Consultation paper

Options for regulation of unregistered health practitioners

February 2011

Australian Health Ministers' Advisory Council

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This paper was prepared by the Victorian Department of Health, on behalf of the Australian Health Ministers' Advisory Council

Contents

Executive summary

In November 2010, the Australian Health Workforce Ministerial Council[1] (AHWMC) agreed that a national consultation should be undertaken to consider whether there is a need for strengthened regulatory protections for consumers who use the services of unregistered health practitioners.

A new national registration scheme for health practitioners, the National Registration and Accreditation Scheme, commenced operation on 1 July 2010. Practitioners from ten health professions are now registered nationally and may practise in any State or Territory. A further four professions are scheduled to enter the National Scheme from 1 July 2012. National Boards have been set up, one for each regulated profession, with extensive powers to protect the public. However, these powers do not extend to practitioners in health professions and occupations where registration is not a prerequisite for practice (referred to here as unregistered health practitioners).

A number of government reports and inquiries in New South Wales, Victoria and South Australia, have raised concerns about public protection in relation to unregistered health practitioners. Of particular concern are the small number of practitioners who engage in serious misconduct that would suggest they are not 'fit and proper' to provide health services. In such cases, the conduct may be so serious that, if the practitioner had been registered, the conduct would have resulted in cancellation of their registration and removal of their right to practise. Sometimes the practitioner has committed offences under a number of different laws, repeatedly and over an extended period.

In 2007, the NSW Parliament enacted legislation to address what was seen as a gap in regulation to strengthen public protection for health consumers who use the services of unregistered health practitioners. The NSW scheme established a statutory Code of Conduct that applies to any unregistered practitioner who provides health services. It also established powers for the NSW Health Care Complaints Commission to investigate breaches of the Code and issue prohibition orders if necessary. A prohibition order may limit or attach conditions to the practitioner's practice, or prohibit them from providing health services altogether. Breaches of a prohibition order are subject to prosecution through the courts. Legislation is before the South Australian Parliament which, if enacted, will establish a similar regulatory scheme in that State.

This consultation paper sets out current regulatory arrangements that apply to unregistered health practitioners. It provides details of the NSW regulatory scheme and the Code of Conduct that applies to all unregistered health practitioners who provide health services in that State.

A number of options are proposed for consideration. They are:

Option 1: No change – rely on existing regulatory and non-regulatory mechanisms

Option 2: Strengthen self regulation – a voluntary code of practice

Option 3: Strengthen health complaints mechanisms – a statutory code of conduct

The consultation is intended to gather information and views to assist in determining the adequacy of existing protections for consumers who use the services of unregistered health practitioners and, if further public protection measures are required, what these should be and how they should be structured and administered.

Respondents are asked to consider whether regulatory protections such as those in NSW and under consideration in South Australia are required in all States and Territories, and the extent to which uniform arrangements are necessary or desirable for the terms of the code of conduct and for its enforcement.

[1] The Australian Health Workforce Ministerial Council is established under the *Health Practitioner Regulation National Law Act 2009* and comprises Health Ministers of the governments of the Commonwealth and all States and Territories.

Interested parties are invited to make submissions addressing the issues raised in the paper. Questions have been placed throughout the paper to assist with submissions and a Quick Response form is available to assist in framing responses.

Consultation arrangements

Information

This consultation is being conducted under the auspices of the Australian Health Ministers' Advisory Council (AHMAC), on behalf of State, Territory and Commonwealth Health Ministers.

Further information on this consultation is available from:

Ms Anne-Louise Carlton
Manager, Health Practitioner Regulation Unit
Health Regulation and Reform Branch
Department of Health Victoria
Tel: 03 9096 7610
Fax: 03 9096 9253
Email: Anne-Louise.Carlton@health.vic.gov.au

Copies of the consultation paper

The consultation paper is available on the Internet at the following address:
www.ahmac.gov.au

If you are unable to access the website to obtain a copy of the paper, you can contact:

Ms Glenys Sleeman
Project Officer
Health Practitioner Regulation Unit
Department of Health Victoria
Tel: 03 9096 1160

OR

Ms Marie Tirant
Operations Manager
Health Regulation and Reform Branch
Department of Health Victoria
Tel: 03 9096 8816

Submissions

Written submissions, making comment on the proposals in the consultation paper, may be emailed to:

Email: unregisteredhealthpractitioners@health.vic.gov.au

or mailed to:

Anne-Louise Carlton
Manager, Health Practitioner Regulation Unit
Health Regulation and Reform Branch
Department of Health Victoria
GPO Box 4541
Melbourne 3001

Submissions should be received by: Friday 15 April 2011

To assist you in preparing your submission, a Quick Response form can be downloaded at:
www.ahmac.gov.au

Note: All submissions will be considered public documents and will be posted on the website of the Australian Health Ministers' Advisory Council (AHMAC) above, unless marked 'private and confidential'.

1 Introduction

1.1 Background

A new national registration scheme for health practitioners commenced operation on 1 July 2010. Under the scheme, known as the National Registration and Accreditation Scheme for the Health Professions (the National Scheme), practitioners from ten health professions are required to be nationally registered in order to practise in any State or Territory. A further four professions are scheduled to enter the scheme from 1 July 2012. Further information on the National Scheme is available at: www.ahpra.gov.au.

While the scheme provides extensive powers for National Boards to protect the public by regulating practitioners from these 'statutorily regulated' health professions, these powers do not extend to practitioners from other 'unregulated' health professions and occupations.

In February 2010, the Australian Health Workforce Ministerial Council[2] (AHWMC) agreed that a national consultation be undertaken to assess whether additional public protection measures are required nationally in relation to health services delivered by health practitioners who are not registered under the National Scheme. Successive government reports and inquiries in New South Wales, Victoria and South Australia had raised concerns about how well the public is protected in relation to unregistered health practitioners (see *Appendix 1*).

Of particular concern are those practitioners who engage in serious misconduct that would suggest they are not 'fit and proper' to provide health services. In such cases, the conduct may be so serious that, if the practitioner had been registered under the National Scheme, the conduct would have resulted in cancellation of their registration and removal of their right to practise.

In 2007, the NSW Parliament enacted legislation to address what was seen as a gap in regulation and strengthen public protection of health consumers who use the services of unregistered health practitioners. The NSW scheme established by regulation a statutory Code of Conduct with which all unregistered practitioners who provide health services are required to comply. The scheme also established powers for the NSW Health Care Complaints Commission to investigate breaches of the Code and issue prohibition orders if necessary. A prohibition order may limit or attach conditions to the practitioner's practice, or prohibit them from providing health services altogether. Breaches of a prohibition order are subject to prosecution through the Courts.

Legislation is before the South Australian Parliament which, if enacted, will establish a similar regulatory scheme in that State.

This national consultation is to consider:

- whether there is a need for strengthened regulatory protections for consumers with respect to the services provided by unregistered health practitioners in those States and Territories without statutory codes of conduct for unregistered health practitioners, and
- if further public protection measures are required, what these should be, how they should be structured and administered and in particular, the extent to which national uniformity in the regulatory arrangements is necessary or desirable.

[2] The Australian Health Workforce Ministerial Council is established under the *Health Practitioner Regulation National Law Act 2009* and comprises Health Ministers of the governments of the Commonwealth and all States and Territories.

1.2 Scope of this consultation paper

This consultation paper has been prepared to assist community consultation about the most appropriate regulatory or non-regulatory mechanism for the protection of the public from unregistered health practitioners who fail to observe minimum standards of professional conduct.

This consultation paper invites interested parties to comment on a number of options, and some related policy and implementation issues.

Unregistered health practitioners

Practitioners who may be affected by these regulatory proposals include, **but are not limited to**:

- Audiologists and audiometrists
- Complementary health practitioners
- Counsellors and psychotherapists
- Dental technicians (in States and Territories other than Queensland)
- Dental assistants
- Dietitians
- Homeopaths
- Hypnotherapists
- Naturopaths and Western herbalists
- Massage therapists
- Music therapists, dance and drama therapists
- Optical dispensers
- Orthoptists
- Orthotists and prosthetists
- Pharmacy assistants
- Phlebotomists
- Reiki practitioners
- Sonographers
- Speech pathologists (in States and Territories other than Queensland)

This is not an exhaustive list. Any practitioner who provides a service that could be defined as a 'health service' and is not registered under the National Scheme may be considered to be within the scope of the consultation. See *Appendix 2* for the definitions of a 'health service' adopted in State and Territory health complaints legislation. The term 'unregistered practitioner' includes practitioners who were registered in a State or Territory or under the National Registration and Accreditation Scheme, who have had their registration cancelled or withdrawn.

It is difficult to estimate the number of practitioners or the size of the sector affected by these proposals. This will be the subject of further analysis.

Questions to assist with submissions

- If you are a professional association, can you provide an estimate of the number of unregistered health practitioners you believe to be practising in your profession or field?

Registered health practitioners

Many practitioners who are currently or soon to be registered under the National Scheme will also have an interest in these proposals. The proposals under consideration may capture such practitioners when they provide health services that are unrelated to their registration, for example, a registered nurse who works as a massage therapist, or a registered chiropractor who works as a naturopath. The health professions regulated under the National Scheme are:

- Aboriginal and Torres Strait Islander Health workers (from 1 July 2012)
- Chinese medicine practitioners (acupuncturists, Chinese herbal medicine practitioners, Chinese herbal dispensers) (from 1 July 2012)
- Chiropractors
- Dental care providers (dentists, dental hygienists, dental therapists, oral health therapists, and dental prosthetists)
- Medical practitioners
- Medical radiation practitioners (diagnostic radiographers, nuclear medicine technologists, radiation therapists) (from 1 July 2012)
- Nurses and midwives
- Occupational therapists (from 1 July 2012)
- Optometrists
- Osteopaths
- Pharmacists
- Physiotherapists
- Podiatrists
- Psychologists

1.3 Policy context

Intergovernmental agreement

On 26 March 2008, COAG signed the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (IGA). The IGA set out the framework for a single national system of registration and accreditation of health practitioners in Australia, commencing with the nine professions[3] regulated in every State and Territory.

The IGA can be accessed at the following address:
http://www.coag.gov.au/coag_meeting_outcomes/2008-03-26/docs/iga_health_workforce.rtf

Seamless National Economy

The COAG National Partnership Agreement (NPA) is designed to deliver a Seamless National Economy. The driving force behind the NPA is to deliver more consistent regulation across jurisdictions, to address unnecessary or poorly designed regulation, and to reduce excessive compliance costs on business, restrictions on competition and distortions in the allocation of resources in the economy. The NPA provides that the States and Territories have a responsibility to implement a co-ordinated national approach in a number of areas, including with respect to the health workforce. The milestones set out in the Implementation Plan to the NPA included implementation of the National Scheme for the health professions.

[3] The podiatry profession was added as the tenth profession to be regulated under the National Registration and Accreditation Scheme, but after the IGA was signed by COAG.

While the NPA does not specifically include milestones with respect to the regulation of unregistered health practitioners, the principles set out in the NPA are applicable to the regulatory reforms addressed in this consultation paper.

The NPA can be accessed at the following address:
http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/seamless_national_economy_np.pdf

Council of Australian Governments

The Council of Australian Governments (COAG) requires that a 'Regulatory Impact Statement' (RIS) be prepared and published whenever a Ministerial Council is considering the introduction of new regulation. This is in order to maximise the efficiency of new and amended regulation and avoid unnecessary compliance costs and restrictions on competition (Council of Australian Governments *Best Practice Regulation. A Guide for Ministerial Councils and National Standard Setting Bodies*, October 2007).

The RIS requirements apply to any decisions of a Ministerial Council that are to be given effect through legislation which, when implemented, would encourage or force businesses or individuals to pursue their interests in ways they would not otherwise have done. This consultation paper has been prepared in accordance with the COAG guidelines.

2 Current regulatory arrangements

Health practitioners are subject to a range of laws that impact on and shape their practice. These include occupational licensing laws, health complaints laws, laws that regulate specific activities such as use of medicines and therapeutic goods, use of radiation equipment, regulation of public health threats such as infectious diseases, consumer protection laws, employment law, as well as the criminal law, tort law (negligence) and the law of contracts. Those laws that are most relevant to the current discussions are outlined in more detail below.

2.1 Health Practitioner Regulation National Law Act (the National Law)

Registered practitioners and the National Law

The National Law provides National Boards with extensive powers to regulate registered practitioners. **These powers do not apply to unregistered practitioners.** However, it is useful to understand the nature of these powers and how they operate to protect the public, in order to inform discussions about the risks and regulatory options for unregistered health practitioners.

Probity checking

National Boards have powers to undertake probity checking of all applicants for registration before deciding to grant registration. When a practitioner applies to be registered for the first time, they must not only demonstrate that they are qualified and competent to practise, they must satisfy probity checks, including a check of their criminal history. There is a range of matters that a National Board must take into account in determining whether a practitioner is a 'suitable person' to practise the profession (see *Appendix 3* for relevant provisions of the National Law on the National Boards' probity checking powers). A National Board may also, at any time, obtain a criminal history check of a registered practitioner.

Unprofessional conduct, professional misconduct and impairment

National Boards have powers to deal with any registered practitioner who the relevant Board considers has acted unprofessionally, has an impairment[4] that places the public at risk, is incompetent, or otherwise not a 'suitable person' or a 'fit and proper person' to continue providing regulated health services.

The benchmark against which a registered health practitioner's conduct is judged is set out in the National Law. See *Appendix 4* for full definitions of 'unprofessional conduct', 'professional misconduct', 'unsatisfactory professional performance' and 'impairment'.

Unprofessional conduct is defined as 'professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers'. The definition includes examples, such as 'the conviction of the practitioner for an offence under an Act, the nature of which may affect the practitioner's suitability to continue to practise the profession'.

The definition of 'professional misconduct' includes 'conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the

[4] Section 5 of the *Health Practitioner Regulation National Law Act 2009* defines 'impairment' as 'a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practise the profession'.

practitioner being a fit and proper person to hold registration in the profession'. There is case law on what constitutes 'fit and proper' and when a person is not considered to be a fit and proper person[5].

Prohibition orders

When a National Board refers a matter for hearing by a State or Territory tribunal, the tribunal may decide that the practitioner has engaged in professional misconduct that is 'inconsistent with the practitioner being a fit and proper person to hold registration in the profession'. Where the tribunal decides to cancel the practitioner's registration, it may also decide to 'prohibit the person from using a specified title or providing a specified health service'. These powers are only available to a tribunal at the point at which they cancel a practitioner's registration.

Unregistered health practitioners and the National Law

The powers to undertake probity checking, deal with breaches of professional standards and issue a 'prohibition order' when a practitioner is found not to be a fit and proper person to practise the profession **do not** apply to unregistered health practitioners. However, the National Law does impact on unregistered health practitioners in a range of ways, particularly in relation to 'holding out' offences[6] and restrictions on the use of professional titles.

The National Law contains a series of offences, with powers for the National Boards to refer matters to the Police for investigation or to initiate prosecutions themselves through State and Territory courts for breaches of the National Law.

Where an unregistered health practitioner unlawfully uses certain professional titles or misleads others (including their clients) into believing that they are qualified and registered when they are not, they may be guilty of a 'holding out' offence. The National Law also makes it an offence to provide certain types of services or procedures when unregistered. These 'practice protections' include:

- Restricted dental acts[7]
- Prescribing of an optical appliance[8]
- Manipulation of the cervical spine[9]

2.2 Health complaints regulation

A 'health complaints entity' (HCE) is defined under the National Law as 'an entity that is established by or under an Act of a participating jurisdiction and whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system'.

Appendix 5 provides a list of State and Territory HCEs and a summary of their powers. There are two main models in operation. In NSW, the Health Care Complaints Commission ('the HCCC') is defined under the National Law as a 'co-regulatory authority' and has powers not only to conciliate complaints between consumers and health service providers, but also powers to initiate the prosecution of registered practitioners for professional misconduct. The NSW HCCC (rather than the National Boards) investigates and prosecutes cases of alleged professional misconduct by registered health practitioners before the relevant NSW disciplinary tribunal. Under the regulatory arrangements outlined in section 3, the NSW HCCC's powers have been extended to allow investigation and imposition of sanctions (such as conditions or prohibition from practice) on practitioners who are not registered.

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5 Freckelton, I, *"Good Character" and the regulation of medical practitioners*, Journal of Law and Medicine, 2008 16, 1.

6 'Holding out' offences are offences where a person who is not registered in a profession takes or uses a restricted professional title, or otherwise 'holds themselves out' as qualified or registered to practise the profession.

7 A 'restricted dental act' is defined in section 121 of the *Health Practitioner Regulation National Law Act 2009* (Qld)

8 An 'optical appliance' is defined in section 122 of the *Health Practitioner Regulation National Law Act 2009* (Qld)

9 'Manipulation of the cervical spine' is defined in section 123 of the *Health Practitioner Regulation National Law Act 2009* (Qld)

In all other States and Territories, responsibility for the investigation and prosecution of professional misconduct by registered health practitioners resides with the National Boards and the Australian Health Practitioner Regulation Agency.[10] In these jurisdictions, the primary functions of HCEs are the investigation, resolution and conciliation of consumer complaints against health service providers (including unregistered health practitioners), and investigation of health system failures. When an HCE investigates a complaint against a registered health practitioner and finds evidence of professional misconduct, the HCE may refer the matter to the relevant registration board for further action, including referral to a tribunal for hearing if necessary. Where the practitioner is not registered, the HCE may seek to resolve the complaint between the complainant and the practitioner, investigate the complaint, or attempt formal conciliation. After an investigation, the HCE may refer the matter to another entity (for example, the police), but there is no avenue available, except in NSW, through which a prosecution and hearing may be conducted and sanctions imposed.

2.3 Public health regulation

All States and Territories have in place public health laws that are designed to promote, protect and improve public health in a range of ways such as:

- controlling risks to public health that lead to illness, injury, or premature death
- preventing and controlling the spread of infectious diseases
- responding to public health emergencies
- supporting local government authorities in their role in enforcement activities.

Such legislation regulates areas such as safe drinking water, legionella and other disease control, and skin penetration. Authorised officers under these laws generally have powers to check compliance with the legislation, including powers of inspection, and the power to enter and search premises.

These laws provide offences and penalties for persons who breach the legislation, and powers to prosecute such persons before the relevant court.

Relevant State and Territory Acts are:

ACT – *Public Health Act 1997*
NSW – *Public Health Act 2010*
Northern Territory – *Public Health Act*
Queensland – *Public Health Act 2005*
South Australia – *Public and Environmental Health Act 1987*
Tasmania – *Public Health Act 1997*
Victoria – *Public Health and Wellbeing Act 2008*
Western Australia – *Health Act 1911*

2.4 Consumer protection regulation

Recent reforms have been enacted to Commonwealth, State and Territory consumer protection laws, with passage of the Australian Consumer Law. These reforms draw on the final report of the Productivity Commission *Review of Australia's Consumer Policy Framework*, published in April 2008, and were implemented on 1 January 2011. The Australian Consumer Law applies nationally, in all States and Territories, and to all Australian businesses. The package of reforms includes:

- establishment of a single, national consumer law: the Australian Consumer Law
- a new national product safety system

[10] The ACT Health Services Commissioner has powers to appear at a disciplinary hearing and give evidence although the action is brought by the relevant National Board.

- new penalties, enforcement powers and consumer redress options

The Productivity Commission's report identified that Australia's consumer regulators have access to a range of tools for dealing with breaches of the law. These include criminal penalties (for higher level breaches), civil remedies (used for restorative purposes), administrative settlements (such as enforceable undertakings), and persuasion, liaison and education programs. This single, generic consumer law is based on the consumer provisions in the *Competition and Consumer Act 2010* (Cth) (CCA) that have been modified to address gaps in the CCA's coverage and scope. It provides powers to deal with:

- unconscionable conduct[11]
- misleading or deceptive conduct
- false or misleading representations

and powers to:

- grant an injunction to prevent contravention of the Law
- issue a public warning notice
- issue a substantiation notice requiring a person to provide information to substantiate or support any claim or representation they have made
- issue an order disqualifying a person who has committed or attempted to commit a contravention of the Law from managing a corporation.

2.5 Regulation of therapeutic goods and medicines

The *Commonwealth Therapeutic Goods Act 1989* (the Act) provides for the establishment and maintenance of a national system of controls relating to the quality, safety, efficacy and timely availability of therapeutic goods that are used in Australia (whether produced in Australia or elsewhere) or exported from Australia. The Act also provides a framework for the States and Territories to adopt a uniform approach to control the availability and accessibility of medicines and poisons in Australia and ensure their safe handling.

Therapeutic goods regulation

The Act establishes an Australian Register of Therapeutic Good (ARTG), a computer database of information about therapeutic goods for human use approved for supply in, or export from, Australia. Unless specifically exempt or excluded, all product must be entered on the ARTG before it can be supplied in Australia.

The Act, Regulations and Orders set out the requirements for inclusion of therapeutic goods in the ARTG, including advertising, labeling, product appearance and appeal guidelines. The Act also includes provisions for reviews of decisions. Some provisions such as the scheduling of substances and the safe storage of therapeutic goods are covered by the relevant State or Territory legislation.

Medicines regulation

All States and Territories have Acts and Regulations that regulate the manufacture, sale, supply, storage, possession and use of medicines, variously labelled 'drugs', 'poisons', 'restricted substances' and 'controlled substances'. These laws provide offences and penalties for persons who breach the legislation, and powers to prosecute such persons before the relevant court.

[11] The judicial meaning of unconscionable conduct has not been settled but the courts in considering the issue have described unconscionable conduct as something being clearly unfair and unreasonable, conduct which shows no regard for conscience and conduct which is irreconcilable with what is right or reasonable.

Relevant State and Territory Acts are:

ACT – *Medicines, Poisons and Therapeutic Goods Act 2008*
NSW – *Poisons and Therapeutic Drugs Act 1966*
Northern Territory – *Poisons & Dangerous Drugs Act*
Queensland – *Health Act 1937*
South Australia – *Controlled Substances Act 1984*
Tasmania – *Poisons Act 1971*
Victoria – *Drugs, Poisons and Controlled Substances Act 1981*
Western Australia – *Poisons Act 1964*

2.6 Regulation of radiation equipment and use

Radiation safety is regulated by means of a licensing framework, with the Commonwealth, States and Territories each enacting and administering radiation protection legislation. The Commonwealth legislation, the *Australian Radiation Protection and Nuclear Safety Act 1998* (Cth) is administered by the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) and regulates radiation practices of Commonwealth entities such as ANSTO, CSIRO, the Department of Defence and the Australian National University.

The National Directory for Radiation Protection, developed by the Radiation Health Committee[12] sets out the uniform national framework for radiation protection. State and Territory legislation regulates non-Commonwealth entities such as hospitals, universities and industry users of radioactive sources, and applies the National Directory. Radiation regulators in State and Territory Governments are located in either the health portfolios or environment protection agencies of each jurisdiction.

Radiation protection legislation typically includes the following areas:

- setting maximum dose limits
- licensing of people to undertake practices using radiation
- registration of radiation emitting equipment
- safety procedures
- responsibilities
- powers of inspection for the regulator
- enforcement provisions and penalties.

All jurisdictions require a company or person conducting a radiation practice to be appropriately qualified and licensed. All health-related radiation practices conducted within Australia are subject to a common platform of radiation controls under State and Territory legislation, whether or not the group or persons conducting the practice are part of a regulated health profession.

With respect to emerging issues, such as the use of lasers and intense pulsed light technology (IPLs) for cosmetic treatments, a case for regulation, including a regulatory impact statement, is being developed by the Australian Radiation Protection and Nuclear Safety Agency on behalf of the national Radiation Health Committee. If the Radiation Health Committee determines that the use of lasers and IPLs warrants regulation, these modalities will be prescribed inclusions in the National Directory for Radiation Protection. Inclusion in the National Directory for Radiation Protection would mean that lasers and IPLs would be subjected to uniform nationally consistent regulatory controls in all Australian jurisdictions.

[12] The Radiation Health Committee is a statutory committee established under section 22 of the *Australian Radiation Protection and Nuclear Safety Act 1998*. Its membership includes a representative from each State and Territory who is a radiation control officer – a person who holds a senior position in a regulatory body of a State or Territory and is responsible for matters relating to radiation protection and nuclear safety.

3 NSW regulation of unregistered health practitioners

3.1 Scope of NSW scheme[13]

NSW has introduced a scheme to better regulate unregistered health practitioners. There are two main elements of the scheme:

- a statutory code of conduct that sets standards that apply to all unregistered health practitioners (and registered health practitioners who provide health services that are unrelated to their registration), and
- an avenue for dealing with complaints from consumers about practitioners who breach the code of conduct.

The NSW arrangements were enacted by legislation in 2006, with the passage of the *Health Legislation Amendment (Unregistered Health Practitioners) Act 2006*. Under the *Public Health Act 1991* (NSW), the NSW Minister for Health has the power to make, by regulation, a 'Code of Conduct' for the provision of health services by unregistered health practitioners. In addition, the NSW Health Care Complaints Commission has enhanced statutory powers when dealing with complaints under the *Health Care Complaints Commission Act 1993* (NSW), to investigate a complaint that an unregistered practitioner has breached the Code of Conduct, and if necessary, issue a court enforceable 'prohibition order', either banning or restricting the person's practice (NSW Department of Health, 2008).

3.2 Key features of the NSW scheme

The NSW scheme is a form of 'negative licensing'. As a regulatory model, it sits on a continuum of regulation between self-regulation and statutory registration. It is a more targeted, less restrictive and less costly form of regulation than statutory regulation, since it provides the regulatory tools to deal directly with those who behave illegally or in an incompetent, exploitative or predatory manner and, if necessary, prohibit them from practising. It leaves the vast majority of ethical and competent members of an unregulated health profession to self-regulate, but provides an additional level of public protection with respect to unregistered practitioners, at minimal additional cost to the community.

The NSW Code of Conduct provides a framework against which to objectively assess the conduct of unregistered health practitioners. Importantly, it facilitates the investigation of complaints and permits disciplinary action against practitioners found to be exploiting or taking advantage of vulnerable people.

A health practitioner is defined as 'a natural person who provides a health service (whether or not the person is registered under the Health Practitioner Regulation National Law)'.

The NSW Code applies to the provision of health services by:

a) health practitioners who are not registered under the National Law (including those who have been deregistered), and
b) health practitioners who are registered under the National Law but who provide health services that are unrelated to their registration.

The term 'health service' has the same meaning as in the *Health Care Complaints Act 1993* (NSW) – see *Appendix 2* for definitions of 'health service' contained in State and Territory health complaints legislation.

[13] Much of the information in this section has been drawn from the website of the Health Care Complaints Commission of New South Wales, at www.hccc.nsw.gov.au

Key features of the NSW scheme are:

- a 'negative licensing' regulatory regime that does not restrict entry to practice, but allows effective action to be taken against a practitioner who fails to comply with proper standards of conduct or practice
- a set of objective and clear standards against which to assess a practitioner's conduct and practice in the event of a complaint
- an independent investigator to receive and investigate complaints
- power for the independent investigator to issue prohibition orders and give public warnings about practitioners who have failed to abide by the required standards of conduct and practice, and
- offence provisions for any person who breaches a prohibition order to be prosecuted through the appropriate court.

3.3 The NSW Code of Conduct

The NSW *Code of Conduct for unregistered health practitioners* came into effect on 1 August 2008. The intention of the Code is to set out the minimum practice and ethical standards with which unregistered health service providers are required to comply.

The Code of Conduct informs consumers about what they can expect from practitioners and the mechanisms by which they may complain about the conduct of, or services provided by, an unregistered health service provider.

A full copy of the Code of Conduct is at *Appendix 6*. The key aspects of the Code are:

- Health practitioners must provide health services in a safe and ethical manner.
- Health practitioners diagnosed with an infectious medical condition must ensure that he or she practises in a manner that does not put clients at risk.
- Health practitioners must not make claims to cure certain serious illnesses.
- Health practitioners must adopt standard precautions for infection control.
- Health practitioners must not dissuade clients from seeking or continuing with treatment by a registered medical practitioner and must accept the rights of their clients to make informed choices in relation to their health care.
- Health practitioners must not practise under the influence of alcohol or other drugs.
- Health practitioners must not practise with certain physical or mental conditions.
- Health practitioners must not financially exploit clients.
- Health practitioners are required to have an adequate clinical basis for treatments.
- Health practitioners must not misinform their clients.
- Health practitioners must not engage in a sexual or improper personal relationship with a client.
- Health practitioners must comply with relevant privacy laws.
- Health practitioners must keep appropriate records.
- Health practitioners must keep appropriate insurance.
- Health practitioners must display the Code and other information (with some exceptions).

The NSW Government undertook an Impact Assessment prior to making the Regulations that gave effect to the Code.

3.4 Powers of the NSW Health Care Complaints Commission

The Commission has the power to:

- issue an order prohibiting a person from providing health services for a period of time
- issue an order placing conditions on the provision of health services
- provide a warning to the public about a practitioner and his or her services.

To do so, the Commission must find that:

- a provider has breached the code of conduct or been convicted of a 'relevant offence', and
- in the opinion of the Commission, the provider poses a risk to the health and safety of members of the public.

A relevant offence is:

- an offence under Part 2A of the *Public Health Act 1991* (NSW), or
- an offence under the *Fair Trading Act 1987* (NSW) or the *Competition and Consumer Act 2010* (Cth) that relates to the provision of health care services.

3.5 Stages in the NSW complaints process

When dealing with complaints about unregistered health practitioners the Commission will generally take the following steps:

1. Commission receives complaint – When the Commission receives a complaint, it will contact the complainant to clarify the issues, notify the provider and seek their response to the complaint.
2. Assessment – When assessing a complaint the Commission may obtain health records to assist the assessment of clinical issues and may seek advice from independent experts in the area. At the end of the assessment, the Commission may:
   a. Refer to another body (such as the Therapeutic Goods Administration or the Office of Fair Trading)
   b. Refer to assisted resolution (voluntary)
   c. Refer to conciliation
   d. Discontinue
   e. Investigate
3. Investigation – the purpose of investigation is to obtain information so that the Commission can determine the most appropriate action (if any) to take. The focus of investigations is on protection of public health and safety. At the end of an investigation the Commission may:
   a. Terminate
   b. Refer the matter to the Director of Public Prosecutions
   c. Make comments
   d. Issue a public warning
   e. Issue a prohibition order placing conditions
   f. Issue a blanket prohibition order
4. Right to appeal – the practitioner has the right to appeal against the Commission's decision. The appeal has to be made to the Administrative Decisions Tribunal within 28 days from the date of the Commission's decision.

3.6 How the NSW scheme is working

The NSW HCCC has advised that each year it receives approximately 60-80 complaints that relate to unregistered health practitioners. Since August 2008 when the Code of Conduct came into force, the Commission has used its prohibition order powers in seven cases, posted on the Commission's website. Following investigation, the HCCC has issued five prohibition orders on practitioners and issued one public statement about a practitioner and one about a non-profit organisation. To date there have been no appeals to the NSW Administrative Decisions Tribunal against prohibition orders issued by the Commission.

The public statements and prohibition orders issued by the NSW HCCC are published on the website of the HCCC, and can be accessed at the following address:

http://www.hccc.nsw.gov.au/Decisions/Public-Statements-Warnings/default/aspx

The Commission has advised that the scheme works well and provides a useful mechanism to address the worst cases of poor practice and improper conduct by unregistered practitioners. The Commission has memorandums of understanding (MOUs) with the NSW Police and a number of other regulatory agencies which allow for the sharing of information between agencies. In some cases the Commission plays a coordinating role amongst these agencies, which enables it to gather evidence of breaches of a variety of laws. Such breaches may be indicative of a pattern of conduct which demonstrates that the practitioner is likely to continue to breach the Code of Conduct and place public health and safety at risk. This pattern of conduct may warrant the issue of a prohibition order.

The cost of the regime has been low, as a relatively small number of cases have been dealt with so far and no additional infrastructure has been required. However, the Commission has advised that the number of complaints it is receiving is increasing, as awareness of the scheme grows.

4 The nature of the problem

4.1 Overview

The standards against which a registered health practitioner's conduct is assessed are set out in the National Law (see section 2.1 above). As outlined above, NSW has legislated (with South Australia following a similar path) to enact standards of conduct for unregistered health practitioners and a mechanism for dealing with breaches. Civil and criminal remedies are available in other States and Territories. However, no nationally uniform or consistent legally enforceable qualifications or probity checks are required before an unregistered health practitioner can commence practice. There is also no mechanism for prohibiting or limiting practice when an unregistered health practitioner is impaired, incompetent or unprofessional and not 'fit and proper' to practise (except in NSW).

The vast majority of unregistered health practitioners practise in a safe, competent and ethical manner. There are, however, a small number of practitioners who engage in exploitative, predatory and illegal behaviour that, if they were registered, would result in a decision that they are not a 'suitable person' to be registered and lead to cancellation of their registration and removal of their right to practise. There is evidence that such practitioners sometimes move to those jurisdictions that have less regulatory scrutiny and continue their illegal or unethical conduct.

The Australian Consumer Law provides a regulatory framework that is designed to protect consumers from unconscionable or deceptive conduct and from unsafe or defective goods and services. However, questions have been raised about whether the powers of consumer protection regulators are sufficient to protect the public from future harm, where a practitioner is a 'repeat offender' with a pattern of unethical behaviour and/or illegal activities which suggests that they are not a fit and proper person to continue providing health services.

While each year there may be only a handful of unregistered health practitioners whose conduct is so serious that it comes to the attention of regulatory authorities, the seriousness of the conduct means the impact on the lives of patients and families affected can be significant.

In many of these cases, the practitioners have been subject to investigation and regulatory action by a number of regulatory bodies in one or more jurisdictions at various times during a period spanning several decades. However, in those States and Territories that do not have a mechanism through which the evidence from multiple regulatory bodies can be collected and considered as a whole in order to establish a pattern of conduct and make a determination that the practitioner is not a fit and proper person to continue providing health services, consumers continue to be harmed by the exploitative and predatory behaviour of these practitioners. While they represent a very small proportion of health service providers, these 'repeat offenders' impose a disproportionate burden on the health system.

4.2 Type of conduct of concern

Appendix 7 provides details of a number of cases that have caused concern. While some cases cross more than one area, the cases fall into the following broad types:

- Sexual misconduct – involving sexual assault or sexual relationships with patients/clients
- Cancer care – combining a range of financially exploitative, misleading and deceptive conduct
- Other unprofessional conduct that places the public at risk

A number of the cases involve prosecutions by trade practices/fair trading regulators. In all cases, the practitioners have been 'known to' or investigated by a number of other regulators up to a decade prior to their most recent prosecutions.

Sexual misconduct

A number of cases have involved sexual assault by practitioners of patients in their care and other sexual misconduct in the form of sexual relationships between treating practitioners and patients.

Examples include:

- a South Australian practitioner who was deregistered as a psychologist in 2007 for various boundary violations and sexual misconduct, but continues to practise as a psychotherapist
- a Victorian massage therapist who sexually assaulted a number of clients during treatment and was convicted of the assaults, who has returned to practice
- a Tasmanian massage therapist who was convicted of sexual assault and jailed, and continues to practise

In some cases, where the offence is a single and isolated event and the practitioner is remorseful, he or she may be unlikely to reoffend. But in other cases, repeated offences have occurred, sometimes over many years, reflecting a pattern of behaviour that, if dealt with earlier, might have reduced the risk of repeat offences and further victims.

It is also acknowledged that there may be significant underreporting of sexual misconduct, where it involves practitioners who commence a sexual relationship with a patient while the patient is under their care.

In cases of sexual misconduct, even where a criminal prosecution has been successful, the practitioner will not be under any obligation to inform prospective patients of their criminal history, and consumer protection laws do not provide a remedy since there may be no misrepresentation or deceptive conduct at issue. If the practitioner were regulated, they might require the practitioner inform patients, and in some cases, have a chaperone present during treatments.

Cancer care

In the context of cancer care, some practitioners have specifically targeted vulnerable cancer patients, engaged in exploitative and predatory behaviour, using ‘hard sell’ tactics and charging unjustifiably high fees (sometimes in the tens of thousands of dollars), generally for treatments of unproven or questionable benefit. Some of these practitioners have characterised their treatments as ‘complementary or alternative medicine’ and presented themselves as ‘pioneers’ in the treatment of patients for whom Western medicine has allegedly failed. Such exploitative and predatory behaviour is not condoned by reputable complementary medicine practitioners and brings these professions into disrepute.

This area of health regulation overlaps with consumer protection law, because such practitioners may use false or misleading advertising and display deceptive credentials to recruit patients, in addition to providing poor clinical advice and unproven treatments.

Steps are being taken in some jurisdictions to better educate consumers as to some of the pitfalls of seeking unconventional treatments and in how to identify and deal with potentially exploitative providers when making health care choices. However, community education has its limitations in these circumstances, particularly for patients whose vulnerability is heightened due to a life threatening illness. The NSW Joint Parliamentary Committee found:

> A great many health services are provided by people who do not come within a statutory registration scheme, and the overwhelming majority of them are honest, caring and competent. However, a few health practitioners are anything but honest and competent and care for nothing more than their own financial advancement…..When patients seek health services they are entitled to be protected from the shonks and rip-off merchants who peddle false hope. People battling serious or terminal illnesses can be desperate, and will sometimes hand over large amounts of money for useless treatments. They may also be influenced to forgo proven medical treatments (Parliament of New South Wales, 2006 p.2083).

Other unprofessional conduct

There is a range of practitioner behaviour that may result in serious harm to consumers. Examples include:

- practitioners who advise or encourage their patients to cease conventional treatments for conditions as serious as epilepsy, diabetes, and cancer
- practitioners who fail to recognise the limitations of their practice, to the extent that where a patient's condition does not respond to treatment, they fail to refer on appropriately
- practitioners who practise under the influence of alcohol or unlawful drugs
- practitioners who have a physical or mental disorder and who have little or no insight into how their condition is impacting on their capacity to practise and placing the public at risk.

In the absence of a mechanism for early intervention with unregistered health practitioners, warning signs cannot be acted upon quickly and effectively unless a breach of legislation has occurred. Some of the case studies in *Appendix 7* relate to practitioners with a history of two or more decades of unethical practice where earlier intervention by a regulator with a broad mandate to regulate professional conduct may have dealt with their behaviour at an earlier stage, thereby reducing the number of victims.

4.3 Government reports

A number of government reports and inquiries have raised concerns about:

- what appears to be a steady increase in the number and complexity of complaints concerning unregistered health practitioners who have allegedly engaged in seriously unethical and/or illegal behaviour and continue to practise with impunity; and
- the perceived limitations of existing regulatory arrangements to adequately protect the public from unethical unregistered health practitioners.

These reports include:

- NSW Parliament Joint Committee on Health care Complaints Commission, 1998, *Unregistered Health Practitioners, The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints – Final Report*
- Victorian Department of Human Services, 2003, *Regulation of the Health Professions in Victoria. A discussion paper*
- NSW Parliament Joint Committee on the Health Care Complaints Commission, 2005, *Final Report, Report into Traditional Chinese Medicine*
- NSW Parliament Joint Committee on the Health Care Complaints Commission, 2006, Review of the 1998 *Report into Unregistered Health Practitioners, The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints*
- Victorian Health Services Commissioner, 2008, *Noel Campbell Inquiry Report*
- Parliament of South Australia, Social Development Committee, 2009, *Inquiry into Bogus, Unregistered and Deregistered Health Practitioners*
- Victorian Health Services Commissioner, 2009, *Investigation into Peter de Angelis (Shamir Shalom)*

Prior to the introduction in NSW of the Code of Conduct for Unregistered Health Practitioners, the NSW Joint Committee on the Health Care Complaints Commission's 1998 report titled *Unregulated Health Practitioners: The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints* noted a relatively low but increasing number of complaints about unregistered health practitioners.

The report can be accessed at the following address:

http://www.parliament.nsw.gov.au/Prod/parlment/committee.nsf/0/C8FC7ABE92EF4891CA25708300226D50

The report stated:

> It would appear that the range of mechanisms available to complain about unregistered health practitioners only provide very limited and piecemeal protection for consumers. Further, many of the agencies who administer the relevant Acts do not see the protection of standards of health care as their core business. The result is that complaining about such practitioners can be a confusing, frustrating and ultimately fruitless task for health consumers. Further, on the basis of the evidence received from the HCCC, it does not fare much better in its attempts to refer matters on. (Joint Committee on Health Care Complaints Commission p. 41)

In December 2005, the NSW Joint Committee on the Health Care Complaints Committee decided to review the previous Committee's 1998 Report into 'Unregistered Health Practitioners: The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints'. This was a direct result of concerns raised about unregistered professionals in other health fields during the Committee's 2005 Inquiry into Traditional Chinese Medicine. The Joint Committee issued a further report in September 2006 titled *Review of the 1998 'Report into Unregistered Health Practitioners: The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints'*

This report can be accessed at the following address:

http://www.parliament.nsw.gov.au/Prod/parlment/committee.nsf/0/35273DA1923C8FDDCA2571F800036D9C

In June 2009 the Parliament of South Australia (SA) Social Development Committee released the *Inquiry into Bogus, Unregistered and Deregistered Health Practitioners*.

The report of the Inquiry can be accessed at the following address:

http://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx

The Social Development Committee found:

> The evidence presented to the Inquiry has raised a number of serious concerns about unregistered practitioners who make unsubstantiated claims about 'cures' for cancer, or employ techniques and procedures that are unsupported by any credible evidence as to their safety or efficacy. The Committee considers that the current absence of a sound regulatory structure makes it difficult for consumers to identify properly skilled and qualified health practitioners. The case studies presented to the Inquiry strengthen the case for greater regulation to ensure health consumers are better protected from untrained and unqualified health practitioners (p.46).

In the absence of an effective mechanism for dealing in a timely manner with those unregistered health practitioners who exhibit a pattern of predatory and exploitative behaviour towards their patients or clients, governments are under increasing pressure to extend statutory registration to additional health professions, when the costs to the community may outweigh the benefits.

4.4 Deregistered practitioners

Most regulated health professions have practitioners who have either been deregistered, or let their registration lapse, but have continued to practise despite serious concerns about sexual misconduct, physical assault of patients, fraud, or other unethical practices. While the numbers of deregistered practitioners is small, and some State and Territory laws have been tightened in recent years to empower disciplinary tribunals to issue prohibition orders when deregistering a practitioner, there are cases of:

- former nurses who continue to practise as personal care workers
- former midwives who continue to practise under the title of 'doula' or birth attendant
- former physiotherapists, chiropractors or osteopaths who continue to practise under the title 'remedial masseur'; and
- former psychiatrists or psychologists who continue to practise as counsellors or psychotherapists
- former Chinese medicine practitioners who continue to practise as complementary medicine practitioners.

The South Australian Social Development Committee report documented four cases reported by registration boards, involving two former medical practitioners, one former dentist and one former psychologist.

While it does not necessarily follow that these deregistered practitioners are continuing to engage in unethical or illegal activity, their deregistration would, in most cases, indicate that they are not fit and proper to be providing the same services that they previously provided as a registered practitioner. The fact that these practitioners have been willing to restructure and rebadge their practice arrangements to continue practising free of regulatory oversight suggests there is a heightened risks for consumers.

Under the National Law a State or Territory Tribunal has the power, at the time it decides to cancel a practitioner's registration, to 'prohibit the person from using a specified title or providing a specified health service' (see section 196(4)(b)). While these powers are yet to be tested, their impact in protecting the public is limited because the powers cannot be applied retrospectively to practitioners who have already been deregistered prior to the introduction of the National Law, or to practitioners who have previously let their registration lapse and the relevant State or Territory registration board had no powers to pursue the matter or decided not to. There are a number of practitioners referred to in *Appendix 7* who fall into this category.

4.5 Available data on risks and complaints

Assessment of risk

Risk is defined as 'the probability of an undesirable event occurring' (COAG Best Practice Regulation Guide p.18). Risk assessment is a means of analysing the risk of an undesirable event occurring, and the consequences that are liable to arise if it does occur. Such an assessment assists in determining what action may be necessary to reduce or eliminate the risk and/or its consequences.

There are risks associated with any form of health care. However, identifying and quantifying the risk and assessing its significance is particularly complex in this context because the scope of the health industry is so broad, and the extent to which risks are realised or contained in practice depends on a wide range of factors and the interaction between them. Also, there is very little systematically collected information available about the extent of the problem, although there have been some high profile cases of unacceptable outcomes for consumers and for the health system.

The nature, frequency and severity of risk presented by a practitioner depends, in part, on the nature and scope of their practice, and the extent to which the practitioner undertakes potentially high risk procedures or activities. Risks may be divided into two main categories:

- risks associated with the exercise of clinical judgement by a practitioner such as:
  - removal of therapy
  - incorrect prescribing or other application of treatment
  - misdiagnosis
  - failure to refer
  - failure to explain precautions or contraindications
- risks inherent in the procedures, activities or treatments applied, for example:
  - risks associated with the ingestion of substances:
    - predictable toxicity reactions due to overdose, drug interactions, drug/herb or drug/food interactions
    - unpredictable reactions such as allergy, anaphylaxis, idiosyncratic reactions
    - failures of good manufacturing practice such as misidentification

  - risks associated with the use of radiation equipment or therapeutic goods
  - risks associated with poor infection control procedures
  - risks associated with trust and the nature of the practitioner/patient relationship.

Risk of harm to the public may be exacerbated when:

- the practitioner works in isolation from peer or supervisor support
- the practitioner suffers from a physical or mental impairment
- the practitioner is unqualified or incompetent
- the practitioner has a criminal history, falsified identity or false qualifications
- the practitioner's behaviour places their own interests above those of their patients.

Appendix 8 provides further detail on risks associated with the provision of health services by unregistered health practitioners.

Complaints data

Health Complaints Entities from NSW, Queensland, Victoria and Western Australia have provided data on the numbers and types of complaints received in relation to unregistered health practitioners. *Appendix 9* provides details of the data provided, which includes data on:

- the number of complaints by type or category of unregistered health practitioner, for example social workers, counsellors/therapists or alternative health providers, and
- the number of complaints by the issue raised in the complaint, for example treatment, communication or fees.

However, it is difficult to make comparisons or draw conclusions from the data because there is no standardisation across jurisdictions in collection and reporting. Further analysis of complaints data, including data from consumer protection regulators, will be undertaken as part of this project.

Questions to assist with submissions

- What do you think are the risks associated with the provision of health services by unregistered health practitioners?
- To what extent have the risks associated with these activities been realised in practice?
- Do you know of instances of actual harm or injury?
- What evidence is available on the nature, frequency and severity of risks?
- What factors exacerbate or ameliorate the risk that individuals will suffer harm as a result of the activities of unregistered health practitioners?

5 The objectives of government action

Given the nature of the problems identified above, the objective of government action is to better protect health service users within Australia from harm arising from unregistered health practitioners who breach their legal and professional obligations and are not fit and proper persons to be providing health services. Such harm may be physical, psychological or financial.

Questions to assist with submissions

- What do you think should be the objectives of government action in this area?

6 The options for strengthening public protection

6.1 Overview of options

There are a number of options for regulatory reform. They are set out below.

Option 1: No change – rely on existing regulatory and non-regulatory mechanisms

This option generally entails no change to existing health regulation, but may involve broader application of existing regulation both within and outside the health portfolio.

Under this option, existing regulatory protections continue to apply, such as those available under the Australian Consumer Law, therapeutic goods, scheduled medicines, radiation safety, infectious diseases and health complaints laws, supported by the common law remedies for individuals to pursue action for negligence or breach of contract, and of course the criminal law.

Changes may be made over time to strengthen these existing regulatory regimes in individual States and Territories, or through nationally uniform schemes outside the health portfolio such as those introduced with the passage and adoption of the Australian Consumer Law.

Administrative effort may be directed at improving the coordination of existing regulators, for example, through the adoption of protocols for improved information sharing and joint regulatory action.

The additional statutory protections that have been enacted in NSW and outlined in section 3 of this paper continue to apply, and similar protections will apply in South Australia if the bill currently before the South Australian Parliament is enacted. In the absence of a nationally agreed approach, other States and Territories may or may not enact similar laws.

Also, the National Law may be amended from time to time to extend the scope of the National Registration and Accreditation Scheme to include additional health professions. It is possible within these existing arrangements for any or all health professions to be assessed for inclusion in the National Registration and Accreditation Scheme. The process through which this assessment may occur is outlined below.

Inclusion of new professions in the National Registration and Accreditation Scheme

There is, under current arrangements, an inter-governmental process whereby State, Territory and Commonwealth Health Ministers (sitting as the Australian Health Workforce Ministerial Council) may agree, from time to time, for amendments to be made to the National Law to extend the National Registration and Accreditation Scheme to regulate additional professions.

Attachment B of the IGA sets out the criteria for assessing unregistered health professions for inclusion in the National Scheme (the IGA criteria). The assessment process is overseen by a committee of the Health Workforce Principal Committee (HWPC) of the Australian Health Ministers' Advisory Council (AHMAC). Any recommendations for extension of the National Scheme arising from the assessment may be considered by the Australian Health Workforce Ministerial Council (AHWMC). If AHWMC accepts that a prima face case exists for statutory registration of another health profession, then a COAG Regulatory Impact Statement (RIS) process will be required to assess costs and benefits of all feasible options (including no change) and identify the most suitable option.

The COAG RIS process must be undertaken in accordance with the Council of Australian Governments Guidelines titled *Best Practice Regulation: A Guide for Ministerial Councils and National Standard Setting Bodies October 2007*. These guidelines are available at the following address: http://www.finance.gov.au/obpr/proposal/coag-guidance.html

Where a stakeholder is of the view that the National Registration and Accreditation Scheme should be extended to regulate an additional profession, they may make a submission to any State or Territory requesting that an assessment against the IGA criteria be undertaken

Stakeholders interested in pursuing a request for assessment of a health profession for inclusion in the National Scheme should refer to the IGA criteria, contained in Attachment B of the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, available at the following address:

http://www.ahpra.gov.au/Legislation-and-Publications/Ministerial-Directives-and-Communiques.aspx

Option 2: Strengthen self regulation – a voluntary code of practice

Under this option, professional standards would be set out in a voluntary code of practice, developed in cooperation with professional associations and other industry bodies that represent unregistered health practitioners. Government effort would be directed at:

- leading the development of a national code of practice for unregistered health practitioners including conduct of public consultations
- encouraging professional associations to adopt the national code of practice as a membership requirement for their practitioner members, or to amend their existing codes to include core professional standards
- assisting with community education designed to inform consumers about:
  - what constitutes acceptable and unacceptable professional conduct and what to expect from unregistered health practitioners
  - the importance of ensuring the health practitioners they choose are properly trained and qualified, and
  - the avenues available to them for dealing with any complaints that might arise
- providing advice and support to self-regulating professional associations to better implement the voluntary code with respect to their members.

This option would allow health practitioners and their representative bodies to continue to set their own professional and ethical standards, but with access to additional materials designed to better educate practitioners and their clients about what constitutes acceptable professional conduct, and what avenues are available when things go wrong.

Apart from existing Health Complaints Entity powers to investigate complaints against unregistered health practitioners and attempt to resolve or conciliate such complaints where appropriate, there would be no statutory body (except in NSW) with powers to investigate and prosecute and prohibit from practice unregistered health practitioners who breach the voluntary code. Rather, professional associations would be encouraged to make observance of the code a condition of membership. Professional associations would also be responsible for monitoring observance of the code, and reporting (via their annual reports) data on complaints received and how these have been resolved or managed.

Option 3: Strengthen health complaints mechanisms – a statutory code of conduct

Under this option, a nationally consistent and statutory code of conduct would set out accepted professional standards of practice for all unregistered health practitioners. The Code would apply in all States and Territories, and would specify standards along the lines of those of the *NSW Code of Conduct for unregistered health practitioners* (see *Appendix 6*).

Consumers would be able to make a complaint that an unregistered health practitioner has failed to comply with the code of conduct. Following an investigation of the allegations, if the practitioner is found to have breached the code of conduct and the breach is serious enough, an order could be made prohibiting the practitioner from continuing to provide health services, or attaching conditions to their practice. A register of prohibition orders would be publicly accessible on a website or websites, for consumers to access the details. Breach of a prohibition order would be a criminal offence, prosecutable through the courts.

Implementation issues such as the scope of the proposed scheme and its legislative and administrative arrangements are discussed in section 6.3 below.

6.2 Discussion of options

Option 1: No change – rely on existing regulatory and non-regulatory mechanisms

Option 1 is the 'base case', with no regulatory changes to health legislation in response to the problems identified. One benefit of the status quo is that it allows existing regulators (such as Consumer Protection, Therapeutic Goods and Radiation Safety regulators) to build expertise in investigations of unregistered health practitioners. Another is that, compared with Options 2 and Option 3, there are no costs associated with additional regulatory or self-regulatory measures.

Potential costs associated with this option relate primarily to the failure to deal in an effective and timely manner with 'repeat offenders', and prevent further victims. These potential costs include:

- for regulatory agencies responsible for enforcing the existing regulatory regime – costs associated with the investigation and prosecution of 'repeat offenders' who fail to heed warnings to refrain from high risk, exploitative or predatory behaviour
- for individuals and their families who have suffered harm – costs associated with their pursuit of private actions for damages
- for the health system – costs associated with treating or caring for individuals (and their families) who have been harmed by practitioners convicted of offences under various Acts who have continued to practise
- for the economy – costs associated with lost productivity of individuals unable to work due to harm suffered.

Under this option, unregistered health professions can make a case at any time for statutory registration, and a new profession may be included in the National Registration and Accreditation Scheme, where it can be demonstrated that there would be a net benefit to the community. This arrangement provides flexibility to consider changing circumstances, such as where the scope of practice of a profession expands to include more high risk types of activities that may warrant greater public protection.

Nevertheless, regulatory coverage is likely to be seen as inconsistent, with some health practitioners required to comply with extensive registration obligations and others subject only to general consumer protection law. There may be potential for consumer confusion as a result. There may also be potential for inconsistencies in decision making because of the different environment that exists each time a new occupational group is assessed against the IGA criteria.

Costs that are imposed by the statutory registration scheme are of three main types:

- establishment costs that are generally met by governments, such as the cost of legislative drafting and Parliamentary sitting time, the cost of establishing the infrastructure to support additional registration functions, the costs associated with establishing a registration board or boards in advance of an available funding stream from registration fees
- ongoing costs of administering the regulatory regime, to be recovered from the registration fees paid by regulated practitioners
- other compliance costs for individual practitioners, for example, the costs associated with achieving the qualifications necessary for initial registration, and the costs associated with meeting other regulatory requirements, such as maintaining professional competence, undertaking continuing professional development, and maintaining professional indemnity insurance.

Annual registration fees for the currently regulated professions range from $115 for nurses, through to $650 for medical practitioners, with the unweighted average being around $385 a year.

Registration aims to reduce the risk of unethical or fraudulent behaviour by applying fit and proper person requirements (to screen applicants for registration) and enforcing sanctions for example, through deregistration. The purpose of regulatory oversight is to reduce health and safety risks and costs for consumers (see section 4.5) than would otherwise occur.

The risks to consumer health associated with the practice of registered health practitioners are likely to be greater than for unregistered health practitioners, primarily because of the extent to which the registered health professions use invasive techniques and equipment and carry out other types of high risk procedures (see *Appendix 8*). Where the incidence of harm associated with unregistered health practitioners is small, the benefits of across-the-board registration of all these practitioners will also be small. Therefore, the costs to the community of extending the statutory registration regime to cover all currently unregistered health practitioners are likely to outweigh the benefits and would be a disproportionate response to the risk.

Is reliance on consumer protection law sufficient?

The NSW Impact Assessment Statement on the Unregistered Health Practitioners Code of Conduct found:

> While fair trading legislation and provisions in the Public Health Act dealing with false, misleading or deceptive advertising are able to address individual instances of this type of advertising, the processes involved in bringing these matters to conclusion can be lengthy and in many respects provide little if any ongoing protection for consumers[…]. Incorporating this provision in the code of conduct gives practitioners clear guidance that advertising cures for cancer and other terminal illnesses is unacceptable and will allow the Health Care Complaints Commission to take effective action to prevent a practitioner from continuing to do so. (NSW Unregistered Health Practitioners Code of Conduct Impact Assessment Statement, p. 11).

Since the NSW Joint Committee on Health Care Complaints Commission first raised concerns in 1998 about the adequacy of laws governing unregistered health practitioners, there has been a number of high profile prosecutions of unregistered health practitioners by consumer protection regulators, notably:

- the ACCC's prosecution in 2007-08 of Paul John Rana and his company *NuEra Wellness* which led to a six month jail sentence for breaches of the *Competition and Consumer Act 2010* (Cth),
- Fair Trading NSW prosecutions of Jeffrey Dummett and Paul Perrett
- Consumer Affairs Victoria's prosecution of Noel Campbell for alleged breaches of the *Fair Trading Act* (Vic) (not yet finalised).

While consumer protection regulators have had success with these cases, there is a risk that relying on consumer protection legislation to deal with repeated and wilful unethical conduct of unregistered health practitioners may be insufficient to protect public health and safety. Reasons are:

Prioritisation of resource allocation and access to expertise

Consumer protection law is broad in scope and does not provide a singular or targeted focus on health services. In most cases, consumer protection regulators will not have access to the expertise required to adequately investigate and prosecute such cases, and will have to secure this expertise from outside the organisation.

The Productivity Commission's Inquiry Report Review of Australia's Consumer Policy Framework published in April 2008 noted:

- according to many, under-resourcing of some Fair Trading Authorities has led to patchy enforcement of the generic law and thereby contributed to over-reliance on industry-specific regulation (Vol 1 p. 39)
- the evidence suggests that there has there has probably been too little rather than too much court-based enforcement…[W]ithout the back-up of an effective enforcement tool kit, education and other business compliance programs are likely to be less effective (Vol 1 p.43)
- more consistent enforcement could be achieved by addressing the resourcing constraints facing some jurisdictional regulators (Vol 1 p.46)
- specific additional strategies may be required to deal with the circumstances of some vulnerable and disadvantaged groups (Vol 1 p.52)

This supports the view that the resources required for investigation and prosecution are scarce and allocation decisions are always required. Given the complexity and cost of cases, the specialist knowledge that may be required, and the absence of a history of enforcement activity in the health area, such cases may be afforded a lower priority than perhaps they should be, given the potential for harm.

Focus on early intervention and harm minimisation

Consumer protection laws are designed to protect consumers and provide consumer guarantees that goods and services a trader offers are without defect and are fit for purpose. These laws also provide redress when reasonable consumer expectations are not met. There has been a traditional focus on product safety rather than service safety, and detriment arising from contracts and implied contracts. In regulating consumer contracts, the test applied is one of 'fairness' and whether the reasonable expectations of consumers have been met. However, in the context of health, procedures are often inherently high risk, consumers are often more vulnerable, and regulation is aimed at harm minimisation. Many of the matters addressed in health practitioner regulation, as demonstrated by the NSW Code of Conduct, go beyond what would be expected to be regulated under consumer protection laws.

Thus, while the Australian Consumer Law will provide powers to issue banning orders and cease trading orders, these powers will not deal effectively and in a timely manner with all serious cases of exploitative and predatory behaviour by unregistered health practitioners where the conduct of concern may be unprofessional but not illegal, or where prevention of future harm is the objective. For example, a practitioner who has been convicted of sexual assault of patients is able to return to practice after serving his or her sentence. In such circumstances, there may be no misrepresentation or other breach of consumer protection legislation, but there may be a pattern of conduct that indicates the practitioner is not a fit and proper person to continue to provide health services.

Practitioners with a pattern of non-compliance

Those health practitioners who have been successfully prosecuted under consumer protection law usually have a history of alleged breaches of various State, Territory and Commonwealth regulations (not just consumer protection laws), and have become adept at skirting around the various regulatory requirements. In some cases, practitioners have been 'known' to regulatory authorities for many years

and while questions have continued to be raised about their character and fitness to practice, gathering the evidence required to secure a successful prosecution by a single regulatory agency has proven a difficult and highly resource intensive. It seems only the most serious cases have been prosecuted, and only after an extended period, with repeat offences and multiple victims.

Even when prosecuted, fines and/or suspended sentences have not had sufficient deterrent effect and often these practitioners have returned to practice. While banning orders have been applied in some jurisdictions, these are generally limited in time and/or scope. The evidentiary burden is likely to be very high for a permanent banning and requires a court to be satisfied of a theoretical construct – that the practitioner is likely to offend again.

Implications of a statutory code of conduct applying only in some States and Territories

A statutory code of conduct for unregistered health practitioners may apply only in some States and Territories (two at present), but not all. If this is the case, then a number of consequences are possible.

First, health service users in jurisdictions without a statutory code will have fewer and arguably less effective avenues available for pursuing complaints against unregistered health practitioners, and limited mechanisms for prohibiting from practice those practitioners found not to be fit and proper to provide health services.

Second, it is possible that unregistered health practitioners in those jurisdictions where a statutory code applies may shift to another jurisdiction to avoid investigation and prosecution. There is evidence that this has occurred when statutory registration of a profession has been introduced in one jurisdiction but not others.

Third, where a prohibition order has been issued, it will have no effect outside the jurisdiction where it is issued, unless the laws provide for ‘mutual recognition’ of prohibition orders. Even where one jurisdiction recognises and applies, under mutual recognition, the prohibition orders of another jurisdiction, this is not a failsafe mechanism. The limitations of mutual recognition under (now repealed) state and territory registration laws were evident when the National Scheme commenced. On transition to national registration, a number of practitioners were found to have been registered in one jurisdiction while ‘struck off’ in another.

Option 2: Strengthen self regulation – a voluntary code of practice

A voluntary code of practice has the potential to provide a more flexible and less costly approach than introducing new regulation. A voluntary code can be tailored to the circumstances of the profession or occupation and readily updated as necessary. It also allows practitioners to develop least-cost compliance strategies.

Possible costs associated with this option include:

- administrative costs to governments of developing and implementing the code of practice - consultation costs, community education costs, monitoring, review and evaluation costs
- costs to professional associations and their members of supporting development and implementation of a voluntary code of practice
- costs to individuals, families and communities harmed by rogue or bogus practitioners who fail to comply with a voluntary code and continue to practise outside the self-regulatory arrangements
- costs to individuals of private actions for damages by consumers harmed by unregistered health practitioners who breach minimum standards of practice
- costs to governments of successive prosecutions of practitioners who have a history of offending behaviour and choose not to comply with a voluntary code of practice.

Some of the possible benefits of a voluntary code include:

- provision of guidance and education to practitioners and professional associations about appropriate standards of practice.
- flexibility to tailor the code of practice to the circumstances of each profession, and to amend codes over time as necessary.
- increased cooperation and engagement between professional associations and government in design and implementation of the code.

A voluntary code might be strengthened by governments 'recognising' in some way those professional associations that adopt and apply the code as a condition of membership, and educating consumers of which associations are 'code compliant'.

Reliance on self-regulation and a voluntary code can be problematic for the following reasons:

- The representative arrangements in some professions are fragmented, with no single peak body. In such circumstances, there is often a lack of consensus amongst stakeholders on minimum standards for entry to and practise of the profession. There may also be concerns about governance arrangements and resourcing issues, all of which may compromise the capacity of professional associations to apply and enforce a voluntary code in a fair, transparent and effective manner.
- The main difficulty with a voluntary code of practice is the lack of incentives for voluntary observance. Rogue or bogus practitioners who exploit sick and vulnerable patients rarely participate in self-regulatory arrangements. With a non-binding code, practitioners can continue to practise if disciplined by or expelled from an association for misconduct. When self-regulatory arrangements fail and practitioners are not prepared to enter conciliation, the main option for aggrieved consumers is common law action.
- If a practitioner is the subject of a complaint to their professional association and they choose not to cooperate with the investigation and disciplinary process, they may resign their membership (or let it lapse) and continue practising with no sanctions and few if any consequences. This is a significant driver for many self-regulating professions to seek statutory registration.

Sylvan (2002) reported on the Australian Consumers' Association's assessment of four important self regulatory schemes and rated them on the basis of a number of criteria, including whether they had industry coverage, whether there was an open and participative consumer consultation process in the development of the industry code against which participants were regulated, whether the regulator had a balanced representative structure, whether there was public reporting of complaints, including statistics and public naming of poor industry performers, whether the disciplinary body had at its disposal a hierarchy of escalating complaints, and whether the scheme was subject to external audit (Sylvan pp: 7-8).

Sylvan concluded that self-regulation should not be used where the market is characterised by information asymmetries, where consumers are dealing with non-experiential goods or services, where public health and safety is an issue, or in situations of limited competition – either natural monopolies or where a firm has achieved dominance (Sylvan pp: 8). Self-regulation was considered to work best where it is underpinned in some way by the government, with an interested regulator in the background who has a 'big stick' to use, if necessary.

Self-regulation may not be effective in protecting the public, particularly with respect to services provided by practitioners from the emerging professions, unless governments take a lead role in overseeing the self-regulatory structures and processes and providing incentives for compliance. However, there are costs to government in taking a more active role in self-regulatory arrangements and questions remain about the efficacy of self-regulation in dealing with practitioners who have a history of non-compliance with legal as well as professional obligations.

Option 3: Strengthen health complaints mechanisms – a statutory code of conduct

A statutory code of conduct, such as the model that applies in NSW (and is under consideration in South Australia) has the potential to provide, in those jurisdictions, a more immediate and responsive mechanism for dealing with breaches of professional and ethical standards in health care, particularly in cases where a practitioner has been convicted of an offence under another Act (suggesting he or she may not be a fit and proper person to provide health services) but is continuing to practise. Such a scheme is not designed to remove responsibility from consumers to make sensible choices about their own health care. Rather, it is intended to be applied where there is a risk to public health and safety that has not adequately been dealt with through other means. In NSW, it provides a relatively low cost targeted complaints mechanism that complements other available remedies, including civil action.

This type of regulatory scheme does not set minimum requirements for entry to a profession. Rather, it relies on the making of a complaint to draw the attention of the regulator to poor, unethical or illegal practice, usually after some harm has occurred. Intervention by government is kept to a minimum, and only occurs when things go wrong that result in a complaint. It addresses a perceived gap in the regulatory arrangements for those professions and occupations that are unlikely to meet the requirements for statutory registration. It also builds on or complements existing practitioner regulation and health complaints arrangements, providing a synergy of function and economies of scale. By providing direct powers to deal with unethical practitioners, it also reduces pressure on governments to legislate to regulate additional professions via statutory registration.

The NSW Code of Conduct, for example, draws together in one place, under one regulatory regime, the fundamental ethical and legal obligations of unregistered health practitioners, and facilitates ethical discourse amongst members of the unregistered health professions about their professional and legal obligations.

Costs associated with this option may include:

- costs associated with the development and passage of new or amending legislation in each State and Territory
- establishment costs associated with a new regulator, or an existing regulator taking on new functions
- ongoing costs associated with investigation and prosecution of breaches of code of conduct.

The possible benefits of regulating unregistered practitioners within an occupational regulation framework, rather than relying solely on existing laws include:

- Minimum acceptable standards of practice can be enforced, regardless of whether the practitioner is registered, thus minimising the costs to the community if all practitioners were required to be registered.
- Persons who are not fit and proper to be providing health services can be prevented from doing so, thereby providing a more direct, responsive and long term solution to the problem of ‘rogue’ practitioners who persistently engage in exploitative behaviour, compared with remedies available through other avenues
- It facilitates regulatory scrutiny of practitioners where their conduct suggests a pattern of non-compliance which spans multiple jurisdictions and regulatory regimes.
- The standard of proof that applies in the prosecution of breaches within an occupational licensing framework is lower than for criminal prosecutions, that is, ‘on the balance of probabilities’ rather than ‘beyond reasonable doubt’.

Questions to assist with submissions

- Do you think there is a case for further regulatory action by governments in this area?
- What do you think of the various options?
  - **Option 1:** No change
  - **Option 2:** Strengthen existing self-regulation – A voluntary code of practice for unregistered health practitioners
  - **Option 3:** Strengthen health complaints mechanisms – A statutory code of conduct for unregistered health practitioners
- On balance, do you have a preferred option? What are your reasons?
- What do you think are the costs and benefits of the three options?
- If you are a practitioner, can you advise of what additional costs you think you might incur with the introduction of a statutory code? Are there some aspects of a statutory code that are likely to be more costly than others?

6.3 Policy and implementation issues

There are a number of policy and implementation issues that arise in relation to Option 3. Some of these are outlined below, and feedback is sought from stakeholders.

6.3.1 National uniformity and diversity

Under Australia's federal system of government, diversity is to be expected, and in some cases may be desirable. With respect to regulatory schemes, there is a spectrum of uniformity, ranging from complete uniformity to no uniformity, with variations in between involving harmonisation, reciprocity (for example mutual recognition schemes), co-ordination of legislation and/or policy and mechanisms for exchange of information (The University of Melbourne 1999 p. 12).

When considering options for regulation of unregistered health practitioners within a federal system, it is necessary to consider what level of uniformity and coordination is necessary, appropriate and achievable to deal with the problems and achieve the desired outcomes.

To what extent, for example, is it necessary or desirable for there to be:

- nationally uniform standards of conduct against which all unregistered health practitioners are judged, regardless of the State or Territory in which they practise
- nationally uniform or nationally consistent policy and scope of a legislative scheme or schemes
- nationally uniform or nationally consistent arrangements through which breaches of standards are investigated, prosecuted and determined
- a single centralised administrative body that is directly responsible for day to day administration?

Questions to assist with submissions

- Do you think there should be a nationally uniform code of conduct for unregistered health practitioners or are different codes in each State and Territory acceptable?
- Should there be nationally uniform or nationally consistent arrangements for investigating breaches of the code and issuing of prohibition orders, or should States and Territories each implement their own arrangements?
- Should there be a centralised administrative body that administers the regulatory scheme, or should it be administered by each State and Territory government?

6.3.2 Scope of the regulatory scheme

The scope of an extended regulatory scheme would need to be determined. The NSW regulatory scheme applies to 'health practitioners' who deliver 'health services'. It applies to two classes of health practitioner:

- Practitioners who are not registered under the National Law
- Practitioners who are registered under the National Law who provide health services that are unrelated to their registration.

The NSW scheme does not apply to employers, owners or operators of businesses that provide health services, where they deliver services through the agency of another person.

The NSW scheme does not directly regulate health products, except to the extent that health practitioners use such products in their practice in a way that breaches the Code of Practice, for example, by making false or misleading claims about the products used in treatments, financially exploiting or misinforming clients, or using products in treatment without an adequate clinical basis.

Questions to assist with submissions

- If a statutory code of conduct were to be enacted, to whom should it apply?
- Which practitioners, professions or occupations should be included?
- Should it apply only to practitioners who deliver health services? If so, what should be the definition of a health service?
- Should it apply to registered practitioners who provide health services that are unrelated to their registration, for example, a registered nurse who is working as a naturopath or massage therapist?
- Should it only apply to practitioners who directly deliver services, or should it also apply to those who deliver health services through the agency of another person, for example, the owners or operators of businesses that provide health services?

6.3.3 Administrative arrangements

There are at least two options with respect to the administrative arrangements through which a national statutory code of conduct might be applied to unregistered health practitioners.

Option 3A: State and Territory based schemes

Under this option, the powers of existing State and Territory Health Complaints Entities (other than in NSW and South Australia) would be extended to issue prohibition orders for breach of a code of conduct. It would be up to each State or Territory to determine the body empowered to issue orders under legislation, such as the HCE itself (as in NSW and proposed in South Australia), or an independent tribunal.

This option would build on existing State and Territory health complaints arrangements, including the power to investigate complaints against unregistered practitioners, providing a synergy of function and economies of scale with the existing Health Complaints Entity functions.

The enabling legislation would need to ensure that banning orders imposed by one State body would automatically apply in every other State and Territory, in order to deal with those practitioners who might be tempted to move states to avoid regulatory action. There are, however, concerns about the effectiveness of mutual recognition arrangements in dealing with practitioners who are mobile and are motivated to avoid regulatory scrutiny. The limitations of mutual recognition arrangements were a key factor in the decision to establish a national registration scheme for registered health practitioners.

Option 3B: A single nationally administered scheme

Under this option, the regulation of unregistered health practitioners through a statutory code of conduct would be administered by a national Complaints Commissioner for unregistered health practitioners. The Commissioner would have powers to:

- receive and investigate complaints about breaches of the code of conduct
- liaise with State and Territory HCEs concerning the handling of such complaints
- bring prosecutions for serious breaches forward to the responsible State or Territory Tribunal for hearing.

The Commissioner may be supported in his/her role by the Australian Health Practitioner Regulation Agency (AHPRA) and its State and Territory Offices.

This option strengthens the move towards national systems of regulation. If the Commissioner was supported administratively by AHPRA, would provide a synergy of function across all professions and the greatest economies of scale. It would provide for nationally consistent application of standards of conduct and practice for all unregistered health practitioners and nationally consistent administration of the investigation and prosecution of breaches of the code. The enabling legislation would need to ensure that banning orders imposed by one State-based body would automatically apply in every other State and Territory.

However, this option has the potential to divert the National Agency's attention from its responsibilities under the National Law to administer regulation of the statutorily registered professions, at a time when the National Registration and Accreditation Scheme is still in its infancy, with four additional professions still to be brought into the Scheme from 1 July 2012.

Also, AHPRA would require a separate funding stream for this function, with transparency in the accounting and reporting arrangements, in order to avoid cross subsidisation from fees paid by registered health practitioners.

This model would also duplicate the role of State and Territory HCEs, which already receive and investigate complaints against unregistered health practitioners. AHPRA would need to liaise and work cooperatively with HCEs in the same way that liaison occurs in relation to complaints against registered practitioners.

The establishment of a new entity (a national Commissioner) may be more costly than extending the powers of State and Territory HCEs. Further analysis of the costs will be undertaken as part of this project.

Questions to assist with submissions

- Do you have a preferred option for the administrative arrangements through which a code of conduct for unregistered health practitioners is administered and complaints about breaches of the code are investigated and prosecuted?
- What are your reasons?

6.3.4 Content of code of conduct

The NSW Code of Conduct for Unregistered Health Practitioners provides a model for the development of a national statutory code of conduct for unregistered health practitioners. Interested parties are asked to consider the detail of the NSW Code of Conduct and whether it provides a suitable model for other jurisdictions or for a national code, or, if amendments are required, in what areas they are needed.

Questions to assist with submissions

- What do you think should be included in a statutory code of conduct?
- Do you have any comments on the NSW Code of Conduct for Unregistered Health Practitioners?
- What do you think are the strengths and weaknesses of the NSW Code?
- Do you think it provides a suitable model for other jurisdictions or for a national code? What are your reasons?

6.3.5 Prosecutions and hearings

The NSW regulatory scheme empowers the Health Care Complaints Commission, following an investigation, to issue a prohibition order that may, for example, prohibit a practitioner from continuing to practise or provide specific types of health services. If the Commission intends to issue a prohibition order or public statement about a health practitioner, section 39 of the Act requires the Commission to inform the practitioner of the substance of the grounds for its proposed action and give the practitioner the right to make submissions. Section 41 requires the Commission to review a decision to issue a prohibition order, if requested by the complainant.

The NSW scheme does not afford unregistered health practitioners the right to a hearing before a prohibition order is made, a right which is available to registered health practitioners in NSW under the tribunal arrangements of the National Law. However, a practitioner who is aggrieved by a decision of the Commission to issue a prohibition order has a right under section 41C to apply to the Administrative Decisions Tribunal for a review of the decision.

Using the same organisation to both investigate/prosecute breaches and impose sanctions (prohibition orders) has strengths and weaknesses. On the one hand, it allows the Commission to respond quickly and efficiently to public health risks presented by unregistered practitioners, more quickly than if the Commission was required to prepare and prosecute a case before a tribunal or court to obtain a prohibition order. On the other hand, it treats registered and unregistered practitioners differently. Under the National Registration and Accreditation Scheme, there is a ‘separation of powers’ between those who investigate and prosecute breaches of professional standards (the Australian Health Practitioner Regulation Agency), and those who hear and adjudicate matters and impose sanctions (a State or Territory tribunal). Also, registered practitioners are afforded under nationally uniform legislation the right to a hearing before an order prohibiting their practice can be made. Unregistered practitioners in NSW are not.

The NSW legislative scheme has recently been amended to empower the Commission to issue, during an investigation, an ‘interim prohibition order’ if the Commission has a reasonable belief that the practitioner has breached the Code of Conduct, that the practitioner poses a serious risk to public health and safety and that an order is necessary to protect public health and safety. Similar powers apply to registered practitioners under the National Law. This allows quick action in circumstances where the Commissioner considers the public to be at risk.

Questions to assist with submissions

- Do you have a preferred option for the mechanism through which prohibition orders should be issued?
- Should a Commissioner be empowered to investigate, prosecute and determine breaches of a code and impose sanctions (prohibition orders), or should there be separation of the investigation/prosecution of breaches from the hearing of breaches, with the latter undertaken by a tribunal or court?
- What are your reasons?

6.3.6 Grounds for issuing a prohibition order

Under the NSW regulatory scheme, in order for the Commission to issue a prohibition order, it must find that :

- the provider has breached the code of conduct, or
- the provider has been convicted of a 'relevant offence'

  and
- there is a risk to public health and safety.

A relevant offence is defined as:

- an offence under Part 2A of the *Public Health Act 1991 (NSW)*, or
- an offence under the *Fair Trading Act 1987* (NSW) or the *Competition and Consumer Act 2010* (Cth) that relates to the provision of health care services.

If such a scheme is to be adopted nationally, then consideration would need to be given to the grounds for issuing a prohibition order. If 'relevant offences' are to provide grounds for action, then consideration should be given to what offences should be included.

There are also questions about whether the need to demonstrate that a risk to public health and safety exists before making an order is too limiting for the protection of the public. Other breaches of a code would constitute unprofessional conduct and, if committed by a registered practitioner, would constitute grounds for taking action against the practitioner by a National Board. The most notable example for unregistered practitioners is the exploitation of vulnerable persons for financial gain. There have been many instances of unregistered practitioners using ineffective treatments and financially exploiting persons with terminal illnesses. Other areas of concern would include a practitioner having sexual relations with a client or practising beyond their competence. In NSW, the legislation makes clear the limits of the HCCC's powers under the Code. Thus, any matter that relates only to financial exploitation but does not present risks to public health and safety is considered the domain of consumer protection bodies rather than the HCCC.

Questions to assist with submissions

- What 'relevant offences' (if any) should provide grounds for a prohibition order to be issued?
- What other grounds should apply before a prohibition order may be issued?

6.3.7 Financing of the scheme

Under the National Registration and Accreditation Scheme, investigation of complaints and the prosecution of practitioners for breach of professional standards are funded from the registration fees paid by practitioners. While governments jointly funded the establishment of the National Scheme, its ongoing operations are entirely self-funded. However, there is no similar source of funding available to support a regulatory scheme for unregistered health practitioners since they do not require a license (registration) to practise and therefore do not pay registration fees.

In NSW, the operations of the Health Care Complaints Commission are funded by the NSW Government, including the activities associated with enforcement of the Code of Conduct for Unregistered Health Practitioners. The principle of user pays has not been applied when dealing with complaints of this nature in any State or Territory.

Views are sought on what sources of funding might be available to cover the costs of investigating consumer complaints and the prosecution of unregistered practitioners for serious breaches of a national code of conduct.

Questions to assist with submissions

- How do you think a regulatory scheme to investigate and prosecute breaches of a national statutory code of conduct for unregistered health practitioners should be funded?
- What are your reasons?

Quick response form

Are you a:

- Consumer of health services
- Unregistered health practitioner
- Registered health practitioner
- Employer of health practitioners
- Professional association
- Regulator
- Other – Please state: _____

Section 2 – Scope

- If you are a professional association, can you provide an estimate of the number of unregistered health practitioners you believe to be practising in your profession or field.

Section 4 – The problem

Risks

- What do you think are the risks associated with the provision of health services by unregistered health practitioners?
- To what extent have the risks associated with these activities been realised in practice?
- Do you know of instances of actual harm or injury?
- What evidence is available on the nature, frequency and severity of risks?
- What factors increase or reduce the risk that individuals will suffer harm as a result of the activities of unregistered health practitioners?

Section 5 – The objectives of government action

- What do you think should be the objectives of government action in this area?

Section 6 – The options

- Do you think there is a case for further regulatory action by governments in this area?
- What do you think of the various options?
  - Option 1: No change
  - Option 2: A voluntary code of practice for unregistered health practitioners
  - Option 3: A national statutory code of conduct for unregistered health practitioners
- On balance, do you have a preferred option? What are your reasons?
- What do you think are the costs and benefits of the three options?
- If you are a practitioner, can you advise of what additional costs you think you would incur with the introduction of a statutory code? Are there are some aspects of a statutory code that are likely to be more costly than others?

Extent to which national uniformity is desirable (section 6.3.1)

- Do you think there should be a nationally uniform code of conduct for unregistered health practitioners or are different codes in each State and Territory acceptable?
- Should there be nationally uniform or nationally consistent arrangements for investigating breaches of the code and issuing of prohibition orders, or should States and Territories each implement their own arrangements?
- Should there be a centralised administrative body that administers the regulatory scheme, or should it be administered by each State and Territory government?

Scope of scheme (section 6.3.2)

- If a statutory code of conduct were to be enacted, to whom should it apply?
- Which practitioners, professions or occupations should be included?
- Should it apply only to practitioners who deliver health services? If so, what should be the definition of a health service?
- Should it apply to registered practitioners who provide health services that are unrelated to their registration, for example, a registered nurse who is working as a naturopath or massage therapist?
- Should it only apply to practitioners who directly deliver services, or should it also apply to those who deliver health services through the agency of another person, for example, the owners or operators of businesses that provide health services?

Administrative arrangements (section 6.3.3)

- Do you have a preferred option for the legislative and administrative arrangements through which a code of conduct for unregistered health practitioners is administered and complaints about breaches of the code are investigated and prosecuted?
- What are your reasons?

Content of a national code of conduct (section 6.3.4)

- What do you think should be included in a national statutory code of conduct?
- Do you have any comments on the NSW Code of Conduct for Unregistered Health Practitioners?
- What do you think are the strengths and weaknesses of the NSW Code?
- Do you think it provides a good model? What are your reasons?

Prosecutions and hearings (section 6.3.5)

- Do you have a preferred option for the mechanism through which prohibition orders should be issued, that is, via an administrative order decided by a Commissioner, or via a tribunal or court hearing?
- What are your reasons?

Grounds for issuing a prohibition order (section 6.3.6)

- What ‘relevant offences’ (if any) should provide grounds for a prohibition order to be issued?
- What other grounds should apply before a prohibition order may be issued?

Financing of scheme (section 6.3.7)

- How do you think a regulatory scheme to investigate and prosecute breaches of a national statutory code of conduct for unregistered health practitioners should be funded?
- What are your reasons?

Any other comments

- Do you have any other comments to make about these proposals?

Name:
Address:

Email:

Would you like to be informed of the outcome of the consultation?

Yes/No

Thank you for taking the time to make a submission.

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Appendices

Appendix 1

Events relevant to this consultation on regulation of unregistered health practitioners

Date	Event
1998	Release of NSW Parliament Joint Committee on Health Care Complaints Commission final report Unregistered Health Practitioners, *The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints*.
2003	Release of Victorian Department of Human Services report, *Regulation of the Health Professions in Victoria. A discussion paper*, proposing a negative licensing scheme for unregistered health practitioners.
2005	Release of NSW Parliament Joint Committee on the Health Care Complaints Commission report Review of the 1998 *Report into Unregistered Health Practitioners, The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints*
December 2006	Passage of *Health Legislation Amendment (Unregistered Health Practitioners) Act 2006* (NSW), amending various Acts to provide for the regulation of health practitioners who are not registered under a health registration Act.
March 2007	The Australian Health Ministers' Conference endorses a process and criteria for assessing the partially regulated and unregistered health occupations for future inclusion in the National Registration and Accreditation Scheme for the health professions.
May 2007	Release of South Australian Parliament's Social Development Committee report *Bogus, unregistered and deregistered health practitioners* which recommends expanding the Health and Community Services Commissioner's legislative powers to allow prohibition orders to be made against those practitioners who pose a substantial risk to public health.
January 2008	Release of NSW Health *Unregistered Health Practitioners Code of Conduct Impact Assessment Statement*
26 March 2008	The Council of Australian Governments (COAG) signs an Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions that includes arrangements for assessing unregistered health professions for inclusion in the National Scheme.
18 April 2008	Australian Health Ministers' Conference requests a paper addressing options for regulation of the unregistered health professions, in the context of the National Registration and Accreditation Scheme.
July 2008	Release of Health Services Commissioner's report *Inquiry into Noel Campbell*, containing 14 recommendations including that the Minister for Health gives consideration to the New South Wales approach to unregistered health practitioners to determine if 'negative licensing' or some variation of it is warranted in Victoria.
1 August 2008	NSW Code of *Conduct for unregistered health practitioners made under the Public Health (General) Regulation 2002 (NSW)*, Schedule 3 comes into force.
12 Feb 2010	Health Ministers agreed to commence a national consultation process on options for the future regulation of unregistered practitioners

Appendix 2

Definitions of 'health service' from State and Territory health complaints legislation

ACT - Human Rights Commission Act 2005

Section 7 What is a health service?

(1) For this Act, a health service is a service provided in the ACT to someone (the service user) for any of the following purposes:
   (a) assessing, recording, maintaining or improving the physical, mental or emotional health, comfort or wellbeing of the service user;
   (b) diagnosing or treating an illness, disability, disorder or condition of the service user.

(2) In applying this Act in relation to a health professional who is a veterinary surgeon, a health service is a service provided to an animal (the service user) for any of the purposes mentioned in subsection (1) (a) or (b).

(3) A "health service "includes—
   (a) service provided by a health professional or health practitioner in the professional's capacity as a health professional or health practitioner; and
   (b) a service provided specifically for carers of people receiving health services or carers of people with physical or mental conditions.

NSW - Health Care Complaints Act 1993

Section 4 Definitions

"health service" includes the following services, whether provided as public or private services:

a. medical, hospital and nursing services,
b. dental services,
c. mental health services,
d. pharmaceutical services,
e. ambulance services,
f. community health services,
g. health education services,
h. welfare services necessary to implement any services referred to in paragraphs (a)-(g),
i. services provided by podiatrists, chiropractors, osteopaths, optometrists, physiotherapists and psychologists,
j. services provided by optical dispensers, dietitians, masseurs, naturopaths, acupuncturists, occupational therapists, speech therapists, audiologists, audiometrists and radiographers,
k. services provided in other alternative health care fields,
   (k1) forensic pathology services,
(l) a service prescribed by the regulations as a health service for the purposes of this Act.

"health service provider" means a person who provides a health service (being a health practitioner or a health organisation).

Northern Territory - Health and Community Services Complaints Act

Section 4 Interpretation

health service means a service provided or to be provided in the Territory for, or purportedly for, the benefit of the health of a person and includes:

(a) a service specified by the Regulations as being a health service; and

(b) an administrative service directly related to a health service,

but does not include a service specified by the Regulations as not being a health service.

Queensland – Health Quality and Complaints Commission Act 2006

Section 8 Meaning of health service

Health service means--

(a) a service provided to an individual for, or purportedly for, the benefit of human health--

  (i) including a service stated in schedule 1, part 1; and

  (ii) excluding a service stated in schedule 1, part 2; or

(b) an administrative process or service related to a health service under paragraph (a).

Schedule 1 Part 1: Declared health services

1. Hospital, health institution or nursing home services.
2. Medical, dental, pharmaceutical, paramedical, mental health, community health, environmental health, specialised health or allied services.
3. Services provided in association with the use of premises for the care, treatment or accommodation of persons who are aged or have a physical or mental illness.
4. Laboratory services provided in support of health services.
5. Laundry, cleaning, catering or other support services provided to a hospital, health institution, nursing home or premises mentioned in item 3, if the services affect the care or treatment of patients or residents.
6. Social work, welfare, recreational or leisure services, if provided as part of a health service.
7. Ambulance services.
8. Services provided by registered providers.
9. Services provided by dietitians, audiologists, audiometrists, prosthetists, optical dispensers, child guidance therapists, psychotherapists, therapeutic counsellors and services provided by other professional, technical and operational persons that directly contribute to the provision of a health service.
10. Services provided by practitioners of hypnosis, massage, naturopathy, acupuncture or in other natural or alternative health care or diagnostic fields.
11. Services provided in relation to health promotion, education and information.

Schedule 1 Part 2 : Services declared not to be health services

1. An opinion of a provider, or a decision made, for a claim under the Workers' Compensation and Rehabilitation Act 2003.
2. An opinion of a provider, or a decision made, for the purpose of a notice, order, or appeal under the Workplace Health and Safety Act 1995.
3. Services provided by an officer of a department (other than the department in which this Act is administered), excluding services provided by an officer who--
   (a) is a registered provider; and
   (b) provides the services in the course of performing duties in a position for which registration as a registered provider of that type is a requirement.

4. Services provided by the State Emergency Service and by volunteers in emergency situations, including first aid and life support services, for example services provided by lifesavers, coastal rescue groups, teachers, teachers aides and school administrative staff.
5. Health services provided by a public authority of the Commonwealth.

South Australia - Health and Community Services Complaints Act 2004

Section 4 Interpretation

"health service" means—

(a) a service designed to benefit or promote human health; or

(b) a service provided in association with the use of premises for the care, treatment or accommodation of persons who are aged or who have a physical disability or mental dysfunction; or

(c) a diagnostic or screening service; or

(d) an ambulance service; or

(e) a service to treat or prevent illness, injury, disease or disability; or

(f) a service provided by a health professional; or

(g) a service involving the provision of information relating to the promotion or provision of health care or health education; or

(h) a service of a class included within the ambit of this definition by the regulations; or

(i) a social, welfare, recreational or leisure service if provided as part of a service referred to in a preceding paragraph; or

(aj an administration service directly related to a service referred to in a preceding paragraph,

but does not include—

(k) the process of writing, or the content of, a health status report;

(l) a service of a class excluded from the ambit of this definition by the regulations;

Examples—

The following are examples of health services:

- a service provided at a hospital, health institution or aged care facility;
- a medical, dental, pharmaceutical, mental health, community health or environmental health service;
- a laboratory service;
- a laundry, dry cleaning, catering or other support service provided in a hospital, health institution or aged care facility.

"health service provider" means a person, government agency or body of persons (whether corporate or unincorporated) who or which—

(a) provides a health service; or

(b) holds himself, herself or itself out as being able to provide a health service;

Tasmania - Health Complaints Act 1995

Section 3 Interpretation

"health service" means –

(a) a service provided to a person for, or purportedly for, the benefit of human health –

  (i) including services specified in Part 1 of Schedule 1; but

  (ii) excluding services specified in Part 2 of Schedule 1; or

(b) an administrative service directly related to a health service specified in paragraph (a);

"health service provider" means –

(a) a person who provides a health service; or

(b) a person who holds himself, herself or itself out as being able to provide a health service;

Victoria - Health Services (Conciliation and Review) Act 1987

Section 3 Definitions

Health service includes any of the following services-

(a) medical, hospital and nursing services;

(b) dental services

(c) psychiatric services;

(d) pharmaceutical services;

(e) ambulance services;

(f) community health services;

(g) health education services;

(h) welfare and social work services necessary to implement any services referred to in paragraphs (a) to (g);

(ha) therapeutic counselling and psychotherapeutic services;

(hb) laundry, cleaning and catering services, where those services affect health care or treatment of a person using or receiving a service referred to in this definition;

(i) services provided by chiropodists, chiropractors, osteopaths, dietitians, optometrists, audiologists, audiometrists, prosthetists, physiotherapists and psychologists;

(j) services provided by optical dispensers, masseurs, occupational therapists and speech therapists;

(k) services provided by practitioners of naturopathy, acupuncture and in other alternative health care fields;

(ka) services provided by Chinese herbal medicine practitioners, acupuncturists and Chinese herbal dispensers;

(l) a service prescribed as a health service for the purposes of this Act- and includes any service provided by the Department of Health and the Secretary to the Department of Health; industrial tribunal means Fair Work Australia or the Australian Industrial Relations Commission;

Provider includes-

(a) a person or body providing a health service; and

(ab) a person or body which holds himself, herself or itself out as providing a health service; and

(b) the Secretary to the Department of Health; and

(c) a registered provider; and

(d) a person who manages a health care institution and who is registered, certificated or licensed by the Secretary to the Department of Health; and

(e) a health care institution which is registered, certificated or licensed by the Secretary to the Department of Health; and

(f) any public hospital, private hospital, supported residential service, registered community health centre, ambulance service, psychiatric hospital or clinic, mental health hospital or clinic; and

(fa) a residential care service within the meaning of the Health Services Act 1988; and

(g) the chief executive officer of any body listed in paragraph (f) or (fa); and

(h) any local government body providing a health service; and

(i) a person or organisation that is prescribed as a provider for the purposes of this Act or that is included in a class of persons or organisations prescribed as providers for the purposes of this Act;

Western Australia - Health and Disability Services (Complaints) Act 1995

Section 3 Terms used in this Act

health service means any service provided by way of —

(a) diagnosis or treatment of physical or mental disorder or suspected disorder;

(b) health care, including palliative health care;

(c) a preventive health care programme, including a screening or immunization programme; and

(d) medical or epidemiological research,

and includes any —

(e) ambulance service;

(f) welfare service that is complementary to a health service;

(g) service coming within paragraph (a), (b) or (c) that is provided by a person who advertises or holds himself or herself out as a person who provides any health care or treatment; and

(h) prescribed service,

but does not include an excluded service;

excluded service means a health service that is provided without remuneration in a rescue or emergency situation;

Appendix 3

Health Practitioner Regulation National Law Act – powers of National Boards to undertake probity checking of applicants for registration

53 Qualifications for general registration

An individual is qualified for general registration in a health profession if—

(a) the individual holds an approved qualification for the health profession; or

(b) the individual holds a qualification the National Board established for the health profession considers to be substantially equivalent, or based on similar competencies, to an approved qualification; or

(c) the individual holds a qualification, not referred to in paragraph (a) or (b), relevant to the health profession and has successfully completed an examination or other assessment required by the National Board for the purpose of general registration in the health profession; or

(d) the individual—

  (i) holds a qualification, not referred to in paragraph (a) or (b), that under this Law or a corresponding prior Act qualified the individual for general registration (however described) in the health profession; and

  (ii) was previously registered under this Law or the corresponding prior Act on the basis of holding that qualification.

55 Unsuitability to hold general registration

(1) A National Board may decide an individual is not a suitable person to hold general registration in a health profession if—

  (a) in the Board's opinion, the individual has an impairment that would detrimentally affect the individual's capacity to practise the profession to such an extent that it would or may place the safety of the public at risk; or

  (b) having regard to the individual's criminal history to the extent that is relevant to the individual's practice of the profession, the individual is not, in the Board's opinion, an appropriate person to practise the profession or it is not in the public interest for the individual to practise the profession; or

  (c) the individual has previously been registered under a relevant law and during the period of that registration proceedings under Part 8, or proceedings that substantially correspond to proceedings under Part 8, were started against the individual but not finalised; or

  (d) in the Board's opinion, the individual's competency in speaking or otherwise communicating in English is not sufficient for the individual to practise the profession; or

  (e) the individual's registration (however described) in the health profession in a jurisdiction that is not a participating jurisdiction, whether in Australia or elsewhere, is currently suspended or cancelled on a ground for which an adjudication body could suspend or cancel a health practitioner's registration in Australia; or

  (f) the nature, extent, period and recency of any previous practice of the profession is not sufficient to meet the requirements specified in an approved registration standard relevant to general registration in the profession; or

  (g) the individual fails to meet any other requirement in an approved registration standard for the profession about the suitability of individuals to be registered in the profession or to competently and safely practise the profession; or

(h) in the Board's opinion, the individual is for any other reason—

(i) not a fit and proper person for general registration in the profession; or

(ii) unable to practise the profession competently and safely.

(2) In this section— ***relevant law*** means—

(a) this Law or a corresponding prior Act; or

(b) the law of another jurisdiction, whether in Australia or elsewhere.

78 Power to check applicant's proof of identity

(1) If an applicant for registration gives a National Board a document as evidence of the applicant's identity under this section, the Board may, by written notice, ask the entity that issued the document—

(a) to confirm the validity of the document; or

(b) to give the Board other information relevant to the applicant's identity.

(2) An entity given a notice under subsection (1) is authorised to give the National Board the information requested in the notice.

79 Power to check applicant's criminal history

(1) Before deciding an application for registration, a National Board must check the applicant's criminal history.

(2) For the purposes of checking an applicant's criminal history, a National Board may obtain a written report about the criminal history of the applicant from any of the following—

(a) CrimTrac;

(b) a police commissioner;

(c) an entity in a jurisdiction outside Australia that has access to records about the criminal history of persons in that jurisdiction.

(3) A criminal history law does not apply to a report about an applicant's criminal history under subsection (2).

80 Boards' other powers before deciding application for registration

(1) Before deciding an application for registration, a National Board may—

(a) investigate the applicant, including, for example, by asking an entity—

(i) to give the Board information about the applicant; or

(ii) to verify information or a document that relates to the applicant;

Examples. If the applicant is or has been registered by another registration authority, the National Board may ask the registration authority for information about the applicant's registration status.

The National Board may ask an entity that issued qualifications that the applicant believes qualifies the applicant for registration for confirmation that the qualification was issued to the applicant.

(b) by written notice given to the applicant, require the applicant to give the Board, within a reasonable time stated in the notice, further information or a document the Board reasonably requires to decide the application; and

(c) by written notice given to the applicant, require the applicant to attend before the Board, within a reasonable time stated in the notice and at a reasonable place, to answer any questions of the Board relating to the application; and

(d) by written notice given to the applicant, require the applicant to undergo an examination or assessment, within a reasonable time stated in the notice and at a

(e) reasonable place, to assess the applicant's ability to practise the health profession in which registration is sought; and

(f) by written notice given to the applicant, require the applicant to undergo a health assessment, within a reasonable time stated in the notice and at a reasonable place.

(2) The National Board may require the information or document referred to in subsection (1)(b) to be verified by a statutory declaration.

(3) If the National Board requires an applicant to undertake an examination or assessment under subsection (1)(d) to assess the applicant's ability to practise the health profession—

(a) the examination or assessment must be conducted by an accreditation authority for the health profession, unless the Board decides otherwise; and

(b) the National Agency may require the applicant to pay the relevant fee.

(4) A notice under subsection (1)(d) or (e) must state—

(a) the reason for the examination or assessment; and

(b) the name and qualifications of the person appointed by the National Board to conduct the examination or assessment; and

(c) the place where, and the day and time at which, the examination or assessment is to be conducted.

(5) The applicant is taken to have withdrawn the application if, within the stated time, the applicant does not comply with a requirement under subsection (1).

109 Annual statement

(1) An application for renewal of registration must include or be accompanied by a statement that includes the following—

(a) a declaration by the applicant that—

(i) the applicant does not have an impairment; and

(ii) the applicant has met any recency of practice requirements stated in an approved registration standard for the health profession; and

(iii) the applicant has completed the continuing professional development the applicant was required by an approved registration standard to undertake during the applicant's preceding period of registration; and

(iv) the applicant has not practised the health profession during the preceding period of registration without appropriate professional indemnity insurance arrangements being in place in relation to the applicant; and

(v) if the applicant's registration is renewed the applicant will not practise the health profession unless appropriate professional indemnity insurance arrangements are in place in relation to the applicant;

(b) details of any change in the applicant's criminal history that occurred during the applicant's preceding period of registration;

Note. See the definition of ***criminal history*** which applies to offences in participating jurisdictions and elsewhere, including outside Australia.

(c) if the applicant's right to practise at a hospital or another facility at which health services are provided was withdrawn or restricted during the applicant's preceding period of registration because of the applicant's conduct, professional performance or health, details of the withdrawal or restriction of the right to practise;

(d) if the applicant's billing privileges were withdrawn or restricted under the *Medicare Australia Act 1973* of the Commonwealth during the applicant's preceding period of registration because of the applicant's conduct, professional performance or health, details of the withdrawal or restriction of the privileges;

(e) details of any complaint made about the applicant to a registration authority or another entity having functions relating to professional services provided by health practitioners or the regulation of health practitioners;

(f) any other information required by an approved registration standard.

(2) Subsection (1)(a)(ii), (iii) and (iv), (c) and (d) does not apply to an applicant who is applying for the renewal of non-practising registration.

130 Registered health practitioner or student to give National

Board notice of certain events

(1) A registered health practitioner or student must, within 7 days after becoming aware that a relevant event has occurred in relation to the practitioner or student, give the National Board that registered the practitioner or student written notice of the event.

(2) A contravention of subsection (1) by a registered health practitioner or student does not constitute an offence but may constitute behaviour for which health, conduct or performance action may be taken.

(3) In this section—

relevant event means—

(a) in relation to a registered health practitioner—

(i) the practitioner is charged, whether in a participating jurisdiction or elsewhere, with an offence punishable by 12 months imprisonment or more; or

(ii) the practitioner is convicted of or the subject of a finding of guilt for an offence, whether in a participating jurisdiction or elsewhere, punishable by imprisonment; or

(iii) appropriate professional indemnity insurance arrangements are no longer in place in relation to the practitioner's practice of the profession; or

(iv) the practitioner's right to practise at a hospital or another facility at which health services are provided is withdrawn or restricted because of the practitioner's conduct, professional performance or health; or

(v) the practitioner's billing privileges are withdrawn or restricted under the *Medicare Australia Act 1973* of the Commonwealth because of the practitioner's conduct, professional performance or health; or

(vi) the practitioner's authority under a law of a State or Territory to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of

(vii) scheduled medicines is cancelled or restricted; or

(viii) a complaint is made about the practitioner to an entity referred to in section 219(1)(a) to (e); or

(viii) the practitioner's registration under the law of another country that provides for the registration of health practitioners is suspended or cancelled or made subject to a condition or another restriction; or

(b) in relation to a student—

(i) the student is charged with an offence punishable by 12 months imprisonment or more; or

(ii) the student is convicted of or the subject of a finding of guilt for an offence punishable by imprisonment; or

(iii) the student's registration under the law of another country that provides for the registration of students has been suspended or cancelled.

134 Evidence of identity

(1) A National Board may, at any time, require a registered health practitioner to provide evidence of the practitioner's identity.

(2) A requirement under subsection (1) must be made by written notice given to the registered health practitioner.

(3) The registered health practitioner must not, without reasonable excuse, fail to comply with the notice.

(4) A contravention of subsection (3) by a registered health practitioner does not constitute an offence but may constitute behaviour for which health, conduct or performance action may be taken.

(5) If a registered health practitioner gives a National Board a document as evidence of the practitioner's identity under this section, the Board may, by written notice, ask the entity that issued the document—

  (a) to confirm the validity of the document; or

  (b) to give the Board other information relevant to the practitioner's identity.

(6) An entity given a notice under subsection (5) is authorised to provide the information requested.

135 Criminal history check

(1) A National Board may, at any time, obtain a written report about a registered health practitioner's criminal history from any of the following—

  (a) CrimTrac;

  (b) a police commissioner;

  (c) an entity in a jurisdiction outside Australia that has access to records about the criminal history of persons in that jurisdiction.

(2) Without limiting subsection (1), a report may be obtained under that subsection—

  (a) to check a statement made by a registered health practitioner in the practitioner's application for renewal of registration; or

  (b) as part of an audit carried out by a National Board, to check statements made by registered health practitioners.

(3) A criminal history law does not apply to a report under subsection (1).

Appendix 4

Health Practitioner Regulation National Law Act – Statutory definitions of 'unprofessional conduct', 'professional misconduct', 'unsatisfactory professional performance' and 'impairment'

unprofessional conduct, of a registered health practitioner, means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers, and includes—

(a) a contravention by the practitioner of this Law, whether or not the practitioner has been prosecuted for, or convicted of, an offence in relation to the contravention; and

(b) a contravention by the practitioner of—

  (i) a condition to which the practitioner's registration was subject; or

  (ii) an undertaking given by the practitioner to the National Board that registers the practitioner; and

(c) the conviction of the practitioner for an offence under another Act, the nature of which may affect the practitioner's suitability to continue to practise the profession; and

(d) providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's well-being; and

(e) influencing, or attempting to influence, the conduct of another registered health practitioner in a way that may compromise patient care; and

(f) accepting a benefit as inducement, consideration or reward for referring another person to a health service provider or recommending another person use or consult with a health service provider; and

(g) offering or giving a person a benefit, consideration or reward in return for the person referring another person to the practitioner or recommending to another person that the person use a health service provided by the practitioner; and

(h) referring a person to, or recommending that a person use or consult, another health service provider, health service or health product if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation.

unsatisfactory professional performance, of a registered health practitioner, means the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience.

professional misconduct, of a registered health practitioner, includes—

(a) unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and

(b) more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and

(c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

impairment, in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect—

(a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or

(b) for a student, the student's capacity to undertake clinical training—

  (i) as part of the approved program of study in which the student is enrolled; or

  (ii) arranged by an education provider.

Appendix 5

Health Complaints Commissioners - comparison of powers and functions across Australian jurisdictions

Jurisdiction	Commissioner	Who can make a complaint	Matters that may be the subject of a complaint	Complaints resolution functions	Other functions	Ancillary bodies with complaints related functions
ACT *Human Rights Commission Act 2005* *Health Professionals Act 2004* *Health Records (Privacy and Access) Act 1997*	Health Services Commissioner of Human Rights Commission	Human Rights Commission Act health service or older persons service complaint – anyone. Health Records complaint – a person.	Health service complaint: • The service is not being provided appropriately or is not being provided • The person complaining believes that the provider of the service has acted inconsistently with specified standards, e.g. for health services: – the health code or health provision principles; – a generally accepted standard of health service delivery expected of providers of the same kind; – any standard of practice applying to the provider under the National Law or the or the *Health Professionals Act 2004* (ACT); etc. Health records complaint: • where there has been a contravention of the privacy principles in relation to a consumer; • a refusal to give access to a health record relating to a consumer; or • a refusal by a record keeper of a health record to give access to the health record	Complaints receipt and provision of complaints resolution process: • Conciliation including to binding agreement; • May compel parties to conciliation (offence to fail to appear); • Consideration of the complaint (separate from conciliation) to provide information that may be used to help conciliation of the complaint to work out whether the conduct complained about was engaged in the way complained about and whether there is adequate grounds for Commission to report; • Make recommendations in final report – note it is a strict liability offence (50 penalty units) not to advise the Commission of action taking following its recommendation. • Where the Commission considers a registered health professional's behaviour, it must give a copy of complaint and all related documents it gets to the relevant health profession board. (However it may continue to consider complaint); • May report to Minister on its own initiative.	In relation to health services and services for older people: • Encouraging and assisting users and providers of health services, and services for older people, to make improvements in the provision of services, particularly by encouraging and assisting service users and providers to contribute to the review and improvement of service quality; • Encouraging and assisting people providing services and people engaging in conduct that may be complained about under this Act, to develop and improve procedures for dealing with complaints; • Promoting community discussion, and providing community education and information about relevant matters; • Identifying, inquiring into and reviewing issues relating to the matters that may be complained about under the *Human Rights Commission Act* and reporting to the Minister, and other appropriate entities, about each inquiry and review; • Advising the Minister about any matter in relation to the Human Rights Commission Act (or a related Act;	**Health profession boards** Relationship with Human Rights Commission: • Commission must consult with the board for a health profession in relation to a complaint made to the Commission under the *Human Rights Commission Act 2005* (the *HRC Act*) relating to a health professional in the profession. • In considering a report including a final review report relating to a registered health professional (i.e. a report that the practitioner has contravened a required standard of practice or does not satisfy the suitability to practice requirements) the board must consult with the commission. If the health

Jurisdiction	Commissioner	Who can make a complaint	Matters that may be the subject of a complaint	Complaints resolution functions	Other functions	Ancillary bodies with complaints related functions
					• Collecting information about operation of the Human Rights Commission Act and related Acts, and publishing the information.	profession board and the commission cannot agree about the action to be taken in relation to a report, the most serious action chosen by the board or commission prevails.
New South Wales *Health Care Complaints Act 1993*	Health Care Complaints Commission	Any person.	The professional conduct of a health practitioner or of a code of conduct prescribed under section 10AM of Public Health Act 1991), or A health service which affects the clinical management or care of an individual client and/or Against a health service provider.	To receive and deal with the following complaints: • complaints relating to the professional conduct of health practitioners • complaints concerning the clinical management or care of individual clients by health service providers • complaints referred to it by a professional council under the National law. Assess to determine whether further action required and if so: • Investigate; • Conciliate; • Use voluntary resolution processes under Part 2 Div 9 • Refer to the Director-Genera (Dept of Health) • Refer to professional council or other appropriate public health organisation or other body (s26) Where complaint concerns a health practitioner, after investigation the Commission must consult with professional council and then: • refer the complaint to the Director of Proceedings; or • refer the complaint to the appropriate professional council (if any) for consideration of the taking	*Prosecution functions:* Director of Proceedings, HCCC functions are: (a) to determine whether the complaint should be prosecuted before a disciplinary body and, if so, whether it should be prosecuted by the Commission or referred to another person or body for prosecution, (b) if the Director determines that the complaint should be prosecuted before a disciplinary body by the Commission, to prosecute the complaint before the disciplinary body, (c) to intervene in any proceedings that may be taken before a disciplinary body in relation to the complaint.	**Health profession registration authorities** Registration authorities are responsible for the registration of health professionals. (s3A) **Professional councils** Professional councils are responsible for the management of complaints in conjunction with the Commission and protecting the public through promoting and maintaining professional standards.

Jurisdiction	Commissioner	Who can make a complaint	Matters that may be the subject of a complaint	Complaints resolution functions	Other functions	Ancillary bodies with complaints related functions
				of action under the National Law (such as the referral of the health practitioner for performance assessment or impairment assessment) or • make comments to the health practitioner on the matter the subject of the complaint, or • terminate the matter, • refer the matter the subject of the complaint to the Director of Public Prosecutions, • in relation to unregistered health practitioners, make a prohibition order under s 41A (where it finds the practitioner has breached code of conduct or been convicted of a serious offence and where it is of the opinion there is a risk to the health or safety of members of the public.		
Northern Territory *Health and Community Services Complaints Act*	Health and Community Services Complaints Commission	A user of a health or community service or • in some cases, their representative, • an MP or the Minister or the Chief Executive of the Department or • in some cases, a person appointed by the Commissioner, • in some cases, a health or community service provider	That a provider acted unreasonably: • in providing a health service or community service or • by not providing a health service or community service, or • in the manner of providing a health service or community service; • by denying or restricting a user access to his or her records; • not making available to a user information about the user's condition that the provider was able to make available; • in disclosing information in relation to a user That the provision of a health service or community service or a part of a health service or community service was not necessary;	Conciliate and investigate complaints Inquire into and report on any matter relating to health services or community services on receiving a complaint [or on a reference from the Minister or the Legislative Assembly]	Inquire into and report on any matter relating to health services or community services on a reference from the Minister or the Legislative Assembly Encourage and assist users and providers to resolve complaints directly with each other; Record and keep a register of complaints; Suggest ways of improving health services and community services and promoting community and health rights and responsibilities; Review and identify the causes of complaints and to suggest ways: • to remove, resolve and minimise those causes or • of improving policies and	**Health and Community Services Complaints Review Committee** **Health practitioner registration boards**

Jurisdiction	Commissioner	Who can make a complaint	Matters that may be the subject of a complaint	Complaints resolution functions	Other functions	Ancillary bodies with complaints related functions
		• any other person, or any body, that, in the opinion of the Commissioner, should be able to make a particular complaint in the public interest	That a provider or manager acted unreasonably in respect of a complaint made by a user about the provider's action not taking, or causing to be taken, proper action in relation to the complaint; or not properly investigating the complaint or causing it to be properly investigated. That a provider acted in disregard of, or in a manner inconsistent with the Code, Regulations etc. That an applicable organisation failed to comply with the Carers Charter.		procedures; and • to detect and review trends in the delivery of health services and community services; Consider, promote and recommend ways to improve the health and community services complaints system; Assist providers to develop procedures to effectively resolve complaints; Provide information, education, advice and reports.	
Queensland *Health Quality and Complaints Commission Act 2006*	Health Quality and Complaints Commission	For a health services complaint – a user, a person on behalf of a user (in some cases), the Minister or, if in the public interest, another person. (ss 40-41)	For a health services complaint: • hat a provider of a health service (person or body or institution etc) has acted unreasonably by: – providing or not providing a health service for the user; or – in the way of providing a health service; or – in denying or restricting access to a user's health records to the user, or in disclosing information relating to a user; • That a registered provider acted in a way that would be a ground for disciplinary action under the National law. • That an entity providing a health service has acted unreasonably by not investigating or taking proper action in relation to a complaint.	For health services complaints: • receive, assess (to determine whether to accept) and manage; • encourage and help users to resolve complaints; • help providers to develop systems to effectively resolve complaints; • (for complaints it accepts): – conciliate or – investigate and produce a report with recommendations (e.g. may recommend a Board take action) or – if the complaint is about a registered health services provider, refer to the relevant registration board (if in the public interest).	Develop Code of Health Rights and Responsibilities for consideration of the Minister Information, education and advise to users about health rights and responsibilities (s16) Suggesting ways of improving health services. Monitor and report on providers' compliance with section 20(1) (duty of a provider (s20) to establish, maintain and implement reasonable processes to improve the quality of health services; and comply with any Commission standard) Make **standards** relating to the quality of health services; Assess the quality o f health services and processes associated with health services; Promote continuous quality improvement in health services; Promote the effective coordination of reviews of health services carried out by public or other bodies; Receive, analyse and disseminate information about the quality of health	**Health profession boards** HSC may refer complaints about a registered health services provider to the relevant registration board, if the Board is consulted and it is in the public interest (s66).
		For a health quality complaint – anyone (s38).	For a health quality complaint: • The quality of a health service; • Any breach of duty of a provider (s20) to establish, maintain and implement reasonable processes to improve the quality of health	For health quality complaints: • respond to health quality complaints, including by conducting investigations and inquiries; • recommend ways of improving health services;		

Jurisdiction	Commissioner	Who can make a complaint	Matters that may be the subject of a complaint	Complaints resolution functions	Other functions	Ancillary bodies with complaints related functions
			services; and comply with any Commission standard.	• identify and review issues arising from health complaints. Conduct inquiries if in the public interest or as directed by the Minister.	services. Conduct inquiries if in the public interest or as directed by the Minister.	
South Australia *Health and Community Services Complaints Act 2004*	Health and Community Services Complaints Commissioner	-A user of a health or community service or • in some cases, their representative, • an MP or the Minister or the Chief Executive of the Department or • in some cases, a person appointed by the Commissioner, • in some cases, a health or community service provider • any other person, or any body, that, in the opinion of the Commissioner, should be able to make a particular complaint in the public interest.	That a health *or community** service provider: • Has acted unreasonably: – by not providing or health or community service; – in the manner of providing a health or community service; – denying or restricting a user's access to records relating to the user; or – in not making available to a health or community service user information about the user's condition that the health service provider was able to make available; – in disclosing information in relation to a health or community service user to a third person; • Has provided all or part of a health or community service that was not necessary or was inappropriate. • Has failed to exercise due skill. • Has failed to treat a health or community service user in an appropriate professional manner. • Has failed to respect a health or community service user's privacy or dignity. • Has acted unreasonably by failing to provide a health or community service user with sufficient information or a reasonable opportunity to make an informed decision; or otherwise provided inadequate information about	To receive, assess and resolve complaints, and where accept to: (a) Conciliate – including to enforceable agreement (Part 5); and/or; (b) Investigate and produce a report with opinions, comments and recommendations (Part 6); and/or (c) Consult with the registration body in relation to a complaint regarding a registered service provider and: – may refer with the agreement of registration body; – if they cannot agree – party that considers investigation is warranted may investigate or if both parties consider it warrants investigation, Commission may decide who investigates.	To prepare and regularly review the Charter of Health and Community Services Rights; To identify and review issues arising out of complaints and to make recommendations for improving health and community services and preserving and increasing the rights of people who use those services; and To review and identify the causes of complaints and to— (i) recommend ways to remove, resolve or minimise those causes; and (ii) detect and review trends in the delivery of health or community services; and To provide information, education and advice To encourage and assist health and community service users to resolve complaints directly with health and community service providers; and to assist health and community service providers to develop or improve procedures to resolve complaints; and To inquire into and report on any matter relating to health or community services on the Commissioner's own motion or at the request of the Minister; and To advise, and report to, the Minister on any matter relating to health or community services or the administration or operation of this Act; and To provide information, advice and	**Health profession registration boards** – must deal with complains as referred **Health and Community Services Advisory Council** Functions include: Advising the Minister and Commissioner in relation to: • the redress of grievances relating to health or community services or their provision; and • means of educating and informing users, providers and the public on the availability of means for making health or community service complaints or expressing grievances • the operation of the Act; • any other matter on which the Minister requests the advice of the Council. • referring matters to the Commissioner.

Jurisdiction	Commissioner	Who can make a complaint	Matters that may be the subject of a complaint	Complaints resolution functions	Other functions	Ancillary bodies with complaints related functions
			treatment, prognosis, further advice and education etc. • Has acted unreasonably by not taking proper action in relation to a complaint made to him or her by the user about a provider's action of a kind referred to in this section; • Has acted in any other manner that is inconsistent with the Charter of Health and Community Services Rights; • Has acted in any other manner that did not conform with the generally accepted standard of service delivery expected of a provider of the kind of service.		reports to registration authorities and to work with registration authorities to develop or improve procedures relating to the assessment and investigation of complaints and grievances.	
Tasmania *Health Complaints Act 1995*	Health Complaints Commissioner	A user of a health or community service or • in some cases, their representative, • an MP or the Minister or the Chief Executive of the Department or • in some cases, a person appointed by the Commissioner, • in some cases, a health or community service provider • any other person, or any body, that, in the opinion of the	That a health service provider: • - Has acted unreasonably: – by not providing or health service; – in the manner of providing a health service; – by denying or restricting access to records relating to the user or other information about the user's condition; or – in disclosing information in relation to a health service user; • provided a health service or of part of a health service was not necessary; • failed to exercise due skill; • failed to treat a user in an appropriate professional manner or user's privacy or dignity; • failed to provide user with sufficient information or a reasonable opportunity to make an informed decision; or otherwise provided inadequate information about	To receive, assess and resolve complaints: • May refer to the Ombudsman, a relevant registration board (after consulting the board) or other person more appropriate under a Tasmanian law; or • Conciliate (including to reach an enforceable agreement) unless there is a significant issue of public safety or public interest or a significant question as to the practice of a health service. • Investigate and produce a report	Prepare and regularly review a Charter of Health Rights Identify and review issues arising out of complaints and suggest ways of improving health services and preserving and increasing health rights; Provide information, education and advice in relation to – (i) the Charter; and (ii) health rights and responsibilities; and (iii) procedures for resolving complaints To encourage and assist health service users to resolve complaints directly with health service providers; To assist health service providers to develop procedures to resolve complaints; and To inquire into and report on any matter relating to health services at own discretion or on the direction of the Health Minister and to advise and	Health registration boards (must investigate complaints referred)

Jurisdiction	Commissioner	Who can make a complaint	Matters that may be the subject of a complaint	Complaints resolution functions	Other functions	Ancillary bodies with complaints related functions
		Commissioner, should be able to make a particular complaint in the public interest	treatment, prognosis, further advice and education etc. • acted unreasonably by not taking proper action in relation to a complaint made to him or her by the user; • acted in any other manner that was inconsistent with the Charter.		report to the Minister and the Health Minister on any matter relating to health services or the administration of the Act; and To provide information, advice and reports to registration boards.	
Victoria *Health Services (Conciliation and Review) Act 1987* *Health Records Act 2001*	Health Services Commissioner	Health services complaint – A user, their representative or in some cases a provider. Health records complaint – an individual in relation to an interference of their privacy (including right of access to their health information)	That a provider of a health service (person or body or institution etc) has acted unreasonably: • by providing or not providing a health service for the user; or • in the manner of providing a health service. That a health care institution has acted unreasonably by not properly investigating or not taking proper action in relation to a complaint made to it about a provider. Health records complaint - That there has been an act or practice that may be an interference with the privacy of an individual (i.e. breach of Part 5 of the Act relating to access to health information or a breach of the health privacy principles).	Receive and Investigate complaints and: • review and identify causes of complaints, and suggest ways of removing causes; • conciliate between user and provider.	Investigate any matter referred to the Commissioner by Parliament or a Committee, or the Minister or the Health Review Council (subject to the approval of the Minister) Provide advice to Health Services Review Council/refer issues to HSRC for advice Maintain register of complaints Publish info about complaints Determine what action has been taken by providers where complaints have been found to be justified Education, training and guidance about the prevention or resolution of complaints Conduct research into complaints relating to health services and mechanisms for resolving complaints relating to health services Issue guidelines under the Health Privacy Principles.	Health Services Review Council HSRC functions are to: • advise the Minister on the health complaints system and the operations of the Commissioner and • advise the Minister and the Commissioner on issues referred to it by the Commissioner. Health profession registration boards Related duties/ functions of HSC: • have a duty to stop complaint where should be dealt with by Board or VCAT. (Board must notify/copy to the HSC and, if agreed between Board and HSC that it is suitable for conciliation, may refer to HSC for conciliation).

Jurisdiction	Commissioner	Who can make a complaint	Matters that may be the subject of a complaint	Complaints resolution functions	Other functions	Ancillary bodies with complaints related functions
Western Australia *Health Services (Conciliation and Review) Act 1995*	Office of Health Review	A user, a user's recognised representative or in some cases, a provider of a health service.	• - A public provider has acted unreasonably: – in providing not providing a health service for the user; • - a provider has acted unreasonably in the manner of providing a health service for the user; – by denying or restricting the user's access to records kept by the provider and relating to the user; – in disclosing or using theusers health records or confidential information about the user; • A manager has acted unreasonably in respect of a complaint made to an institution by a user about a provider's action which is of a kind mentioned in paragraphs (a) to (e) by not properly investigating the complaint or causing it to be properly investigated; or not taking proper action on the complaint; • A provider has acted unreasonably by charging the user an excessive fee; or otherwise acted unreasonably with respect to a fee; • A provider that is an applicable organisation as defined in section 4 of the *Carers Recognition Act 2004* has failed to comply with the Carers Charter as defined in that section.	Undertake the receipt, conciliation and investigation of complaints; Provide advice on any matter relating to complaints under the Act, in particular— • advice to users on the making of complaints to registration boards; and • advice to users as to other avenues available for dealing with complaints. Refer a matter to a registration board if it relates to a registered provider and in the Director's opinion the complaint— (a) is not suitable for conciliation or investigation; or (b) should be dealt with by a registration board, (c) after consultation with that board; and (d) with the written consent of the person who made the complaint.	Review and identify the causes of complaints, and to suggest ways of removing and minimizing those causes and bringing them to the notice of the public; Bring to the notice of users and providers details of complaints procedures; Assist providers in developing and improving complaints procedures and the training of staff in handling complaints; With the approval of the Minister, inquire into broader issues of health care arising out of complaints received; Publish information about the work of the Office. Investigate matters at the direction of the Minister. Maintain a register of complaints Take proceedings for an offence against the Act.	Health practitioner registration boards

Appendix 6

NSW Code of Conduct for unregistered health practitioners

Made under the Public Health (General) Regulation 2002, Schedule 3

1 Definitions

In this code of conduct:

health practitioner and ***health service*** have the same meaning as in the Health Care Complaints Act 1993.

Note. The *Health Care Complaints Act 1993* defines those terms as follows:

health practitioner means a natural person who provides a health service (whether or not the person is registered under the Health Practitioner Regulation National Law).

health service includes the following services, whether provided as public or private services:

(a) medical, hospital and nursing services,

(b) dental services,

(c) mental health services,

(d) pharmaceutical services,

(e) ambulance services,

(f) community health services,

(g) health education services,

(h) welfare services necessary to implement any services referred to in paragraphs (a)–(g),

(i) services provided by podiatrists, chiropractors, osteopaths, optometrists, physiotherapists, and psychologists,

(j) services provided by optical dispensers, dietitians, masseurs, naturopaths, acupuncturists, occupational therapists, speech therapists, audiologists, audiometrists and radiographers,

(k) services provided in other alternative health care fields,

(l) forensic pathology services,

(m) a service prescribed by the regulations as a health service for the purposes of the *Health Care Complaints Act 1993*.

2 Application of code of conduct

This code of **conduct** applies to the provision of health services by:

(a) health practitioners who are not required to be registered under the Health Practitioner Regulation National Law (including de-registered health practitioners), and

(b) health practitioners who are registered under the Health Practitioner Regulation National Law who provide health services that are unrelated to their registration.

Note. Health practitioners may be subject to other requirements relating to the provision of health services to which this Code applies, including, for example, requirements imposed by Part 2A of the Act and the regulations under the Act relating to skin penetration procedures.

3 Health practitioners to provide services in safe and ethical manner

(1) A health practitioner must provide health services in a safe and ethical manner.

(2) Without limiting subclause (1), health practitioners must comply with the following principles:

(a) a health practitioner must maintain the necessary competence in his or her field of practice,

(b) a health practitioner must not provide health care of a type that is outside his or her experience or training,

(b1) a health practitioner must not provide services that he or she is not qualified to provide,

(b2) a health practitioner must not use his or her possession of particular qualifications to mislead or deceive his or her clients as to his or her competence in his or her field of practice or ability to provide treatment,

(c) a health practitioner must prescribe only treatments or appliances that serve the needs of the client,

(d) a health practitioner must recognise the limitations of the treatment he or she can provide and refer clients to other competent health practitioners in appropriate circumstances,

(e) a health practitioner must recommend to his or her clients that additional opinions and services be sought, where appropriate,

(f) a health practitioner must assist his or her clients to find other appropriate health care professionals, if required and practicable,

(g) a health practitioner must encourage his or her clients to inform their treating medical practitioner (if any) of the treatments they are receiving,

(h) a health practitioner must have a sound understanding of any adverse interactions between the therapies and treatments he or she provides or prescribes and any other medications or treatments, whether prescribed or not, that the health practitioner is aware the client is taking or receiving,

(i) a health practitioner must ensure that appropriate first aid is available to deal with any misadventure during a client consultation,

(j) a health practitioner must obtain appropriate emergency assistance (for example, from the Ambulance Service) in the event of any serious misadventure during a client consultation.

4 Health practitioners diagnosed with infectious medical condition

(1) A health practitioner who has been diagnosed with a medical condition that can be passed on to clients must ensure that he or she practises in a manner that does not put clients at risk.

(2) Without limiting subclause (1), a health practitioner who has been diagnosed with a medical condition that can be passed on to clients should take and follow advice from an appropriate medical practitioner on the steps to be taken to modify his or her practice to avoid the possibility of transmitting that condition to clients.

5 Health practitioners not to make claims to cure certain serious illnesses

(1) A health practitioner must not hold himself or herself out as qualified, able or willing to cure cancer and other terminal illnesses.

(2) A health practitioner may make a claim as to his or her ability or willingness to treat or alleviate the symptoms of those illnesses if that claim can be substantiated.

6 Health practitioners to adopt standard precautions for infection control

(1) A health practitioner must adopt standard precautions for the control of infection in his or her practice.

(2) Without limiting subclause (1), a health practitioner who carries out a skin penetration procedure within the meaning of section 51 (3) of the Act must comply with the relevant regulations under the Act in relation to the carrying out of the procedure.

7 Appropriate conduct in relation to treatment advice

(1) A health practitioner must not attempt to dissuade clients from seeking or continuing with treatment by a registered medical practitioner.

(2) A health practitioner must accept the right of his or her clients to make informed choices in relation to their health care.

(3) A health practitioner should communicate and co-operate with colleagues and other health care practitioners and agencies in the best interests of their clients.

(4) A health practitioner who has serious concerns about the treatment provided to any of his or her clients by another health practitioner must refer the matter to the Health Care Complaints Commission.

8 Health practitioners not to practise under influence or alcohol or drugs

(1) A health practitioner must not practise under the influence of alcohol or unlawful drugs.

(2) A health practitioner who is taking prescribed medication must obtain advice from the prescribing health practitioner on the impact of the medication on his or her ability to practice and must refrain from treating clients in circumstances where his or her ability is or may be impaired.

9 Health practitioners not to practise with certain physical or mental conditions

A health practitioner must not practise while suffering from a physical or mental impairment, disability, condition or disorder (including an addiction to alcohol or a drug, whether or not prescribed) that detrimentally affects, or is likely to detrimentally affect, his or her ability to practise or that places clients at risk of harm.

10 Health practitioners not to financially exploit clients

(1) A health practitioner must not accept financial inducements or gifts for referring clients to other health practitioners or to the suppliers of medications or therapeutic goods or devices.

(2) A health practitioner must not offer financial inducements or gifts in return for client referrals from other health practitioners.

(3) A health practitioner must not provide services and treatments to clients unless they are designed to maintain or improve the clients' health or wellbeing.

11 Health practitioners required to have clinical basis for treatments

A health practitioner must not diagnose or treat an illness or condition without an adequate clinical basis.

12 Health practitioners not to misinform their clients

(1) A health practitioner must not engage in any form of misinformation or misrepresentation in relation to the products or services he or she provides or as to his or her qualifications, training or professional affiliations.

(2) A health practitioner must provide truthful information as to his or her qualifications, training or professional affiliations if asked by a client.

(3) A health practitioner must not make claims, either directly or in advertising or promotional material, about the efficacy of treatment or services provided if those claims cannot be substantiated.

13 Health practitioners not to engage in sexual or improper personal relationship with client

(1) A health practitioner must not engage in a sexual or other close personal relationship with a client.

(2) Before engaging in a sexual or other close personal relationship with a former client, a health practitioner must ensure that a suitable period of time has elapsed since the conclusion of their therapeutic relationship.

14 Health practitioners to comply with relevant privacy laws

A health practitioner must comply with the relevant legislation of the State or the Commonwealth relating to his or her clients' personal information.

15 Health practitioners to keep appropriate records

A health practitioner must maintain accurate, legible and contemporaneous clinical records for each client consultation.

16 Health practitioners to keep appropriate insurance

A health practitioner should ensure that appropriate indemnity insurance arrangements are in place in relation to his or her practice.

17 Certain health practitioners to display code and other information

(1) A health practitioner must display a copy of each of the following documents at all premises where the health practitioner carries on his or her practice:

  (a) this code of conduct,

  (b) a document that gives information about the way in which clients may make a complaint to the Health Care Complaints Commission, being a document in a form approved by the Director-General of the Department of Health.

(2) Copies of those documents must be displayed in a position and manner that makes them easily visible to clients entering the relevant premises.

(3) This clause does not apply to any of the following premises:

  (a) the premises of any body within the public health system (as defined in section 6 of the *Health Services Act 1997*),

  (b) private hospitals or day procedure centres (as defined in the *Private Hospitals and Day Procedure Centres Act 1988*),

  (c) premises of the Ambulance Service of NSW (as defined in the *Health Services Act 1997*),

  (d) premises of approved providers (within the meaning of the *Aged Care Act 1997* of the Commonwealth).

18 Sale and supply of optical appliances

(1) A health practitioner must not sell or supply an optical appliance (other than cosmetic contact lenses) to a person unless he or she does so in accordance with a prescription from a person authorised to prescribe the optical appliance under section 122 of the Health Practitioner Regulation National Law.

(2) A health practitioner must not sell or supply contact lenses to a person unless he or she:

  (a) was licensed under the *Optical Dispensers Act 1963* immediately before its repeal, or

  (b) has a Certificate IV in optical dispensing or an equivalent qualification.

(3) A health practitioner who sells or supplies contact lenses to a person must provide the person with written information about the care, handling and wearing of contact lenses, including advice about possible adverse reactions to wearing contact lenses.

(4) This clause does not apply to the sale or supply of the following:

(a) hand-held magnifiers,

(b) corrective lenses designed for use only in diving masks or swimming goggles,

(c) ready made spectacles that:

(i) are designed to alleviate the effects of presbyopia only, and

(ii) comprise 2 lenses of equal power, being a power of plus one dioptre or more but not exceeding plus 3.5 dioptres.

(5) In this clause:

cosmetic contact lenses means contact lenses that are not designed to correct, remedy or relieve any refractive abnormality or defect of sight.

optical appliance has the same meaning as it has in section 122 of the Health Practitioner Regulation National Law.

Concerned about your health care?

The Code of Conduct for unregistered health practitioners sets out what you can expect from your provider. If you are concerned about the health service that was provided to you or your next of kin, talk to the practitioner immediately. In most cases the health service provider will try to resolve them.

If you are not satisfied with the provider's response, contact the Inquiry Service of the Health Care Complaints Commission on (02) 9219 7444 or toll free on 1800 043 159 for a confidential discussion. If your complaint is about sexual or physical assault or relates to the immediate health or safety of a person, you should contact the Commission immediately.

What is the Health Care Complaints Commission?

The Health Care Complaints Commission is an independent body dealing with complaints about health services to protect the public health and safety.

Service in other languages

The Commission uses interpreting services to assist people whose first language is not English. If you need an interpreter, please contact the Translating and Interpreting Service (TIS National) on 131 450 and ask to be connected to the Health Care Complaints Commission on 1800 043 159 (9.00 am to 5.00 pm Monday to Friday).

More information

For more information about the Health Care Complaints Commission, please visit the website www.hccc.nsw.gov.au.

Contact the Health Care Complaints Commission

Office address: Level 13, 323 Castlereagh Street, SYDNEY NSW 2000 Post address: Locked Mail Bag 18, STRAWBERRY HILLS NSW 2012

Telephone: (02) 9219 7444 Toll Free in NSW: 1800 043 159 Fax: (02) 9281 4585 E-mail: hccc@hccc.nsw.gov.au

People using telephone typewriters please call (02) 9219 7555

Appendix 7

Case studies of unregistered health practitioners who have been found to have engaged in unprofessional or illegal activities

Case 1

A Victorian based shamanic healer was the subject of an inquiry by the Victorian Health Services Commissioner ('the HSC') and was found to have engaged in sexual relationships with a number of his clients. The practitioner failed to take action as a result of the recommendations of the HSC and as a consequence the HSC, in order to prevent further risk to public safety, tabled the report in the Victorian Parliament. The case raised questions about whether the practitioner was a fit and proper person to continue providing health services, but in the absence of banning powers, the Victorian HSC's powers were limited to public 'naming and shaming'.

Case 2

A NSW based naturopath who was implicated by the NSW Coroner in the death of a patient with end-stage renal failure undertaking a live-in de-toxification program. In 2007 the practitioner was cleared of a charge of manslaughter by the NSW Supreme Court. He had previously been found guilty of falsely claiming he was a medical practitioner under the *Medical Practice Act 1992* (NSW). In 2005 he changed his name and shifted his practice. In April 2008 the NSW Supreme Court permanently banned the practitioner from being involved in any business that offers naturopathy, medical herbalism, herbalism, iridology, hydrotherapy, sports medicine, osteopathy, blood analysis, and diet or nutrition advice in the treatment and prevention of illness. He was also permanently restrained from using in any way, in trade or commerce, the doctorate of philosophy conferred upon him in August 1998 by the Faculty of Medical Studies, Medicinea Alternativa Institute, affiliated to the Open International University for Complementary Medicines.

Case 3

A Port Stephens (NSW) based naturopath convicted in 2004 of the manslaughter of an 18 day old baby who required surgery to repair an aortic stenosis (heart defect). The baby died of heart failure following treatment with herbal drops and a 'Mora machine' that the practitioner advised the parents had cured the problem.

Case 4

A Victorian based massage therapist who was convicted in 2008 of indecent assault of two female clients and received a seven month jail sentence, suspended for 18 months. His name has been placed on the Victorian Register of Sex Offenders.

Case 5

A South Australian based practitioner whose registration as a psychologist was cancelled by the South Australian Psychological Board in November 2007. The Board found the practitioner guilty of, amongst other things, boundary violations with patients. The Board advised that the practitioner has amended his website to remove any reference to the words 'psychologist' and 'psychology' and appears to be continuing his practice involving treatment of vulnerable female patients.

Case 6

A Newcastle based practitioner who was the subject of order issued in October 2007 by the NSW Supreme Court for breaches of the misleading and deceptive provisions of the NSW *Fair Trading Act 1987*. The Orders permanently banned the practitioner from claiming he can treat people with cancer and other illnesses, and found that he falsely represented his background, and offered his clients false hope of being cured or extending and improving the quality of their lives.

Case 7

A Victorian based cancer care practitioner who was successfully prosecuted in 2008 by the Australian Competition and Consumer Commission for a range of breaches of the *Trade Practices Act 1987* (Cth) associated with his clinics.

The court found the practitioner and his company engaged in misleading or deceptive conduct and made false or misleading representations in breach of the Act by representing to persons suffering terminal illnesses (including cancer) and to their families that his system of care:

- could cure cancer, or reverse, stop or slow its progress or would prolong the life of a person suffering cancer, when this was not the case, and
- was based on generally accepted science, when this was not correct.

The court also declared that the practitioner had engaged in unconscionable conduct towards highly vulnerable consumers when “signing them up” to pay for treatment, and that significant sums of money were extracted from these persons and their families on the basis of false hopes that the sufferers could be cured or their lives prolonged.

Case 8

A former US based registered medical practitioner who was jailed in Virginia and New York in the 1990s, was arrested in Thailand in 2006 and implicated in the deaths of seven cancer patients in Western Australia in 2005. The Western Australian Coroner has commenced an inquest into the deaths.

Case 9

A Victorian based practitioner whose registration was cancelled for sexual misconduct. The Chinese Medicine Registration Board held two formal hearings in relation to allegations of practising without professional indemnity insurance, failing to disclose to an insurer, and sexual misconduct. He continues to practise in Victoria as a massage therapist.

Case 10

A Victorian based practitioner and registered dentist and now a cancer care practitioner who was the subject of an inquiry by the Victorian Health Services Commissioner in 2006, who continues to run a clinic offering complementary health care to cancer patients and is currently being prosecuted by the Consumer Affairs Victoria for alleged breaches of the *Fair Trading Act 1999* (Vic).

Appendix 8

Risks associated with the provision of health services by unregistered health practitioners

Overview

In order to determine whether further regulatory measures are required with respect to the provision of health services by unregistered health practitioners, an assessment is required of the activities of the professions or occupations concerned, to determine whether they pose a significant risk of harm to the health and safety of the public.

Factors to consider when assessing the significance of risk include:

- the nature and severity of the risk to the client group
- the nature and severity of the risk to the wider public, and
- the nature and severity of the risk to the practitioner.

Relevant considerations include:

- to what extent the practice of the profession or occupation involves the use of equipment, materials or processes which could cause a serious threat to public health and safety
- to what extent the failure of a practitioner to practise in particular ways (that is, follow certain procedures, observe certain standards, or attend to certain matters), result in a serious threat to public health and safety
- to what extent are intrusive techniques used in the practice of the profession or occupation, which can cause a serious or life threatening danger
- to what extent are certain substances used in the practice of the occupation, with particular emphasis on pharmaceutical compounds, dangerous chemicals or radioactive substances, and
- to what extent there is significant potential for practitioners to cause damage to the environment.

Risks associated with the type of procedure or activity

Thirteen types of procedure or activity have been identified that are undertaken by health practitioners (either registered or unregistered) and which carry risk. In some overseas jurisdictions (notably some Canadian states such as Ontario), these procedures or activities are restricted and may only be carried out by registered health practitioners. They are:

1. Putting an instrument, hand or finger into a body cavity, that is, beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening in the body.
2. Manipulation of the joints of the spine beyond the individual's usual physiological range of motion, using a high velocity, low amplitude thrust
3. Application of a hazardous form of energy or radiation, such as electricity for aversive conditioning, cardiac pacemaker therapy, cardioversion, defibrillation, electrocoagulation, electroconvulsive shock therapy, fulguration, nerve conduction studies or transcutaneous cardiac pacing, low frequency electro magnetic waves/fields for magnetic resonance imaging and high frequency soundwaves for diagnostic ultrasound or lithotripsy.
4. Procedures below the dermis, mucous membrane, in or below the surface of the cornea or teeth.
5. Prescribing a scheduled drug, supplying a scheduled drug (including compounding), supervising that part of a pharmacy that dispenses scheduled medicines.
6. Administering a scheduled drug or substance by injection.
7. Supplying substances for ingestion.

8. Managing labour or delivering a baby.
9. Undertaking psychological interventions to treat serious disorders or with potential for harm.
10. Setting or casting a fracture of a bone or reducing dislocation of a joint.
11. Provision of a primary care service to patients with or without a referral from a registered practitioner.
12. Treatment that commonly occurs without any other persons present.
13. Treatment that commonly requires patients to disrobe.

Source: Adapted from the *Regulated Health Professions Act 1991* (Ontario).

Using the ABS data, a list of health professions and occupations has been generated. Table 10.1 below lists the 13 types of activity identified above, and identifies whether these activities are typically part of the scope of practice of these professions or occupations.

While high risk activities can be identified and defined, gathering evidence on their frequency and likelihood of occurrence is problematic. Also, some of these activities are subject to specific regulation, such as the use of scheduled medicines and application of hazardous forms of radiation, but most are not.

By way of example, during development of the National Registration and Accreditation Scheme, a risk analysis was undertaken in relation to the practice of spinal manipulation, in order to determine whether a practice restriction should be included in the National Law. The analysis included literature searches of national and international literature on:

- the extent, cause and incidence of the risks of spinal manipulation
- the extent to which untrained and/or unregulated practitioners are undertaking spinal manipulation; and
- the regulation of spinal manipulation, including any evidence that regulation has reduced the risks associated with this practice. (Australian Health Ministers' Advisory Council 2009 p.61).

The review identified:

- conflicting streams of research suggesting:
  - on the one hand, a range of risks from minor to serious and life-threatening, with differing findings about the frequency of serious complications and suggestions of under-reporting; and
  - on the other hand that the practice is safe when performed by qualified practitioners, and that adverse outcomes have been misattributed;
- little available information about the extent to which unregistered or not specifically qualified practitioners undertake spinal manipulation, even in Victoria where no practice restriction applied.

The review found that 'the evidence justifying a practice restriction for spinal manipulation is mixed and there are some gaps and contested areas in the research'. The review concluded that 'although incidences of serious injury arising from manipulation of the cervical spine are rare, when such an incident does eventuate it has the potential to have catastrophic consequences' and that such risks are less likely if the practitioner is qualified in the practice (AHMAC, 2009 p.62).

Institutional arrangements and risk

The extent of problems associated with illegal or unethical practice are likely to be greater in the emerging professions compared with well established professions. This is because the established professions have stronger institutional arrangements that operate to contain risk, for example, by increasing the barriers to entry to the profession, enforcing minimum qualifications requirements for training and practice, limiting the settings within which the profession may be practised, and making peer review mechanisms more effective.

Professions with established government accredited training programs, a single peak professional association (rather than fragmented representative arrangements), accreditation arrangements with

private health insurers and/or government insurance programs such as Medicare, Veterans Affairs, traffic accident and workers compensation schemes, and employment opportunities primarily in publicly funded health services may be less likely to have practitioners who engage in illegal or unethical practice.

While such factors operate to reduce the risk, they do not eliminate it altogether. Employers may enforce minimum qualification standards and undertake probity checks. However, following an incident, an employee may agree to 'go quietly' rather than be dismissed, and any reference checks by subsequent employers may fail to reveal the details of their employment history. On occasions, the signing of a confidentiality agreement on termination has meant pertinent information has not been available to subsequent employers. The problem may be solved for the first employer, but health consumers remain at risk.

The United Kingdom Working Group on Extending Professional Regulation's July 2009 report provides a good overview of the challenges of risk assessment in this context. The report identifies many factors that contribute to the extent to which particular theoretical risks are realised in practice, for example:

- whether the act is carried out by a practitioner on their own or as part of a supervised team who can support, guide and scrutinise practice
- whether the act is carried out by a practitioner who is part of a well managed organisation that has in place managerial assurance systems to protect patients and the public
- whether the act is carried out by a practitioner who has a stable employment pattern, where any problems might be identified over time, or whether it is carried out by a more mobile short term tenure practitioner working in a variety of locations whose practice is less likely to receive consistent oversight,
- the quality of education and training of the practitioner carrying out the act,
- the experience of the practitioner carrying out the act,
- whether there are systems in place to ensure that the practitioner is regularly and effectively appraised and developed to ensure that they are up to date with current practice (2009, p.21).

The Working Group notes some factors that are likely to increase the incidence of poor, unethical or incompetent practice:

- practising without the supervision or support of peers, managers and other regulated staff
- practising with vulnerable or isolated individuals
- highly mobile, locum or short tenure
- practice that is not guided by a strong professional (or employer) code of conduct and
- practice in roles where the training and educational requirements are short and there is no extended period through which the ethos and values that underpin safe practice can be imbued (2009, p. 21).

The Working Group recognised the need for a robust evidence based approach to risk assessment (2009, p. 8), but noted that there is currently no clear way to judge the risk associated with roles, due to the uncertainty and complexity:

> The risk, benefits and costs of professional regulation are complex and multi-dimensional, involving difficult trade-offs and judgements. Where there is uncertainty and complexity, it is important that there is rigorous analysis of available evidence, clear criteria for decision making, and effective governance of the decision making process to avoid conflicts of interests and ensure that patients and the public are at the heart of the system.

A number of jurisdictions suggest the value in examining actuarial systems for assessing the degree of risk and therefore the costs of providing cover (Working Group 2009 pp.22, Virginia Board of Health Professions).

Appendix 9

Complaints data from Health Complaints Entities in relation to unregistered health practitioners

Appendix 9.1: NSW Health Care Complaints Commission Complaint Statistics regarding unregistered health practitioner

Complaints received about health practitioners 2005-06 – 2009–10

	2005 06		2006 07		2007 08		2008 09		2009 10	
Health practitioner	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Registered health practitioner										
Medical practitioner	1,227	68.6%	1,104	66.6%	1,145	64.7%	1,270	60.8%	1,263	56.2%
Dentist	165	9.2%	173	10.4%	177	10.0%	292	14.0%	410	18.2%
Nurse/midwife	154	8.6%	177	10.7%	224	12.6%	254	12.2%	221	9.8%
Psychologist	70	3.9%	81	4.9%	77	4.3%	84	4.0%	132	5.9%
Dental technician and prosthetist	24	1.3%	8	0.5%	21	1.2%	17	0.8%	42	1.9%
Chiropractor	17	1.0%	18	1.1%	15	0.8%	30	1.4%	24	1.1%
Physiotherapist	19	1.1%	15	0.9%	15	0.8%	25	1.2%	23	1.0%
Pharmacist	17	1.0%	21	1.3%	9	0.5%	21	1.0%	22	1.0%
Optometrist	6	0.3%	10	0.6%	5	0.3%	18	0.9%	15	0.7%
Podiatrist	10	0.6%	13	0.8%	8	0.5%	9	0.4%	14	0.6%
Osteopath	1	0.1%	4	0.2%	2	0.1%	1	0.0%	3	0.1%
Optical dispenser	–	0.0%	1	0.0%	–	0.0%	1	0.0%	1	0.0%
Total registered health practitioners	**1,710**	**95.6%**	**1,625**	**98.0%**	**1,698**	**95.9%**	**2,022**	**96.7%**	**2,170**	**96.5%**
Unregistered health practitioner										
Administration/clerical staff	2	0.1%	2	0.1%	1	0.1%	7	0.3%	15	0.7%
Other/unknown	30	1.7%	7	0.4%	1	0.1%	8	0.4%	9	0.4%
Massage therapist	n/a	0.0%	n/a	0.0%	n/a	0.0%	4	0.2%	8	0.4%
Social worker	1	0.1%	–	0.0%	2	0.1%	6	0.3%	8	0.4%
Alternative health provider	17	1.0%	5	0.3%	10	0.6%	1	0.0%	6	0.3%
Counsellor/therapist	7	0.4%	2	0.1%	1	0.1%	8	0.4%	6	0.3%
Previously registered health practitioner	1	0.1%	3	0.2%	44	2.5%	18	0.9%	5	0.2%
Naturopath	2	0.1%	1	0.1%	2	0.1%	2	0.1%	3	0.1%
Occupational therapist	1	0.1%	1	0.1%	–	0.0%	1	0.0%	3	0.1%
Acupuncturist	1	0.1%	–	0.0%	2	0.1%	–	0.0%	2	0.1%
Dietitian/nutritionist	–	0.0%	1	0.1%	1	0.1%	1	0.0%	2	0.1%
Psychotherapist	2	0.1%	1	0.1%	3	0.2%	–	0.0%	2	0.1%
Radiographer	–	0.0%	1	0.1%	3	0.2%	3	0.1%	2	0.1%
Traditional Chinese medicine practitioner	8	0.4%	2	0.1%	–	0.0%	2	0.1%	2	0.1%
Assistant in nursing	2	0.1%	2	0.1%	–	0.0%	1	0.0%	1	0.0%
Homeopath	n/a	0.0%	n/a	0.0%	n/a	0.0%	2	0.1%	1	0.0%
Hypnotherapist	n/a	0.0%	n/a	0.0%	n/a	0.0%	–	0.0%	1	0.0%
Natural therapist	4	0.2%	2	0.1%	–	0.0%	2	0.1%	1	0.0%
Reflexologist	n/a	0.0%	n/a	0.0%	n/a	0.0%	–	0.0%	1	0.0%
Residential care worker	–	0.0%	–	0.0%	3	0.2%	–	0.0%	1	0.0%
Ambulance personnel	–	0.0%	2	0.1%	–	0.0%	–	0.0%	–	0.0%
Speech therapist	–	0.0%	–	0.0%	–	0.0%	2	0.1%	–	0.0%
Total unregistered health practitioners	**78**	**4.4%**	**32**	**2.0%**	**73**	**4.1%**	**68**	**3.3%**	**79**	**3.5%**
Grand total	**1,788**	**100.0%**	**1,657**	**100.0%**	**1,771**	**100.0%**	**2,090**	**100.0%**	**2,249**	**100.0%**

Counted by provider identified in complaint

Issues raised in complaints received about unregistered health practitioners in 2009-10

	Unregistered health practitioner																			Total	
Issue category	Administration/clerical staff	Social worker	Counsellor/therapist	Other/unknown	Massage therapist	Alternative health provider	Previously registered practitioner	Occupational therapist	Naturopath	Psychotherapist	Natural therapist	Acupuncturist	Dietitian/nutritionist	Traditional Chinese medicine practitioner	Assistant in nursing	Radiographer	Reflexologist	Homeopath	Residential care worker	Hypnotherapist	No.	%
Professional conduct	8	5	5	2	9	6	3	–	2	2	–	1	–	2	2	1	1	–	1	–	50	47.2%
Treatment	–	3	2	1	–	–	4	–	–	1	1	1	1	–	–	1	–	1	–	1	17	16.0%
Communication/information	1	5	3	1	–	1	1	2	1	–	–	–	2	–	–	–	–	–	–	–	17	16.0%
Environment/management of facilities	3	–	–	3	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	6	5.7%
Fees/costs	–	–	–	1	–	–	1	–	–	–	2	1	–	–	–	–	–	–	–	–	5	4.7%
Reports/certificates	–	–	–	1	–	–	–	2	–	–	–	–	–	–	–	–	–	–	–	–	3	2.8%
Grievance processes	3	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	3	2.8%
Medical records	2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2	1.9%
Access	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	0.9%
Medication	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	1	0.9%
Consent	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	0.9%
Total	**18**	**14**	**10**	**9**	**9**	**7**	**9**	**4**	**4**	**3**	**3**	**3**	**3**	**2**	**2**	**2**	**1**	**1**	**1**	**1**	**108**	**100.0%**

Counted by issues raised in complaint

A breakdown of issues raised in complaints for previous years can be found in the appendices of the annual reports of the Health Care Complaints Commission, which are available on its website at http://www.hccc.nsw.gov.au/Publications/Annual-Reports/default.aspx

The Commission made the following assessment decision in relation to complaints about unregistered health practitioners.

Outcome of assessment of complaints about unregistered health practitioners 2005-06 to 2009-10

Outcome	2005 06	2006 07	2007 08	2008 09	2009 10
Discontinued	21	21	14	28	56
Investigation	26	4	11	7	12
Refer to Registration Board*	7	4	1	8	5
Refer to another body	–	–	2	2	5
Resolution/Conciliation	3	1	2	6	3
Resolved during assessment process	–	–	1	–	2
Grand Total	59	30	31	51	83

* These cases mainly involve practitioners in registered professions who were not registered at the time of the incident complained about.

The following table summarises the number of investigation finalised in the past five years. In 2009-10, there were six investigation against unregistered health practitioners finalised (2.2% of all investigations)

	Description	2005 06		2006 07		2007 08		2008 09		2009 10	
		No.	%	No.	%	No.	%	No.	%	No.	%
Health organisations	Public hospital	65	70.7%	63	68.5%	63	75.0%	46	75.4%	30	85.7%
	Private hospital	10	10.9%	7	7.6%	6	7.1%	4	6.6%	2	5.7%
	Area health service	1	1.1%	–	0.0%	3	3.6%	3	4.9%	2	5.7%
	Aged care facility	5	5.4%	8	8.7%	4	4.8%	2	3.3%	1	2.9%
	Pathology centre/lab	–	0.0%	–	0.0%	1	1.2%	2	3.3%	–	0.0%
	Dental facility	–	0.0%	–	0.0%	–	0.0%	1	1.6%	–	0.0%
	Drug and alcohol service	2	2.2%	2	2.2%	–	0.0%	1	1.6%	–	0.0%
	Medical centre	4	4.3%	1	1.1%	1	1.2%	1	1.6%	–	0.0%
	Radiology practice	1	1.1%	1	1.1%	1	1.2%	1	1.6%	–	0.0%
	Ambulance service	1	1.1%	2	2.2%	–	0.0%	–	0.0%	–	0.0%
	Other/unknown	–	0.0%	–	0.0%	2	2.4%	–	0.0%	–	0.0%
	Community health service	1	1.1%	2	2.2%	1	1.2%	–	0.0%	–	0.0%
	Correction and detention facility	2	2.2%	–	0.0%	2	2.4%	–	0.0%	–	0.0%
	Supported accommodation services	–	0.0%	1	1.1%	–	0.0%	–	0.0%	–	0.0%
	Medical practice	–	0.0%	5	5.4%	–	0.0%	–	0.0%	–	0.0%
	Health organisation total	**92**	**100.0%**	**92**	**100.0%**	**84**	**100.0%**	**61**	**100.0%**	**35**	**100.0%**
Health practitioners	Medical practitioner	191	55.2%	175	60.6%	150	59.1%	112	56.0%	149	62.9%
	Nurse/midwife	113	32.7%	68	23.5%	75	29.5%	69	34.5%	53	22.4%
	Pharmacist	2	0.6%	2	0.7%	2	0.8%	–	0.0%	12	5.1%
	Chiropractor	3	0.9%	3	1.0%	3	1.2%	1	0.5%	6	2.5%
	Dentist	2	0.6%	11	3.8%	2	0.8%	1	0.5%	3	1.3%
	Physiotherapist	2	0.6%	2	0.7%	2	0.8%	1	0.5%	3	1.3%
	Psychologist	9	2.6%	17	5.9%	9	3.5%	6	3.0%	3	1.3%
	Dental technician and prosthetist	1	0.3%	–	0.0%	–	0.0%	–	0.0%	2	0.8%
	Administration/clerical staff	–	0.0%	–	0.0%	–	0.0%	–	0.0%	1	0.4%
	Alternative health provider	17	4.9%	–	0.0%	6	2.4%	1	0.5%	1	0.4%
	Massage therapist	n/a	0.0%	n/a	0.0%	–	0.0%	1	0.5%	1	0.4%
	Natural therapist	–	0.0%	2	0.7%	–	0.0%	–	0.0%	1	0.4%
	Psychotherapist	–	0.0%	1	0.3%	–	0.0%	1	0.5%	1	0.4%
	Traditional Chinese medicine practitioner	–	0.0%	7	2.4%	–	0.0%	–	0.0%	1	0.4%
	Acupuncturist	1	0.3%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
	Ambulance personnel	–	0.0%	–	0.0%	2	0.8%	–	0.0%	–	0.0%
	Assistant in nursing	1	0.3%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
	Homeopath	n/a	0.0%	n/a	0.0%	n/a	0.0%	1	0.5%	–	0.0%
	Naturopath	–	0.0%	–	0.0%	2	0.8%	–	0.0%	–	0.0%
	Optometrist	1	0.3%	–	0.0%	–	0.0%	1	0.5%	–	0.0%
	Osteopath	–	0.0%	–	0.0%	–	0.0%	1	0.5%	–	0.0%
	Podiatrist	2	0.6%	–	0.0%	1	0.4%	2	1.0%	–	0.0%
	Radiographer	–	0.0%	–	0.0%	–	0.0%	2	1.0%	–	0.0%
	Social worker	1	0.3%	1	0.3%	–	0.0%	–	0.0%	–	0.0%
	Health practitioner total	**346**	**100.0%**	**289**	**100.0%**	**254**	**100.0%**	**200**	**100.0%**	**237**	**100.0%**
	Grand total	**438**	**100.0%**	**381**	**100.0%**	**338**	**100.0%**	**261**	**100.0%**	**272**	**100.0%**

Counted by provider identified in complaint

In 2009-10, the Commission took finalised its investigation into health practitioners with the following outcomes.

	Health practitioner														Total	
Outcome	Medical practitioner	Nurse	Pharmacist	Chiropractor	Dentist	Physiotherapist	Psychologist	Dental technician and prosthetist	Administration/clerical staff	Alternative health practitioner	Massage therapist	Natural therapist	Psychotherapist	Traditional Chinese medicine practitioner	No.	%
Referred to Director of Proceedings	91	32	7	4	2	2	3	–	–	–	–	–	–	–	141	59.5%
Referred to registration board	26	12	3	2	–	1	–	–	–	–	–	–	–	–	44	18.6%
No further action	20	8	1	–	1	–	–	–	1	–	–	–	–	1	32	13.5%
Comments	10	1	1	–	–	–	–	–	–	–	–	1	1	–	14	5.9%
Prohibition order/public statement	–	–	–	–	–	–	–	2	–	1	1	–	–	–	4	1.7%
Referred to Director of Public Prosecutions	2	–	–	–	–	–	–	–	–	–	–	–	–	–	2	0.8%
Total	**149**	**53**	**12**	**6**	**3**	**3**	**3**	**2**	**1**	**1**	**1**	**1**	**1**	**1**	**237**	**100.0%**

In relation to unregistered health practitioners, the Commission made two prohibition orders. In addition, the Commission made a prohibition order in two complaints against a dental technician who had offered services as a dentist. Two investigations against unregistered health practitioners were finalised without any further action taken; another two investigations resulted in the Commission making comments to the practitioner.

A breakdown of the outcomes of Commission investigation for previous year can be found in the appendices of the Commission's annual reports, which are available online at http://www.hccc.nsw.gov.au/Publications/Annual-Reports/default.aspx

Appendix 9.2: QLD complaints data

Types of issues raised regarding unregistered providers between 2008-2009 with the Health Quality and Complaints Commissioner in Queensland

Clinical Setting Tier 1	Stage	Open Status	Issue Category	Issue Level 1
Alternative care	Investigation	Closed	Professional Conduct	Assault
Alternative care	Intake	Closed	Communication & Information	Inadequate information provided
Alternative care	Intake	Closed	Communication & Information	Inadequate information provided
Alternative care	Intake	Closed	Professional Conduct	Assault
Alternative care	Intake	Closed	Treatment	Conduct of treatment
Alternative care	Intake	Closed	Treatment	Unexpected treatment outcome/complications
Alternative care	Intake	Closed	Reports/Certificates	Issue false or misleading certificate / report
Alternative care	Intake	Closed	Privacy / Confidentiality	Inappropriate disclosure of information
Alternative care	Assessment	Closed	Treatment	Conduct of treatment
Alternative care	Investigation	Closed	Treatment	Conduct of treatment
Alternative care	Intake	Closed	Treatment	Conduct of treatment
Alternative care	Intake	Closed	Treatment	Conduct of treatment
Alternative care	Intake	Closed	Fees, Costs & Rebates	Billing Practices
Alternative care	Referral to External Agency	Open	Medication	Adverse reaction to correct medication
Alternative care	Intake	Closed	Communication & Information	Inadequate information provided
Alternative care	Referred to Board	Open	Medication	Medication error
Alternative care	Investigation	Closed	Treatment	Conduct of treatment
Alternative care	Referred to Board	Open	Professional Conduct	Misrepresentation of qualifications
Alternative care	Intake	Closed	Professional Conduct	Assault
Alternative care	Intake	Closed	Treatment	Rough and painful treatment
Alternative care	Intake	Closed	Professional Conduct	Illegal practice
Alternative care	Assessment	Open	Treatment	Wrong/inappropriate treatment
Alternative care	Assessment	Closed	Consent	Uninformed consent
Alternative care	Intake	Closed	Treatment	Co-ordination of treatment
Alternative care	Investigation	Open	Professional Conduct	Illegal practice
Alternative care	Intake	Closed	Treatment	Inadequate treatment
Alternative care	Intake	Closed	Professional Conduct	Boundary violation
Alternative care	Assessment	Open	Treatment	Wrong/inappropriate treatment

Appendix 9.3: Victoria complaints data

Types of unregistered practitioners and numbers of complaints made to the Health Services Commissioner between 2006-2010 in Victoria

Type	2010	2009	2008	2007	2006	Total	
Alcohol & Drug Service	2	4	1	1	1	**9**	5%
Alternative therapist	11	16	5	18	12	**62**	38%
Audiologist	0	1	1	0	2	**4**	2%
Beauticians/ laser therapy/ beauty clinics	13	9	9	7	11	**49**	30%
Counsellor/counselling service	4	6	4	5	3	**22**	13%
Medical Technician	0	1	1	0	1	**3**	2%
Occupational therapist	4	3	2	2	3	**14**	8%
Social Worker	0	1	1	0	0	**2**	1%
Total	**34**	**41**	**24**	**33**	**33**	**165**	**100%**
	21%	25%	15%	20%	20%	100%	

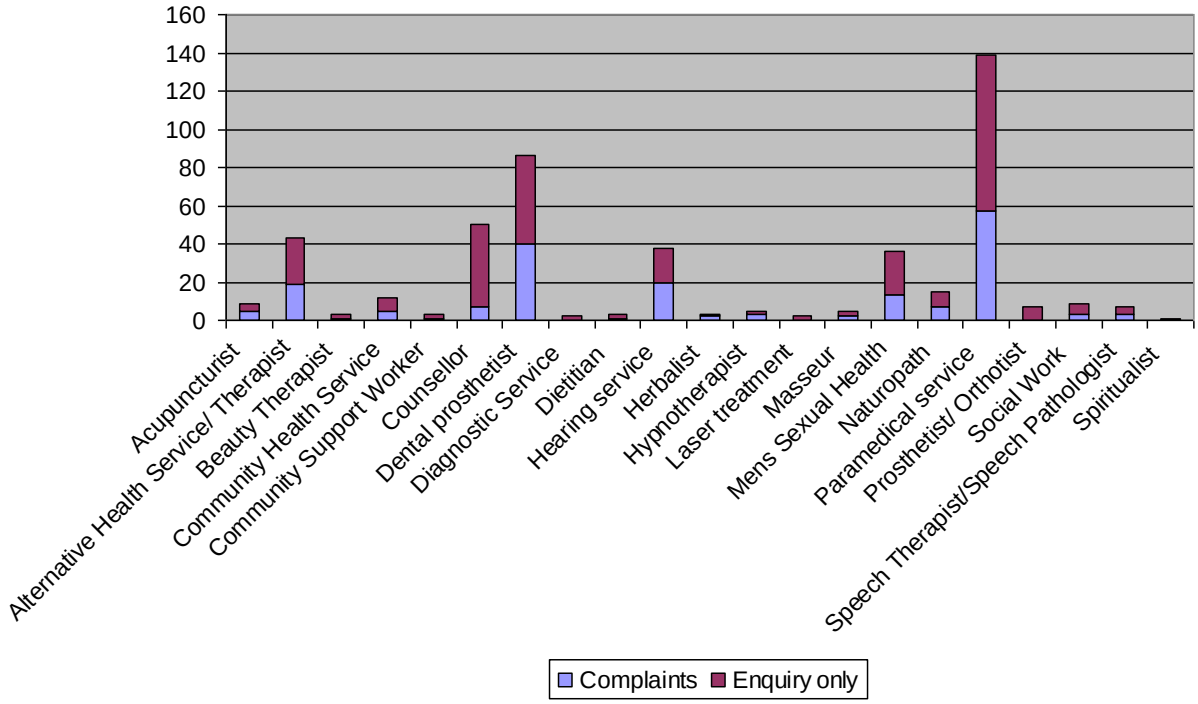
Appendix 9.4: Western Australia complaints data

Office of Health Review, Government of Western Australia: Complaints statistics report – Period: 1 January 2000 – 1 June 2010

Summary

Unregistered practitioner information available on OHR databases shows a total of 478 new enquiries and complaints made between January 2000 and June 2010. This equates to 46 new non registered practitioners enquiries and complaints per year, with 18 submitted in writing to become a complaint (40 per cent) and 28 remaining an enquiry (60 per cent).

Enquiries and complaints by non registered service: 1 Jan 2000 – 1 Jun 2010



On average, the Office of Health Review received 1970 new enquiries each year since 2000/01. This shows that 2.3 per cent of all new enquiries and complaints received relate to non registered practitioners.

The most common type of unregistered provider enquired about was paramedical services, followed by dental prosthetists.

Non registered service	Total enquiries and complaints	Written complaints	Enquiry only
Acupuncturist	9	5	4
Alternative Health Service/ Therapist	43	19	24
Beauty Therapist	3	1	2
Community Health Service	12	5	7
Community Support Worker	3	1	2
Counsellor	50	7	43
Dental prosthetist	86	40	46
Diagnostic Service	2		2
Dietitian	3	1	2
Hearing service	38	20	18

Non registered service	Total enquiries and complaints	Written complaints	Enquiry only
Herbalist	3	2	1
Hypnotherapist	5	3	2
Laser treatment	2		2
Masseur	5	2	3
Mens Sexual Health	36	13	23
Naturopath	15	7	8
Paramedical service	139	57	82
Prosthetist/ Orthotist	7		7
Social Work	9	3	6
Speech Therapist/Speech Pathologist	7	3	4
Spiritualist	1		1
Total	**478**	**189**	**289**
Average per year	**46**	**18**	**28**

Issues raised

Enquiries and complaints often raise more than one issue. The most common issue for all enquiries and complaints relating to unregistered practitioners was ‘inadequate treatment’, which was a factor in 24 per cent of cases. This was followed by ‘unsatisfactory billing practices’ which was an issue in 19 per cent of enquiries and complaints.

Most common issues raised by unregistered practitioner complaints and enquiries: 1 January 2000 1 June 2010	
Inadequate treatment	117
Unsatisfactory billing practices	90
Unskilful/ incomplete treatment	47
Overcharging	46
Inadequate information on costs	37
Adverse outcome	23
Unprofessional conduct	15
No/ inadequate service	14
Breach of condition	14
Attitude/ Manner	13
Other	204
Total issues raised	**620**
Total enquiries and complaints	**478**

Most common issues raised by unregistered practitioner complaints and enquiries: 1 January 2000 – 1 June 2010