
<https://www.aph.gov.au/DocumentStore.ashx?id=de580e84-2507-4c6b-8513-3874f4d6f258>
- Australian Institute of Health and Welfare. (2019). *Welfare workforce: Australia's welfare 2019*. Welfare workforce snapshot data tables. Australian Institute of Health and Welfare. <https://www.aihw.gov.au/getmedia/599d4a33-7446-49b8-b4bf-990af4b5b42b/Data-tables-Australia-s-welfare-2019-Welfare-workforce-snapshot.xlsx.aspx>
- Australian Institute of Health and Welfare. (2021). *Primary health care. Australia's health 2020*. <https://www.aihw.gov.au/reports/australias-health/primary-health-care>
- Australian Institute of Health and Welfare. (2022). *Use of chronic disease management and allied health Medicare services. Spending on Medicare-subsidised allied health services*. 15 December 2022.
<https://www.aihw.gov.au/reports/chronic-disease/medicare-chronic-disease-allied-health-items/contents/allied-health-services/spending-on-medicare-subsidised-allied-health-serv>

- Australian Institute of Health and Welfare. (2023). *Australia's welfare 2023: Data insights*. 7 September 2023. Catalogue number AUS 246. AIHW, Australian Government. <https://www.aihw.gov.au/reports/australias-welfare/australias-welfare-2023-data-insights/contents/summary>
- Australian Naturopathic Council. (2020). *Why do we need registration/regulation of the naturopathic profession in Australia?* 9 June 2020. <https://www.naturopathiccouncil.org.au/2020/06/09/why-do-we-need-registration-regulation-of-the-naturopathic-profession-in-australia/>
- Australian Naturopathic Council. (2025). *Australian Naturopathic Council*. <https://www.naturopathiccouncil.org.au/>
- Australian Orthoptic Board. (n.d.). *Welcome to the Australian Orthoptic Board*. <https://www.australianorthopticboard.au/>
- Australian Register of Counsellors & Psychotherapists. (2011). *ARCAP response to consultation on options for regulation of unregistered health practitioners*. https://www.arcapregister.com.au/wp-content/uploads/2017/10/arcap_response_to_consultation_on_regulation_2.pdf
- Australian Register of Counsellors & Psychotherapists. (2022). *Australian Register of Counsellors & Psychotherapists*. <https://www.arcapregister.com.au/>
- Australian Register of Naturopaths and Herbalists. (2014). *Alignment of complementary health qualifications to the Australian Qualifications Framework*. <http://www.aronah.org/cshisc-support/>
- Australian Register of Naturopaths and Herbalists. (n.d.). *Australian Register of naturopaths and Herbalists*. <https://www.aronah.org/>
- Australian Taxation Office. (2024). *Other health services. Listed health services*. 12 June 2024. <https://www.ato.gov.au/businesses-and-organisations/gst-excise-and-indirect-taxes/gst/in-detail/your-industry/gst-and-health/other-health-services#Eligiblehealthservices>
- Ayres, I., & Braithwaite, J. (1992). *Responsive regulation: Transcending the deregulation debate*. Oxford University Press.
- Baggott, R. (2002). Regulatory politics, health professionals, and the public interest. In J. Allsop & M. Saks (Eds.), *Regulating the health professions* (pp. 31-46). SAGE.
- Baker, P. (2013). Doing health policy research: How to interview policy elites. In C. Banwell, S. Ulijaszek, & J. Dixon (Eds.), *When culture impacts health* (pp. 309-317). Academic Press. <https://doi.org/10.1016/B978-0-12-415921-1.00026-9>
- Baldwin, R., & Black, J. (2008). Really responsive regulation. *The Modern Law Review*, 71(1), 59-94. <https://doi.org/10.1111/j.1468-2230.2008.00681.x>

- Baldwin, R., Cave, M., & Lodge, M. (2012). *Understanding regulation: Theory, strategy, and practice* (2nd ed.). Oxford University Press.
- Ball, S.J. (1994). Political interviews and the politics of interviewing. In G. Walford (Ed.), *Researching the powerful in education* (pp. 96-115). UCL Press.
- Barber, B. (1963). Some problems in the sociology of the professions. *Daedalus*, 92(4), 669-688. <https://www.jstor.org/stable/20026806>
- Barber, B. (1993). *Constructing the social system*. Transaction Publishers.
- Barry, C.A. (2006). The role of evidence in alternative medicine: Contrasting biomedical and anthropological approaches. *Social Science and Medicine*, 62(11), 2646-2657. <https://doi.org/10.1016/j.socscimed.2005.11.025>
- Bartle, I., & Vass, P. (2005). *Self-regulation and the regulatory state: A survey of policy and practice*. Research report 17. Centre for the Study of Regulated Industries, University of Bath School of Management, Bath. <https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=fac3c18f29183e5429e2b39bf40b3d0ec49a984e>
- Becker, H.S. (2017). *Sociological work: Method and substance*. Routledge.
- Beilharz, P. (1987). Reading politics: Social theory and social policy. *The Australian and New Zealand Journal of Sociology*, 23(3), 388-406. <https://doi.org/10.1177/144078338702300305>
- Bennett, B., Carney, T., Chiarella, M., Walton, M., Kelly, P., Satchell, C., & Beaupert, F. (2018). Australia's National Registration and Accreditation Scheme for health practitioners: A national approach to polycentric regulation. *Sydney Law Review*, 40, 159-181.
- Bensoussan, A., & Myers, S.P. (1996). *Towards a safer choice: The practice of traditional Chinese medicine in Australia*. Faculty of Health, University of Western Sydney, Macarthur. <https://webarchive.nla.gov.au/awa/20030220133617/http://www.dhs.vic.gov.au/pdpc/chinese/report/contents.html>.
- Bensoussan, A., Myers, S.P., Wu, S., & O'Connor, K. (2004). Naturopathic and Western herbal medicine practice in Australia—a workforce survey. *Complementary Therapies in Medicine*, 12(1), 17-27. <https://doi.org/10.1016/j.ctim.2004.01.001>
- Benton, D.C., González-Jurado, M.A., & Beneit-Montesinos, J.V. (2013). A typology of professional nurse regulatory models and their administration. *Journal of Nursing Regulation*, 4(2), 22-29. [https://doi.org/10.1016/s2155-8256\(15\)30153-8](https://doi.org/10.1016/s2155-8256(15)30153-8)

- Berry, J.M. (2002). Validity and reliability issues in elite interviewing. *Political Science & Politics*, 35(04), 679-682. <https://www.cambridge.org/core/journals/ps-political-science-and-politics/article/abs/validity-and-reliability-issues-in-elite-interviewing/5E54417C1463B4290CDADDC32C429169>
- Bevir, M. (2012). *Governance: A very short introduction*. Oxford University Press. <https://academic.oup.com/book/500>.
- Bhaskar, R. (1975). *A realist theory of science*. Leeds Books.
- Bhaskar, R. (1979). *The possibility of naturalism: a philosophical critique of the contemporary human sciences*. Harvester Press.
- Bhaskar, R. (1986). *Scientific realism and human emancipation*. Verso.
- Bhaskar, R. (1989). *Reclaiming reality: A critical introduction to contemporary philosophy*. Verso.
- Bhaskar, R. (1998). *The possibility of naturalism: A philosophical critique of the contemporary human sciences* (3rd ed.). Routledge.
- Bhaskar, R. (2008). *A realist theory of science*. Routledge. <https://doi.org/10.4324/9780203090732>.
- Bhavnani, K.K., Chua, P., & Collins, D. (2014). Critical approaches to qualitative research. In P. Leavy (Ed.), *The Oxford Handbook of qualitative research* (pp. 165-178). Oxford University Press.
- Bismark, M.M., Brennan, T.A., Paterson, R.J., Davis, P.B., & Studdert, D.M. (2006). Relationship between complaints and quality of care in New Zealand: A descriptive analysis of complainants and non-complainants following adverse events. *Quality & safety in health care*, 15(1), 17-22. <https://doi.org/10.1136/qshc.2005.015743>
- Bismark, M.M., & Studdert, D.M. (2010). Realising the research power of complaints data. *The New Zealand Medical Journal*, 123(1314), 12-17.
- Black, J. (1996). Constitutionalising self-regulation. *The Modern Law Review*, 59(1), 24-55. <https://doi.org/10.1111/j.1468-2230.1996.tb02064.x>
- Black, J. (2002). Critical reflections on regulation. *Australasian Journal of Legal Philosophy*, 27. <https://classic.austlii.edu.au/au/journals/AUJLegPhil/2002/1.pdf>
- Black, J. (2005). The emergence of risk-based regulation and the new public risk management in the United Kingdom. *Public Law, Autumn*, 512-548.
- Black, J., & Baldwin, R. (2010). Really responsive risk-based regulation. *Law & Policy*, 32(2), 181-213. <https://doi.org/10.1111/j.1467-9930.2010.00318.x>
- Blaikie, N. (2010). *Designing social research: The logic of anticipation*. Polity Press.
- Blaikie, N., & Priest, J. (2017). *Social research: Paradigms in action*. Polity Press.

- Boon, H., Welsh, S., Kelner, M., & Wellman, B. (2004). CAM practitioners and the professionalisation process: A Canadian comparative case study. In P. Tovey, G. Easthope, & J. Adams (Eds.), *The mainstreaming of complementary and alternative medicine: Studies in social context* (pp. 123-139). Routledge.
- Borthwick, A. (2014). What's in a name? Reflections on professional title. *Podiatry Now*, August, 2.
<https://eprints.soton.ac.uk/373913/2/Borthwick%2520What%2527s%2520i%2520a%2520name.pdf>
- Borthwick, A.M., Boyce, R.A., & Nancarrow, S.A. (2015). Symbolic power and professional titles: The case of “podiatric surgeon”. *Health Sociology Review*, 24(3), 310-322. <https://doi.org/10.1080/14461242.2015.1051081>
- Borthwick, A.M., Nancarrow, S., Bristow, I., & Bowen, C. (2024). Contested role boundaries and professional title: Implications of the independent review of podiatric surgery in Australia. *Journal of Foot and Ankle Research*, 17(4), e70007. <https://doi.org/10.1002/jfa2.70007>
- Botha, M. (2021). Critical realism, community psychology, and the curious case of autism: A philosophy and practice of science with social justice in mind. *Journal of Community Psychology*. <https://doi.org/10.1002/jcop.22764>
- Bourdieu, P. (1977a). *Outline of a theory of practice* (R. Nice, Trans.). Cambridge University Press.
- Bourdieu, P. (1977b). Symbolic power (C. Wringe, Trans.). In D. Gleeson (Ed.), *Identity and structure: Issues in the sociology of education* (pp. 112-119). Nafferton Books.
- Bourdieu, P. (1985). The social space and the genesis of groups. *Theory and Society*, 14(6), 723-744. <https://doi.org/10.1177/053901885024002001>
- Bourdieu, P. (1986). The forms of capital. In J.G. Richardson (Ed.), *Handbook of theory and research for the sociology of education* (pp. 241-258). Greenwood Press.
- Bourdieu, P. (1987). What makes a social class? On the theoretical and practical existence of groups. *Berkeley Journal of Sociology*, 32, 1–17.
<http://www.jstor.org/stable/41035356>
- Bourdieu, P. (1989). Social space and symbolic power. *Sociological Theory*, 7(1), 14-25.
<https://doi.org/10.2307/202060>
- Bourdieu, P. (1990a). *In other words: Essays towards a reflexive sociology* (M. Adamson, Trans.). Stanford University Press.
- Bourdieu, P. (1990b). *The logic of practice* (R. Nice, Trans.). Polity Press.
- Bourdieu, P. (1991). *Language and symbolic power* (G. Raymond & M. Adamson, Trans.). Polity Press.

- Bourdieu, P. (1992). Thinking about limits. *Theory, Culture & Society*, 9(1), 37-49. <https://doi.org/10.1177/026327692009001003>
- Bourdieu, P. (1994). Rethinking the state: Genesis and structure of the bureaucratic field. (L.J.D. Wacquant & S. Farage, Trans.). *Sociological Theory*, 12(1), 1-18. <https://doi.org/10.2307/202032>
- Bourdieu, P. (1996a). *Distinction: A social critique of the judgement of taste* (R. Nice, Trans.). Harvard University Press.
- Bourdieu, P. (1996b). *The state nobility: Elite schools in the field of power* (L.C. Clough, Trans.). Polity Press.
- Bourdieu, P. (1998). *Practical reason: On the theory of action*. Stanford University Press.
- Bourdieu, P. (1999). *The weight of the world: Social suffering in contemporary society* (P.P. Ferguson, S. Emanuel, J. Johnson, & S.T. Waryn, Trans.). Stanford University Press.
- Bourdieu, P. (2000). *Pascalian meditations* (R. Nice, Trans.). Polity Press.
- Bourdieu, P. (2001). *Masculine domination* (R. Nice, Trans.). Polity Press.
- Bourdieu, P. (2005). Habitus. In J. Hillier & E. Rooksby (Eds.), *Habitus: A sense of place* (2nd ed., pp. 43-49). Ashgate.
- Bourdieu, P. (2014). Lecture of 12 December 1991 (D. Fernbach, Trans.). In P. Champagne, R. Lenoir, F. Poupeau, & M.-C. Riviere (Eds.), *On the state: Lectures at the Collège de France, 1989-1992* (pp. 354-370). Polity Press.
- Bourdieu, P., & Eagleton, T. (1992). Doxa and common life. *New Left Review*, 191(1), 111-121.
- Bourdieu, P., & Wacquant, L.J. (1992). *An invitation to reflexive sociology*. University of Chicago Press.
- Boyatzis, R.E. (1998). *Transforming qualitative information: Thematic analysis and code development*. SAGE.
- Boyfield, K. (2007). *RIAs: Why don't they work? A submission to the Business Council for Britain*. July 2007. Centre for Policy Studies. <https://cps.org.uk/wp-content/uploads/2021/07/111027171101-20070726EconomyRias.pdf>
- Braithwaite, J., Coglianese, C., & Levi-Faur, D. (2007). Can regulation and governance make a difference? *Regulation & Governance*, 1(1), 1-7. <https://doi.org/10.1111/j.1748-5991.2007.00006.x>
- Braun, L.A., Spitzer, O., Tiralongo, E., Wilkinson, J.M., Bailey, M., Poole, S.G., & Dooley, M. (2013). Naturopaths and Western herbalists' attitudes to evidence, regulation, information sources and knowledge about popular complementary medicines. *Complementary Therapies in Medicine*, 21(1), 58-64. <https://doi.org/10.1016/j.ctim.2012.11.008>

- Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.
- Brewer, J., & Hunter, A. (2006). *Foundations of multimethod research: Synthesizing styles*. SAGE.
- Bright, C. (2018). *Counsellors' strength-based practices in secondary schools: Managing multiple metanarratives* [Doctor of Education, Auckland University of Technology (New Zealand)].
<https://openrepository.aut.ac.nz/handle/10292/11576>
- Brooks, E., & Lauber, K. (2024). Administering a chill pill? Better regulation and the potential for regulatory chill in European Union health policy. *Journal of Health Politics, Policy and Law*, 49(5), 743-768.
<https://doi.org/10.1215/03616878-11257072>
- Brosnan, C. (2015). 'Quackery' in the academy? Professional knowledge, autonomy and the debate over complementary medicine degrees. *Sociology*, 49(6), 1047-1064. <https://doi.org/10.1177/0038038514557912>
- Brubaker, R. (1985). Rethinking classical theory: The sociological vision of Pierre Bourdieu. *Theory and Society*, 14(6), 745-775.
<https://doi.org/10.1007/BF00174049>
- Bryman, A. (2012). *Social research methods* (4th ed.). Oxford University Press.
- Bucher, R., & Strauss, A. (1961). Professions in Process. *American Journal of Sociology*, 66(4), 325-334.
- Bupa See Bupa HI Pty Ltd
- Bupa HI Pty Ltd. (n.d.). *Recognition criteria - Chinese herbal medicine*.
<https://www.bupa.com.au/for-providers/ancillary/chinese-herbal-medicine#:~:text=Minimum%20educational%20qualifications,majoring%20in%20Chinese%20Herbal%20Medicine>.
- Buse, K., Mays, N., & Walt, G. (2012). *Making health policy* (2nd ed.). McGraw-Hill Education Open University Press.
- Butler, M. (2025). *Select natural therapies return to private health insurance*. Media Release, Australian Government Minister for Health and Aged Care, 14 April, 2025. <https://www.markbutler.net.au/news/media-releases/yf7nvwdw52bzu2sirzmk27pmdmw609>
- Byrne, B. (2018). Qualitative interviewing. In C. Seale (Ed.), *Researching society and culture* (4th ed., pp. 217-235). SAGE.
- CAA See Council of Ambulance Authorities
- Cairney, P. (2023). The politics of policy analysis: Theoretical insights on real world problems. *Journal of European Public Policy*, 30(9), 1820-1838.
<https://doi.org/10.1080/13501763.2023.2221282>

- Cairney, P., & Oliver, K. (2017). Evidence-based policymaking is not like evidence-based medicine, so how far should you go to bridge the divide between evidence and policy? *Health Research Policy and Systems*, 15(1), 35. <https://doi.org/10.1186/s12961-017-0192-x>
- Canaway, R. (2009). A culture of dissent: Australian naturopaths perspectives on practitioner regulation. *Complementary Health Practice Review*, 14(3), 136-152. <https://doi.org/10.1177/1533210109360308>
- Carè, J., Steel, A., & Wardle, J. (2021). Stakeholder attitudes to the regulation of traditional and complementary medicine professions: A systematic review. *Human Resources for Health*, 19(1), 42. <https://doi.org/10.1186/s12960-021-00579-y>
- Carlton, A.-L. (2006). National models for regulation of the health professions. *Law in Context*, 23(2), 21-51. <https://search.informit.org/doi/10.3316/ielapa.114642393174735>
- Carlton, A.-L., Carè, J., Myers, S.P., Doolan, A., Gerontakos, S., & Steel, A. (2025). *Assuring safe and integrated health care. A review of the risks, benefits, and regulatory requirements for the professions of naturopathy and Western herbal medicine: A research report commissioned by the members of the Australian Naturopathic Council*. April 2025. Australian Naturopathic Council.
- Carlton, A.-L., Leslie, K., Bourgeault, I.L., Balasubramanian, M., Mirshahi, R., Short, S., Carè, J., & Lin, V. (2024). *Health practitioner regulation systems: A large-scale rapid review of the design, operation and strengthening of health practitioner regulation systems*. Working Paper Series, January 2024. Canadian Health Workforce Network. https://www.hhr-rhs.ca/images/PDFs/HPRS_Report_Jan.2024.pdf
- Carr-Saunders, A.M., & Wilson, P.A. (1964). *The professions*. Frank Cass & Co. Ltd.
- CCAA See Christian Counsellors Association of Australia
- Champagne, P., Lenoir, R., Poupeau, F., & Riviere, M.-C. (Eds.). (2014). *On the state: Lectures at the Collège de France, 1989-1992* (D. Fernbach, Trans.). Polity Press.
- CHC See Council of Australian Governments Health Council
- Christian Counsellors Association of Australia. (2022). *PACFA, ACA and ARCAP*. <https://ccaa.net.au/about/pacfa-and-arcap/>
- Clark-Grill, M. (2007). Questionable gate-keeping: Scientific evidence for complementary and alternative medicines (CAM): Response to Malcolm Parker. *Journal of Bioethical Inquiry*, 4(1), 21-28. <https://doi.org/10.1007/s11673-007-9035-8>

- Claussen, S., & Osborne, J. (2012). Bourdieu's notion of cultural capital and its implications for the science curriculum. *Science Education*, 97(1), 58-79. <https://doi.org/10.1002/sce.21040>
- COAG See Council of Australian Governments
- Cobb, R.W., & Elder, C.D. (1983). *Participation in American politics: The dynamics of agenda-building* (2nd ed.). The John Hopkins University Press.
- Coburn, D. (1993). State authority, medical dominance, and trends in the regulation of the health professions: The Ontario case. *Social Science and Medicine*, 37(7), 841-850. [https://doi.org/10.1016/0277-9536\(93\)90137-s](https://doi.org/10.1016/0277-9536(93)90137-s)
- Coburn, D., & Willis, E. (2000). The medical profession: Knowledge, power, and autonomy. In G.L. Albrecht, R. Fitzpatrick, & S.C. Scrimshaw (Eds.), *Handbook of social studies in health and medicine* (pp. 377–393). SAGE.
- Coffey, A. (2014). Analysing documents. In U. Flick (Ed.), *The SAGE Handbook of qualitative data analysis* (pp. 367-379). SAGE.
- Cohen, M.M., Penman, S., Pirotta, M., & da Costa, C. (2005). The integration of complementary therapies in Australian general practice: Results of a national survey. *Journal of Alternative and Complementary Medicine*, 11(6), 995-1004. <https://doi.org/10.1089/acm.2005.11.995>
- Comcare. (2023). *Allied health professionals*. <https://www.comcare.gov.au/service-providers/medical-allied-health/allied-health>
- Cormack, M. (2024). *Unleashing the potential of our health workforce: Scope of practice review*. Final report. October 2024. <https://www.health.gov.au/resources/publications/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report>
- Council of Ambulance Authorities. (2025). *The Council of Ambulance Authorities*. <https://www.caa.net.au/about>
- Council of Australian Governments. (1992). *Intergovernmental Agreement on Mutual Recognition*. <https://federation.gov.au/about/agreements/agreement-relating-mutual-recognition>
- Council of Australian Governments. (2006). *Communiqué: Council of Australian Governments meeting*. 14 July 2006. Canberra. <http://ncp.ncc.gov.au/docs/Council%20of%20Australian%20Governments%20Meeting%20-%202014%20July%202006.pdf>
- Council of Australian Governments. (2008a). *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the health professions*. 26 March 2008. <https://federation.gov.au/about/agreements/intergovernmental-agreement-health-workforce>

- Council of Australian Governments. (2008b). *National Partnership Agreement to deliver a seamless national economy*. December 2008.
https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/seamless_national_economy_NP.pdf
- Council of Australian Governments. (2012). *About COAG*.
<https://webarchive.nla.gov.au/awa/20210121023318/https://www.coag.gov.au/about-coag>
- Council of Australian Governments. (2016). *Communiqué: Council of Australian Governments meeting*. 8 April 2016. Perth.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD16%2F20010&dbid=AP&chksum=E749kywOy2J%2FfLpIwY95g%3D%3D>
- Council of Australian Governments Health Council. (2015a). *Communiqué: Council of Australian Governments meeting*. 6 November 2015. Adelaide.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31805&dbid=AP&chksum=p%2bOSKj0Pfd%2fU6FzEfFVjZQ%3d%3d>
- Council of Australian Governments Health Council. (2015b). *Communiqué: Council of Australian Governments meeting. A National Code of Conduct for health workers*. 17 April 2015. Sydney.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31795&dbid=AP&chksum=KBWAgQM3aVO2g8BSSM3%2FKw%3D%3D>
- Council of Australian Governments Health Council. (2015c). *Communiqué: Council of Australian Governments meeting. The Independent Review of the National Registration and Accreditation Scheme for health professions*. Meeting as the Australian Health Workforce Ministerial Council. 7 August 2015. Darwin.
https://www.ahpra.gov.au/documents/default.aspx?record=WD15%2f17740&dbid=AP&chksum=FDOrpf%2fq0SfpDKC5lvVNsg%3d%3d&_gl=1*19lss1q*_ga*MTg2MDQ4NzE3LjE3MzY3MzUwNjE.*_ga_F1G6LRCHZB*MTczNzU4OTIzMy4zLjEuMTczNzU4OTI3Ny4wLjAuMA
- Council of Australian Governments Health Council. (2015d). *A National Code of Conduct for health care workers*. Final report. 17 April 2015. Australian Health Ministers' Advisory Council.
<https://www.anpa.asn.au/files/Final%20Report%20-%20A%20National%20Code%20of%20Conduct%20for%20health%20care%20workers%20-%20April%2017%202015.pdf>
- Council of Australian Governments Health Council. (2016). *Communiqué: Council of Australian Governments meeting*. 7 October 2016. Canberra.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD16%2f21506&dbid=AP&chksum=BPf8EmH25MWLAVHVx05BZA%3d%3d>

- Council of Australian Governments Health Council. (2018). *Communiqué: Council of Australian Governments meeting. Purpose of the National Registration and Accreditation Scheme*. 11 September 2018.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31799&dbid=AP&chksum=Do7bKOrNq5bLPPvgl6dqfw%3d%3d>
- Council of Australian Governments Health Council. (2019). *Communiqué: Council of Australian Governments meeting*. 31 October - 1 November 2019. Perth.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31796&dbid=AP&chksum=tHA6PF0%2b1BCQKwFYnUDTWw%3d%3d>
- Council of Australian Governments Health Council. (2020). *Policy Direction 2019-01 – Paramountcy of public protection when administering the National Scheme*. 3 January 2020.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD20%2f29447&dbid=AP&chksum=zAwX6DuV0pz9ombMcgfkpQ%3d%3d>
- Craig Hodges Consulting. (2011). *The views of Australians regarding regulatory requirements of counsellors and qualified therapists*. October 2011. Summary paper of research conducted by Roy Morgan on behalf of the Australian Association of Social Workers.
<https://web.archive.org/web/20230311152848/https://www.aasw.asn.au/document/item/1819>
- Creswell, J.W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). SAGE.
- Creswell, J.W., & Miller, D.L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice*, 39(3), 124-130. https://doi.org/10.1207/s15430421tip3903_2
- Creswell, J.W., & Poth, C.N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. SAGE.
- Cruess, S.R., Johnston, S., & Cruess, R.L. (2002). Professionalism for medicine: Opportunities and obligations. *Medical Journal of Australia*, 177(4), 208-211.
<https://doi.org/10.5694/j.1326-5377.2002.tb04735.x>
- DalGLISH, S.L., Khalid, H., & McMahon, S.A. (2020). Document analysis in health policy research: The READ approach. *Health Policy and Planning*, 35(10), 1424-1431. <https://doi.org/10.1093/heapol/czaa064>
- Danermark, B., Ekström, M., & Karlsson, J.C. (2019). *Explaining society: Critical realism in the social sciences* (2nd ed.). Routledge.
- Das, U.S., & Quintyn, M. (2002). *Crisis prevention and crisis management: The role of regulatory governance*. September 2002. IMF Working Paper, WP/02/163.
<https://www.imf.org/external/pubs/ft/wp/2002/wp02163.pdf>

- Dawson, S. (2024). *Regulating for results. Review of complexity in the National Registration and Accreditation Scheme*. Consultation paper 1. 12 September 2024. <https://www.health.gov.au/resources/publications/consultation-paper-1-review-of-complexity-in-the-national-registration-and-accreditation-scheme?language=en>
- Deer, C. (2012). Doxa. In M. Grenfell (Ed.), *Pierre Bourdieu: Key concepts* (2nd ed., pp. 114-125). Routledge.
- Denzin, N.K. (1978). *The research act: A theoretical introduction to sociological methods* (2nd ed.). McGraw Hill.
- Denzin, N.K. (1989). *Interpretive interactionism*. SAGE.
- DISER See Australian Government, Department of Industry, Science, Energy and Resources
- DOH See Australian Government, Department of Health
- DOHAC See Australian Government, Department of Health and Aged Care
- Donato, R., & Onur, I. (2018). *Private health insurance in Australia: Policy reform approaches towards greater competition and efficiency to improve health system performance*. October 2018. Monash University, Monash Business School, Australian Centre for Financial Studies.
https://www.monash.edu/__data/assets/pdf_file/0005/2325884/Private-health-insurance-in-Australia.pdf
- Dooley, M., Braun, L., Poole, S., Bailey, M., Spitzer, O., Tiralongo, E., & Wilkinson, J. (2010). *Investigating the integration of complementary medicines in community pharmacy practice*. Melbourne. Canberra, ACT: The Pharmacy Guild of Australia and Australian Government Department of Health and Aging.
https://researchoutput.csu.edu.au/ws/portalfiles/portal/9388987/58792_Report
- Doron, I., Gal, I., Shavit, M., & Weisberg-Yosub, P. (2011). Unheard voices: Complaint patterns of older persons in the health care system. *European Journal of Ageing*, 8(1), 63-71. <https://doi.org/10.1007/s10433-011-0177-5>
- Dower, C., Moore, J., & Langelier, M. (2013). It is time to restructure health professions scope-of-practice regulations to remove barriers to care. *Health Affairs*, 32(11), 1971-1976. <https://doi.org/10.1377/hlthaff.2013.0537>
- DPMC See Australian Government, Department of the Prime Minister and Cabinet
- Drummond, G. (1998). New theorizing about organizations: The emergence of narrative and social theory for management. *Current Topics in Management*, 3(2), 93-122.

- Dubois, C.-A., Dixon, A., & McKee, M. (2006). Reshaping the regulation of the workforce in European health care systems. In C.-A. Dubois, M. McKee, & E. Nolte (Eds.), *Human resources for health in Europe* (pp. 173-192). World Health Organization on behalf of the European Observatory on Health Systems and Policies. Open University Press.
<https://eurohealthobservatory.who.int/publications/m/human-resources-for-health-in-europe>
- Duckett, S., & Willcox, S. (2015). *The Australian health care system* (5th ed.). Oxford University Press.
- Duke, K. (2002). Getting beyond the 'official line': Reflections on dilemmas of access, knowledge and power in researching policy networks. *Journal of Social Policy*, 31(1), 39-59. <https://doi.org/10.1017/s0047279402006505>
- DVA See Australian Government, Department of Veterans' Affairs
- Dwyer, J. (2019). Reflections on the unexpected depth of a problem. *Australasian Science*, 40(3), 44.
<https://search.informit.org/doi/abs/10.3316/informit.079054029484860>
- Ebell, M.H., Sokol, R., Lee, A., Simons, C., & Early, J. (2017). How good is the evidence to support primary care practice? *BMJ Evidence-Based Medicine*, 22(3), 88-92. <https://doi.org/10.1136/ebmed-2017-110704>
- Elder-Vass, D. (2010). *The causal power of social structures: Emergence, structure and agency*. Cambridge University Press.
- ESSA See Exercise and Sports Science Australia
- Essex, R., Kennedy, J., Miller, D., & Jameson, J. (2023). A scoping review exploring the impact and negotiation of hierarchy in healthcare organisations. *Nursing Inquiry*, 30(4), e12571. <https://doi.org/10.1111/nin.12571>
- Everett, J. (2002). Organizational research and the praxeology of Pierre Bourdieu. *Organizational Research Methods*, 5(1), 56-80.
<https://doi.org/10.1177/1094428102051005>
- Evetts, J. (2003). The sociological analysis of professionalism: Occupational change in the modern world. *International Sociology*, 18(2), 395-415.
<https://doi.org/10.1177/0268580903018002005>
- Exercise and Sports Science Australia. (2021). *Annual Report 2020-21*.
<https://www.essa.org.au/Common/Uploaded%20files/Reports/annual-report-2021.pdf>
- Ferguson, A., & Day, L. (2021). Major review of cosmetic surgery industry announced after Four Corners investigation into Dr Daniel Lanzer. 30 November 2021. *ABC News*. <https://www.abc.net.au/news/2021-11-30/four-corners-cosmetic-surgery-industry-review/100661216>

- Fernandopulle, N. (2021). To what extent does hierarchical leadership affect health care outcomes? *Medical Journal of the Islamic Republic of Iran*, 35(1), 117. <https://doi.org/10.47176/mjiri.35.117>
- Fielding, N. (2016). Pulling together: Postmodernism and multiple method research. In N.K. Denzin & M.D. Giardina (Eds.), *Qualitative inquiry and the politics of advocacy* (pp. 145-162). Routledge.
- Fischer, F., Miller, G.J., & Sydney, M.S. (2007). *Handbook of public policy analysis. Theory, politics, and methods*. CRC Press, Taylor & Francis Group.
- Foucault, M. (1982). The subject and power. *Critical inquiry*, 8(4), 777-795. <https://doi.org/10.1086/448181>
- Fournier, V. (2000). Boundary work and the (un)making of the professions. In N. Malin (Ed.), *Professionalism, boundaries and the workplace* (pp. 67–86). Routledge.
- Freckelton, I. (2000). Regulation of Chinese medicine: Editorial. *Journal of Law and Medicine*, 8(1), 5–17. <https://search.informit.org/doi/10.3316/agispt.20004000>
- Freckelton, I. (2008). Regulating the unregistered. *Journal of Law and Medicine*, 16(3), 413-418. <https://pubmed.ncbi.nlm.nih.gov/19205304/>
- Freckelton, I. (2010). Regulation of health practitioners: National reform in Australia. *Journal of Law and Medicine*, 18(2), 207-220. <https://pubmed.ncbi.nlm.nih.gov/21355425/>
- Freckelton, I. (2020). Prohibition orders and the regulation of unregistered health practitioners. *Journal of Law and Medicine*, 27(3), 551-560. <https://pubmed.ncbi.nlm.nih.gov/32406619/>
- Freeman, R.E. (1984). *Strategic management: A stakeholder approach*. Pitman.
- Freiberg, A. (2017). *Regulation in Australia*. The Federation Press.
- Freidson, E. (1970). *Professional dominance: The social structure of medical care*. Atherton Press.
- Freidson, E. (1994). *Professionalism reborn: Theory, prophecy, and policy*. University of Chicago Press.
- Freidson, E. (2001). *Professionalism: The third logic*. Polity Press.
- Fuchs, C. (2003). Some implications of Pierre Bourdieu's works for a theory of social self-organization. *European Journal of Social Theory*, 6(4), 387-408. <https://doi.org/10.1177/13684310030064002>
- Gale, N. (2014). The sociology of traditional, complementary and alternative medicine. *Sociology Compass*, 8(6), 805-822. <https://doi.org/10.1111/soc4.12182>
- Garcia-Villegas, M. (2003). Symbolic power without symbolic violence? *Florida Law Review*, 55(1), 157-189. <https://scholarship.law.ufl.edu/flr/vol55/iss1/5>

- Gay, L.R., Mills, G.E., & Airasian, P. (2006). *Educational research: Competencies for analysis and applications* (8th ed.). Pearson Merrill Prentice Hall.
- Giddens, A. (1984). *The constitution of society: Outline of the theory of structuration*. Polity Press.
- Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age*. Polity Press.
- Gieryn, T.F. (1983). Boundary-work and the demarcation of science from non-science: Strains and interests in professional ideologies of scientists. *American Sociological Review*, 48(6), 781-795.
<https://pdfs.semanticscholar.org/efae/173f1bd98e3d5d277eb49b1d64bea8f0b824.pdf>
- Goffman, E. (1959). *The presentation of self in everyday life*. Doubleday Anchor Books.
- Goode, W.J. (1960). Encroachment, charlatanism, and the emerging profession: Psychology, medicine, and sociology. *American Sociological Review*, 25(6), 902-914. <http://www.jstor.org/stable/2089988>
- Goodin, R.E., Rein, M., & Moran, M. (2006). The public and its policies. In M. Moran, M. Rein, & R.E. Goodin (Eds.), *The Oxford Handbook of public policy* (pp. 3-30). Oxford University Press.
- Greenwood, E. (1957). Attributes of a Profession. *Social Work*, 2(3), 45-55.
<https://doi.org/10.1093/sw/2.3.45>
- Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). SAGE.
- Guest, G.S., MacQueen, K.M., & Namey, E.E. (2012). *Applied thematic analysis*. SAGE.
- Gunningham, N. (2004). Codes of practice: The Australian experience. In K. Webb (Ed.), *Voluntary codes: Private governance, the public interest and innovation* (pp. 317-334). Carleton Research Institute on Innovation, Science and the Environment, Carleton University.
- Gunningham, N., & Bluff, L. (2008). *A review of key characteristics that determine the efficacy of OHS instruments*. Canberra. Australian Safety and Compensation Council.
https://www.safeworkaustralia.gov.au/system/files/documents/1702/review_keycharacteristicsthatdetermineefficacy_ohsinstruments_2008_pdf.pdf
- Gunningham, N., & Grabosky, P. (2004). *Smart regulation: Designing environmental policy*. Oxford University Press.
- Gunningham, N., & Rees, J. (1997). Industry self-regulation: An institutional perspective. *Law & Policy*, 19(4), 363-414. <https://doi.org/10.1111/1467-9930.t01-1-00033>

- Gunningham, N., & Sinclair, D. (1999). Designing smart regulation. In B.M. Hutter (Ed.), *A reader in environment law* (pp. 305-334). Oxford University Press.
- Gunningham, N., & Sinclair, D. (2004). Designing environmental policy. In N. Gunningham & P. Grabosky (Eds.), *Smart regulation: Designing environmental policy* (pp. 375-454). Oxford University Press.
- Habenstein, R.W. (1963). Critique of "profession" as a sociological category. *The Sociological Quarterly*, 4(4), 291-300. <https://doi.org/10.1111/j.1533-8525.1963.tb01594.x>
- Haines, F. (2011). *The paradox of regulation: What regulation can achieve and what it cannot*. Edward Elgar. <https://doi.org/10.4337/9780857933157>.
- Hammersley, M. (1992). *What's wrong with ethnography?* Routledge.
- Harker, R. (1984). On reproduction, habitus and education. *British Journal of Sociology of Education*, 5(2), 117-127. <https://doi.org/10.1080/0142569840050202>
- Hart, C. (2018). *Doing a literature review: Releasing the research imagination* (2nd ed.). SAGE.
- Harvey, L. (1990). *Critical social research*. Unwin Hyman.
- Harvey, L. (2022). Critical social research: Re-examining quality. *Quality in Higher Education*, 28(2), 145-152. <https://doi.org/10.1080/13538322.2022.2037762>
- HBF See HBF Health Limited
- HBF Health Limited. (2024). *Ancillary providers: Information for ancillary providers and registration requirements with HBF*. <https://www.hbf.com.au/about-hbf/for-providers/ancillary>
- HCF See Hospitals Contribution Fund of Australia Limited
- HCPC See UK Health and Care Professions Council
- Healey, M. (1991). Obtaining information from businesses. In M.J. Healey (Ed.), *Economic activity and land use: The changing information base for local and regional studies* (pp. 193-251). Longman Scientific & Technical.
- Health and Community Services (Further Amendment) Act 1993* (Vic). (No. 124 of 1993). https://www.austlii.edu.au/au/legis/vic/hist_act/hacsaa1993470.pdf
- Health and Community Services Complaints Commission Northern Territory. (2023). *Annual Report 2022-23*. <https://hcsc.nt.gov.au/about-us/resources/annual-reports>
- Health and Community Services Complaints Commissioner South Australia. (2024). *Annual Report 2023-24*. <https://www.hcsc.sa.gov.au/reports-2/>
- Health and Disability Services Complaints Office Western Australia. (2024). *Annual Report 2023-24*. <https://www.hadsco.wa.gov.au/About-Us/Annual-Report>

- Health Canada. (2021–2024). *Regulated health professions*. Alberta: <https://www.alberta.ca/regulated-health-professions.aspx>, British Columbia: <https://bchealthregulators.ca/health-regulation-in-bc/regulated-health-professions/>, Ontario: <https://www.ontario.ca/page/regulated-health-professions>, Quebec: <https://www.quebec.ca/emploi/informer-metier-profession/ordres-professionnels/liste-repertoire-membres>
- Health Care Complaints Act 1993* (NSW). (No. 105). (Current version for 31 May 2024). <https://legislation.nsw.gov.au/view/html/inforce/current/act-1993-105>
- Health Complaints Commissioner Tasmania. (2024). *Annual Report 2023-24*. <https://www.healthcomplaints.tas.gov.au/publications>
- Health Complaints Commissioner Victoria. (2024). *Annual Report 2023-24. Supporting safe and ethical care*. <https://hcc.vic.gov.au/resources/publications/annual-reports>
- Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (Qld). (Act No. 62 of 2008). <https://www.legislation.qld.gov.au/view/pdf/asmade/act-2008-062>
- Health Practitioner Regulation National Law Act 2009* (Qld). (Act No. 45 of 2009). <https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-045/lh>
- Health Practitioner Regulation National Law Act 2009 (2024)* (Qld). (Current as at 1 July 2024). <https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2009-045>
- Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017* (Qld). (Act No. 32 of 2017). <https://www.legislation.qld.gov.au/view/html/asmade/act-2017-032>
- Health Practitioner Regulation National Law and Other Legislation Amendment Act 2022* (Qld). (Act No. 22 of 2022). <https://www.legislation.qld.gov.au/view/html/asmade/act-2022-022>
- Health Professionals Act 2004* (ACT). (A2004-38). <https://www.legislation.act.gov.au/DownloadFile/a/2004-38/20041118-14870/PDF/2004-38.PDF>
- Health Professions Registration Act 2005* (Vic). (Act No. 97/2005). <https://www.legislation.vic.gov.au/as-made/acts/health-professions-registration-act-2005>
- Health Rights Commission Act 1991* (Qld). (No. 88 of 1991). <https://www.legislation.qld.gov.au/view/pdf/asmade/act-1991-088>

- Healthwatch England. (2014). *Suffering in silence*. October 2014. A Healthwatch England report.
<http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/hwe-complaints-report.pdf>
- Hesse-Biber, S., Rodriguez, D., & Frost, N.A. (2015). A qualitatively driven approach to multimethod and mixed methods research. In S. Hesse-Biber & R.B. Johnson (Eds.), *The Oxford Handbook of multimethod and mixed methods research inquiry* (pp. 3-20). Oxford University Press.
- Hill, M.R. (1984). Epistemology, axiology, and ideology in sociology. *Mid-American Review of Sociology*, 9(2), 59-77. <https://doi.org/10.17161/str.1808.4967>
- Hill, S., Bensoussan, A., Myers, S.P., Condrón, J., & Wu, S.M. (2005). Consumers of naturopathy and Western herbal medicine. In V. Lin, A. Bensoussan, S. Myers, P. McCabe, M. Cohen, S. Hill, & G. Howse. *The practice and regulatory requirements of naturopathy and Western herbal medicine* (pp. 233-253). November 2005. School of Public Health, La Trobe University.
<https://www.aronah.org/wp-content/uploads/naturopathy-final1106.pdf>.
 In.
- Hobbs, E., & Evans, N. (2017). Social work perceptions and identity: How social workers perceive public and professional attitudes towards their vocation and discipline. *Aotearoa New Zealand Social Work*, 29(4), 19-31.
<https://doi.org/10.11157/anzswj-vol29iss4id378>
- Hodder, I. (1994). The interpretation of documents and material culture. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 393-402). SAGE.
- Holmes, B. (2011). *Citizens' engagement in policymaking and the design of public services*. Research paper No. 1, 2011–12. Parliament of Australia, Department of Parliamentary Services. Canberra: Parliamentary Library.
<https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id:%22library/prspub/942018%22>
- Holstein, J.A., & Gubrium, J.F. (2004). The active interview. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice* (2nd ed., pp. 140-161). SAGE.
- Hospitals Contribution Fund of Australia Limited. (2023). Recognition requirements for providers of Chinese herbal medicine.
https://www.hcf.com.au/pdf/Chinese_herbal_medicine_recognition_criteria.pdf
- Hotho, S. (2008). Professional identity – product of structure, product of choice: Linking changing professional identity and changing professions. *Journal of Organizational Change Management*, 21(6), 721-742.
<https://doi.org/10.1108/09534810810915745>

- Hoy, D., Brooks, P., Woolf, A., Blyth, F., March, L., Bain, C., Baker, P., Smith, E., & Buchbinder, R. (2012). Assessing risk of bias in prevalence studies: Modification of an existing tool and evidence of interrater agreement. *Journal of Clinical Epidemiology*, 65(9), 934-939. <https://doi.org/10.1016/j.jclinepi.2011.11.014>
- Hughes, E.C. (1958). *Men and their work*. The Free Press of Glencoe.
- Hughes, E.C. (1984). *The sociological eye: Selected papers*. Transaction.
- Hunter, A., & Brewer, J. (2015). Designing multimethod research. In S. Hesse-Biber & R.B. Johnson (Eds.), *The Oxford Handbook of multimethod and mixed methods research inquiry* (pp. 185-205). Oxford University Press.
- Hutter, B.M. (2015). *What makes a regulator excellent? A risk regulation perspective*. Paper prepared for the Penn Program on Regulation's Best-in-Class Regulator Initiative. June 2015. <https://www.law.upenn.edu/live/files/4719-hutter-ppr-bicregulatordiscussionpaper-06-2015pdf>
- James, P.L. (2013). Striving for the professionalisation of Australian paramedics. *International Paramedic Practice*, 3(3), 74-78. <https://doi.org/10.12968/ippr.2013.3.3.74>
- Jenkins, R. (1982). Pierre Bourdieu and the reproduction of determinism. *Sociology*, 16(2), 270-281. <https://doi.org/10.1177/0038038582016002008>
- Jessop, B. (1995). The regulation approach, governance and post-Fordism: Alternative perspectives on economic and political change? *Economy and Society*, 24(3), 307-333. <https://doi.org/10.1080/03085149500000013>
- Jobs and Skills Australia
See Australian Government, Jobs and Skills Australia
- Johnson, R. (1993). Editor's introduction: Pierre Bourdieu on art, literature and culture. In R. Johnson & P. Bourdieu (Eds.), *The field of cultural production: Essays on art and literature* (pp. 1-25). Polity Press.
- Johnson, T.J. (1972). *Professions and power*. Macmillan.
- Jones, B.D. (2016). A radical idea tamed: The work of Roger Cobb and Charles Elder. In N. Zahariadis (Ed.), *Handbook of public policy agenda setting* (pp. 25-34). Edward Elgar.
- Keat, R., & Urry, J. (1982). *Social theory as science* (2nd ed.). Routledge & Kegan Paul.
- Kelly, M., Hardwick, K., Moritz, S., Kelner, M., Rickhi, B., & Quan, H. (2005). Towards integration: Opinions of health policy makers on complementary and alternative medicine. *Evidence Based Integrative Medicine*, 2(2), 79-86. <https://doi.org/10.2165/01197065-200502020-00003>

- Kelner, M., Wellman, B., Boon, H., & Welsh, S. (2004a). Responses of established healthcare to the professionalization of complementary and alternative medicine in Ontario. *Social Science and Medicine*, 59(5), 915-930. <https://doi.org/10.1016/j.socscimed.2003.12.017>
- Kelner, M., Wellman, B., Boon, H., & Welsh, S. (2004b). The role of the state in the social inclusion of complementary and alternative medical occupations. *Complementary Therapies in Medicine*, 12(2-3), 79-89. <https://doi.org/10.1016/j.ctim.2004.09.002>
- Kelner, M., Wellman, B., Welsh, S., & Boon, H. (2006). How far can complementary and alternative medicine go? The case of chiropractic and homeopathy. *Social Science and Medicine*, 63(10), 2617-2627. <https://doi.org/10.1016/j.socscimed.2006.07.005>
- Kincheloe, J.L., & McLaren, P.L. (1994). Rethinking critical theory and qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 138-157). SAGE.
- King, O., Borthwick, A., Nancarrow, S., & Grace, S. (2018). Sociology of the professions: What it means for podiatry. *Journal of Foot and Ankle Research*, 11(30), 1-8. <https://doi.org/10.1186/s13047-018-0275-0>
- Kingdon, J.W. (2003). *Agendas, alternatives, and public policies* (2nd ed.). Addison-Wesley Educational Publishers.
- Kingdon, J.W. (2014). *Agendas, alternatives, and public policies* (2nd ed.). Pearson Education.
- Kjaer, P.F., & Vetterlein, A. (2018). Regulatory governance: Rules, resistance and responsibility. *Contemporary Politics*, 24(5), 497-506. <https://doi.org/10.1080/13569775.2018.1452527>
- Kmietowicz, Z. (2010). Registering herbalists will improve patients' safety, says health secretary. *BMJ*, 340, c1897. <https://doi.org/10.1136/bmj.c1897>
- Koumenta, M., Humphris, A., Kleiner, M., & Pagliero, M. (2014). *Occupational regulation in the EU and UK: Prevalence and labour market impacts*. Final report. Department for Business, Innovation and Skills. Queen Mary University of London. London. <https://assets.publishing.service.gov.uk/media/5a7e31b840f0b62305b81676/bis-14-999-occupational-regulation-in-the-EU-and-UK.pdf>
- Kvale, S. (2006). Dominance through interviews and dialogues. *Qualitative Inquiry*, 12(3), 480-500. <https://doi.org/10.1177/1077800406286235>
- Lamont, M., & Lareau, A. (1988). Cultural capital: Allusions, gaps and glissandos in recent theoretical developments. *Sociological Theory*, 6(2), 153-168. <https://doi.org/10.2307/202113>

- Lancaster, K., Ritter, A., & Colebatch, H. (2014). Problems, policy and politics: Making sense of Australia's 'ice epidemic'. *Policy Studies*, 35(2), 147-171. <https://doi.org/10.1080/01442872.2013.875144>
- Larson, M.S. (1977). *The rise of professionalism: A sociological analysis*. University of California Press.
- Leach, M.J. (2012). Using role substitution to address the health workforce shortage and to facilitate integration? *Journal of Complementary and Integrative Medicine*, 9(1), Article 30. <https://doi.org/10.1515/1553-3840.1519>
- Legal Services Commission. (2024). *What is a law?* <https://www.lawhandbook.sa.gov.au/ch27s01.php>
- Leslie, K., Bourgeault, I.L., Carlton, A.-L., Balasubramanian, M., Mirshahi, R., Short, S., Carè, J., Cometto, G., & Lin, V. (2023). Design, operation and strengthening of health practitioner regulation systems: A rapid integrative review. *Human Resources for Health*, 21(1), 72. <https://doi.org/10.1186/s12960-023-00848-y>
- Levi-Faur, D. (2010). *Regulation and regulatory governance*. (Jerusalem Papers in Regulation & Governance). Jerusalem, Israel. Jerusalem Forum on Regulation & Governance. February 2010. https://www.researchgate.net/profile/David-Levi-Faur/publication/254908793_Regulation_Regulatory_Governance/links/54ec471a0cf27fbfd76f0d6c/Regulation-Regulatory-Governance.pdf
- Lewis, J.M. (2005). *Health policy and politics: Networks, ideas and power*. IP Communications.
- Lin, V., Bensoussan, A., Myers, S., McCabe, P., Cohen, M., Hill, S., & Howse, G. (2005). *The practice and regulatory requirements of naturopathy and Western herbal medicine*. November 2005. School of Public Health, La Trobe University. <https://www.aronah.org/wp-content/uploads/naturopathy-final1106.pdf>
- Lin, V., Bensoussan, A., Myers, S., McCabe, P., Cohen, M., Hill, S., & Howse, G. (2009). The practice and regulatory requirements of naturopathy and western herbal medicine in Australia. *Risk Management and Healthcare Policy*, 2, 21-33. <https://doi.org/10.2147/RMHP.S4652>
- Lin, V., & Gillick, D. (2011). Does workforce regulation have the intended effect? The case of Chinese medicine practitioner registration. *Australian Health Review*, 35(4), A-G. <https://doi.org/10.1071/AH10869>
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. SAGE.

- Lipsig-Mumme, C. (2006). Negotiating regulation: The state, the professions and the dilemma of autonomy. In C. Arup, P. Gahan, J. Howe, R. Johnstone, R. Mitchell, & O.D. Anthony (Eds.), *Labour law and labour market regulation: Essays on the construction, constitution and regulation of labour markets and work relationships* (pp. 470 - 482). The Federation Press.
- Liu, J.X., Goryakin, Y., Maeda, A., Bruckner, T., & Scheffler, R. (2017). Global health workforce labor market projections for 2030. *Human Resources for Health*, 15(1), 11. <https://doi.org/10.1186/s12960-017-0187-2>
- Liu, L., Tang, Y., Baxter, G.D., Yin, H., & Tumilty, S. (2021). Complementary and alternative medicine - practice, attitudes, and knowledge among healthcare professionals in New Zealand: An integrative review. *BMC Complementary Medicine and Therapies*, 21(1), 63. <https://doi.org/10.1186/s12906-021-03235-z>
- Livingston, C.J., Krass, I., & Li, G.Q. (2010). Factors predicting the recommendations of general practitioners on herbal therapies and dietary supplements to patients. *Journal of Complementary and Integrative Medicine*, 7(1), 36. <https://doi.org/10.2202/1553-3840.1370>
- Lockwood, C., Munn, Z., & Porritt, K. (2015). Qualitative research synthesis: Methodological guidance for systematic reviewers utilizing meta-aggregation. *International Journal of Evidence-Based Healthcare*, 13(3), 179–187. <https://doi.org/10.1097/XEB.0000000000000062>
- Low, J. (2013). Unstructured and semi-structured interviews in health research. In M. Saks & J. Allsop (Eds.), *Researching health: Qualitative, quantitative and mixed methods* (2nd ed., pp. 87-105).
- Loyal, S. (2017). *Bourdieu's theory of the state: A critical introduction*. Palgrave Macmillan. <https://doi.org/10.1057/978-1-137-58350-5>.
- Lynam, M.J., Browne, A.J., Reimer Kirkham, S., & Anderson, J.M. (2007). Re-thinking the complexities of 'culture': What might we learn from Bourdieu? *Nursing Inquiry*, 14(1), 23-34. <https://doi.org/10.1111/j.1440-1800.2007.00348.x>
- Macdonald, K.M. (1995). *The sociology of the professions*. SAGE.
- Mahat, A., Dhillon, I., Benton, D.C., Fletcher, M., & Wafula, F. (2023). Health practitioner regulation and national health goals. *101*(9), 595-604. <https://doi.org/10.2471/BLT.21.287728>
- Malhotra, V., Harnett, J., Wong, K., & Saini, B. (2020). The perspectives of Australian naturopaths about providing health services for people with sleep disorders. *Behavioral Sleep Medicine*, 19(3), 318-332. <https://doi.org/10.1080/15402002.2020.1751164>
- Maton, K. (2014). Habitus. In M. Grenfell (Ed.), *Pierre Bourdieu: Key concepts* (2nd ed., pp. 48-64). Routledge.

- Maxwell, J.A. (2010). Using numbers in qualitative research. *Qualitative Inquiry*, 16(6), 475-482. <https://doi.org/10.1177/1077800410364740>
- Maxwell, J.A. (2012). *A realist approach for qualitative research*. SAGE.
- McCabe, P. (2005a). *Representation of practitioners of naturopathy and Western herbal medicine by professional associations*. In V. Lin, A. Bensoussan, S. Myers, P. McCabe, M. Cohen, S. Hill, & G. Howse. *The practice and regulatory requirements of naturopathy and Western herbal medicine* (pp. 157-182). November 2005. School of Public Health, La Trobe University. <https://www.aronah.org/wp-content/uploads/naturopathy-final1106.pdf>.
- McCabe, P. (2005b). *Tertiary education in naturopathy and Western herbal medicine*. In V. Lin, A. Bensoussan, S. Myers, P. McCabe, M. Cohen, S. Hill, & G. Howse. *The practice and regulatory requirements of naturopathy and Western herbal medicine* (pp. 118-156). November 2005. School of Public Health, La Trobe University. <https://www.aronah.org/wp-content/uploads/naturopathy-final1106.pdf>.
- McCabe, P. (2008). Education in naturopathy and Western herbal medicine in Australia: Results of a survey of education providers. *Complementary Therapies in Clinical Practice*, 14(3), 168-175. <https://doi.org/10.1016/j.ctcp.2008.02.002>
- McCauley, T.P. (2006). Theoretical foundations for the study of work and professions. In M. Jacobs & S.E. Bosanac (Eds.), *The professionalization of work* (pp. 64–89). de Sitter Publications.
- McClelland, C.E. (1990). Escape from freedom reflections on German professionalization 1870–1933. In R. Torstendahl & M. Burrage (Eds.), *The formation of professions: Knowledge, state and strategy* (pp. 97-113). SAGE.
- McCready, L.A. (1982). Emerging health care occupations: The system under siege. *Health Care Management Review*, 7(4), 71-76. <https://doi.org/10.1097/00004010-198200740-00009>
- McDonald, R. (2014). 'Bourdieu', medical elites and 'social class': A qualitative study of 'desert island' doctors. *Sociology of Health and Illness*, 36(6), 902-916. <https://doi.org/10.1111/1467-9566.12121>
- McIntyre, E., Oorschot, T., Steel, A., Leach, M.J., Adams, J., & Harnett, J. (2021). Conventional and complementary health care use and out-of-pocket expenses among Australians with a self-reported mental health diagnosis: A cross-sectional survey. *BMC Health Services Research*, 21(1), 1266. <https://doi.org/10.1186/s12913-021-07162-0>
- Medibank See Medibank Private Limited
- Medibank Private Limited. (2024). *Ancillary provider recognition*. <https://www.medibank.com.au/providers/requirements/>

- Medical Board of Australia. (2023). *Doctors on notice as cosmetic surgery practice and advertising changes come into effect*. 3 July 2023.
https://www.medicalboard.gov.au/News/2023-07-03-Cos-surgery-changes.aspx?_gl=1*136cb7b*_ga*MTU2Nzc0OTgzMS4xNzEzMzA0MzQ3*_ga_F1G6LRCHZB*MTcxMzMwNDM0Ni4xLjEuMTcxMzMwNDQ5My4wLjAuMA
- Medicare Agreements Act 1992 (Cth). (No. 226, 1992 - SECT 6).
https://www.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/num_act/maa1992168/s6.html
- Menadue, J. (2005). *Health workforce reform* (Submission 149). In Australian Government, Productivity Commission. *Australia's health workforce*. Research Report. 22 December 2005. Canberra.
<https://www.pc.gov.au/inquiries/completed/health-workforce/report/healthworkforce.pdf>
- Merton, R.K. (1969). The functions of the professional association. *American Journal of Health-System Pharmacy*, 26(11), 636-641.
<https://doi.org/10.1093/ajhp/26.11.636>
- Miles, M.B., & Huberman, A.M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). SAGE.
- Millbank, J., Kaye, M., Stuhmcke, A., Sibbritt, D., Karpin, I., & Wardle, J. (2017). Complementary health practitioners disciplined for misconduct in Australia 2010-2016. *Journal of Law and Medicine*, 24(4), 788-802.
<http://classic.austlii.edu.au/au/journals/UTSLRS/2017/30.pdf>
- Miller, J.J., Deck, S.M., Grise-Owens, E., & Borders, K. (2015). Exploring graduate students' perceptions about social work licensing. *Social Work Education*, 34(8), 986-1004. <https://doi.org/10.1080/02615479.2015.1096924>
- Millerson, G. (1998). *Qualifying associations: A study in professionalization*. Routledge.
- Mills, C. (2008). Reproduction and transformation of inequalities in schooling: The transformative potential of the theoretical constructs of Bourdieu. *British Journal of Sociology of Education*, 29(1), 79-89.
<https://doi.org/10.1080/01425690701737481>
- Mishler, E.G. (2003). Representing discourse: The rhetoric of transcription. In Y.S. Lincoln & N.K. Denzin (Eds.), *Turning points in qualitative research: Tying knots in a handkerchief* (pp. 297-326). AltaMira Press.
- Mitnick, B.M. (1980). *The political economy of regulation: Creating, designing, and removing regulatory forms*. Columbia University Press.
- Montgomery, M.L.T., Shepard, B., Mokgolodi, H., Qian, M., & Tang, M. (2018). Professionalization of counseling: Perspectives from different international regions. *International Journal for the Advancement of Counselling*, 40(4), 343-364. <https://doi.org/10.1007/s10447-018-9330-6>

- Moran, M. (2002). The health professions in international perspective. In J. Allsop & M. Saks (Eds.), *Regulating the health professions* (pp. 19-30). SAGE.
- Morgan, D.L. (1993). Qualitative content analysis: A guide to paths not taken. *Qualitative Health Research*, 3(1), 112-121.
<https://doi.org/10.1177/104973239300300107>
- Morris, J., Moore, J., & Bismark, M. (2018). Health complaints entities in Australia and New Zealand: Serving the public interest? In J.M. Chamberlain, M. Dent, & M. Saks (Eds.), *Professional health regulation in the public interest: International perspectives* (pp. 221-244). Polity Press.
<https://doi.org/10.51952/9781447332275.ch012>
- Morrow, R.A., & Brown, D.D. (1994). *Critical theory and methodology* (Vol. 3). SAGE.
- Nancarrow, S., & Borthwick, A. (2021). *The allied health professions: A sociological perspective*. Policy Press.
- NASRHP See National Alliance of Self Regulating Health Professions
- National Alliance of Self Regulating Health Professions. (2012). *Harnessing self-regulation to support safety and quality in healthcare delivering: A comprehensive model for regulating all health practitioners*. Proposal by the National Alliance of Self-Regulating Health Professions. 1 March 2012. Allied Health Professions Australia.
<https://www.aopa.org.au/documents/item/123>
- National Alliance of Self Regulating Health Professions. (2025). *About NASRHP*.
<https://nasrhp.org.au/about/>
- National Disability Insurance Agency. (2023). *National Disability Insurance Scheme: 2022-23 annual pricing review report*. June 2023.
<https://www.ndis.gov.au/media/6051/download?attachment>
- Natow, R.S. (2020). The use of triangulation in qualitative studies employing elite interviews. *Qualitative Research*, 20(2), 160-173.
<https://doi.org/10.1177/1468794119830077>
- Naturopaths and Herbalists Association of Australia. (2020). *Private health insurance campaign*. 17 September 2020. <https://nhaa.org.au/private-health-insurance-campaign/>
- Navarro, V. (1986). *Crisis, health, and medicine: A social critique*. Tavistock Publications.
- NDIA See National Disability Insurance Agency
- NDIS See NDIS Quality and Safeguards Commission

- NDIS Quality and Safeguards Commission. (2018). *Suitability assessment process guide: Information for NDIS Providers and their 'key personnel'*. Version 1. July 2018. https://www.ndiscommission.gov.au/sites/default/files/2022-02/suit-assess-process-guide0-2_0.pdf
- Neu, D., Everett, J., Rahaman, A.S., & Martinez, D. (2013). Accounting and networks of corruption. *Accounting, Organizations and Society*, 38(6-7), 505-524. <https://doi.org/10.1016/j.aos.2012.01.003>
- New South Wales Health Care Complaints Commission. (2024). *Annual Report 2023-24. Protecting public health and safety*. <https://www.hccc.nsw.gov.au/About-us/Our-Performance/Annual-Reports>
- New Zealand Government, Productivity Commission. (2014). *Regulatory institutions and practices*. Final report. 30 June 2014. The New Zealand Productivity Commission. <https://www.treasury.govt.nz/sites/default/files/2024-05/pc-inq-rip-final-report-regulatory-institutions-and-practices-v2.pdf>
- New Zealand Ministry of Health, Manatū Hauora. (2023a). *Regulating a new profession*. 24 February 2025. <https://www.health.govt.nz/regulation-legislation/health-practitioners/regulating-a-new-profession>
- New Zealand Ministry of Health, Manatū Hauora. (2023b). *Responsible authorities under the Act*. 29 November 2023. <https://www.health.govt.nz/regulation-legislation/health-practitioners/responsible-authorities>
- NHAA See Naturopaths and Herbalists Association of Australia
- NIB See NIB Health Funds Limited
- NIB Health Funds Limited. (2024). *Ancillary providers*. <https://www.nib.com.au/providers/ancillary>
- Nicolaescu, C. (2010). Bourdieu–Habitus, symbolic violence, the gift: “You give me/I give you” principle. *Euromentor Journal - Studies about Education*, 1(3), 122-131. http://www.euromentor.ucdc.ro/en/nr1_vol3/engleza_articole/cristina_nicolaescu.pdf
- Noble, G. (2005). The discomfort of strangers: Racism, incivility and ontological security in a relaxed and comfortable nation. *Journal of Intercultural Studies*, 26(1-2), 107-120. <https://doi.org/10.1080/07256860500074128>
- Noll, R.G. (1985). Government regulatory behavior: A multidisciplinary survey and synthesis. In R.G. Noll (Ed.), *Regulatory policy and the social sciences* (pp. 9–63). University of California Press.
- Northern Territory
See Parliament of the Northern Territory
- NSW HCCC See New South Wales, Health Care Complaints Commission

NSW Joint Committee

See Parliament of New South Wales, Joint Committee on the Health Complaints Commission

Nutrition Society of Australia. (2021). *Who we are*. <https://www.nsa.asn.au/about-us/about-nsa/>

NZ MOH See New Zealand Ministry of Health, Manatū Hauora

Occupational Therapists Board of Queensland. (2009). *Annual Report 2008-09*. <https://documents.parliament.qld.gov.au/tp/2009/5309T1405.pdf>

Occupational Therapists Board of Queensland. (2011). *Annual Report 2010-11*. <https://apps.parliament.qld.gov.au/find?id=5311T5414>

OECD. (2014). *The governance of regulators, OECD best practice principles for regulatory policy*. OECD Publishing.
<http://dx.doi.org/10.1787/9789264209015-en>.

OECD. (2025). *OECD regulatory policy outlook*. OECD Publishing, Paris.
<https://doi.org/10.1787/56b60e39-en>

Ogus, A. (1995). Rethinking self-regulation. *Oxford Journal of Legal Studies*, 15(1), 97–108. <http://www.jstor.org/stable/764582>

Ogus, A. (2004). *Regulation: Legal form and economic theory*. Hart Publishers.

Oke, L. (2013). *Self-regulating health professions get proactive about standards of practice*. 24 October 2013.
<https://www.hospitalhealth.com.au/content/aged-allied-health/article/self-regulating-health-professionals-get-proactive-about-standards-of-practice-27581429>

Orrock, P.J. (2017). *Developing an evidence base for osteopathic healthcare: An exploration of osteopathic healthcare to inform the design of an appropriate methodology to investigate its effectiveness* [PhD Thesis, Southern Cross University (Australia)].
<https://researchportal.scu.edu.au/esploro/outputs/doctoral/Developing-an-evidence-base-for-osteopathic/991012820892502368>

OTBOQ See Occupational Therapists Board of Queensland

Occupational Therapists Board of Queensland. (2012). Occupational Therapists Board of Queensland: a history.
<https://www.occupationaltherapyboard.gov.au/documents/default.aspx?record=WD12%2F8399&dbid=AP&checksum=SfMd1xjsN%2F1k47blbbm7MA%3D%3D>

Otter.ai <https://otter.ai/>

- Özpolat, G. (2023). A negative sociology of the state: Thinking the state with Pierre Bourdieu. *İctimaiyat*, 7(2), 659-674.
<https://doi.org/10.33709/ictimaiyat.1294753>
- Özpolat, G., & Arap, İ. (2023). A synthesis at the crossroads of sociological thought: Bourdieu's intellectual dance with Marx, Weber and Durkheim. *Sosyoloji Dergisi*, 46, 191-220. <https://doi.org/10.59572/sosder.1335308>
- Pacey, F.J. (2018). *The origins and development of the National Registration and Accreditation Scheme for the health professions in Australia 2005-2010* [PhD thesis, The University of Sydney (Australia)].
<https://ses.library.usyd.edu.au/handle/2123/19630>
- Palatchie, B., Beban, A., & Andersen, B. (2021). The myth of medical multiculturalism: How social closure marginalises traditional Chinese medicine in New Zealand. *Health Sociology Review*, 31(3), 262-277.
<https://doi.org/10.1080/14461242.2021.1987955>
- Parents of Deaf Children and Aussie Deaf Kids. (2017). *Submission to the Joint Standing Committee on the National Disability Insurance Scheme on the provision of hearing services under the National Disability Insurance Scheme (NDIS)*. January 2017. https://www.aussiedeafkids.org.au/site/user-assets/docs/NDIS_submission_PODC_ADK.pdf
- Parkin, F. (1974). Strategies of social closure in class formation. In F. Parkin (Ed.), *The social analysis of class structure* (pp. 1-18). Tavistock Publications.
- Parkin, F. (1979). *Marxism and class theory: A bourgeois critique*. Columbia University Press.
- Parliament of COA
 See Parliament of the Commonwealth of Australia
- Parliament of New South Wales, Joint Committee on the Health Care Complaints Commission. (2005). *Comparison of the various models of regulation of traditional Chinese medicine August/September 2005*. Report No. 11/53. November 2005. Committee on the Health Care Complaints Commission. Sydney. <https://www.parliament.nsw.gov.au/la/papers/Pages/tailed-paper-details.aspx?pk=48691>
- Parliament of New South Wales, Joint Committee on the Health Care Complaints Commission. (2006). *Review of the 1998 report into 'unregistered health practitioners: The adequacy and appropriateness of current mechanisms for resolving complaints'*. Final report. Report No. 13/53. September 2006. Committee on the Health Care Complaints Commission. Sydney.
<https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=1976#tab-reportsandgovernmentresponses>

- Parliament of New South Wales, Joint Committee on the Health Care Complaints Commission. (2010). *Operation of the Health Care Complaints Act 1993*. Final report. Report No. 7/54. June 2010. Committee on the Health Care Complaints Commission. Sydney.
<https://www.parliament.nsw.gov.au/ladocs/inquiries/1615/Operation%20of%20the%20Health%20Care%20Complaints%20Act%201993%20-.pdf>
- Parliament of South Australia, Social Development Committee. (2009). *Inquiry into bogus, unregistered and deregistered health practitioners*. Thirtieth report. Social Development Committee. Adelaide. <http://s3.danscomp.net/30th-Report-Bogus-Unregistered-Deregistered-HealthPract-1.pdf>
- Parliament of the Commonwealth of Australia. (1977). *Chiropractic, osteopathy, homeopathy and naturopathy*. Parliamentary Paper No. 102/1977. April 1977. Report of Committee of Inquiry. Canberra. <https://nla.gov.au/nla.obj-1351159246/view?partId=nla.obj-1355511493>
- Parsons, T. (1964). *The social system*. The Free Press of Glencoe.
- Patton, M.Q. (2015). *Qualitative research & evaluation methods* (4th ed.). SAGE.
- Phipps, D.L., Noyce, P.R., Walshe, K., Parker, D., & Ashcroft, D.M. (2011). Risk-based regulation of healthcare professionals: What are the implications for pharmacists? *Health, Risk & Society*, 13(3), 277-292.
<https://doi.org/10.1080/13698575.2011.558624>
- Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., & Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews: A product from the ESRC Methods Programme*. Version 1. April 2006.
<https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=ed8b23836338f6fdea0cc55e161b0fc5805f9e27>
- Price, M.E., & Verhulst, S.G. (2005). *Self-regulation and the internet*. Kluwer Law International.
- Priest, M. (1998). The privatization of regulation: Five models of self-regulation. *Ottawa Law Review*, 29(2), 233-302.
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2723562
- Prior, L. (2008). Repositioning documents in social research. *Sociology*, 42(5), 821-836.
<https://journals.sagepub.com/doi/abs/10.1177/0038038508094564>
- Productivity Commission
 See Australian Government, Productivity Commission
- Productivity Commission Act 1998* (Cth).
<https://www.legislation.gov.au/C2004A05326/2018-04-12/textPSA>
- Professional Standards Councils. (2024). *About us*. <https://www.psc.gov.au/about-us>

- Psychotherapy and Counselling Federation of Australia. (2024). *PACFA Annual Report Summary 2023-24*.
https://pacfa.org.au/common/Uploaded%20files/board/PACFA-AnnualReport_2024_1124.pdf
- Psychotherapy and Counselling Federation of Australia. (n.d.). *About PACFA*.
<https://www.pacfa.org.au/portal/portal/About/About.aspx?hkey=2afa9cff-85e0-4bfb-9415-c8ed5d60218c>
- Public Health Act 2010 (2024) (NSW)*. (No. 127. Current version for 27 September 2024). <https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-2010-127>
- QSR International. (2019). NVivo. (Version 12 Pro) QSR International Pty Ltd.
<https://lumivero.com/>
- Queensland Government, Queensland Health. (2014). *Ministerial Taskforce on health practitioner expanded scope of practice*. Final report. June 2014. Allied Health Professions' Office of Queensland. Brisbane.
https://www.health.qld.gov.au/__data/assets/pdf_file/0031/161977/minist-erial-taskforce-report.pdf
- Queensland Government, Queensland Health. (2024a). *Audiology Decision RIS*. Consultation paper. Brisbane.
https://www.health.qld.gov.au/__data/assets/pdf_file/0035/1327976/audiology-ris-consultation-paper.pdf
- Queensland Government, Queensland Health. (2024b). *Audiology decision RIS*. Consultation paper 2. Brisbane. https://www.deafnessforum.org.au/wp-content/uploads/2024/12/Audiology-Decision-RIS_Consultation-Paper-2.pdf
- Queensland Office of the Health Ombudsman. (2024). *Annual Report 2023-24*.
<https://www.oho.qld.gov.au/resources/annual-reports>
- Rabinow, P., & Sullivan, W.M. (1979). Introduction. The interpretive turn: Emergence of an approach. In P. Rabinow & W.M. Sullivan (Eds.), *Interpretive social science: A reader* (pp. 1-21). University of California Press.
- Rajan, D., Rohrer, K., Koch, K., Kunjumen, T., Diallo, K., Velazquez Berumen, A., Nannei, C., & Sprunken, J. (2022). Resource generation. In I. Papanicolas, D. Rajan, M. Karanikolos, A. Soucat, & J. Figueras (Eds.), *Health system performance assessment: A framework for policy analysis* (pp. 78-130). (Health Policy Series 57). Licence: CC BY-NC-SA 3.0 IGO. World Health Organization. Geneva. <https://iris.who.int/handle/10665/352686>
- Reed, B., Cowin, L., O'Meara, P., Metusela, C., & Wilson, I. (2023). An exploration of perceptions and experiences of Australian paramedics following the introduction of professional regulation. *International Journal of Health Governance*, 28(4), 438-452. <https://doi.org/10.1108/ijhg-02-2023-0022>

- Reed, B., Cowin, L., O'Meara, P., Metusela, C., & Wilson, I. (2024). Perceptions of Australian paramedics following the introduction of professional regulation: A qualitative exploration. *International Journal of Emergency Services*, 13(1), 98-110. <https://doi.org/10.1108/ijes-03-2023-0004>
- Reed, B., Cowin, L., O'Meara, P., & Wilson, I. (2021). Perceptions and knowledge of self-regulation of paramedics in Australia. *Australasian Journal of Paramedicine*, 18, 1-12. <https://doi.org/10.33151/ajp.18.963>
- Reed, B., Cowin, L., O'Meara, P., & Wilson, I. (2022). A qualitative exploration of the perceptions of professional registration by Australian paramedics during the transition into professional regulation. *Medical Law International*, 22(4), 327-348. <https://doi.org/10.1177/09685332221117995>
- Ribeiro, F., & Miraldi, J. (2022). Bourdieu, reflexivity, and scientific practice. *Configurações*, (29), 111-130. <https://doi.org/10.4000/configuracoes.15157>
- Richards, L., & Morse, J.M. (2013). *README FIRST for a user's guide to qualitative methods* (3rd ed.). SAGE.
- Ricoeur, P. (1973). The model of the text: Meaningful action considered as a text. *New Literary History*, 5(1), 91-117. <https://doi.org/10.2307/468410>
- Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R.G. Burgess (Eds.), *Analyzing Qualitative Data* (pp. 173-194). Routledge.
- Rogers, W.S., & Willig, C. (2017). Introduction. In C. Willig & W.S. Rogers (Eds.), *The SAGE Handbook of qualitative research in psychology* (2nd ed., pp. 1-13). SAGE.
- Ross, J.K. (2017). *The inverted pyramid: 10 less restrictive alternatives to occupational licensing*. November 2017. The Institute for Justice. <https://dataspace.princeton.edu/handle/88435/dsp01zk51vk91g>
- Roth, J.A. (1974). Professionalism: The sociologist's decoy. *Sociology of Work and Occupations*, 1(1), 6-23. <https://doi.org/10.1177/073088847400100102>
- Rothstein, H., Irving, P., Walden, T., & Yearsley, R. (2006). The risks of risk-based regulation: Insights from the environmental policy domain. *Environment International*, 32(8), 1056-1065. <https://doi.org/10.1016/j.envint.2006.06.008>
- Roy, A. (2004, November 3). Peace and the new corporate liberation theology. City of Sydney Peace Prize Lecture. CPACS Occasional Paper No. 04/2. Sydney, Australia. <https://sydneypeacefoundation.org.au/peace-prize-recipients/2004-arundhati-roy/>
- Russell, J., Greenhalgh, T., Byrne, E., & McDonnell, J. (2008). Recognizing rhetoric in health care policy analysis. *Journal of Health Services Research and Policy*, 13(1), 40-46. <https://doi.org/10.1258/jhsrp.2007.006029>

- Rycroft-Malone, J., Seers, K., Titchen, A., Harvey, G., Kitson, A., & McCormack, B. (2004). What counts as evidence in evidence-based practice? *Journal of Advanced Nursing*, 47(1), 81-90. <https://doi.org/10.1111/j.1365-2648.2004.03068.x>
- Saks, M. (1983). Removing the blinkers? A critique of recent contributions to the sociology of professions. *The Sociological Review*, 31(1), 3-21. <https://doi.org/10.1111/j.1467-954X.1983.tb00677.x>
- Saks, M. (1995). *Professions and the public interest: Medical power, altruism and alternative medicine*. Routledge. <https://doi.org/10.4324/9780203991404>.
- Saks, M. (1998). Deconstructing or reconstructing professions? Interpreting the role of professional groups in society. In V. Olgiati, L. Orzack, & M. Saks (Eds.), *Professions, identity, and order in comparative perspective* (pp. 351-364). International Institute for the Sociology of Law.
- Saks, M. (1999). The wheel turns? Professionalisation and alternative medicine in Britain. *Journal of Interprofessional Care*, 13(2), 129-138. <https://doi.org/10.3109/13561829909025545>
- Saks, M. (2003). *Orthodox and alternative medicine: Politics, professionalization, and health care*. SAGE.
- Saks, M. (2010). Analyzing the professions: The case for the neo-Weberian approach. *Comparative Sociology*, 9(6), 887-915. <https://doi.org/10.1163/156913310x522624>
- Saks, M. (2012). Defining a profession: The role of knowledge and expertise. *Professions and Professionalism*, 2(1), 1-10. <https://journals.oslomet.no/index.php/pp/article/view/151>
- Saks, M. (2014). Regulating the English healthcare professions: Zoos, circuses or safari parks? *Journal of Professions and Organization*, 1(1), 84-98. <https://doi.org/10.1093/jpo/jot001>
- Saks, M. (2015). Inequalities, marginality and the professions. *Current Sociology*, 63(6), 850-868. <https://doi.org/10.1177/0011392115587332>
- Saks, M. (2016). A review of theories of professions, organizations and society: The case for neo-Weberianism, neo-institutionalism and eclecticism. *Journal of Professions and Organization*, 3(2), 170-187. <https://doi.org/10.1093/jpo/jow005>
- Saks, M. (2021). *Professions: A key idea for business and society*. Routledge. <https://doi.org/10.4324/9780429465802>.
- Saks, M., & Adams, T.L. (2019). Neo-Weberianism, professional formation and the state: Inside the black box. *Professions and Professionalism*, 9(2), Article e3190. <https://doi.org/10.7577/pp.3190>

- Saks, M., & Allsop, J. (2007). Social policy, professional regulation and health support work in the United Kingdom. *Social Policy and Society*, 6(2), 165-177. <https://doi.org/10.1017/s1474746406003435>
- Saldaña, J. (2009). *The coding manual for qualitative researchers*. SAGE.
- Saldaña, J. (2011). *Fundamentals of qualitative research*. Oxford University Press.
- Salve, S., Harris, K., Sheikh, K., & Porter, J.D.H. (2018). Understanding the complex relationships among actors involved in the implementation of public-private mix (PPM) for TB control in India, using social theory. *International Journal for Equity in Health*, 17(1), 73. <https://doi.org/10.1186/s12939-018-0785-1>
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27-37. <https://doi.org/10.1097/00012272-198604000-00005>
- Sandelowski, M. (2001). Real qualitative researchers do not count: The use of numbers in qualitative research. *Research in Nursing and Health*, 24(3), 230-240. <https://doi.org/10.1002/nur.1025>
- Sandelowski, M., & Barroso, J. (2003). Classifying the findings in qualitative studies. *Qualitative Health Research*, 13(7), 905-923. <https://doi.org/10.1177/1049732303253488>
- SA SDC See Parliament of South Australia, Social Development Committee
- Saunders, M.N., Lewis, P., & Thornhill, A. (2019). *Research methods for business students* (8th ed.). Pearson Education.
- Sayer, A. (2018). Pierre Bourdieu: Ally or foe of discourse analysis? In R. Wodak & B. Forchtner (Eds.), *The Routledge Handbook of language and politics* (pp. 109-121). Routledge.
- Schinkel, W., & Noordegraaf, M. (2011). Professionalism as symbolic capital: Materials for a Bourdieusian theory of professionalism. *Comparative Sociology*, 10(1), 67-96. <https://doi.org/10.1163/156913310x514083>
- Schofield, M. (2008). *Best practice self-regulation model for psychotherapy and counselling in Australia*. Final report. February 2008. Psychotherapy and Counselling Federation of Australia. <https://www.pacfa.org.au/common/Uploaded%20files/PCFA/Documents/Research/2008-self-regulation-report.pdf>
- Sciulli, D. (2009). *Professions in civil society and the state: Invariant foundations and consequences*. Brill. <https://brill.com/display/title/17038?language=en>.
- Seale, M. (2009, October). *Letter to the Right Honourable Andy Burnham MP, Secretary of State for Health Department of Health, regarding the statutory regulation of sonographers*. <https://www.hcpc-uk.org/globalassets/meetings-attachments3/council-meeting/2009/october/20091007-council---enc-7---sonographers>

- Senate Community Affairs Legislation Committee
See Australian Government, Senate Community Affairs Legislation Committee
- Senate Community Affairs References Committee
See Australian Government, Senate Community Affairs References Committee
- Senate Finance and Public Administration References Committee
See Australian Government, Senate Finance and Public Administration References Committee
- Senate Standing Committees on Community Affairs
See Australian Government, Senate Standing Committees on Community Affairs
- Services Australia
See Australian Government, Services Australia
- Sharpley, C.F., & Agnew, C.J. (2003). What GPs think of counsellors: A survey of attitudes regarding relevance and expertise. *Australian Journal of Guidance and Counselling*, 13(2), 179-191.
<https://doi.org/10.1017/s1037291100002879>
- Sharpley, C.F., Bond, J.E., & Agnew, C.J. (2004). Why go to a counsellor? Attitudes to, and knowledge of counselling in Australia, 2002. *International Journal for the Advancement of Counselling*, 26(1), 95-108.
<https://doi.org/10.1023/B:ADCO.0000021552.13762.dd>
- Silverman, D. (1993). *Interpreting qualitative research: Methods for analysing talk, text and interaction*. SAGE.
- Slevin, E., & Sines, D. (1999). Enhancing the truthfulness, consistency and transferability of a qualitative study: Utilising a manifold of approaches. *Nurse Researcher*, 7(2), 79-98.
<https://doi.org/10.7748/nr2000.01.7.2.79.c6113>
- Smith, J.K. (1993). *After the demise of empiricism: The problem of judging social and educational inquiry*. Ablex Publishing.
- Smith, M.J. (2009). *Power and the State*. Palgrave Macmillan.
- Social Workers Registration Bill 2018* (SA). (No. 45, 5 September 2018).
https://www.legislation.sa.gov.au/__legislation/lz/b/archive/social%20workers%20registration%20bill%202018_%20hon%20tammy%20franks%20mlc/b_as%20introduced%20in%20lc/social%20workers%20registration%20bill%202018.un.pdf
- SPA See Speech Pathology Australia
- Sparrow, M.K. (2008). *The character of harms: Operational challenges in control*. Cambridge University Press.

- Speech Pathology Australia. (2023). *Speech pathology workforce analysis: Preparing for our future*. March 2023. AHP Workforce Consulting Group.
<https://www.speechpathologyaustralia.org.au/resource?resource=446>
- Speech Pathology Australia. (2025). *Speech pathologists' preferences on workforce regulation: Insights from the November 2024 Advocacy Survey*. 4 February 2025. <https://speechpathologyaustralia.org.au/AdvocacySurvey>
- Standing Council on Health. (2013). *Communiqué: Council of Australian Governments meeting. Regulation of unregistered health practitioners*. 1 August 2013.
https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/research-and-reports/c/communique_regulation-of-unregistered-health-practitioners_issued-1-08-13---pdf.pdf
- Standing Council on Health. (2014). *Communiqué: Council of Australian Governments meeting. National Registration and Accreditation Scheme for the health professions. Review Terms of Reference*. Meeting as the Australian Health Workforce Ministerial Council. 11 April 2014.
<https://www.ahpra.gov.au/documents/default.aspx?record=WD14%2F13705&dbid=AP&chksum=wmkfvaZIIlQu5d%2FsTv066g%3D%3D>
- Stark, A., Thompson, N.K., & Marston, G. (2021). Public deliberation and policy design. *Policy Design and Practice*, 4(4), 452-464.
<https://doi.org/10.1080/25741292.2021.1912906>
- Steel, A., Diezel, H., Leach, M., & Bugarcic, A. (2023). Providing naturopathic care in the community: Perspectives of recent naturopathy graduates in Australia. *Complementary Therapies in Clinical Practice*, 51, 101737.
<https://doi.org/10.1016/j.ctcp.2023.101737>
- Steel, A., Rickwood, C., Bradley, R., Foley, H., & Harnett, J.E. (2020a). Australian naturopaths' approach to caring for people with cardiovascular disease and associated risk factors: A qualitative study of the providers' perspective. *Journal of Alternative and Complementary Medicine*, 26(10), 902-910.
<https://doi.org/10.1089/acm.2020.0095>
- Steel, A., Schloss, J., Leach, M., & Adams, J. (2020b). The naturopathic profession in Australia: A secondary analysis of the Practitioner Research and Collaboration Initiative (PRACI). *Complementary Therapies in Clinical Practice*, 40, Article 101220. <https://doi.org/10.1016/j.ctcp.2020.101220>
- Stigler, G.J. (1971). The theory of economic regulation. *The Bell Journal of Economics and Management Science*, 2(1), 3-21. <https://doi.org/10.2307/3003160>
- Suddaby, R., & Muzio, D. (2015). Theoretical perspectives on the professions. In L. Empson, D. Muzio, J. Broschak, & B. Hinings (Eds.), *The Oxford Handbook of professional service firms* (pp. 25–47). Oxford University Press.
- Swartz, D. (1997). *Culture and power: The sociology of Pierre Bourdieu*. University of Chicago Press.

- Sylvan, L. (2002, September 2-3). *Self-regulation - who's in charge here?* [Paper presentation]. Australian Institute of Criminology, Current Issues in Regulation: Enforcement and Compliance Conference. Melbourne, Australia. https://web.archive.org.au/awa/20040516191129mp_/http://www.aic.gov.au/conferences/regulation/sylvan.pdf
- Tan, S. (2011). Understanding the 'structure' and the 'agency' debate in the social sciences. *Habitus*, 1, 37-50. <https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=4ecfa927601fff6ae54cd6cf38246726eddd24aa#page=39>
- Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. SAGE.
- Taskforce on Industry Self-Regulation
See Australian Government Taskforce on Industry Self-Regulation
- Taylor, C. (1979). Interpretation and the sciences of man. In P. Rabinow & W.M. Sullivan (Eds.), *Interpretive social science: A reader* (pp. 25-71). University of California Press.
- Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. The Falmer Press.
- TGA See Australian Government, Therapeutic Goods Administration
- Tholen, G. (2016). Symbolic closure: Towards a renewed sociological perspective on the relationship between higher education, credentials and the graduate labour market. *Sociology*, 51(5), 1067-1083. <https://doi.org/10.1177/0038038516641857>
- Thomson, P. (2014). Field. In M. Grenfell (Ed.), *Pierre Bourdieu: Key concepts* (2nd ed., pp. 65-80). Routledge.
- Timmermans, S., & Oh, H. (2010). The continued social transformation of the medical profession. *Journal of Health and Social Behavior*, 51, S94-S106. <https://doi.org/10.1177/0022146510383500>
- Tingle, L. (2015). Political amnesia: How we forgot how to govern. *Quarterly Essay*, 60, 1-86. <https://www.quarterlyessay.com.au/essay/2015/11/political-amnesia/extract>
- Tiralongo, E., Braun, L., Wilkinson, J., Spitzer, O., Bailey, M., Poole, S., & Dooley, M. (2010). Exploring the integration of complementary medicines into Australian pharmacy practice with a focus on different practice settings and background knowledge. *Journal of Complementary and Integrative Medicine*, 7(1), 1-21. <https://doi.org/10.2202/1553-3840.1411>

- Tricco, A.C., Lillie, E., Zarin, W., O'Brien, K.K., Colquhoun, H., Levac, D., Moher, D., Peters, M.D.J., Horsley, T., Weeks, L., Hempel, S., Akl, E.A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M.G., Garritty, C., Lewin, S., Godfrey, C.M., Macdonald, M.T., Langlois, E.V., Soares-Weiser, K., Moriarty, J., Clifford, T., Tunçalp, Ö., & Straus, S.E. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): Checklist and explanation. *Annals of Internal Medicine*, 169(7), 467-473. <https://doi.org/10.7326/M18-0850>
- Trochim, W.M., Donnelly, J.P., & Arora, K. (2016). *Research methods: The essential knowledge base* (2nd ed.). Cengage Learning.
- UK Care Quality Commission. (2018). *Opening the door to change: NHS safety culture and the need for transformation*. December 2018. <https://www.cqc.org.uk/publications/themed-work/opening-door-change>
- UK Department of Health. (2008). *Statutory regulation of practitioners of acupuncture, herbal medicine, traditional Chinese medicine and other traditional medicine systems practised in the UK*. Report to Ministers from the Department of Health Steering Group. May 2008. <http://data.parliament.uk/DepositedPapers/Files/DEP2008-2163/DEP2008-2163.pdf>
- UK Department of Health, Extending Professional Regulation Working Group. (2009). *Extending professional and occupational regulation*. The Report of the Working Group on Extending Professional Regulation. 16 July 2009. https://webarchive.nationalarchives.gov.uk/ukgwa/20130103005749mp_/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102818.pdf
- UK DOH See UK Department of Health
- UK HCPC See UK Health and Care Professions Council
- UK Health and Care Professions Council. (2024). Professions and protected titles. <https://www.hcpc-uk.org/about-us/who-we-regulate/the-professions/>
- UK PSA See UK Professional Standards Authority
- UK Professional Standards Authority. (2015). *Rethinking regulation*. August 2015. <https://www.professionalstandards.org.uk/publications/detail/rethinking-regulation#:~:text=Rethinking%20regulation%20makes%20a%20series,Transparent%20benchmarking%20to%20set%20standards>
- UK Professional Standards Authority. (2024a). *Find a regulator*. <https://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/find-a-regulator>
- UK Professional Standards Authority. (2024b). *Find an accredited register*. <https://www.professionalstandards.org.uk/what-we-do/accredited-registers/find-a-register>

- Ung, C.O.L., Harnett, J., & Hu, H. (2017). Key stakeholder perspectives on the barriers and solutions to pharmacy practice towards complementary medicines: An Australian experience. *BMC Complementary and Alternative Medicine*, 17(1), Article 394. <https://doi.org/10.1186/s12906-017-1899-5>
- van der Heijden, J. (2019). *Risk governance and risk-based regulation: A review of the international academic literature*. State of the Art in Regulatory Governance Research Paper – 2019.02. Wellington: Victoria University of Wellington/Government Regulatory Practice Initiative. <https://ssrn.com/abstract=3406998>
- van Dijk, T.A. (1993). Principles of critical discourse analysis. *Discourse & Society*, 4(2), 249-283. <https://doi.org/10.1177/0957926593004002006>
- Vandenberghe, F. (2014). *What's critical about critical realism? Essays in reconstructive social theory*. Routledge.
- Vic DOHS See Victorian Department of Human Services
- Vic HCC See Victorian Health Complaints Commissioner
- Victoria See Parliament of Victoria
- Victorian Government Department of Human Services. (1998). *Traditional Chinese medicine: Report on options for regulation of practitioners*. July 1998. Victorian Ministerial Advisory Committee. Human Services Communications Unit. Melbourne. <http://ncp.ncc.gov.au/docs/VIC%20traditional%20chinese%20medicine.pdf>
- Victorian Government Department of Human Services. (2003). *Regulation of the health professions in Victoria. A discussion paper*. October 2003. Policy and Strategic Projects Division. Melbourne. <https://vgls.sdp.sirsidynix.net.au/client/search/asset/1160624>
- Victorian Ombudsman. (2023). *Alleged politicisation of the public sector: Investigation of a matter referred from the Legislative Council on 9 February 2022 – Part 2*. 6 December 2023. <https://www.ombudsman.vic.gov.au/our-impact/investigation-reports/alleged-politicisation-of-the-public-sector/>
- Walker, R. (1985). An introduction to applied qualitative research. In R. Walker (Ed.), *Applied qualitative research* (pp. 3-26). Gower.
- Ward, E.C. (2019). Elizabeth Usher memorial lecture. Expanding scope of practice - inspiring practice change and raising new considerations. *International Journal of Speech-Language Pathology*, 21(3), 228-239. <https://doi.org/10.1080/17549507.2019.1572224>
- Wardle, J. (2008). Why run a risk agenda for CAM regulation? *Australian Journal of Medical Herbalism*, 20(4), 136-141.

- Wardle, J. (2014). Holding unregistered health practitioners to account: An analysis of current regulatory and legislative approaches. *Journal of Law and Medicine*, 22(2), 350-375. <https://pubmed.ncbi.nlm.nih.gov/25715537/>.
- Wardle, J., Adams, J., Lui, C.-W., & Steel, A.E. (2013). Current challenges and future directions for naturopathic medicine in Australia: A qualitative examination of perceptions and experiences from grassroots practice. *BMC Complementary and Alternative Medicine*, 13(15). <https://doi.org/10.1186/1472-6882-13-15>
- Wardle, J., Sibbritt, D., Broom, A., Steel, A., & Adams, J. (2016). Is health practitioner regulation keeping pace with the changing practitioner and health-care landscape? An Australian perspective. *Frontiers in Public Health*, 4, Article 91. <https://doi.org/10.3389/fpubh.2016.00091>
- Webb, J., Schirato, T., & Danaher, G. (2002). *Understanding Bourdieu*. Allen & Unwin.
- Weininger, E.B. (2005). Foundations of Pierre Bourdieu's class analysis. In E.O. Wright (Ed.), *Approaches to class analysis* (pp. 82-118). Cambridge University Press.
- Welsh, S., Kelner, M., Wellman, B., & Boon, H. (2004). Moving forward? Complementary and alternative practitioners seeking self-regulation. *Sociology of Health and Illness*, 26(2), 216-241. <https://doi.org/10.1111/j.1467-9566.2004.00387.x>
- Wessel, M., Lynoe, N., Juth, N., & Helgesson, G. (2012). The tip of an iceberg? A cross-sectional study of the general public's experiences of reporting healthcare complaints in Stockholm, Sweden. *BMJ Open*, 2(1), e000489. <https://doi.org/10.1136/bmjopen-2011-000489>
- West, D., Heath, D., & Ennis, G. (2009). Northern Territory social work: Views and approaches. *Australian Social Work*, 62(1), 74-89. <https://doi.org/10.1080/03124070802428522>
- Whittington, R. (2010). Giddens, structuration theory and strategy as practice. In D. Golsorkhi, L. Rouleau, D. Seidl, & E. Vaara (Eds.), *Cambridge Handbook of strategy as practice* (pp. 109-126). Cambridge University Press. <https://doi.org/10.1017/CBO9780511777882>
- WHO See World Health Organization
- Wilensky, H.L. (1964). The professionalization of everyone? *American Journal of Sociology*, 70(2), 137-158. <https://doi.org/10.1086/223790>
- Williams, B., Fielder, C., Strong, G., Acker, J., & Thompson, S. (2015). Are paramedic students ready to be professional? An international comparison study. *International Emergency Nursing*, 23(2), 120-126. <https://doi.org/10.1016/j.ienj.2014.07.004>
- Williams, B., Onsmann, A., & Brown, T. (2010). Is the Australian paramedic discipline a full profession? *Australasian Journal of Paramedicine*, 8, 1-10. <https://doi.org/10.33151/ajp.8.1.113>

- Williams, B., Onsman, A., & Brown, T. (2012). Is the Australian paramedic discipline a profession? A national perspective. *International Paramedic Practice*, 2(3), 77-84. <https://doi.org/10.12968/ippr.2012.2.3.77>
- Williams, B., & Webb, V. (2015). A national study of paramedic and nursing students' readiness for interprofessional learning (IPL): Results from nine universities. *Nurse Education Today*, 35(9), e31-e37. <https://doi.org/10.1016/j.nedt.2015.05.007>
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Open University Press.
- Willis, J.W. (2007). *Foundations of qualitative research: Interpretive and critical approaches*. SAGE.
- Wolcott, H.F. (1994). *Transforming qualitative data: Description, analysis, and interpretation*. SAGE.
- Wood, D., Griffiths, K., & Chivers, C. (2018). *Who's in the room? Access and influence in Australian politics*. September 2018. Grattan Institute. <https://grattan.edu.au/wp-content/uploads/2018/09/908-Who-s-in-the-room-Access-and-influence-in-Australian-politics.pdf>
- World Health Organization. (2016). *Global strategy on human resources for health: Workforce 2030*. World Health Organization. Geneva. <https://www.who.int/publications/i/item/9789241511131>
- World Health Organization. (2021). *Research on the design, reform and implementation of health practitioner regulation across countries*. Request for proposal. Reference: 2021/UHL/HWF/HWP/01. 11 January 2021. World Health Organization. Geneva. <https://www.ungm.org/Public/Notice/120438>
- World Health Organization. (2024). *Health practitioner regulation: Design, reform and implementation guidance*. World Health Organization. Geneva. <https://www.who.int/publications/i/item/9789240095014>
- Wu, X., Ma, L., Low, D., Sharma, S., & Papishev, G. (2023). Beyond precautionary principle: Policy-making under uncertainty and complexity. *Policy Design and Practice*, 7(1), 1-16. <https://doi.org/10.1080/25741292.2023.2229090>
- Yackee, S.W. (2006). Sweet-talking the fourth branch: The influence of interest group comments on federal agency rulemaking. *Journal of Public Administration Research and Theory*, 16(1), 103-124. <https://doi.org/10.1093/jopart/mui042>
- Yam, C.H.K., Griffiths, S.M., Liu, S., Wong, E.L.Y., Chung, V.C.H., & Yeoh, E.K. (2016). Medical regulation: Ten key trends emerging from an international review. *Journal of Medical Regulation*, 102(1), 16-27. <https://doi.org/10.30770/2572-1852-102.1.16>