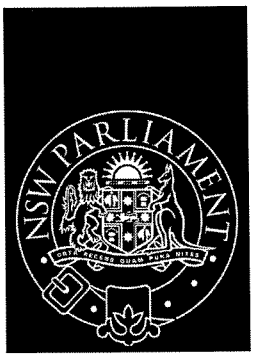

Parliament of New South Wales

Committee on the Health Care Complaints Commission

UNREGISTERED HEALTH PRACTITIONERS

The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints - Discussion Paper

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CHAIRMAN'S FOREWORD

An effective complaints handling system is one of the principal ways in which the community can maintain the highest standards of health care delivery and protect health care consumers.

The pattern of health care delivery in Australia is changing. In recent tradition, all but a small percentage of health care was provided by registered professionals well-trained in Western scientific medicine, operating within the legal framework of guaranteed qualifications and training, annual re-registration, licensing, peer review and so on.

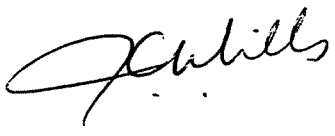
Now possibly over one quarter of occasions of service in health care are provided outside the registered health practitioners system. Yet only as few as one twentieth of the number of complaints made to the Health Care Complaints Commission last year related to services provided by unregistered health care practitioners.

The reasons for this low rate of complaints are not clear, and may include a different level of expectation about the service to be provided in unregistered health care fields, compared with registered.

The Joint Parliamentary Committee which oversights the Health Care Complaints Commission will enquire into the experience of consumers in dealing with unregistered health practitioners, so as to be able to recommend any improvements needed in existing complaint handling mechanisms concerning unregistered health care practitioners and any regulatory mechanisms which may improve consumer protection in the expanding unregistered and alternative health care fields.

This Discussion Paper has been prepared to assist practitioners, organisations, community groups and individuals to prepare submissions to the Committee's enquiry into unregistered health practitioners.

The Committee looks forward to receiving assistance from the community in dealing with this issue.



JOHN MILLS, MP
Chairman

GLOSSARY

registered health care practitioner	-	a person who provides a health service and is registered under a New South Wales health registration Act
unregistered health care practitioner	-	a person who provides a health service and is not registered under a New South Wales health registration Act
alternative medicine	-	systems of care based on treatment methods or theories of disease that differ from those taught in Western-orientated medical schools. *(Black's Medical Dictionary)*

TERMS OF REFERENCE

On 6 May 1998, the Joint Committee on Health Care Complaints Commission (the Committee) resolved to conduct an inquiry with the following terms of reference:

That the Committee examine the experience of consumers in dealing with unregistered health practitioners (including those practising in alternative health care fields) with a view to establishing:

(a) *what complaint mechanisms exist for consumers;*

(b) *whether these complaint mechanisms are effective;*

(c) *whether there is scope for strengthening voluntary codes of behaviour or conduct*

(d) *whether the provisions in the Health Care Complaints Act 1993, relating to unregistered health practitioners are appropriate or whether they need strengthening;*

(e) *any other related matters.*

1. Background

1.1 Context of the Inquiry

Under Section 65(1) of the *Health Care Complaints Act* 1993 (the Act), the Committee has the power:

> *(a) to report to both Houses of Parliament, with such comments as it sees fit, on any matter appertaining to the Commission and the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed;*
>
> *(b) to examine each annual and other report by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report.*

The Health Care Complaints Commission (HCCC), both in its annual reports and during meetings with the Committee has raised ongoing problems arising from its limited ability to deal adequately with complaints concerning unregistered health practitioners.

The Health Care Complaints Commissioner, Merrilyn Walton, provided the following statement to the Committee on the Commission's position in relation to its powers to deal with complaints against unregistered health care practitioners.

> *The Health Care Complaints Commission has the power under the Health Care Complaints Act (the Act) to receive and investigate complaints against all health care providers. Health practitioners cover both registered health professionals as well as practitioners in occupations which are not subject to registration.*
>
> *Under section 39 of the Act, when an investigation concerning a registered health professional is finalised, the Commission has a number of options available to it, including, in serious cases, the prosecution of a complaint before a disciplinary body of the appropriate registration board.*
>
> *The only relevant action for the Commission in substantiated complaints against unregistered health practitioners is to make adverse comments to the respondent. The Commission is not able*
>
> *to make these findings public nor is it able to take any enforcement action in relation to its recommendations to the practitioner.*

to make these findings public nor is it able to take any enforcement action in relation to its recommendations to the practitioner.

The Commission considers that the public interest would be served and standards across all health services would be better maintained by amending the Act to allow the Commission to take appropriate action at the end of its investigations, including the discretion to make its findings public. The Commission further considers that a mechanism should be established which would allow enforcement action to be taken against unregistered health professionals when serious complaints have been sustained (Statement provided to the Joint Parliamentary Committee on 9 July 1998).

1.2 Unregistered Health Practitioners and the Health Care Complaints Act 1993

Section 7 of the *Health Care Complaints Act* (the Act) specifies the type of complaints which can be made to the HCCC.

> *(1) A complaint may be made under this Act concerning:*
>
> *(a) the professional conduct of a health practitioner; or*
>
> *(b) a health service which affects the clinical management or care of an individual client .*
>
> *(2) A complaint may be made against a health service provider.*
>
> *(3) A complaint may be made against a health service provider even though, at the time the complaint is made, the health service provider is not qualified or entitled to provide the health service concerned.*

Section 4 of the Act defines a 'health practitioner' as a person who provides a health service whether or not the person is registered under one of the health registration Acts listed below:-

- *Chiropractors and Osteopaths Act 1991*
- *Dental Technicians Registration Act 1975*
- *Dentists Act 1989*
- *Medical Practice Act 1992*
- *Nurses Act 1991*
- *Optical Dispensers Act 1963*
- *Optometrists Act 1930*
- *Pharmacy Act 1964*

- *Podiatrists Act 1989*
- *Psychologists Act 1989.*

The Act defines 'health service' as including the following fields of health care whether they are provided as public or private services: dietitians, masseurs, naturopaths, acupuncturists, occupational therapists, speech therapists, audiologists, audiometrists, radiographers and **people providing services in other alternative health care fields.**

Other alternative health care fields not defined under the Act include counselling, iridology, reflexology, social work, homeopathy, herbalism, traditional Chinese medicine, kinesiology, iridology, depth tissue therapy, aromatheraphy and reiki.

The Act allows the HCCC to investigate and conciliate complaints against registered and unregistered health practitioners but does not give the Commission the power to impose the same disciplinary procedures on both categories of practitioner.

Section 39 prescribes the action which the Commission can take after investigation of a complaint.

> *(1) At the end of the investigation of a complaint against a health practitioner, the Commission must do one or more of the following:*
>
> *(a) prosecute the complaint as a complainant before a disciplinary body;*
>
> *(b) intervene in the proceedings that may be taken before a disciplinary body;*
>
> *(c) refer the complaint to the appropriate registration authority (if any) with a recommendation as to any disciplinary action the Commission considers appropriate in respect of the complaint;*
>
> *(d) make comments to the health practitioner on the matter the subject of the complaint;*
>
> *(e) terminate the matter;*
>
> *(f) refer the matter the subject of the complaint to the Director of Public Prosecutions*

The section defines 'disciplinary body' as meaning a person or body, including a professional standards committee, established under a health registration Act, that has the power to discipline, suspend or cancel the

The section defines 'disciplinary body' as meaning a person or body, including a professional standards committee, established under a health registration Act, that has the power to discipline, suspend or cancel the registration of health practitioner.

A 'registration authority' is defined in section 4 of the Act as a person who has the function, under a health registration Act, of determining an application for registration under the Act.

The action the Commission can take against an unregistered practitioner is restricted to making comment to the practitioner about the complaint, terminating the complaint or referring the matter the subject of the complaint to the Director of Public Prosecutions.

The impact of the Commission's restricted powers to discipline unregistered practitioners needs to be considered in the context of the self-regulated nature of alternative health care.

Alternative health care is characterised by a proliferation of disciplines, modalities, concepts and techniques and a wide range of standards, educational qualifications and efficacy. At present any person can practice as an alternative health practitioner without having to meet any objective criteria.

Self-regulation is only effective for those practitioners who are members of a professional association with appropriately structured entry criteria and with the capacity to enforce minimum standards of practice, regular upgrading of clinical and professional skills and adherence to an ethical code of conduct (correspondence from the Australian Acupuncture and Chinese Medicine Association Ltd dated 19 June 1998).

1.3 Complaints received by the HCCC

Complaints received by the HCCC concerning unregistered health practitioners increased from approximately 30 in 1994/95 to 54 in 1997/98. This figure is low when compared to over 1000 complaints received in 1997/98 concerning registered health practitioners and is unlikely to reflect the true extent of consumer dissatisfaction with unregistered health practitioners.

The Health Care Complaints Commissioner, Ms Merrilyn Walton, advised the Committee that the small number of complaints could be due to a range of important issues including:-

- the HCCC has not focussed on unregistered health practitioners nor targeted its clients with relevant information about its role in complaint handling;

- people accessing the services of unregistered health practitioners may not be aware of the HCCC's jurisdiction; and

- people who have found orthodox medicine unsuccessful in treating a terminal or chronic illness might consult unregistered health practitioners with a full understanding and acceptance of the risks involved.

> *They are a group of people who perhaps have purposefully shunned orthodox health services for some alternative and in a way they accept the risk attached to that...a lot of people probably go there when they have chronic problems, like sinus or persistent headaches, where orthodox medicine has not worked, so when alternative methods or alternative practitioners have not worked they are not going to complain...*(Walton, *Report of Proceedings before the Committee on the Health Care Complaints Commission, Sydney, 28 May, 1998, p12)*

Of the 54 complaints received by the Commission in 1997/98;

- *8 concerned an unregistered counsellor, therapist or psychotherapist;*

- *7 concerned social workers;*

- *3 concerned Traditional Chinese Medicine practitioners;*

- *10 concerned natural therapists including herbalist, homeopath, naturopath;*

- *3 concerned deregistered or previously registered health providers;*

- *4 concerned other alternative health services including massage, reiki, reflexology, iridology, herbalism, kinesiology, deep tissue therapy, aromatherapy ; and*

- *19 concerned other unregistered practitioners*

Of these complaints, 20 involved clinical standards, 8 provider/patient relationship, 10 business practices, 3 fraud and the remaining 13 complaints concerned a range of patient rights and professional practice issues.

The 179 complaints received by the Commission since 1994/95 were dealt with in a variety of ways:-

- *72 referred to another body or person;*
- *60 declined by the Commission;*
- *15 substantiated;*
- *23 not substantiated;*
- *5 directly resolved between parties;*
- *5 terminated by the Commission;*
- *3 terminated on complainant request;*
- *1 investigation remains incomplete; and*
- *1 in conciliation.*

Appendix A contains examples of complaints against unregistered practitioners received by the Health Care Complaints Commission.

1.4 Extent of alternative health care

There is little reliable information available regarding the number of unregistered health practitioners practising in New South Wales and the occasions of service they provide. This situation is further complicated by the fact that many fields of alternative health care do not have one professional association which represents the discipline as a whole but a number of associations each supporting different standards and methods of practice.

A perspective on the prevalence of alternative health care within the community can be obtained from findings of reports referred to below.

A research project into the practice of traditional Chinese medicine (TCM) in Australia, conducted by the Victorian Department of Human Services, New South Wales Department of Health and Queensland Department of Health estimates that there are at least 2.8 million TCM consultations each year in Australia representing a turnover of $84 million within the health economy. TCM includes a wide range of therapies and is best known for the practices of acupuncture and Chinese herbal medicine. The report also states that the importation of Chinese herbal medicines has increased four-

fold in as many years and the number of TCM practitioners in Australia will double by the year 2000. (Bensoussan A, Myers S, *Towards a Safer Choice*, University of Western Sydney, 1996).

A South Australian survey conducted in 1993 to determine the prevalence and cost of alternative medicines and alternative practitioner use in an Australian population found that in the previous year more than 20% of respondents had visited at least one alternative health practitioner and that 48.5% of respondents had used at least one non-medically prescribed alternative medicine. This figure did not include the use of calcium, iron or prescribed vitamins but was made up of non prescribed vitamins (37.6%), herbal medicine (9.9%) and homeopathic medicines (4.4%). The survey estimated that in 1992-93 Australians spent close to $1000 million on alternative health care. This figure comprised more than $309 million on alternative practitioners and $621 million on alternative medicines and far exceeded the patient contribution of $360 million to standard pharmaceuticals (MacLennan A, Wilson S, Taylor A., Prevalence and cost of alternative medicine in Australia, *Lancet* 1996 347: 569-73)

The high expenditure on alternative treatments is supported by a study on alternative medicines used by cancer patients. It found that approximately 22% of patients involved in the study were using some form of alternative therapy. Of these therapies, dietary and psychological methods were the most prevalent. For these patients the median annual cost of therapy was $530 and ranged up to $20,000. Most patients reported value for money (Begbie SD, Kerestes ZL, and Bell DR, Patterns of alternative medicine used by cancer patients, *Medical Journal of Australia*, 1996: 165: 545-548).

1.5 Acceptance of alternative health care

A number of health insurance companies offer cover for alternative health care including acupuncture, herbalism, homeopathy, iridology, naturopathy and osteopathy. These include: Manchester Unity, Mercantile Mutual, NIB, Teachers Federation (NSW & Vic.), Phonenix Welfare, National Mutual, Government Employees (All states and Territories except ACT) and Commonwealth Bank.

As a general practice health insurance companies provide benefits for alternative health care if the health practitioner is a member of a professional association and registered as a provider with the health fund, however in recent years this situation has gradually changes. In correspondence to the Committee the Australian Acupuncture and Chinese Medicine Association Ltd observes that since the introduction of National Competition Policy health funds can no longer require a practitioner to be a member of a professional health asssociation in order to be listed for

provider recognition. Instead they have entered into a process of direct provider recognition for rebates independent of association membership (correspondence from the Australian Acupuncture and Chinese Medicine Asssociation Ltd dated 19 June 1998).

The education and training standards of alternative health care practitioners vary widely. For example, acupuncture courses range from 2 and 3 day private courses to 4 year degrees.

The study into the practice of traditional Chinese medicine, *Towards a Safer Choice*, found that the twenty-three professional associations representing the various segments of the TCM profession varied markedly in the qualifications they required for membership. These qualifications ranged from a mere interest in using natural therapy to over 2,500 hours of combined training in TCM and western medicine (Bensoussan A, Myers S, 1996 p144).

A number of University degrees and post graduate qualifications are now offered in alternative areas of health care.

The University of Western Sydney (Macarthur), has established the Complementary Medicine Research Unit and will commence its first undergraduate program in Traditional Chinese Medicine in 1999. The Unit has conducted research into the treatment of irritable bowel syndrome with Chinese herbal medicine and, in conjunction with John Hunter Hospital, has researched the treatment of hepatitis with Chinese herbal medicine.

The Southern Cross University (Lismore), has a School of Natural and Complementary Medicine offering a Bachelor degree in Naturopathy. The first graduates will complete the degree in 1998. The School conducts research into the use of herbal remedies including the use of celery seed in treating arthritis.

Undergraduate education in Acupuncture at the University of Technology Sydney commenced in 1994, when it was transferred from the private sector, Acupuncture Colleges (Australia), to the university system. The Faculty of Science offers a degree program in Acupuncture and Chinese Herbal Medicine.

Over recent years the benefits of alternative medicines have been recognised by practitioners in traditional areas of health care. An article in Australian Doctor reports that figures produced by the Royal Australian College of General Practitioners show that the number of general practitioners incorporating alternative medicine in their practices increased from 2,000 to 4,000 between 1992 and 1996. It also reports Medicare statistics show that up to 3,000 general practitioners use acupuncture as

part of their daily practice. The article quotes findings from research into GP involvement in alternative medicine over the past four years conducted by Dr Eastwood of the University of Queensland. Dr Eastwood found that most of the 60 GPs surveyed were interested in acupuncture, manipulative techniques and herbal and nutritional treatments and some believed holistic approaches often achieved better results than pharmaceuticals in the treatment of chronic ailments. Doctors using alternative treatments said they had increased consumer demand and were mindful of the competition presented by non-medically trained therapists (John Barnes, GPs' alternative practices on the rise, *Australian Doctor*, 5 December 1997, p5).

Research into the use of alternative medicine is being undertaken by a number of institutions.

The Royal Hospital for Women has established a natural therapies unit under the School of Obstetrics and Gynaecology, University of New South Wales. This Unit is evaluating alternative methods for treating morning sickness in pregnant women and for treating menopausal women. It is researching a variety of alternatives to conventional medicine including the use of ginger to relieve morning sickness, the role of soy, red clover and other phyto-oestrogens in the relief of menopausal symptoms and acupressure bands for the treatment of nausea (Hospital branches into natural therapies, *Sydney Morning Herald,* 1 Nov, 1997).

In July 1997, Sydney University launched the Herbal Medicines Research and Education Centre within its Pharmacy Department. The centre conducts research into the efficacy and safety of herbal medicines. It also conducts education programs and provides research and safety advice to health professionals. The Centre is currently running a 20 week post graduate level course for Chinese herbalists focusing on herbal pharmacology for safe and effective use of Chinese herbs in Australia.

1.6 Problems associated with the increase in alternative health care services

The increased use of alternative medicines and other forms of alternative health care in recent years has resulted in a range of reports involving adverse reactions to and dissatisfaction with various treatments. The following examples provide an overview.

The Adverse Drug Reactions Advisory Committee has knowledge of three fatalities associated with the energy supplement, Royal Jelly and the product must now carry a prominent warning *'contains royal jelly - avoid if asthma or allergy sufferer'* (GPs demand warnings on royal jelly's deadly sting, *The Australian,* 21 June, 1997).

Between July 1996 and September 1997 there were 11 cases of adverse reactions associated with echinacea reported to the Adverse Drug Reactions Advisory Committee (Echinacea poses allergy risk, claims specialist, Sydney Morning Herald, 16 February, 1998). The Therapeutic Goods Administration is presently reviewing the drug's status as a safe drug (ABC, 7:30 Report, 7 July 1998).

A newspaper reported that a five year old child died after visiting a "Shaman" or "medicine man". The Shaman prescribed a potion to rid the child of evil spirits. The potion was a mixture of water and ashes of fabric painted with ancient hieroglyphics (My potion wasn't poison, *Daily Telegraph*, 25 August, 1997).

A kinesiologist treated a man diagnosed with testicular cancer who had shunned traditional medicine. After some months treatment with the kinesiologist the man had his testicle removed. He died during the operation from the effect of loss of blood after refusing a blood transfusion. At the inquest the family claimed that the kinesiologist talked the man out of surgery for up to six months and the coroner expressed concern about the kinesiologist's influence over the deceased (Coroner: control kinesiologists, The Sydney Morning Herald, 26 July 1996).

Cases involving problems arising from the use of alternative medicines and practices are not always reported to the HCCC. The Adverse Drug Reactions Advisory Committee monitors adverse reactions to all drugs. The procedures for reporting instances to this body are contained in the *Guidelines on the Reporting of Adverse Drug Reactions by Pharmaceutical Companies*. Cases which end in death are usually the subject of a coronial inquiry. The coroner may refer the matter to the HCCC if it is appropriate.

The nature and extent of problems arising from alternative health care services must be considered in light of the extent of services provided and the problems which arise with orthodox forms of medicine. A recent newspaper report states that since the Adverse Drug Reactions Advisory Council opened its register in 1972 it has received notification of 110,000 cases of problems linked to the use of orthodox medicines and only 160 cases linked to the use of herbal remedies. The report acknowledges that these figures may not be a true representation of the situation as there may be significant under-reporting of problems associated with the use of natural therapies. (Bad Medicine, The Australian, 21 June 1997).

2. Occupational Regulation

The feasibility of introducing statutory regulation to areas of unregulated health care must be considered in the existing climate of de-regulation imposed by various government policies.

2.1 Government Policies

The Mutual Recognition Agreement was reached between State and Territory governments and the Commonwealth in 1992. The Mutual Recognition principle which is directed at reducing unnecessary regulation of occupations and achieving flexibility of the labour force, is enshrined in the *Mutual Recognition Act* 1992 (Cth). and supporting state legislation.

The legislation ensures that a person who is registered in connection with an occupation in one State will be entitled to carry on an equivalent occupation in another State. This is achieved without affecting the laws which regulate the operation of the occupation in either state.

As a consequence of this legislation the nation's Health Ministers agreed there was a need to create national standards for each health occupation and that no further action would be taken to regulate any health occupation unless the Australian Health Ministers' Advisory Council (AHMAC) gave its approval.

In 1993 AHMAC agreed that before a State or Territory registered a health occupation, a majority of States should agree that registration was required. To this end the AHMAC formulated the following six criteria for assessing the regulatory requirements of an unregulated health occupation.

- 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?
- Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
- Do existing regulatory or other mechanisms fail to address health and safety issues?

- Is regulation possible to implement for the occupation in question?
- Is regulation practical to implement for the occupation in question?
- Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

In April 1995, the Council of Australian Governments (COAG) implemented the National Competition Policy by signing three intergovernmental agreements, the Conduct Code Agreement, the Competition Principles Agreement and the Agreement to Implement Competition Policy and Related Reforms. The Competition Policy aims to create an overall business environment in which to increase Australia's international competitiveness by eliminating unnecessary regulation.

In accordance with its obligations under these Agreements the NSW Government enacted the *Competition Policy Reform Act* 1995. This Act applies the Competition Code, in the form of a schedule to the *Trade Practices Act* 1974, to the activities of individuals, unincorporated associations and statutory corporations in NSW. The Code prohibits prescribed anti-competitive behaviour. The Australian Competition and Consumer Commission (ACCC) monitors the implementation of Competition Policy.

The Competition Policy requires all States and Territories to apply a Competition Test to new legislation. The Test dictates that any regulatory measures which resist competition must be accompanied by documentation showing that:-

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition.

2.2 Impact of Competition Policies on Health Care Services

Many of the rules governing professional conduct and practice have been criticised on the grounds that they are anti-competitive and have been introduced to further the different professions' own interests. The introduction of these policies has resulted in the removal of rules on

advertising from the professional regulation Acts and their incorporation into the *Trade Practices Act.*

A recent paper on 'Advertising of Impotence Treatments', prepared by the Health Care Complaints Commissioner highlights the effect of the National Competition Policy on advertising in the health industry.

> *The commercialisation of health,....has received a helping hand from the reforms in national competition policies. Medical Boards have been required to ease their restrictions on doctors advertising their services in the market place. The ACCC has informed the medical community that restrictions on doctors advertising their services are no longer necessary provided that advertisements are not misleading or deceptive.*
> *(Advertising of impotence treatments, Merrilyn Walton, 8 May 1998).*

The paper specifically addresses the role of advertising in targeting particular sections of the community through the entrepreneurial promotion of medical treatment in areas such as impotence, anxiety, drug and alcohol dependency, tattoo removal and laser treatment.

The paper notes that in June 1996, the ACCC successfully prosecuted ON Clinic, Men Only Medical Clinic and Potent -C Clinics under Section 53 of the *Trade Practices Act* in relation to misrepresentations made in advertising about efficiency, cost, advantages of treatments and advice offered to men suffering impotence.

The Commission has recently expressed the view that advertising restrictions in the area of health services should be imposed through the establishment of a mandatory industry code under the *Trade Practices Act.* It considers that such action would increase the protection of the public and improve the quality of information available without having an adverse effect on either the level of competition or the efficacy of the delivery of health services (Correspondence from Merrilyn Walton to the Joint Committee on the Health Care Complaints Commission, 18 June 1998).

A discussion paper dealing with options for regulation of practitioners in traditional Chinese medicine notes the negative effect of the National Competition Policy on incentive for voluntary certification. It points out that in the past, eligibility for rebates from private health funds was the main incentive for TCM practitioners to seek membership of associations with higher educational standards. Since the introduction of the National Competition Policy private health funds are reluctant to use practitioner membership of an association as a criterion for payment of rebates and are now assessing qualifications on an individual basis (Traditional Chinese Medicine: Options for Regulation of Practitioners, Discussion Paper, Department of Human Services, Victoria, September 1997).

This situation has affected the ability of professional associations to discipline their members. The Australian Acupuncture and Chinese Medicine Association Ltd states that practitioners who are disciplined or suspended by one association simply resign or discontinue membership, thereby avoiding all disciplinary action but still retaining provider recognition, whereas in the past they would have been forced to comply with that association's requirements in order to retain provider status. This is of particular concern with sexual misconduct and where health complaints bodies have no effective authority over unregistered practitioners (Correspondence to the Committee from the Australian Acupuncture and Chinese Medicine Association Ltd dated 19 June 1998).

2.3 Types of regulation

Occupational regulation can take one of a number of forms. The most common are dealt with below.

Type of regulation	Description of regulation	Example
Registration	In its most simple form can be the listing of practitioners' names on a register. More commonly, in the area of health regulation, it involves the establishment of a registration board which exerts significant powers over registered practitioners.	An integral part of the eleven NSW Health Regulation Acts is the establishment of registration boards. Australian Acupuncture and Chinese Medicine Association Ltd.
Licensing	A restrictive form of regulation which allows only those who are licensed under the relevant Act to carry out certain prescribed activities.	Radiographers are licensed under the *Radiation Control Act* 1990

Negative Licensing	Offers a less restrictive approach by defining activities which are not permitted within an occupation unless the practitioner holds a licence to perform them.	*Dental Technicians Act* 1972 (Vic)
Certification	An accreditation system which recognises practitioners who have met the desired qualifications to practise in the particular field. Certification can be a self-regulatory mechanism or imposed by statute.	Australian Association of Social Workers Ltd. issues a practising certificate to members who complete Continuing Professional Education.
Self-regulation	Codes of practice adopted by members of a profession. These are usually formulated and imposed on members by the professional association to which they belong.	Australian Acupuncture and Chinese Medicine Association Ltd.

2.3.1 Registration

Registration is an integral part of the eleven health regulation Acts in New South Wales. The registration Boards established under these Acts have extensive powers to control registered practitioners.

Some registration Acts cover the registration of a number of professions in the one piece of legislation. The *Health Practitioners and Allied Professionals Registration Act* 1986 (NT) covers the registration of Aboriginal health workers, chiropractors, therapists, osteopaths and physiotherapists. This and other registration Acts in the Northern Territory are presently under review. One option being considered is to replace this Act and the other six health registration Acts with one omnibus piece of legislation. The *Medical and Dental Auxiliaries Act* 1966 (NZ), is another example of omnibus legislation. It covers the registration of chiropodists, dental technicians,

medical technologists, medical radiographers, medical laboratory technologists, medical radiation technologists, and podiatrists.

Registration/accreditation with the Australian Acupuncture and Chinese Medicine Association Limited is based on minimum standards of training and ethical conduct. Access to further services such as health fund provider and work cover recognition requires registered members to have professional indemnity and meet continuing education requirements. Registered members must pay an annual fee and cannot be under suspension for a breach of ethics.

2.3.2 Co- Regulation

In New South Wales co-regulation is achieved through the eleven Health Registration Acts listed earlier in this paper. Each of these Acts provides for the creation of a registration board within the particular profession. The composition of board members is specified and is drawn from the practitioner group, the community and government representatives.

Under these Acts a registration board is given powers to regulate the profession, for instance the *Psychologists Act* 1989, provides that the Psychologists Registration Board may determine whether a person can be registered as a psychologist, establish a code of conduct for the profession, inquire into complaints about the conduct of practitioners and impose disciplinary procedures on members against whom a finding of misconduct is made.

The Acts prescribe the conduct about which a complaint can be made and provide for mandatory notification to the Health Care Complaints Commission of all complaints received by a registration board. They also list the disciplinary action which a board can impose on a practitioner against whom a complaint is sustained. This action includes:

- a caution or reprimand;
- the imposition of conditions on the practitioner's registration;
- an order for the practitioner to undertake further education;
- the imposition of a fine; and
- the suspension or removal of the practitioner's name from the register.

A person aggrieved by a determination of a board may appeal the decision to the District Court. The Court's decision is final and binding on a board and the appellant and is to be taken as the final decision of a board.

The form of regulation provided by the Health Regulation Acts is known as **'protection of title'** because the legislation prevents unregistered people from using the title associated with the registered group. Section 4 of the *Psychologists Act* 1989, prohibits any person, other than a registered psychologist, from taking or using any name, initials, word, title, symbol or description which indicates, is capable of being understood or is calculated to lead anyone to infer that the person practises psychology or is qualified to practise psychology.

2.3.3 Licensing

Licensing restricts specific practices to a particular occupational group or sub-group. Regulation of this nature is referred to as **'protection of practice'.**

This type of regulation does not provide for the fact that many health practitioners have overlapping areas of skills and expertise and can cause unnecessary segmentation of health care. It is also expensive to administer and anti-competitive.

Radiographers are licensed under the *Radiation Control Act* 1990. The Act restricts the use of certain equipment and substances to the holder of a licence. It accredits radiation experts and restricts the performance of prescribed activities to accredited persons. It also requires owners of certain radiation apparatus to register the equipment. The Act provides for the creation of a Radiation Advisory Council which can grant, renew suspend and cancel any licence, registration or accreditation under the Act.

Negative licensing is a less restrictive form of regulation which focuses on specific procedures rather than broad practices. It sets out the procedures not permitted to be undertaken by health practitioners. The restricted or ' licensed acts' which can be carried out by registered health professionals can be defined in separate acts relating to each profession. This form of regulation allows health practitioners to practice in a field as long as they do not undertake a prohibited activity.

This form of regulation is followed in Ontario Canada. The *Regulated Health Professions Act* 1991, (Ontario) sets out all the potentially harmful acts and procedures associated with all health professionals. It contains provisions which restrict the performance of these 'licensed acts' to registered health professions only. To complement this Act each health profession is registered under a separate Act each of which contains a list of specific

authorised or 'licensed acts' that members of the profession may perform. In a discussion paper prepared by Queensland Health this model was said to have the following advantages:-

- it minimises the anti-competitive effects of restricting a broad area of practice to only one occupational group
- because it is based on procedures rather than broad definitions, only those activities which pose a significant risk to health and safety are listed and unregistered practitioners are clearer about what they are not permitted to do
- it has the potential to reduce status distinctions and demarcation disputes among health professions as well as removing the need for exemptions in registration Acts to allow another profession to undertake a specific part of the practice of another profession (Review of Health Practitioner Registration Acts - Discussion Paper, Queensland Health, September 1994, pp 20-21)

An example of this form of legislation occurs with advanced dental technicians in Victoria. They are able to carry out any dental work as long as it is in accordance with the *Dental Technicians Act* 1972 (Vic). The technicians are not able to perform any of the activities restricted to licensed dentists.

2.3.4 Certification

Certification of a profession allows consumers to identify practitioners who have gained the qualifications considered necessary to practice in a particular field.

A system of certification can be self-regulatory or imposed by government. It can focus solely on recognition of qualifications or be of a more complex nature requiring standards of practice and continuing professional education for renewal of certification.

The Australian Association of Social Workers (AASW) has introduced a Continuing Professional Education Policy. Renewal of certification and receipt of an AASW Practice Certificate depend on compliance with the requirements of the policy.

Certification can be achieved by self regulation and does not need statutory backing. Statutory regulation might be of greater significance if the certification scheme involves more than the recognition of qualifications.

2.3.5 Self Regulation

Most fields of health care which are not covered by a Health Registration Act have one or more organisations which impose some form of regulation on their members by prescribing standards of training and practice supported by codes of practice. Membership of these organisations is not compulsory and there may be a number of organisations within the one field, some of which do not recognise or support the practices of others. The scope of control imposed on practitioners by these professional organisations varies greatly.

The Australian Association of Social Workers Ltd (AASW) has pursued the goal of statutory registration for a number of years. In the prevailing economic climate of de-regulation and elimination of anti-competitive practices the AASW has not succeeded in its goal. In an effort to ensure greater accountability of the profession and to meet the increased emphasis on self-regulation the AASW has developed a Code of Ethics which contains:-

- principles of practice;
- standards of practice;
- complaint handling mechanism;
- provision for the appointment of Branch Ethics Committees which hear complaints alleging unethical practice and decide on penalties not involving membership status; and
- provision for the appointment of a National Ethics Committee which can make decisions on the imposition of penalties affecting membership status.

The AASW has also introduced a Continuing Professional Education Policy. Accreditation of members and the issue of an AASW Practice Certificate depend on compliance with the requirements of this policy. The AASW recommends that its members use the initials MAASW after their qualifications to describe their membership.

The AASW is presently surveying its members for their views on the introduction of varying categories of membership.

The Australian Traditional Medical Society Ltd (ATMS) is an umbrella organisation which covers practitioners in many fields of health care including acupuncture, Chinese herbal medicine, colour therapy,

homeopathy, iridology, natural fertility management, natural vision improvement, naturopathy, and osteopathy as well as fourteen different areas of massage therapy. It has over five thousand members made up of training colleges and individual practitioners. The ATMS aims to protect and advance the natural therapy profession while also providing protection to the public. It has a Code of Practice, Code of Ethics, Academic Review Committee which reviews the current standards of all disciplines and investigates the feasibility of including new disciplines and a Complaints Committee which mediates between disputing parties where possible. The Executive Board deals with more serious matters. The ATMS organises a Continuing Professional Education program and encourages its members to participate but attendance is not compulsory.

The study into the practice of traditional Chinese medicine, reported in *Towards a Safer Choice,* looked at the professional associations representing practitioners in the field. It found there were twenty-three professional associations each representing segments of the TCM profession with 50% formed since 1985. Despite the number of associations there is no peak body which represents the entire profession. The associations have a variety of objectives covering a number of interest groups within the profession. Membership numbers amongst associations vary from forty to over seven hundred with a number of practitioners belonging to more than one association. Eligibility criteria for membership of an association also varies. One association requires applicants merely to be interested in using natural therapy while another requires over 2,500 hours of combined training in TCM and western medicine. Fifty percent of associations require members to have a formal TCM qualification recognised by the association and less than a quarter of the associations conduct their own entry examinations for applicants who do not meet qualifying criteria for membership. Eight associations require some continuing professional education in order to maintain membership (Bensoussan A, Myers S, 1996, p144).

The Discussion Paper on Traditional Chinese Medicine contains a model for government monitored self-regulation (GMSR). It describes GMSR as a form of self-regulation whereby a government representative is actively involved along with representatives of the Traditional Chinese Medicine (TCM) profession, consumers and the legal profession in the self-regulation process. The inclusion of a government representative assures the consumer that the self-regulatory process is credible and accountable. Under GMSR the government does not control the self-regulatory process. An integral part of GMSR is accreditation of bona fide TCM practitioners. Accreditation as a practitioner entitles the practitioner to display the GMSR logo . GMSR requires a complaints handling mechanism and powers to sanction practitioners. Accreditation is withdrawn if a practitioner is found to be in serious breach of Code. The model requires an Annual Report be

published on the operation of GMSR. The report must include information on the number and type of complaints handled and their outcomes (Traditional Chinese Medicine: Options for Regulating Practitioners, Discussion Paper, September 1997, Appendix 6).

3. Existing mechanisms for dealing with complaints against unregistered health care practitioners

Complaints concerning the conduct of unregistered health providers are received and investigated by the Health Care Complaints Commission. In some instances they may also be lodged with the relevant professional association or organisation to which the provider belongs or some other prosecuting agency such as the Department of Fair Trading.

3.1 Health Care Complaints Commission

Under existing legislation the Health Care Complaints Commission has the power to investigate complaints against unregistered health care providers but is unable to impose any form of disciplinary proceedings against these practitioners.

Section 7 of the *Health Care Complaints Act* 1993 (the Act) allows for a complaint to be made about the professional conduct of a health practitioner regardless of whether the practitioner is registered under a Health Registration Act.

Section 23 of the Act provides that the HCCC must investigate a complaint if it appears to raise:-

- a significant issue of public health or safety; or
- a significant question about the appropriate care or treatment of a client by a health service provider; or
- provides grounds for disciplinary action against a health practitioner; or
- involves gross negligence on the part of a health practitioner.

Section 39 prescribes the action which the Commission can take after investigation of a complaint. This varies according to whether or not the practitioner practices in an area of health care covered by a Health Registration Act.

In the case of a registered practitioner the Commission has the option of prosecuting before the appropriate disciplinary body, intervening in proceedings taken before the disciplinary body, referring the complaint to the appropriate registration authority with a recommendation as to any disciplinary action the Commission considers appropriate, making comments to the practitioner on the complaint, terminating the matter or referring it to the Director of Public Prosecutions for prosecution. If the practitioner is not registered under a Health Registration Act the Commissioner is unable to prosecute or impose any form of disciplinary action.

Section 24 of the Act provides that the HCCC may refer a complaint to the Health Conciliation Registry for conciliation if the complaint is not required to be investigated under section 23 of the Act and the parties to the complaint consent. In the case of a registered health care provider the appropriate registration authority must also be of the opinion that the complaint should be referred for conciliation. Conciliation is often the Commission's preferred option when dealing with complaints against unregistered practitioners because there are no sanctions which it can impose after investigating these matters.

Section 37 of the Act restricts disclosure of any information obtained in relation to a complaint to the following situations:-

- with the consent of the person to whom the information relates;
- in connection with the execution and administration of the Act;
- for the purposes of any legal proceedings arising out of the Act
- with other lawful excuse.

These provisions place strict restrictions on information which the HCCC can make public. Cases are reported in the Commission's Annual Report but the identity of parties is not disclosed.

In evidence to the Committee, the Health Care Complaints Commissioner, Ms Merrilyn Walton stated that amendments to the Health Care Complaints Act giving the Commission the right to name practitioners, in certain circumstances, could overcome this situation. Ms Walton referred to the naming provisions in the *Fair Trading Act* 1987, as an example of this type of power. The naming provisions in the *Fair Trading Act* permit the Minister

and Department head to reveal the identity of persons, goods, services or business practices when it is in the public interest to do so. The objective of naming is to ensure an informed and fair marketplace while recognising the principles of procedural fairness.

3.2 Prosecution under other Acts

Section 25 of the *Health Care Complaints Act* 1993 provides that following assessment, the HCCC must notify the Director General of the Department of Health of details of a complaint if it appears to the Commission that the complaint involves a possible breach of any of the following Acts or their regulations:-

- *Area Health Service Act 1986*
- *Health Administration Act 1982*
- *Mental Health Act 1990*
- *Nursing Homes Act 1988*
- *Poisons and Therapeutic Goods Act 1966*
- *Private Hospitals and Day Procedure Centre Act 1988*
- *Public Health Act 1991*
- *Public Hospitals Act 1929*

The Commission also refers to the Department complaints which it considers are best investigated by appropriate sections of the Department of Health. The Health Care Complaints Commission Annual Report 1996/97 provides the following information on complaints referred to the Department for that year.

Of the 62 complaints referred to the Director General the Commission requested reports on 39 matters. The following action was recorded in these matters:

- *5 the department took action*
- *11 information provided following investigation*
- *7 policy and procedural changes instituted*

- *5 medical practitioner cautioned by departmental inspectors regarding drug prescription practices. These cases were followed up by the Commission and further action was taken.*

- *11 department investigation continuing*

Section 26 of the Act allows the Commission to refer a complaint to another body if it appears that the complaint raises issues which require investigation by that body. The Commission must continue to deal with the matter the subject of the complaint if it appears to the Commission that:-

- *the matter raises a significant issue of public health or safety;*

- *the matter raises a significant question as to the appropriate care or treatment of a client by a health service provider; or*

- *the matter provides grounds for disciplinary action against a health provider.*

Where appropriate, the Commission tries to facilitate direct resolution of complaints by referring matters to Public Health Units in Area Health Services. The types of complaints referred include those which relate to the standard of hygiene and infection control measures in private surgeries. In its 1996-1997 Annual Report the Commission notes that local authorities and private health providers are developing mechanisms to handle complaints. The Commission assists organisations to develop complaint handling mechanisms and has produced and distributed *Guidelines on Complaint Handling by Health Organisations in New South Wales.*

There are a number of State and Commonwealth Acts which control practices of both registered and unregistered health practitioners. They include:-

- *Fair Trading Act 1987 (NSW)*

- *Trade Practices Act 1974 (Cth)*

- *Poisons and Therapeutic Goods Act 1966 (NSW)*

- *Therapeutic Goods Act 1989 (Cth)*

- *Food Act 1989 (NSW)*

- *Crimes Act 1900 (NSW)*

- *Health Services Act 1997 (NSW)*

- *Medical Practice Act 1992 (NSW)*

This legislation covers a diverse range of practices which might form the subject of a complaint to the HCCC. These practices include:

- importation, exportation, manufacture and supply of therapeutic goods
- prescription of poisonous substances
- sale, preparation and packaging of food
- misleading conduct in relation to services
- false representations in connection with the supply of goods or services
- criminal offences relating to sexual assault

The legislation imposes mandatory requirements on practitioners by prescribing offences and penalties under the Act, however, the application of certain aspects of the legislation to the conduct of health practitioners can be problematic.

Towards a Safer Choice details the difficulties which arise with the application of the Therapeutic Goods Act 1989, to certain herbs and herbal preparations. The report refers to the difficulties which arise when categorising herbs which might fall within the definition of a therapeutic good but are also used in cooking and other non-therapeutic situations *(Bensoussan A, Myers S, p 183).*

In evidence presented to the Joint Committee on the Health Care Complaints Commission on 28 May 1998, the Commissioner, Ms. Walton commented on difficulties which arise when the Commission refers matters to other bodies for prosecution. These include:

- meeting the standard of evidence required in criminal matters prosecuted by the Director of Public Prosecutions;
- meeting the time limit for initiating action under certain statutes;
- the poor success rate in successful prosecution of unregistered health care providers who pass themselves off as medical practitioners in contravention of the *Medical Practice Act 1992*; and

- pursuing prosecutions under the *Fair Trading Act 1987*, when medical services are treated as a commercial product.

3.3 Non-statutory complaint handling mechanisms

Most unregistered fields of health care have one or more associations which impose some form of self-regulation on their members.

The Australian Association of Social Workers has a complaints mechanism which involves investigation of complaints by Branch and National Ethics Committees. If a complaint is substantiated these Committees can impose a number of penalties including a formal written reprimand, imposition of conditions of practice or other forms of intervention which enable the development of more appropriate practices and suspension or termination of membership of the Association. Penalties affecting membership status are published in the Association's Journal and the local and national press. The AASW researched complaints received by the Association between 1986 and 1993. It found that there were 13 formal complaints lodged in the period. These covered a range of practises including quality of service, misrepresentation of qualifications in advertising and breaches of client confidentiality.

Of the 13 formal complaints lodged:

- 5 proceeded to investigation and hearing process
- 3 judged as not giving rise to a case to answer
- 1 indecipherable with no method of contacting complainant
- 4 concerned members who were not members and were not able to be investigated

Of the five complaints investigated:

- 1 substantiated
- 1 dismissed on the grounds that the respondent did not contravene the Code of Ethics
- 2 dismissed on the grounds they could not be substantiated
- 1 proceeded to investigation but record of outcome could not be found.

The Australian Traditional Medical Society Ltd has a complaints committee which mediates between disputing parties where possible. In the Society's 1996/97 Annual Report it states that for the financial year the Complaints Committee received 10 formal complaints about its members. After consideration of the complaints two members were removed from the register of members, one member resigned, four complaints were satisfactorily resolved through conciliation, one with the assistance of the Victorian Health Services Commission and three complaints are still under consideration by the Committee and Executive Board.

The self-regulatory nature of professional Associations limits their ability to discipline practitioners in their particular field of health care. Associations can only deal with practitioners who are members. The Australian Association of Social Workers notes that some members have rescinded their membership to avoid investigation (AASW Position on Registration of Social Workers, Submission from AASW to the Minister for Health). In cases where a professional association terminates a practitioner's membership there is nothing to stop the practitioner from continuing to practice in the same or a similar field.

3.4 Other Jurisdictions

The *Health and Disability Commissioner Act* 1994 (NZ) is administered by the Health and Disability Commission which is the equivalent to the Health Care Complaints Commission of New South Wales. The Act covers the conduct of 'health care providers'

'Health care providers' are defined as including the controlling authority of a hospital or aged person's home, any registered health professional and any person who provides or holds themselves out as providing health services to the public whether or not any charge is made for those services.

The Act defines 'health services' as services to promote or protect health, services to prevent disease or ill health and treatment, diagnostic and rehabilitation services. It specifies that these services include psychotherapy and counselling services, contraception services and advice, fertility and sterilisation services.

Central to the legislation is a Code of Health and Disability Services Consumers' Rights. The Code contains the following ten rights of consumers and the duties of providers:-

- the right to be treated with respect
- the right to freedom from discrimination, co-coercion, harassment and exploitation

- the right to dignity and independence
- the right to services of an appropriate standard
- the right to effective communication
- the right to be fully informed
- the right to make an informed choice and give informed consent
- the right to support
- rights in respect of teaching or research
- the right to complain

Any person can make a complaint alleging a breach of the Code. The Commissioner investigates alleged breaches. If the Commissioner determines that the complaint reveals a breach of the Code the Commissioner may take the following action:-

- report the Commissioner's opinion to the health care provider whose actions were the subject of the complaint and make recommendations including the recommendation that disciplinary proceedings be taken against the employee or member of the health care provider
- report the Commissioner's opinion and recommendations to any person the Commissioner considers appropriate
- make a report to the Minister
- make a complaint to any health professional body in respect of the complaint

The Act contains a right of appeal for aggrieved parties to the Complaints Review Tribunal.

ISSUE NO. 1

Do existing mechanisms offer consumers an effective means of dealing with their complaints against unregistered health practitioners?

The Health Care Complaints Commission has jurisdiction to deal with complaints against practitioners working in alternative fields of health care but is restricted in the action it can take when a complaint is investigated and found to be sustained.

Where possible, the Commission usually chooses to conciliate complaints against unregistered practitioners rather than undertake an investigation because of the limited sanctions it can impose if the complaint is sustained. The Commission also refers complaints of a minor nature to area health services for direct resolution, where appropriate.

Most fields of alternative health care have at least one professional association or organisation which represents the interests of practitioners. These associations are not always representative of the field as a whole and may be considered unofficial by sections of the discipline. They may also vary in the standards and control they impose on their membership. Not all associations have mechanisms to deal with complaints against or the discipline of practitioners.

Membership of any association which covers unregistered practitioners is voluntary and there is nothing to stop a practitioner whose conduct is under investigation from withdrawing his or her membership thereby avoiding any disciplinary action the association might impose. If an association suspends or terminates the membership of a practitioner he or she may continue to practice in the same or a related field of health care.

Certain complaints about unregistered health care providers may be dealt with under other legislation such as the *Fair Trading Act*, *Therapeutic Goods Act or Crimes Act.* There are certain difficulties associated with referral of matters for prosecution by other bodies.

Conciliation is usually the Commission's preferred option when dealing with complaints against unregistered practitioners because there are no sanctions which it can impose after investigating these matters.

Discussion Points

1. Does the number of complaints received by the HCCC against unregistered health care practitioners reflect the true state of consumer dissatisfaction with alternative health care?

2. Why is there a disproportionately small number of complaints lodged against unregistered health care practitioners when compared to the number lodged against registered practitioners?

3. Are consumers of alternative health care less likely to complaint about the standard of care they received than consumers of orthodox health care services.? If so, why?

4. Do existing mechanisms deal effectively with complaints against unregistered health care practitioners? If not, please explain why they are ineffective.

5. What changes need to be made to existing mechanisms dealing with complaints against unregistered health practitioners?

6. What role should the HCCC play in the handling of complaints of a less serioius nature against unregistered practitioners?

7. How can consumers of alternative health care be made aware of the complaints mechanisms available to them?

ISSUE NO. 2

Do the provisions of the Health Care Complaints Act 1993, relating to unregistered health practitioners, require amendment?

Section 39 of the *Health Care Complaints Act* 1993, (the Act) prescribes the action which can be taken after the Health Care Complaints Commission investigates a complaint about a unregistered health care practitioner. This action is limited to making comments to the health practitioner, terminating the complaint or referring the matter the subject of complaint to the Director of Public Prosecutions.

Under the present provisions of the Act the Commission cannot initiate or participate in disciplinary action against an unregistered practitioner. Likewise, it cannot prevent an unregistered practitioner, against whom a complaint is found sustained, from continuing to practice.

Section 37 of the Act deals with the disclosure of information in relation to the investigation of complaints. It provides that information about a complaint can only be disclosed with the consent of the person to whom the information relates or in connection with administration of the Act including any legal proceedings which might arise out of the Act.

The prescriptive nature of sections 39 and 37 prevent the Health Care Complaints Commission from divulging any information about an unregistered practitioner the subject of a complaint or any details of the actual complaint. Facts about these complaints can be recorded in the Commission's Annual Report as long as the identity of the practitioner is not disclosed.

Section 8 states that a complaint can be made by any person including the concerned client, the client's chosen representative, a health service provider or a member of Parliament.

The Act does not invest the Commission or the Commissioner with the power to initiate complaints against health care practitioners.

Discussion Points

8. Should the *Health Care Complaints Act* 1993, be amended to give the HCCC the power to impose disciplinary action on unregistered health care practitioners against whom a complaint is made? If so, what changes would need to be made to the Act and the Commission's powers?

9. Should the confidentiality provisions of the *Health Care Complaints Act* 1993, which prevent the Commission from commenting on complaints against unregistered health care practitioners be amended? If so, what changes are required?

10. Should the *Health Care Complaints Act* 1993, be amended to give the Health Care Complaints Commission the power to initiate complaints against unregistered health care providers? If so, what should be the extent of these powers?

11. Does the *Health Care Complaints Act* 1993, require any other amendment to allow the Health Care Complaints Commission to deal effectively with complaints against unregistered health care practitioners?

ISSUE NO. 3

Is there scope for strengthening self-regulation in unregistered fields of health care?

Professional associations control self-regulation of unregistered areas of health care by setting standards of practice supported by codes of practice and ethics.

If self-regulation is to achieve a uniform high standard of practice throughout a profession the mechanisms should apply to all practitioners in the field. Fragmentation of many unregistered fields of health care poses a problem to the implementation of effective self-regulation.

The standard of self-regulation varies within different fields of alternative health care. Some professional associations such as the Australian Association of Social Workers Ltd have a number of self regulation mechanisms while others do not impose any standards of practice on members.

Many professional associations have complaint handling procedures which include the imposition of sanctions on a practitioner who is found to have breached the required standard of conduct. If the sanction involves termination of membership the association is unable to stop the practitioner from continuing to work in the same or any other health field.

Membership of professional associations is voluntary and incentives are needed to attract practitioners. It has been suggested that the National Competition Policy has had a negative effect on practitioner incentive to join a professional association. The Australian Traditional Medicine Society Ltd offers its members a number of incentives which include health fund rebates and entry in the Society' widely published directory of practitioners.

Discussion Points

12. **Does the present system of self-regulation of unregistered health care providers offer the public a satisfactory standard of health care and safety?**

13. **What problems are caused by professional fragmentation and how can they be overcome?**

14. **What role can professional associations play in the self-regulation of practitioners working within a particular field of health care?**

15. **How can practitioners be encouraged to join a professional association?**

16. **What impact, if any, has the National Competition Policy had on the ability of associations to attract membership and to set standards of practice?**

17. **How can self-regulation provide more effective control of practitioners practising in unregistered fields of health care?**

ISSUE NO. 4

Is further statutory regulation of unregistered health care practitioners required?

Any proposal for statutory regulation must be assessed in accordance with the six criteria adopted by the AHMAC and the competition test imposed by the National Competition Policy.

When the study into the regulation of practitioners in traditional Chinese medicine applied the competition test to this field of health care it concluded that, on balance, the benefits of promoting public safety clearly outweighed the potential negative impacts of occupational regulation. The study based its conclusions on a number of facts including the inherent risks associated with poor practitioner training, the dramatic increase in the use of traditional Chinese medicine, a link between the length of training and reported adverse incident rates and fragmentation within the profession which makes self-regulation unsuccessful. (Traditional Chinese Medicine: Options for Regulation of Practitioners, Discussion Paper, September 1997, p vi)

Statutory regulation of occupations can take a number of forms. The New South Wales health regulation Acts represent co-regulation with the profession and the Government having a role in regulation of the profession. These Acts offer 'protection of title' by restricting the use of a title to registered practitioners. The main purpose of this form of regulation is to protect the public.

Registration is an integral part of the eleven health regulation Acts in New South Wales. Under these Acts Regulation Boards do not only control the recording of eligible practitioners' names on the register they also have significant powers over registered practitioners. These include the power to inquire into complaints and impose sanctions for improper practice. Some registration models such as those in the Northern Territory and New Zealand enable registration of more than one health practitioner group under the one regulatory structure. Under a registration model self-regulation can play an important role in maintaining standards of practice and public confidence in the profession.

Certification allows the public to identify those practitioners who have achieved the level of qualifications considered necessary to practice in a

particular field. This can be achieved by self regulation and does not need statutory backing. Statutory regulation might be a consideration if the certification scheme involves more than the regulation of entry standards.

Regulation of an occupation by licensing practitioners to perform particular activities is described as 'protection of practice'. It is a restrictive form of regulation because unlicensed practitioners are prohibited from performing the licensed activities. This form of regulation can impose tight controls on practitioners, create segmentation within a profession and restrict competition .

In its most simple form statutory regulation facilitates the imposition of uniform standards on practitioners and offers varying degrees of protection and certainty to the community. The main issues to be addressed when considering whether statutory regulation of an occupation is required is whether the activities of the occupation pose a significant risk of harm to the health and safety of the public and whether existing regulatory mechanisms fail to address these issues.

Alternative health care covers a wide range of occupations and practices which pose varying degrees of risk to public safety. This will impact on the relevance of statutory regulation within different health fields.

Discussion Points

18. Is there a need to improve the standard of care provided by practitioners in unregistered fields of health care?

19. Would statutory regulation of unregistered fields of health care provide an improved standard of care to the public?

20. What field/s of health care should be the subject of statutory regulation?

21. What form of statutory regulation is required?

22. What problems would existing competition policies present to the implementation of further statutory regulation of health care?

23. What problems might arise as a result of further statutory regulation of particular fields of health care?

24 Is there support among unregistered health care provider groups for registration rather than a maintenance of the status quo?

Appendix

Examples of complaints made to the HCCC

Example 1.

A complaint was made about a psychotherapist concerning personal and sexual relationship with the client during therapy. The HCCC conducted an investigation and obtained a Peer Review from a psychiatrist. A resume of the respondent showed no formal qualifications or study in the area of psychology or counselling. The respondent was not a member of a professional association. The review revealed that the respondent was under personal stresses and receiving counselling.

Outcome:

The HCCC was able to obtain an undertaking from the respondent that they continue therapy with their own therapist, accept work supervision from a psychiatrist, and permission from the respondent for the supervisor and therapist to intervene in the practice should they consider it necessary to do so.

Example 2.

A complaint was made about a radiographer concerning inappropriate touching of genitals, failure to explain nature and purpose of an x-ray and inadequate communication. The HCCC conducted an investigation as did the employing hospital. The HCCC forwarded the complaint to the professional association for comment and received a report from an internal medical consultant.

Outcome:

The allegation of inappropriate touching of genital area was not substantiated. The other allegations were substantiated and the HCCC made adverse comments.

Example 3.

A complaint was made about a person holding himself out to be a doctor. The HCCC received an anonymous complaint about a person's name in the Medical Directory but not on the Register of Medical Practitioners. The HCCC and police investigated the complaint.

Outcome:
The respondent was charged by police with assault, obtaining a benefit by deception arising out of a consultation with a woman while claiming to be a medical practitioner and holding himself out to be a doctor pursuant to section 105 of the Medical Practice Act. The Respondent was convicted. HCCC closed file.

Example 4.

A complaint was made about a naturopath alleging that the person was holding themselves out to be a doctor. The HCCC found that the respondent had little English and trained as a naturopath in China. The HCCC found that it is likely that the use of the title Doctor resulted from a lack of knowledge about legal restrictions on the use of the title.

Outcome:

The HCCC warned the respondent that a future breach of the Act could result in prosecution. HCCC closed file.

Example 5.

A complaint was made concerning a possible breach of the *Medical Practice Act* and the *Therapeutic Goods and Cosmetics Act* by a naturopath who broadcast on the radio. The naturopath made claims on the radio about the use of aloe vera in connection with cancer. The HCCC investigated. The respondent stated that he had no idea he was breaking the law. Prosecution did not proceed as both Acts are statute barred. The Respondent apologised and stated that he would not do it again. The HCCC consulted with the medical board.

Outcome:

The respondent was warned that if any further complaints are received which allege a breach of legislation that the HCCC would investigate with a view to prosecution.

Example 6.

A complaint was made concerning an Alternative Health Clinic alleging the inappropriate administration of an injection and that the consumer wrongly believed the practitioner to be a medical practitioner. The HCCC conducted an investigation and received a report from the respondent. The HCCC medical adviser reported that the literature advertising the service would not lead the public to believe that the practitioner was a medical practitioner. A peer review report was obtained.

Outcome:

The complaint of holding out as a doctor was not substantiated, however adverse comments were made in respect of the other aspect of the complaint. The HCCC wrote to the respondent noting criticisms concerning the treatment given and risk of infection when substances are injected into joints.

(Information collected by HCCC and provided to the Joint Committee on 3 June 1998).