Patricia Hall, BSW, MSW
Lakshmi Bondu, MDS, MPH
Eva Saar, PhD, BPharm (Hons)
Martin Fletcher, BA(Hons), MMan

COMMENTARY

The Evolution of Community Participation in the Australian National Registration and Accreditation Scheme

Abstract

Public or community participation in planning and decision making helps ensure that healthcare is safer, more equitable and better meets communities' expectations. Public confidence in the regulation of health practitioners is essential to ensure patients or consumers have trust in their practitioners, do not avoid seeking care they need and are prepared to raise a concern if required. This Commentary discusses the evolution of community participation in the operation of the Australian National Registration and Accreditation Scheme that regulates 16 health professions. It describes community advisory initiatives that have developed over the past decade and highlights organizational learnings on the benefits and challenges of greater public participation in health practitioner regulation.

Introduction

Public participation in healthcare is a cornerstone of safety and quality improvement. The World Health Organization Global Patient Safety Action Plan 2021-2030[1] highlights partnering with patients, families, and communities in shaping regulatory, licensing, and accreditation frameworks.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) promotes standards that embed person-centred care in consumer and community participation across all national standards.[2] Many health practitioner regulatory bodies acknowledge that public awareness of, and trust in, regulation is critical for the community to have confidence in the health professions who are regulated.[3] Regulators also need to understand what communities expect and the regulatory responses that might be needed. [4]

This Commentary describes how community participation within Australia's health practitioner regulation system has evolved over time to promote more inclusive, community-driven processes.

Notes on language

For consistency this article uses the terms public and community interchangeably. It uses the term 'community participation' to refer to "any process that involves the public in problem solving or decision making and that uses public input to make better decisions." It includes identifying problems and opportunities, developing alternatives and making decisions. It uses tools and techniques and the level of participation depends on the goals, timeframes, resources and levels of concern in the decisions to be made.[5] The phrase co-design refers to a participatory approach to designing solutions, in which community members are treated as equal collaborators in the design process.[6]

Community as decision-makers

Australia's National Registration and Accreditation Scheme (National Scheme) for health practitioners commenced in July 2010, under the auspices of the Health Practitioner Regulation National Law (the National Law). This established the Australian Health Practitioner Regulation Agency (Ahpra) which now works with 15 National Boards regulating 16 health professions. The National Boards include both health practitioner and community members who are appointed collectively by Australia's Health Ministers for three-year terms. From the beginning, all Board members received equal remuneration and training and shared responsibility for decisions on regulatory standards, policies, and specific regulatory matters.

The National Law mandates that community members comprise at least one third of members on each National Board but requires the Chair to be a practitioner from the profession being regulated. Initially community members were appointed from the general public, essentially as 'non-practitioner members,' often without a health consumer background. For example, lawyers and professionals from other health sectors. This reflected the approach of similar health regulatory bodies overseas.[7, 8]

Community as advisors

In May 2013, Ahpra partnered with the Consumers Health Forum of Australia to establish the Ahpra Community Reference Group (CRG). The ten-member CRG aimed to serve as an informed consumer voice, advising the CEO of Ahpra on strategies to raise public awareness, engagement and understanding of professional regulation.

CRG members did not represent a particular community, but drew on their own expertise, lived experience and their consumer networks. CRG members were appointed for three-year terms. Their remuneration was set at the same level as National Board members to ensure consistency. The CRG met up to four times per year, and communiques were published online after each meeting.

Many health practitioner regulatory bodies acknowledge that public awareness of, and trust in, regulation is critical for the community to have confidence in the health professions who are regulated.

The CRG was designed to be complementary to the decision-making role of community Board members by offering broader consumer perspectives on whole of National Scheme system-level policy issues. Occasionally, the CRG also responded to public consultations and inquiries in its own right.[9,10]

The understanding and scope of the role of the CRG evolved over time. Initially, some National Boards were uncertain about the need for a specific community voice through the CRG and early Board requests were often limited to reviewing completed and static public-facing educational material. Community members on regulatory Boards had not been a feature for all professions in the pre-2010 state regulatory framework so it was important to work with Boards to help them understand how best to incorporate CRG perspectives into their regulatory work. Indeed, the first CRG Chair was a National Board community member to build strong links with Boards and address any concerns.

Positioned within the Ahpra Communications unit the CRG was sometimes narrowly viewed as akin to a public relations initiative. However, over time, perceptions shifted, encouraged by CEO support, advocacy and Ministerial interest.

Changes 2019 – 2024

In 2019, Health Ministers issued two directives to clarify expectations of the National Scheme's connection with the Australian public.[11] First, in defining public protection as the 'paramount' guiding principle, Ahpra and National Boards were required to consider the impact of health practitioners' conduct on the public and to ensure that regulatory actions engendered confidence in the health professions. When considering whether a health practitioner's conduct amounted to unprofessional conduct or professional misconduct, at least equal weight had to be given to both public expectations as well as the National Boards standards, codes and guidelines upheld by professional peers.

Second, Ahpra and National Boards were directed to consult with patient safety and health consumer bodies on new and revised registration standards, codes, and guidelines. It was a requirement to identify, evaluate and publish patient health and safety impact assessments, with specific reference to priority groups such as children, older persons, people living with disability, and those affected by family and domestic violence.

The 2019 policy directives strengthened both the decision-making and advisory aspects of community participation within the National Scheme.

Key changes included:

- **Development of an Ahpra Engagement Strategy 2020-2025.** To incorporate public expectations into decision-making about professional conduct, Ahpra identified sources that included the CRG, analysis of interviews with consumers who had notified or complained about a health practitioner, feedback from various Board consultations that community participants had responded to and the experience of community members on Boards. Recognizing that this approach was fragmented, Ahpra framed a five-year strategy to build relationships and partnerships with key stakeholders, including health consumer bodies.
- **Increased engagement from the Ahpra Board.** The CRG was re-mandated as the Community Advisory Council (CAC) with revised Terms of Reference, joint accountability to the CEO and the Ahpra Board, and collaboration with the Ahpra Board on an annual workplan. Research highlights that public input into organizational governance requires a clear mandate and purpose and 'top down' support from senior leadership.[8]
- **Improved resourcing.** The CAC gained dedicated secretariat and project support from Ahpra, enabling greater capacity to initiate work on specific community participation issues. The CAC

could now convene sub-committees to progress work and meet more frequently, including substantial 'out of session' work.

- **Greater involvement of the CAC Chair.** The CAC Chair joined the Forum of National Scheme Chairs whose members comprise the Chairs of each National Board and the Ahpra Board Chair. This positioned community voice at the heart of Scheme-wide policy discussions.
- **Enhancing diversity and lived experience in the CAC membership.** A separate recruitment strategy was implemented, with all CAC positions publicly advertised and promoted to local health consumer networks and entities across Australia. To retain independence, former Board or committee members and registered health practitioners were ineligible.

  Recruitment campaigns for National Board members were also enhanced, to prioritize community members with stronger community connections. National Board vacancies were publicly advertised more widely, for example, in indigenous media and via social media. People from diverse backgrounds were encouraged to apply, including Aboriginal and Torres Strait Islander Peoples, those living in rural or remote areas in Australia, culturally diverse people, lesbian, gay, bisexual, transgender, intersex, queer/questioning, and asexual (LGBTIQA+) people, people with a disability and carers and people with lived experience of a healthcare safety or quality event.

- **Enhanced joint training for Board members.** A more comprehensive training program was introduced for all Board members, emphasising public safety alongside decision-making competencies. Community and practitioner Board members trained together with subsequent evaluations prompting for more community outreach and diversity.

The evolution of the CRG into the CAC brought enhanced strategic focus and representation to its advisory capability including influencing policy by participation in Senate inquiries and reviews,[10, 12, 13] championing easy English, inclusive language and consumer-accessible documentation, improving consumer health complaints processes,[14] participating in the recruitment of community members on National Boards and in 2024, in the selection panel for a new Ahpra CEO.

CAC members also became more involved in a wider range of advisory committees and reference groups to provide more in-depth community/patient safety focus for improving regulatory policies and processes. By 2024, CAC members were participating in over 20 working groups, for example, a proposal to expand prescribing rights for physiotherapists, the Aboriginal and Torres Strait Islander Health Strategy, Medical Training Surveys, the Notifier Support Service, accreditation standards, multicultural outreach, responses to practitioner distress, and a review of transparency of practitioner criminal history.

Achievements

The value and legitimacy of the CAC and community perspectives, both in decision-making and advisory work, is now better accepted and embedded in the National Scheme.

Key milestones include the 2010 decision by Health Ministers for equal remuneration of community and health practitioner members of Boards, the accountability of the CRG directly to the CEO (2013), the 2019 policy directions by Health Ministers, the championing of a more strategic CAC by the Ahpra Board (2019) and the attendance at the Forum of NRAS Chairs by the Chair of the CAC (2020). These all contributed to the importance of centering community voice and expectations to regulatory governance, strategy, policy and decision making.[15]

> The CRG was designed to be complementary to the decision-making role of community Board members by offering broader consumer perspectives on whole of National Scheme system-level policy issues.

Throughout all these phases the clarity, assertiveness and quiet diplomacy of the CAC members in consultations and on projects consistently messaged the importance of understanding and incorporating community voices into all aspects of health regulation.

National Board and Ahpra requests for CAC input, in policy and consultation documents, project and sub-committee work have increased. As an integral part of project groups, CAC members now directly observe how their advice shapes decisions and is

reflected in recommendations. Ahpra and the National Boards have adopted CAC suggestions to initiate projects for addressing issues such as outreach to multicultural communities, the development of an inclusive language and imagery guide and connecting community members on Boards with each other for support and professional development.

The CAC has made independent recommendations on structural and systemic regulatory issues. For example, in 2022-23 the Australian Government conducted an independent review of health practitioner regulatory settings related to overseas trained health practitioners (the Kruk Review).[13] It directly sought CAC feedback and its final report profiled several CAC recommendations.[13] In 2023–25 the Australian Government initiated a review into the complexity in the National Scheme (the Complexity Review).[12] This Review also sought CAC feedback. Consistent with the CAC's independent submissions to the inquiry about a co-design approach to Scheme strategy, principles of public inclusion, complaints management and gaps in community participation practices, the conclusions of the Complexity Review highlighted opportunities to further strengthen community voices in regulatory settings. The CAC has also hosted visits from international partners from Canada and New Zealand seeking advice on how to implement similar models.

Ahpra continues to strengthen connections between National Boards and health consumers.[16] There is now a concerted effort to appoint community members, especially those with lived health experience, to National Boards, and their committees and State Boards.[17] The CAC has become an important 'talent pool' for Board recruitment. Since 2016, eight former CAC members have been appointed to Board positions as community members.

Where to next?

Community participation in the National Scheme is evolving and maturing, and there are opportunities for further development.

Five areas of focus are proposed:

1. **Broaden mechanisms for gaining community input.** Any health regulator needs a range of mechanisms for public participation to ensure the contribution of a diversity of knowledge, experience and expertise.[18] As noted by the Complexity Review 'mechanisms for calibrating the operation of the National Scheme to community expectations are currently insufficient'.[12] Deliberative methods of outreach are required to engage with and openly listen to distinct Australian communities to be better informed about different needs and expectations. Outreach from Ahpra to broader communities is still evolving. This requires effective longer term, sustainable engagement approaches, to meet in a community's 'own spaces', digital and non-digital, rather than single or one-off exercises.[19] It means that Ahpra and the Boards need to rely on more than the CAC and Board community members to understand and incorporate the range of public perspectives.

2. **Membership of National Boards.** The issue of parity of community and health practitioner members on National Boards and their committees has been flagged in reviews of the National Scheme.[9] In the five years following the 2019 policy directive a number of Boards ensured equal numbers of health practitioner and community members on their decision-making committees (42 committees out of 61 by March 2025). In addition, several Boards appointed community members as committee chairs; 37 of the 61 decision making committees across a number of professions, dealing with specific issues such as boundary violations and immediate actions.[20]

   However, despite these changes, National Boards continue to have a majority of practitioner members with the Chairs exclusively health practitioner members. This power differential has been considered by several government reviews, including the 2025 Complexity Review, which recommend legislative amendment to enable a more equal participation by community members on National Boards.

3. **Systematic application of theories on community engagement.** The next steps in community participation in health regulation could seek to more systematically apply community engagement theory. Evidence shows that using broad frameworks can help an organization to move up the engagement spectrum towards co-design and empowering community members to feel confident in sharing power.[18]

   For example, the current National Scheme Engagement Strategy (the Strategy) 2020-2025 outlines the accepted principles of strategic community participation for the Scheme and Ahpra.[16] The Strategy promotes the Public Participation Spectrum framework (IAP2 framework) by the International Association for Public Participation[5].

The framework sets public participation goals to increase engagement and identifies corresponding organizational promises to the public to realize these participation goals. However, there are opportunities to further embed community participation into the broader regulatory work of the National Scheme. In this regard, the Evaluation Framework provided within the IAP2 consortium[21] identifies standards and indicators for measuring organizational engagement with the public. This framework could be used to develop a clear monitoring pathway, identifying appropriate metrics to measure community participation and specify how this information will be used to strengthen future participation processes. This would provide useful data to understand the processes leading to sustained public participation outcomes.[18]

4. **Opportunities for evaluation.** Beyond anecdotal feedback, there is an opportunity to undertake more formal assessment of the impact and efficacy of enhanced community participation and to understand the organizational processes that have contributed to the impact of the CAC. Such evaluation could consider issues such as CAC member engagement and experience, the role of consumer input in regulatory outcomes and responsiveness through a content analysis of policy documents, codes, and standards and evaluating the impact of the work of the CAC on public trust and confidence in regulation.
5. **Calibrate regulatory actions to community expectations.** Ahpra and the National Boards are encouraged to continue deepening their understanding of the public 'threshold' for regulatory action, noting there are multiple 'publics' served by regulation and community expectations will always be dynamic. Although the CAC has progressively gained acceptance and influence with the National Boards for example, through reviews of policy consultations, it has had less success embedding the benefits of co-design, in which opportunities for more proactive identification of public expectations could occur. Strengthening links to a broader range of health consumer bodies is one avenue to identify and respond to emerging health regulation issues.

Implications for health professional regulation

The National Scheme experience offers valuable insights for regulators globally seeking to strengthen public trust. A significant learning is the impact of a clear, publicly stated commitment to consumer participation. The 2019 policy directives, which made public protection the 'paramount' principle and mandated that public expectations be given equal weight in professional conduct matters, marked a significant step in this process, providing a framework for all subsequent changes. These 2019 directives were discussed in detail, leading to agreement on several criteria for how they should be applied in practice. For example, the CRG submitted a proposal to Ahpra recommending the inclusion of a clear definition of "serious risk" in the procedures, aiming to improve the transparency of decision-making. The evolution of the CAC illustrates a practical approach to building meaningful participation, by widening the community voice from an advisory role to a strategic governance and policy function. Increasing diversity and ensuring parity in decision-making committees reflects a practical commitment to ensuring the public voice is both broad and influential.

The National Scheme experience offers valuable insights for regulators globally seeking to strengthen public trust. A significant learning is the impact of a clear, publicly stated commitment to consumer participation.

The National Scheme's experience also offers lessons in building trust through tangible actions. The CAC's work on "easy English" and accessible documentation is a step in the direction of demystifying regulatory processes. Additionally, the practice of nurturing community leaders who transition from the CAC to Board positions demonstrates a sustainable pathway for embedding public perspectives directly into the system's leadership. By nurturing these members, the system ensures that community input is not a one-off consultation but a continuous, evolving presence within its leadership. Ultimately, the CAC experience serves as an example of methodically working to build a more inclusive and trusted approach, offering a replicable model for others facing similar challenges.

Barriers to community participation in service planning and decision-making also need to be identified and addressed. This may include inadequate support, lack of resources, lack of role clarity or organizational

expectations.[22] It is important to provide community participants in regulation with adequate support, remuneration, resources, tailored on-board training, professional development and connection with one another. It is also essential to provide a good understanding of the relevant legal and health frameworks within which regulation operates.

Summary

The ultimate beneficiaries of health practitioner regulation are members of the public. Globally, efforts to better understand public expectations and seek advice on regulatory responses will continue to grow. Ahpra has sought to contribute to the international knowledge base around public participation in health regulation. The National Scheme has been enriched by targeted and improved recruitment and training of community members on National Boards and their committees, and the formal embedded advisory mechanism of the CAC. Looking ahead, public trust and regulatory effectiveness can be enhanced by embracing co-design, expanding outreach to obtain more diverse community input, and continuing to elevate community voice and participation at strategic levels across the National Scheme.

References

1. World Health Organization (WHO) Global patient safety action plan 2021–2030: Towards eliminating avoidable harm in health care 2021. Accesed August 17, 2026. https://www.who.int/teams/integrated-health-services/patient-safety/policy/global-patient-safety-action-plan
2. Australian Commission on Safety and Quality in Health Care. Partnering with consumers standard. Accessed August 18, 2026. https://www.safetyandquality.gov.au/national-standards/nsqhs-standards/partnering-consumers-standard
3. Health Issues Centre Inc. Setting things right: Improving the consumer experience of Ahpra including the joint notification process between Ahpra and OHSC. Published September 23, 2014. Accessed August 18, 2026. https://apo.org.au/node/308030
4. Picker Institute Europe. The patient voice in revalidation: A discourse analysis. 2011.
5. International Association for Public Participation – IAP2 International. IAP2 Public Participation Spectrum. Published 2018. Accessed August 18, 2026. https://iap2.org.au/resources/spectrum/.
6. Sunlight Foundation. Guide to co-design. Accessed August 18, 2026. https://communities.sunlightfoundation.com/action/codesign/
7. Mahat A, Dhillon IS, Benton DC, Fletcher M, Wafula F. Health practitioner regulation and national health goals. *Bull World Health Organ*. 2023;101(9):595-604. doi: 10.2471/BLT.21.287728
8. Yam CHK, Griffiths SM, Liu S, Wong ELY, Chung VCH, Yeoh EK. Medical regulation: Ten key trends emerging from an international review. *J Med Regul*. 2016;102(1):16-27. doi: 10.30770/2572-1852-102.1.16
9. Senate Community Affairs Committee. Complaints mechanism administered under the Health Practitioner Regulation National Law. Canberra: Commonwealth of Australia. Published May 10, 2017. Accessed August 18, 2026. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ComplaintsMechanism/Report
10. Senate Community Affairs References Committee. Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law. Canberra. Commonwealth of Australia. Published 2022. Accessed August 18, 2026. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AHPRA/Report
11. Council of Australian Governments (COAG) Health Council. Policy Direction 2019-1 and Policy Direction 2019-2. Accessed August 18, 2026. https://www.scribd.com/document/856797711/COAG-Health-Council-Communique-Policy-Direction-2019-01-7-January-2020
12. Dawson S. Consultation Paper 1: Review of complexity in the National Registration and Accreditation Scheme. Canberra. Commonwealth of Australia. Published January 9, 2025. Accessed September 8, 2026. https://www.health.gov.au/our-work/independent-review-of-complexity-in-the-national-registration-and-accreditation-scheme?language=en
13. Kruk R. Independent review of Australia's regulatory settings relating to overseas health practitioners – Final Report. Commonwealth of Australia; 2023. Accessed August 18, 2026. https://www.health.gov.au/our-work/independent-review-of-health-practitioner-regulatory-settings?language=en
14. Australian Health Practitioner Regulation Agency (Ahpra) and Australian Commission on Safety and Quality in Health Care (ACSQHC) Working together to improve the consumer healthcare complaints experience. Melbourne: Ahpra. Published August 5, 2024. Accessed August 18, 2026. https://www.ahpra.gov.au/About-Ahpra/Our-engagement-activities/Joint-project
15. Fletcher M. Reflections on 15 years of national health practitioner regulation in Australia. *Aust Health Rev*. 2025 Jul:49:AH25131. doi: 10.1071/AH25131
16. Australian Health Practitioner Regulation Agency (Ahpra) National Scheme engagement strategy 2023-2025. Ahpra; 2023. Accesed August 18, 2026. https://www.ahpra.gov.au/About-Ahpra/Our-engagement-activities/Engagement-strategy

17. Australian Health Practitioner Regulation Agency (Ahpra). New appointments to National Boards. Ahpra. Published May 16, 2024. Accessed August 18, 2026. https://www.ahpra.gov.au/News/2024-05-16-New-appointments-to-National-Boards.aspx.
18. Tritter JQ, McCallum A. The snakes and ladders of user involvement: Moving beyond Arnstein. *Health Policy*. 2006;76(2):156-68.doi: 10.1016/j.healthpol.2005.05.008
19. Mitton C, Smith N, Peacock S, Evoy B, Abelson J. Public participation in health care priority setting: A scoping review. *Health Policy*. 2009;91(3):219-28. doi: 10.1016/j.healthpol.2009.01.005.
20. Australian Health Practitioner Regulation Agency (Ahpra) Ahpra and National Boards annual report 2020/21. Melbourne. Ahpra. Accessed August 28, 2026. https://www.ahpra.gov.au/Publications/Annual-reports/Annual-Report-2021
21. International Association of Public Participation (IAP2) Quality Assurance Standard for Community and Stakeholder Engagement. IAP2; 2023. Accessed August 18, 2026.
22. Ocloo J, Matthews R. From tokenism to empowerment: progressing patient and public involvement in healthcare improvement. *BMJ Quality & Safety*. 2016;25(8):626-32. doi: 10.1136/bmjqs-2015-004839

About the Authors

Patricia Hall, BSW, MSW, is the Former Chair, Community Advisory Council, Ahpra, Melbourne, VIC, Australia.

Lakshmi Bondu, MDS, MPH, is a Research and Evaluation Officer, Research, Evaluation and Insights, Ahpra, Melbourne, VIC, Australia.

Eva Saar, PhD, BPharm (Hons), is a Manager, Research and Evaluation, Ahpra, Melbourne, VIC, Australia.

Martin Fletcher, BA(Hons), MMan, is the Former Chief Executive Officer, Ahpra (2009-2024), Melbourne, VIC, Australia.

Correspondence should be addressed to: Patricia Hall, BSW, MSW, Australian Health Practitioner Regulation Agency, Level 9/222 Lonsdale St, Melbourne VIC 3000, Australia. E-mail: pat@patriciahall.com.au

Open Access: © 2026 The Authors. Published by the *Journal of Medical Regulation*. This is an Open Access article under the terms of the Creative Commons Attribution-NonCommercial License (CC BY-NC, https://creativecommons.org/licenses/by-nc/4.0/), which permits use and distribution in any medium, provided the original work is properly cited, and the use is noncommercial.

Funding/support: No external funding was sought or provided to support the preparation of this manuscript.

Author Disclosures: The authors declare that they have no conflicts of interest.

Author Contributions: Study concept and design – NA. Acquisition of data – Patricia Hall. Analysis and interpretation of data – NA. Drafting of the manuscript – Patricia Hall, Lakshmi Bondu, Eva Saar, Martin Fletcher. Critical revision of the manuscript for important intellectual content – Patricia Hall, Lakshmi Bondu, Eva Saar, Martin Fletcher

Acknowledgements: Authors would like to acknowledge the work and contributions of; Barbara Yeoh AM, Ahpra Board, Ahpra; Heather Edwards, State Manager, Queensland, Ahpra; Anita Rivera, former National Director, Communications, Ahpra; Liat Watson, Committee Member, Community Advisory Council, Ahpra; Susan Biggar, National Manager, Regulatory Experience and Engagement, Ahpra; and Payal Singh, Manager Statutory Appointments, Ahpra.

Keywords: Health practitioner regulation; health regulation; community participation; public participation; consumer; Ahpra; Australia

Received: April 10, 2025; **revision received:** October 23, 2025; **accepted:** November 11, 2025