Final report

Options for regulation of unregistered health practitioners

April 2013

Australian Health Ministers' Advisory Council

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

Contents

Acronyms

AAESS	Australian Association for Exercise and Sports Science
AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
AHWMC	Australian Health Workforce Ministerial Council
ACAud	Australian College of Audiology
ACA	Australian Consumers Association
ACCC	Australian Competition and Consumer Commission
ADEA	Australian Diabetes Educators Association
AHMAC	Australian Health Ministers' Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
AIMS	Australian Institute of Medical Scientists
ANZSCO	Australian & New Zealand Standard Classification of Occupations
AOB	Australian Orthoptic Board
ARCAP	Australian Register of Counsellors and Psychotherapists
AROH	Australian Register of Homoeopaths
ARONAH	Australian Register of Naturopaths and Herbalists
ARTG	Australian Register of Therapeutic Goods
ASA	Audiological Society of Australia Inc.
ATMS	Australian Traditional Medicine Society
CAM	complementary and alternative medicine
CCA	Competition and Consumers Act 2010 (C'th)
COAG	Council of Australian Governments
CPD	continuing professional development
Cth	Commonwealth
DAA	Dietitians Association of Australia
GST	goods & services tax
HCCC	Health Care Complaints Commission (NSW)
HCE	health complaints entity
IGA	Intergovernmental Agreement
IPL	intense pulse light technology
IARF	Inter-Association Regulatory Forum
MOU	memorandum of understanding
NHAA	National Herbalists Association of Australia
NPA	National Partnership Agreement
NRAS	National Registration and Accreditation Scheme for the health professions
OT Australia	Occupational Therapy Australia
PACFA	Psychotherapy and Counselling Federation of Australia
RIS	regulatory impact statement
SPA	Speech Pathology Australia
TIS	Translating and Interpreting Service
VAHLC	Victorian Allied Health Leaders Council
WHM	Western herbal medicine

Executive summary

Background

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

The term 'unregistered health practitioner' is defined to include any person who provides a health service and who is not registered in one of the 14 professions regulated under the National Registration and Accreditation Scheme for the health professions (NRAS).

The NRAS commenced operation on 1 July 2010. Practitioners from the 14 regulated health professions are registered under statute to practise in any State or Territory. National Boards have been set up, one for each regulated profession, with extensive powers designed to protect the public. However, these powers do not extend to practitioners in health professions and occupations where statutory registration is not a prerequisite for practice.

This does not mean that such practitioners are unregulated. There are a range of laws that apply to their practice. Also, many practitioners are subject to 'voluntary self-regulation', that is, they voluntarily choose to join a professional association, thereby subjecting themselves to the rules of the association. As a condition of their membership, they may agree to abide by a code of ethics, undertake continuing professional development and meet other practice standards. They may have their membership withdrawn by the association for breaches of professional standards. A variety of government and non-government organisations that fund or provide health services (such as Medicare Australia, workers compensation, transport accident insurance, and private health insurance funds) rely on such professional associations to regulate their members. These 'health payers'[2] may require practitioners to be members of an association in order to become a 'recognised provider' of health services that they fund. Depending on how they are configured, these arrangements for credentialing of practitioners may constitute a type of 'co-regulation'.

The problem

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 to cancel their registration and the removal of their right to practise. Sometimes a practitioner has committed offences under a number of different laws over an extended period. Often these practitioners are not members of professional associations with strong self-regulatory standards. If they are, they may decide to let their membership lapse to avoid the scrutiny of their peers, rather than address deficiencies in their practice. There is also evidence that such practitioners sometimes move to those jurisdictions that have less regulatory scrutiny, in order to continue their illegal or unethical conduct.

A number of government reports and inquiries in New South Wales, South Australia and Victoria have highlighted concerns about the adequacy of public protection with respect to services delivered by unregistered health practitioners. In 2007, the NSW Parliament enacted legislation to address what was seen as a gap in regulation in that state, 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. Powers of the NSW

[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.

[2] The term 'health payer' is used here to describe government and non-government organisations that pay for or subsidise the provision of health services to consumers, and includes the Health Insurance Commission, Medicare Australia, the Department of Veterans Affairs and private health insurance funds.

Health Care Complaints Commission were also extended to allow the issue of a 'prohibition order' on a practitioner following investigation of a serious breach of the Code. A prohibition order may place limitations on the practitioner's practice, or prohibit them from providing health services altogether if there is a serious risk to public health and safety. Breaches of a prohibition order are subject to prosecution through the courts. Legislation passed by the South Australian Parliament which is yet to be fully implemented will establish a similar regulatory scheme in that State. The South Australian Code of Conduct is to come into effect in March 2013.

Consultations

A national consultation was undertaken during 2011. The objective of the consultation was 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 a statutory code 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.

A consultation paper was released and forums were held around the country. The consultation paper set out the current regulatory arrangements that apply to unregistered health practitioners and provided details of the NSW regulatory scheme, specifically the Code of Conduct that applies to all health service providers in that State. A number of options were set out and respondents were asked to consider whether regulatory protections such as those in NSW and South Australia are required in all States and Territories. Respondents were also invited to comment on the extent to which uniform arrangements are necessary or desirable for the terms of the code of conduct and for its enforcement.

Content of this Regulatory Impact Statement

This Decision Regulatory Impact Statement (RIS) has been prepared in accordance with the Council of Australian Governments (COAG) requirements to assess the impact on Australian Governments, the health industry and the community of options for strengthening regulation of unregistered health practitioners. The RIS is consistent with the guidelines and principles of best practice regulation. (COAG, 2007).

This RIS presents an analysis of:

- the current arrangements (section 1)
- the nature and extent of problems associated with the practice of unregistered practitioners (section 2)
- the consultations undertaken (section 3)
- the options available for strengthening public protection (section 4)
- the impacts, costs and benefits of each option (section 5)
- the conclusions and recommendations (section 6)
- implementation and review (section 7)

Objectives and options

The following options are assessed in this RIS:

Option 1: No change to the current regulatory regime (the 'base case')

Option 2: Strengthen self regulation – a voluntary code of practice and a number of measures to improve the efficiency and effectiveness of self-regulation of the unregistered health professions

Option 3: Strengthen statutory health complaints mechanisms – a statutory code of conduct and powers to prohibit those who breach the code from continuing to provide health services

Option 4: Extend statutory registration to all currently unregistered health professions.

Conclusions and recommendations

There are risks associated with any form of health care. The harm associated with the provision of health services by unregistered health practitioners is difficult to quantify 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. However, preventable deaths and serious injury associated with poor practice by unregistered health practitioners have been documented. This suggests that further action is required by governments.

This RIS has investigated a number of options to better protect health service consumers from harm arising from services delivered by unregistered health practitioners.

The impact assessment shows that all options have the potential to reduce the harm to consumers compared with Option 1, the base case.

Option 3, a single National Code of Conduct with enforcement powers for breach of the Code is considered likely to deliver the greatest net public benefit to the community. The analysis indicates that Option 3 will be more effective in reducing harm than Options 1 or 2, and compared with all options, it is likely to be the most cost-effective given the level of risk.

In summary, the key benefits of Option 3 over other options are:

- it captures all practitioners whether or not they identify with a particular profession or choose to be members of a self-regulating professional association
- it sets common minimum standards of practice regardless of the practitioner's profession or occupation or the nature of their practice
- it targets enforcement action to those practitioners who avoid their ethical responsibilities or who engage in predatory or exploitative behaviour towards their clients
- it empowers the regulator to deal with practitioners who demonstrate a pattern of conduct indicating they are not a fit and proper person to provide health services, and
- it presents a relatively cost effective method of addressing the worst conduct and, over time, is expected to lead to an overall improvement in standards and a better educated and informed public.

While all instances of harm to health service consumers cannot be prevented, Option 3 is expected to reduce the incidence of harm associated with health services provided by unregistered health practitioners. It is also the option that was most strongly supported by the majority of respondents to the national consultation.

While Option 3 does not set minimum qualifications and probity requirements for entry to practice as a health practitioner and regulatory action is generally triggered only following a complaint, it provides a targeted mechanism for dealing with practitioners who are subject to successive enforcement actions by multiple regulators, suggesting they are not fit and proper to provide health services.

On balance, Option 3 is the recommended option because it is the least cost option while effective in reducing harm and achieving the objective of protecting the public.

While there are costs associated with implementation of Option 3, the reduction in harm that is expected is likely to be well in excess of the cost.

1. Context

This section sets out the context in which proposals to strengthen protections for consumers who use the services of unregistered health practitioners are to be considered. Relevant national agreements are identified, the scope of this Regulatory Impact Statement (RIS) is defined and the current legislative, self-regulatory and co-regulatory arrangements described.

1.1 National agreements

A number of national agreements are relevant to the matters addressed in this RIS. They are set out below.

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.

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 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 Decision Regulatory Impact Statement has been prepared in accordance with the COAG guidelines.

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

The laws that have been enacted in each State and Territory in accordance with this IGA are detailed in section 1.3.

1.2 Scope of this RIS

There are two groups of practitioners that fall within the scope of proposals in this RIS:

- unregistered health practitioners
- health practitioners who are registered under NRAS, to the extent that they practise outside the usual scope of practice of the profession in which they are registered.

These groups are defined below.

The Australian Bureau of Statistics (ABS) defines 'health occupations' as those which produce a good or service that directly treats a physical or mental health condition experienced by people, and those which directly support the provision of such goods and services. It includes occupations with tasks and duties that primarily relate to:

- treatment or restoration of physical and/or mental well-being
- health maintenance
- health promotion and education
- administrative and technical support of health professionals
- health research (ABS 2006a)

The definition excludes occupations whose members produce a good or service that is intended to treat a 'social' health condition. It excludes occupations whose members primarily meet social needs such as companionship, supervision in care facilities, recreation, and assist with housing and finances. (ABS 2006b)

Appendix 1 provides a list of the occupations that the ABS classifies as health occupations.

Appendix 2 sets out the definitions of a 'health service' adopted in State and Territory health complaints legislation.

According to the ABS, in 2009, 11% of the Australian workforce (1,185,300 people) were employed in the 'health and social assistance' industry (ABS 2010). Data collected by the ABS in 2008 indicates a significant rise over the last decade in the number of unregistered practitioners working in health care.

Unregistered health practitioners

The term 'unregistered health practitioner' is defined for the purposes of this RIS to include any person who provides a health service and who is not a registered in one of the 14 professions currently regulated under the National Registration and Accreditation Scheme.

The term captures practitioners who have been registered previously under statute in a State or Territory or under the National Registration and Accreditation Scheme but have had their registration cancelled or withdrawn.

[3] The podiatry profession was added as the tenth profession to be regulated under the National Registration and Accreditation Scheme after the IGA was signed by COAG. Health Ministers subsequently agreed to include four additional professions commencing 1 July 2012, bringing the total number of health professions regulated under the National Scheme to 14.

While there are many health professions and occupations that are likely to be affected by these regulatory proposals, it is difficult to quantify the number of practitioners. This is because:

- new occupations and professions are emerging while others are in decline
- some practitioners do not identify with a particular profession or use professional titles associated with an established profession; others identify with more than one profession or occupation
- sometimes it is only possible to tell whether a service provided by a practitioner is a health service by looking at the context within which it has been provided, including the claims that have been made by the practitioner and the expectations and understanding of the client.

In addition, some of the professions listed below (eg. social work) have members who work in both health and non-health settings. For example, a social worker who works in a clinical setting in an acute hospital is likely be providing services that fit within the definition of a health service, while a social worker who works in a community setting providing adoption support services may not be.

Unregistered health practitioners who may be affected by these regulatory proposals include, **but are not limited to,** the following groups:

art therapists	medical scientists
aromatherapists	music, dance and drama therapists
assistants in nursing	myotherapists
audiologists and audiometrists	naturopaths
ayuvedic medicine practitioners	nutritionists
bioresonance practitioners	optical dispensers
cardiac scientists	orthoptists
clinical perfusionists	orthotists and prosthetists
complementary and alternative medicine (CAM) practitioners	paramedics
counsellors and psychotherapists	pharmacy assistants
dental technicians	phlebotomists
dental assistants	reflexologists
dietitians	reiki practitioners
herbalists	respiratory scientists
homoeopaths	shiatsu therapists
homoeopaths	sleep technologists
hypnotherapists	social workers
lactation consultants	sonographers
massage therapists	speech pathologists

The following occupational groups are considered to be outside the scope of this RIS because the services they provide do not generally fit the definition of a health service:

- beauty therapists
- interpreters and translators

Statutorily registered health practitioners

Most practitioners who are currently registered under the National Registration and Accreditation Scheme will not be directly affected by these proposals. However, a small proportion of registered practitioners will have an interest. This is because the proposals under consideration capture registered practitioners to the extent that they provide health services that are unrelated to their registration.

Examples include a registered nurse who works as a massage therapist or reiki practitioner, or a registered physiotherapist who works as a naturopath.

The health professions regulated under the National Scheme are:

- Aboriginal and Torres Strait Islander health practitioners
- Chinese medicine practitioners (acupuncturists, Chinese herbal medicine practitioners, Chinese herbal dispensers)
- 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)
- Nurses and midwives
- Occupational therapists
- Optometrists
- Osteopaths
- Pharmacists
- Physiotherapists
- Podiatrists
- Psychologists

1.3 Current legislative arrangements

Health practitioners, both registered and unregistered, are subject to a range of laws that affect their practice. These include occupational licensing laws, health complaints laws, laws that regulate specific activities such as use of medicines, therapeutic goods and 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 this RIS are outlined in more detail below.

Health Practitioner Regulation National Law Act (the National Law)

Registered practitioners and the National Law

The National Registration and Accreditation Scheme provides a single trusted source of information for consumers, employers and governments about who is qualified and registered in a regulated health profession. This information is publicly available via the Registers of health practitioners. The scheme provides economies of scale for what is an essential quality assurance function on which the Australian health system relies.

The National Law establishes a National Board for each of the 14 professions regulated and provides these 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 options for strengthening protections with respect to unregistered health practitioners.

Barriers to entry to regulated professions

Under the National Law, the National Boards have powers to set the qualifications and other requirements for registration. Offences for unauthorised use of restricted professional titles and in some cases restrictions on who can carry out certain practices mean that only a practitioner registered in a regulated profession can practise the profession. These arrangements establish barriers to entry to the

regulated professions, and provide a more efficient mechanism for assuring the quality of practitioners than if every consumer, employer, health payer etc had to undertake their own assessment of the qualifications and fitness to practise of 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.

Monitoring of suitability to practise

Under the National Law, every practitioner seeking to renew their registration must make an annual statement and satisfy the relevant National Board that they remain fit and suitable to practice. The annual statement addresses matters such as impairment, criminal history, continuing professional development, recency of practice, professional indemnity insurance, clinical privileges etc. At any time during the registration period, a registered practitioner must notify the relevant national board of certain matters, such as criminal charges, complaints to other regulatory bodies, withdrawal or restriction of prescribing rights, clinical or billing privileges, or withdrawal of professional indemnity coverage.

Disciplinary powers

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 departures from accepted professional standards are judged is set out in the National Law. See *Appendix 4* for 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 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].

National Boards have powers to investigate the professional conduct of a practitioner, or to require the practitioner undergo a performance assessment or health assessment. The National Boards may refer a practitioner to a professional standards panel or health panel for hearing. If the alleged breach of professional standards is serious enough, the National Board may prosecute the matter before the relevant State or Territory tribunal. A range of decisions are open to Panels and Tribunals and are applied to protect the public rather than punish the practitioner.

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[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'.

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

Powers to prohibit practice

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 and can be used to prevent a practitioner from continuing to provide the same services under a different, non-restricted title, following cancellation of their registration. For example, a psychologist may be prevented from practising as a psychotherapist or a counsellor, or a physiotherapist may be prevented from practising as a massage therapist.

Unregistered practitioners and the National Law

The powers outlined above are not available to deal with unregistered health practitioners who breach accepted professional standards. 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]

Health complaints regulation

When a consumer is unhappy with a health service or practitioner, they may lodge a complaint with a State or Territory health complaints entity (HCE). An HCE is defined under the National Law as 'an entity that is established by or under an Act of a participating jurisdiction (a State or Territory) 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. Relevant State and Territory Acts are:

- ACT – *Human Rights Commission Act 2005*
- NSW – *Health Care Complaints Act 1993*
- Northern Territory – *Health and Community Services Complaints Act*
- Queensland – *Health Quality and Complaints Commission Act 2006*
- South Australia – *Health and Community Services Complaints Act 2004*
- Tasmania – *Health Complaints Act 1995*
- Victoria – *Health Services (Conciliation and Review) Act 1987*
- Western Australia – *Health and Disability Services (Complaints) Act 1995*

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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)

There are two main health complaints 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 to initiate the prosecution of registered practitioners for professional misconduct. The NSW HCCC (rather than the National Boards) investigate and prosecute cases of alleged professional misconduct by registered health practitioners before the relevant NSW disciplinary tribunal. Under the regulatory arrangements outlined in section 1.6, the NSW HCCC's powers have been extended to allow investigation and imposition of sanctions (such as conditions or prohibition from practice) on health practitioners who are not registered. Similar powers have been conferred by the South Australian Parliament on the Health and Community Services Complaints Commissioner in South Australia.

In States and Territories other than NSW, 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 National 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 and in South Australia, through which a prosecution and hearing may be conducted and sanctions imposed on an unregistered health practitioner.

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 applies to both registered and unregistered health practitioners and 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*

[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.

Consumer protection regulation

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, including those that employ or are operated by registered and unregistered practitioners. The package of reforms includes:

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

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 products must be entered on the ARTG before they 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. The laws apply to

[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.

both registered and unregistered health practitioners, in relation to the therapeutic goods they might supply to patients in the course of treatment.

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.

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*

These laws authorise use of scheduled medicines (such as administration, supply and prescribing) by members of specified registered and unregistered health professions. While members of some unregistered health professions are authorised to administer scheduled medicine, none are authorised to routinely supply or prescribe.

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 provision for the following:

- 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 powers and penalties.

[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.

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.

Relevant State and Territory Acts are:

- ACT – *Radiation Protection Act 2006*
- NSW – *Radiation Control Act 1990*
- Northern Territory – *Radiation Protection Act*
- Queensland – *Radiation Safety Act 1999*
- South Australia – *Radiation Protection and Control Act 1982*
- Tasmania – Radiation Protection Act 2005
- Victoria – *Radiation Act 2005*
- Western Australia – *Radiation Safety Act 1975*

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 prepared 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.

1.4 Voluntary self-regulation

Voluntary self-regulation is used here to describe a model of regulation of a profession where there are no occupational licensing or registration laws that require practitioners to be registered with a body that has statutory powers to regulate that profession. Instead, members of a profession join together to establish an association, a legal entity with voluntary membership. These professional associations typically regulate their members by:

- setting qualification and other requirements for membership
- accrediting or otherwise assessing and recognising qualifying programs for membership purposes
- requiring members to comply with a code of ethics
- issuing other codes and guidance to members about good practice
- operating a process to deal with complaints against members, and
- disciplining members if they are found to have breached the code of ethics or other rules of the association.

While there is no legal compunction for practitioners to join the association, practitioners agree to be bound by the standards and codes of ethics set by the association when they join. These associations represent their members' interests to government and non-government institutions and may provide a range of member services, such as discounted professional indemnity insurance and continuing professional development programs.

Consumers and health payers who need to identify qualified practitioners may rely on a practitioner's voluntary membership as evidence that the practitioner is suitably qualified, safe to practise and subject to ethical standards.

The national consultation received submissions from 72 self-regulating professional associations. Many submissions provided detail on their self-regulatory arrangements. In addition, a website search was undertaken to identify key features of self-regulating professional associations. The results of this search are set out in *Appendix 6.*

This research suggests that there is considerable variation in the nature and extent of the representative arrangements for unregistered health professions, with significant differences across associations in the resourcing, scope and level of organisation of self-regulatory functions. This variability is likely to be related to a number factors including the size of the profession represented, whether the profession is conventional or CAM, the number of years since it was founded and the extent of institutional recognition achieved. The research suggests that:

- there are a small number of relatively large established conventional professions where the representative arrangements are consolidated into a single peak body that has substantial institutional recognition for its self-regulatory activities. Examples include social work, speech pathology and dietetics
- while there are some large and well established professional associations that represent CAM professions, there is still fragmentation of representative arrangements in professions such as naturopathy, Western herbal medicine and massage therapy
- there are a number of small and relatively new professional associations that represent conventional technology-based professions such as medical scientists and clinical perfusionists, whose small membership base means the range of services they provide to their members is more limited
- there is considerable fragmentation of representative arrangements in some of the smaller CAM professions, such as reiki, reflexology and hypnotherapy.

There is some evidence of a trend towards consolidation of representative arrangements and an interest in pursuing cross profession alliances with potential for economies of scale in carrying out self-regulatory functions. Examples of such initiatives are set out in Table 1 below.

Table 1: Associations that represent multiple health professions

Name	Description
Allied Health Professions Australia (AHPA)	AHPA, formerly called Health Professions Council of Australia (HPCA), is the national peak body for major health professions and their representative bodies other than medical practitioners, nurses and unions. AHPA works to represent the interests of the allied health professions sector, particularly to the Federal Government and to provide a vehicle for liaison and discussion between the professions themselves.
National Alliance of Self Regulating Health Professions	The National Alliance is an organisation that includes associations that represent dietitians, social workers, sonographers, exercise physiologists and audiologists.
Inter-Association Regulatory Forum (IARF)	The IARF consists of over 100 natural therapy associations and organisations that has been meeting regularly with a goal of developing co-regulation through 'a collaboration between government and the professions that will achieve practitioner quality assurance, efficacy and ethical practice while addressing the need for public education and confidence in natural health providers' (IARF Official Communication Vol. 1 No. 1 February 2011).

A number of professions have taken steps to establish bodies to undertake their public protection regulatory functions separately from their professional representative functions. Table 2 below provides details of these arrangements. For two professions (homoeopathy and orthoptics), these arrangements have been modelled on statutory registration boards and have been in place for over 10 years. In a number of others (naturopathy and Western herbal medicine, counselling and psychotherapy), the arrangements are still in the process of being implemented.

Table 2: Voluntary registers established separately from representative professional associations

Name of Register	Year established	Description
Australian Register of Homoeopaths (AROH)	1999	The AROH is the national register of accredited homoeopaths in Australia. AROH accredits Australian homoeopathic courses, registers qualified homoeopaths for practice in Australia, receives and deals with complaints from members of the public about registered homoeopaths, and liaises with government and health funds. See www.aroh.com.au
Australian Orthoptic Board (AOB)	2000	The AOB is the registration body for orthoptists in Australia. The AOB regulates the profession of orthoptics in order to protect the public. The Board holds a register of suitably qualified orthoptists and investigates the professional conduct and fitness to practise of these voluntarily registered

		orthoptists. See www.australianorthopticboard.org.au
Australian Register of Counsellors and Psychotherapists (ARCAP)	2009	ARCAP is established as an independent national register of counsellors and psychotherapists who have completed professional qualifications, meet ongoing professional development requirements and have clinical supervision of their practice. See www.arcapregister.com.au
Australian Register of Naturopaths and Herbalists (ARONAH)	2009	ARONAH is established to provide minimum standards of education and practice for naturopathy and herbal medicine. The Board will develop this independent register which aims to mirror government requirements for the regulation of health practitioners. See www.aronah.org
Natural Medicine Register Ltd (NMRB)	2012	NMRB is established to promote health by ensuring a publicly available national registration and disciplinary mechanism within natural medicine and natural therapies. See www.nmrb.com.au

1.5 Credentialing and co-regulation

The term 'credentialing' in this context describes a formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of a health practitioner for the purpose of forming a view about their competence, performance and professional suitability to provide health services in a particular context or setting[13].

The term 'co-regulation' is used here to describe a type of regulation where government enters into a partnership arrangement with another entity to regulate an activity. There are different types of co-regulation. The key difference between co-regulation and voluntary self-regulation is that some of the functions of self-regulating bodies are either delegated from or recognised by governments, with this recognition or delegation contingent on the body meeting certain governance or operational standards. This in effect establishes a regulatory partnership between government and the credentialing body.

In the absence of a single trusted source of information about which unregistered health practitioners are qualified and competent to provide health services, a range of government and non-government bodies operate their own provider recognition systems. Methods used vary considerably and include:

- direct certification of practitioners
- accreditation of professional organisations to which health providers must belong
- individual accreditation, specifying minimum qualifications which must be obtained from approved education providers
- relying on the accreditation done by another body.

Bodies that credential unregistered health practitioners or their representative bodies for one purpose or another are set out in Table 3 below.

[13] This definition of credentialing has been adapted from the definition of the Australian Commission on Safety and Quality in Health Care's *Standard for Credentialing and Defining the Scope of Practice – A National Standard for credentialing and defining the scope of clinical practice of medical practitioners for use in public and private hospitals*, July 2004.

Table 3: Bodies that credential unregistered health practitioners or accredit their representative bodies

Name	Method of credentialing	Purpose of credentialing
Health Insurance Commission/Medicare Australia	Approved provider status dependent on membership of recognised National Professional Association	Eligibility for Medicare rebates for patients.
State and Territory workers compensation schemes	The range of service providers and their credentialing varies widely between jurisdictions. In most states registered health practitioners are considered to be 'approved providers'. Non-registered health professionals must satisfy various criteria which range from a tertiary degree in the relevant health field to membership of a relevant professional organisation. Professional Indemnity Insurance is a requirement in some states and territories.	Eligibility as an 'approved provider' of rehabilitation services.
State and Territory motor accident compensation schemes	Varies from State to State. Ranges from membership of approved professional association or working with an approved service provider to pre-approval of treatment through a Notice of Commencement of Therapy or approval as a provider through a Provider Application form.	In states and territories with a 'no fault' scheme (Vic, NT, Tas), credentialing limits the types of services that can be accessed by claimants. In other states and territories, insurers make decisions on 'reasonable and appropriate medical and rehabilitation treatment' on a case by case basis.
Commonwealth Department of Veterans Affairs	Any provider who is registered with Medicare Australia as a psychologist, clinical psychologist, social worker (mental health) or occupational therapist (mental health).	Eligibility to claim for allied mental health services provided to entitled persons.
Commonwealth Department of Health and Ageing – Private Health Insurance Accreditation Rules	Under Private Health Insurance (Accreditation) Rules, private health insurance funds may only pay rebates to patients for health services that are delivered by practitioners who are members of professional associations that meet specified requirements: recognition through *Health Insurance* (Allied Health Services) Determination 2010; membership of professional association belonging to Allied Health Professions Australia; or membership of a professional association which meets set requirements.	Recognition as a provider by a health insurance fund.
Australian Taxation Office	Recognised professional status through professional associations recognised as having uniform national registration requirements.	GST not charged in consultation fees and supplied goods for 'recognised professionals'.
Commonwealth Department of Immigration/Australian Education International	A number of national professional associations recognised as 'migration assessing authorities'.	To assess the qualifications of overseas trained practitioners for migration purposes.
Private health insurance providers	Subject to Private Health Insurance (Accreditation) Rules and varies from fund to fund. Ranges from recognised courses, membership of national professional associations and individual practitioner making an application to an independent review panel.	Patients eligible for rebate for services provided by an approved health practitioner.

These arrangements are discussed below.

Medicare Australia

Under Medicare Australia, practitioners from the following allied health professions are eligible to apply for a Medicare provider number to provide services for which Medicare rebates apply:

Aboriginal health workers	Audiologists	Chiropodists
Chiropractors	Diabetes educators	Dietitians
Exercise physiologists	Mental Health Nurses	Occupational therapists
Osteopaths	Physiotherapists	Podiatrists
Psychologists	Social Workers	Speech pathologists

For those professions that are not included in the National Registration and Accreditation Scheme, to achieve approval as a provider by Medicare, a practitioner must be a member of a 'National Professional Association'. Associations that are recognised by Medicare for this purpose include:

- Audiological Society of Australia Inc. (ASA)
- Australian College of Audiology (ACAud)
- Australian Diabetes Educators Association (ADEA)
- Dietitians Association of Australia (DAA)
- Australian Association for Exercise and Sports Science (AAESS)
- Australian Association of Social Workers (AASW)
- OT Australia
- Speech Pathology Australia

For example, to be eligible to provide mental health services under Chronic Disease Management Medicare program, a social worker must be a member of the Australian Association of Social Workers (AASW) and be certified by the AASW as meeting the standards for mental health set out in the document published by the AASW titled *Practice Standards for Mental Health Social Workers*.

In effect, this is a co-regulatory scheme where Medicare Australia delegates to the AASW responsibility for assessing the qualifications and other credentials of social workers. Social workers who meet the AASW's requirements can then apply to become an 'approved provider' with Medicare Australia.

Department of Veterans Affairs

The Department of Veterans' Affairs (DVA) pays for medical and allied health services for eligible patients.

DVA has a Coordinated Veterans Care Program led by GPs and either a practice nurse, community nurse or Aboriginal health worker as a Nurse Coordinator. Allied health services cover 21 health practices and all allied health providers have to be approved providers with Medicare Australia.

Private health insurance funds

A range of private health insurance funds provide reimbursement to their members for the costs they incur in accessing various allied health and CAM services provided by unregistered health practitioners.

Providers of private health insurance rely on statutory registration as the means of identifying members of the medical, nursing and other allied health professions who are eligible for approved provider status. For unregistered health practitioners, private health funds have put in place their own arrangements for establishing the credentials of such practitioners and granting approved provider status for unregistered so that health insurance benefits can be paid to their patients.

Co-regulation operates at two levels in the private health insurance industry:

Commonwealth Private Health Insurance (Accreditation) Rules

The Commonwealth has enacted the legislative framework within which the private health insurance industry operates. This framework sets standards about who can provide treatment for benefits paid under a health insurance policy. Under the *Private Health Insurance (Accreditation) Rules 2008* there are four main classes of health practitioners who are eligible to provide health services covered by a health insurance policy:

- Rule 7: registered health practitioners – those who are registered under an Act of a State or Territory
- Rule 9: for specified allied health services (such as audiology, speech pathology and dietitian services), these allied health professionals must hold qualifications set out in the *Health Insurance (Allied Health Services) Determination 2010*

- Rule 9: for other allied health services, practitioners must be a members of professional organisations which are ordinary members of Allied Health Professions Australia Ltd
- Rule 10: other unregistered health practitioners such as complementary medicine practitioners must be a member of a professional organisation which:
  (a) is a national entity which has membership requirements for the profession; and
  (b) provides assessment of the health care provider in terms of the appropriate level of training and education required to practise in that profession; and
  (c) administers a continuing professional development scheme in which the health care provider is required, as a condition of membership, to participate; and
  (d) maintains a code of conduct which the health care provider must uphold in order to continue to be a member; and
  (e) maintains a formal disciplinary procedure, which includes a process to suspend or expel members, and an appropriate complaints resolution procedure (Rule 10).

Under this co-regulatory arrangement the Commonwealth delegates the credentialing of unregistered health practitioners to professional associations.

Private health insurance funds

Within the framework established by the Commonwealth, private health insurance funds apply different standards and processes for approving providers. For example, some funds recognise graduates of particular courses of study, some recognise practitioners who are members of particular professional associations, some assess applications from practitioners on an individual basis and others refer applications to an independent review panel (La Trobe University, 2005, p.185).

BUPA, a private insurer that made a submission to the national consultation, gives extensive information on qualifications, association membership and other rules for ancillary providers on its company website. The provisions outline minimum educational standards and 'compulsory additional recognition requirements' on top of the requirements listed in the *Private Health Insurance (Accreditation) Rules 2008*.

The administrative costs associated with undertaking this type of credentialing function are built into the insurance premiums paid by the members of the funds, although some funds charge practitioners for the assessment, with fees reported to be between $150 and $350 (La Trobe University, 2005, p. 186).

The Australian Traditional Medicine Society (ATMS) provides a list of health funds on its website that grant provider recognition to ATMS members. For many of the funds listed, the ATMS advises that assessment of eligibility is undertaken by the ATMS Health Funds Department and a list of eligible members is sent to the private health fund monthly. This is in effect a co-regulatory arrangement where the health fund has delegated to the professional association the role of assessing eligibility for provider rebate status with the fund.

This is another example of co-regulation, this time between the private health insurance funds and the professional associations on whose advice they rely for granting approved provider status.

Australian Taxation Office

The Australian Taxation Office (ATO) website lists 21 types of health service that are 'GST free'. The ATO recognises certain non-medical health practitioners who either have statutory registration or are deemed to be 'recognised professionals'. These 'recognised professionals' are not required to charge goods and services tax (GST) on their consultation fees and goods supplied as part of a GST-free health service. For those practitioners who are not subject to statutory registration, their status as 'recognised professionals' is contingent on their membership of a professional association with 'uniform national registration requirements'.

The ATO identifies the following characteristics of a professional association:

- Its members practise in the association's listed profession
- It sets its own admission requirements, including acceptable qualifications
- It sets standards of practice and ethical conduct
- It aims to maintain the standing of the profession as a whole, and often prescribes requirements for maintaining its members' professional skills and knowledge through continuing professional development
- It has sufficient membership to be considered representative, but not necessarily solely representative, of the listed profession
- It is a non-profit body
- It has articles of association, by-laws or codes of conduct for its members, and
- It can impose sanctions on members who break the association's rules.

The ATO has advised that it has strict privacy provisions about disclosing the tax affairs of any individual or organisation, and that it is unable to disclose which professional associations are accepted by the ATO as having uniform national registration requirements (Personal communication 6 June 2011).

This is another type of co-regulation, where the ATO relies on professional associations to act as gatekeepers for access to GST free status by unregistered health professionals.

Workers compensation insurance

The Heads of Workers' Compensation Authorities approved the development of a Nationally Consistent Approval Framework for Workplace Rehabilitation Providers which took effect in all jurisdictions (except Queensland) on 1 July 2010. The framework allows for mutual recognition of rehabilitation providers across jurisdictions. However the provision of health services varies between jurisdictions. Both the range of health practitioners recognised to provide services and the credentialing recognition process varies between jurisdictions. Where registered health providers are recognised, it is generally based on membership of their national registration board. The range of non-registered health practitioner providers recognised varies between States and Territories and accreditation is through the State/Territory Workers Compensation body.

Appendix 7 sets out the various arrangements that apply in States and Territories for recognising providers who are not registered under NRAS.

Motor accident compensation

Motor accident compensation schemes are state and territory based and funded by compulsory third party insurance which is paid annually when a vehicle is registered. These schemes are either modified common-law 'fault-based' schemes (NSW, SA, WA, ACT and Queensland) or statutory 'no fault' schemes (Victoria and NT) or combined 'no-fault' and common-law Schemes (Tasmania). The type of scheme generally dictates the extent to which claimants are able to access different therapies. States and Territories with 'no fault' schemes have a role in credentialing providers of rehabilitation health services for the purposes of determining eligibility.

Appendix 8 sets out the various arrangements that apply in States and Territories for recognising providers who are not registered under NRAS.

Migration assessing authorities

Another type of co-regulatory scheme applies for the assessment of qualifications of overseas trained health practitioners for migration purposes.

Australian Education International (AEI), the international arm of the Australian Government Department of Education, Employment and Workplace Relations, recognises a number of professional associations as 'migration assessing authorities'. These migration assessing authorities assess qualifications and

skills gained overseas for individuals seeking to migrate to Australia under the Australian Government's General Skilled Migration Program. Professional associations recognised as migration assessing authorities include:

- Australian Association of Social Workers (AASW)
- Australian Institute of Medical Scientists (AIMS)
- Dietitians Association Australia (DAA)
- Speech Pathology Australia (SPA)

Under its Professional Services Development Program (PSDP) AEI assists migration assessing authorities and other Australian national professional bodies with activities that improve international recognition of Australian professional qualifications and skills, and recognition in Australia of professional qualifications and skills gained overseas. For example, the AEI website states:

> The Dietitians Association of Australia (DAA) is the professional Association for the dietetics profession in Australia. DAA administers the Accredited Practising Dietitian Program which is the only recognised credential for dietitians working in Australia (http://www.aei.gov.au/AEI)

As a migration assessing authority for the Department of Immigration and Citizenship, DAA conducts skills assessments of overseas-trained dietitians seeking permanent migration to Australia.

Again, this is a type of co-regulation under which the Commonwealth Government delegates to professional associations the role of assessing the qualifications of overseas trained practitioners for migration purposes.

1.6 NSW regulation of unregistered health practitioners

Scope of NSW scheme[14]

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)
- 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).

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. It leaves the vast majority of ethical and competent members of an unregulated health profession to self-regulate,

[14] 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

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.

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.

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 9*. 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 (NSW Health Department 2008)[15].

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.

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

[15] A second Impact assessment statement was released by the NSW Government in 2011 to remake the Code of Conduct under the *Public Health Act 2010* (NSW) that is expected to commence in 2012.

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.

How the NSW scheme is working

The NSW HCCC has advised that each year it receives approximately 90 complaints that relate to unregistered health practitioners (averaged over three years 2009-10, 2010-11 and 2011-12). Since August 2008 when the Code of Conduct came into force, the Commission has used its prohibition order powers in 19 cases, posted on the Commission's website. Following investigation, the HCCC has issued nineteen 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 receives may increase further, as awareness of the scheme grows.

1.7 South Australian regulation of unregistered health practitioners

In March 2011, the South Australian Parliament passed the *Health and Community Services Complaints (Miscellaneous) Amendment Act.* The Act establishes a negative licensing scheme similar to that which applies in NSW. The scheme includes a statutory code of conduct and prohibition order powers. The South Australian Code of Conduct is to come into effect in March 2013.

2. The nature of the problem

This section sets out the nature of the problem that the regulatory proposals in this RIS are intended to address.

2.1 Overview of problem

The vast majority of unregistered health practitioners practise in a safe, competent and ethical manner. There are, however, a small proportion of practitioners who are dangerously incompetent, or engage in exploitative, predatory and illegal behaviour that, if they were registered, would result in cancellation of their registration and removal of their right to practise.

Existing laws provide some protections for consumers (see section 1). Civil and criminal remedies are available in all States and Territories when a consumer suffers harm. 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, two jurisdictions (NSW and most recently South Australia) have considered these powers insufficient, and have moved to strengthen the powers of existing regulators. These new powers allow regulators to deal more effectively with two types of practitioner:

- those who present a serious risk of harm to consumers because of incompetence or impairment, and
- those practitioners who are 'repeat offenders', that is, those who exhibit 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.

Unlike the registered health professions where nationally uniform minimum qualifications and probity checking apply before entry to practice, there are no enforceable hurdle requirements prior to commencing practice in an unregistered health profession. There is also no nationally uniform or consistent mechanism for prohibiting or limiting practice when an unregistered health practitioner is impaired, incompetent or unprofessional and not 'fit and proper' to practise. Also, there is evidence that some practitioners move to those jurisdictions that have less regulatory scrutiny and continue their illegal or unethical conduct.

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 harm means the impact on the lives of patients and families affected can be significant. Deaths have occurred from time to time (see *Appendix 10*). In some cases, the practitioners previously 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. Earlier intervention by a regulator with a mandate to examine all the evidence of breaches of professional standards together may have reduced the number of victims and the incidence of harm to consumers.

NSW and South Australia have legislated to enact standards of conduct for unregistered health practitioners and a mechanism for limiting or prohibiting a practitioner from practising in cases of serious breach. In NSW, where the scheme has been in operation since August 2008, a mechanism exists through which the evidence about a practitioner's conduct can be collected from multiple regulatory bodies and considered as a whole. This allows the lead regulator to establish a pattern of unethical conduct and make a determination that the practitioner is not a fit and proper person to continue providing health services. In jurisdictions without such a mechanism, consumers continue to be placed at risk of harm 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 consumers and undermine trust in the health system.

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, even in cases where this type of regulation is not warranted because the costs to the community as a whole outweigh the benefits.

Regulatory change cannot eliminate all potential risk or harm to the community, but it is possible to reduce ongoing exploitation and malpractice once it becomes evident that a health practitioner is engaging in improper conduct. The consultation has shown that substantial damage to individuals and their families occurs when a small number of practitioners behave inappropriately and no action is able to be taken.

2.2 Government reports

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

- the number and complexity of cases involving unregistered health practitioners who have 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 harm arising 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, 2005, *Inquiry into the Practice of Recovered Memory Therapy*
- Victorian Health Services Commissioner, 2008, *Noel Campbell Inquiry Report*
- Victorian Department of Human Services commissioned report *The Practice and Regulatory Requirements of Naturopathy and Western Herbal Medicine*
- 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)*

NSW

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:

> 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).

The report can be accessed at the following address:

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

In September 2006, the NSW 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'*. The report acknowledged the passage of the *Health Legislation Amendment (Unregistered Health Practitioners) Bill 2006*.

> The Committee is pleased with the range of reforms contained in this legislation, and believes that the legislative amendments will effectively provide the Health Care Complaints Commission with the powers needed to deal with dishonest or incompetent providers in the absence of a registration system.
>
> In reviewing all evidence provided to the Committee, it became apparent that consumers are often unaware that health practitioners are subject to differing levels of regulation, tending to trust that all persons advertising or providing a health service have been subject to Government scrutiny. The Committee strongly believes that members of the public have a right to accurate and accessible information that enables them to make informed choices about their own health care… Moreover, a copy of the Code of Conduct prescribed in the regulations of the *Public Health Act 1991* should be accessible to the consumer at all times… The Committee supports the right of consumers to access a wide range of health care services and to select services that best suit their needs. At the same time of paramount importance to the Committee is the protection of consumers and of public safety in the health care field. The Committee is pleased that progress is being made in NSW towards an appropriate balance of these objectives. (NSW Joint Committee, 2006, ix–x)

This report can be accessed at the following address:

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

In 2009, a Coronial inquest was held into the death of Rebekah Lawrence, who committed suicide in December 2005 by jumping from a window at her workplace after attending an intensive four-day self-development workshop run by practitioners with no formal mental health training.

The Coroner recommended that consideration be given to:

- the need for a legal requirement to have recognised tertiary or other appropriate qualifications before providing counselling or psychotherapy services, and/or
- registration and accreditation of psychotherapy or counselling services either through the inclusion of counselling and psychotherapy in the National Registration and Accreditation Scheme for health professions, or through a statute-based scheme of registration or mandatory self-regulation in NSW.

The report can be accessed at:

http://www.ipc.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/INQUEST_INTO_THE_DEATH_OF_REBEKAH_LAWRENCE.pdf/$file/INQUEST_INTO_THE_DEATH_OF_REBEKAH_LAWRENCE.pdf

South Australia

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).

Victoria

In Victoria, the Health Services Commissioner (HSC) has conducted two inquiries into unregistered health practitioners: Noel Campbell (2005) and Shamir Shalom (2009). In 2005 the HSC conducted an inquiry into the practice of recovered memory therapy (also known as 'false memory therapy').

In the Noel Campbell Inquiry Report July 2008 the HSC noted:

> In Australia, individuals do not have to be registered as health practitioners to provide health services to members of the public. Many who offer alternative treatments do practise in a safe and ethical manner, which includes obtaining informed consent from their patients. This Inquiry has established that Noel Campbell is not one of them. The Hope Clinic has targeted extremely vulnerable patients with terminal cancer. These are people who were desperately seeking some hope for their situation and this Inquiry has determined they have been preyed upon by Noel Campbell. Patients paid large amounts of money for treatments which are largely unproven and some were treated in ways that were not conducive to their dignity or comfort (Health Service Commissioner, 2008, p 1).

The report can be accessed at:
http://www.health.vic.gov.au/hsc/downloads/report_noel_campbell_1.pdf

Western Australia

In 2010, a Coronial inquest was held into the death of Penelope Dingle in August 2005. Ms Dingle rejected conventional medical treatment for an operable rectal tumour and relied instead on treatment prescribed by her homeopath. Despite Ms Dingle's obviously deteriorating condition, her homeopath advised her to avoid pain medication and failed to refer her to a medical practitioner, resulting in Ms Dingle's eventual death in 'extreme and unnecessary pain'.

The Coroner's report recommended that:

> …Commonwealth and State Departments of Health review the legislative framework relating to complementary and alternative medicine practitioners and practices with a view to ensuring that there are no mixed messages provided to vulnerable patients…

The report can be accessed at:
http://www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Dingle_Finding.pdf

2.3 Type of conduct of concern

The National Consultation Paper outlined the types of conduct that were of concern and provided a series of case examples. *Appendix 10* expands on the case examples provided in the consultation paper and supplements these with cases identified during the national consultation.

While some cases cross more than one area, the conduct of most concern is:

- Sexual misconduct – involving sexual assault or sexual relationships with patients/clients
- Other improper relationships with clients – particularly in the context of provision of counselling services
- Cancer care services – combining a range of financially exploitative, misleading and deceptive conduct, including false or misleading claims about the effectiveness of treatment or the nature of qualifications

- Failure to refer, or refer in a timely manner, resulting in delayed diagnosis or treatment and sometimes death.

A number of the cases involve prosecutions by trade practices/fair trading regulators. In such cases, the practitioners had been 'known to' or investigated by a number of regulators, sometimes for over a decade prior to their most recent prosecutions.

Sexual misconduct

Submissions reported significant underreporting of sexual misconduct, particularly of practitioners who commence a sexual relationship with a patient while the patient is under their care. 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 prevented further victims.

Where a criminal prosecution has been successful, the practitioner is not under any obligation to inform prospective patients of their criminal history, and in such instances there is no offence under consumer protection law if no misrepresentation or deceptive conduct has occurred. However, if the practitioner were registered, in order to safely return to practise, they might be required to inform every patient of any limitations placed on their practise, and in some cases, if necessary, have a chaperone present during treatments.

Other improper relationships with clients

Six consumer respondents to this consultation reported extreme trauma and distress associated with family breakdown following a family member attending a counsellor or psychotherapist or attending a self-growth seminar. Consumers reported exploitation and abuse associated with cult-like therapy groups, a common theme being:

> …no certainty of ethical practice or practice standards, no certainty of appropriate training of practitioners, no opportunity for complaints process, no professional standards to guide practice (*Submission 17* at www.ahmac.gov.au/cms_documents/Submissions%20list%20for%20website.doc).

Most of these submissions supported the establishment of an effective body with the power to investigate and act upon complaints from both consumers and others such as family members to prevent harm and protect the health and wellbeing of the public.

Cancer care

In the context of cancer care, there are numerous examples of practitioners who operate outside conventional referral and health service systems and specifically target their services directly to vulnerable cancer patients. In doing so, they may combine the use of misleading claims about their qualifications and/or treatments with pressure sales tactics, and charge unjustifiably high fees (sometimes in the tens of thousands of dollars), generally for treatments of unproven or questionable benefit. They often characterise their treatments as 'complementary or alternative medicine' (CAM) and

present themselves as ‘pioneers’ in the treatment of patients for whom Western medicine has apparently failed. Such exploitative and predatory behaviour is not condoned by reputable CAM practitioners and brings the CAM professions into disrepute.

> 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).

Consumer protection law provides an avenue of redress where practitioners use false or misleading advertising or display deceptive credentials to recruit patients. Some have been prosecuted by consumer protection regulators, with mixed results (see case studies 7 and 10 in *Appendix 10*).

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 (see Cancer Council Victoria fact sheet: *Complementary and alternative medicine: making informed decisions*). However, community education has its limitations in these circumstances, particularly for patients whose vulnerability is heightened due to a life threatening illness or chronic health condition.

Failure to refer on resulting in delayed diagnosis or treatment

Some practitioners have failed 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 (see case studies 3, 15 and 20 in *Appendix 10*)

Other unprofessional conduct

There is a range of other 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, heart disease or cancer (see case studies 3 and 19 in *Appendix 10*)
- practitioners who advise patients to use so-called ‘homoeopathic vaccination’ as an alternative to conventional immunisation to protect against certain infectious diseases
- 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
- practitioners who financially exploit their clients, by charging exorbitant or unreasonable fees for their services, or pressuring clients to sign up to a course of treatment.

2.4 Deregistered practitioners

Some health practitioners 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. The number of practitioners who are deregistered each year 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. Cases have been reported 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’

- former psychiatrists or psychologists who continue to practise as counsellors or psychotherapists
- former Chinese medicine practitioners who continue to practise as massage therapists or natural medicine practitioners.

The South Australian Social Development Committee report documented four cases involving two former medical practitioners, one former dentist and one former psychologist (Social Development Committee 2009, p.48–51).

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 or similar services that they previously provided as a registered practitioner. The fact that these practitioners have been willing to restructure and re-badge their practice arrangements to continue practising free from 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 10* who fall into this category.

2.5 Available data on complaints

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 11* 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.

It is difficult to make comparisons between States and Territories, or to draw conclusions from the data because there is no standardisation across jurisdictions in collection and reporting. However, given the data from NSW following the introduction of a code of conduct, one would expect that the level of complaints/1000 against unregistered health practitioners would be below the level of those for registered health practitioners.

Table 4 shows the notifications to AHPRA about registered health practitioners from 1 August 2010 to 31 May 2011. There is a wide range in the level of complaints/1000 for the different professions, varying from 4/1000 for nurses and midwives to 52/1000 for dental practitioners.

Table 4: Notifications to AHPRA for registered health practitioners 1 July 2011 – 30 June 2012

	Total No of Registrants*	No of Notifications^	Notifications/1000
Chiropractor	4,462	115	26
Dental Practitioner	19,087	992	52
Medical Practitioner	91,648	4,001	44
Nurse & Midwife	343,703	1,452	4
Optometrist	4,568	54	12
Osteopath	1,676	17	10
Pharmacist	26,548	387	15
Physiotherapist	23,501	88	4
Podiatrist	3,690	43	12
Psychologist	29,645	367	12
Not identified		78	
TOTAL	**548,528**	**7,594**	**190**
		Average 14 per 1000 registered health practitioner	

* Registrant numbers as at 30 June 2012

^ 'Notification' includes complaints from consumers, as well as colleagues and employers, and self-referrals.

Source: Annual Report 2011-12 AHPRA and the National Boards

3. Consultations

This section provides details of the national consultation process, and the key themes that emerged from the consultation forums and analysis of submissions.

3.1 Consultation process

The national consultation was conducted in February–April 2011. A consultation paper was released on 28 February 2011 and published on the website of the Secretariat of the Australian Health Ministers Advisory Council (AHMAC). The national consultation and links to the consultation paper were advertised in State and Territory daily newspapers. Public submissions were invited, with a closing date of 15 April 2011. Public comments were guided by a series of questions set out in a 'Quick response form' that could be downloaded from the website.

The options identified in the consultation paper that were the subject of consultation were:

Option 1: Status quo – no change, rely on existing regulatory and non-regulatory mechanisms to protect the public

Option 2: Strengthened self-regulation – a voluntary code of practice

Option 3: Strengthened complaints handling – a statutory code of conduct and strengthened powers to investigate breaches of the code and prohibit a practitioner from continuing to provide health services if the breach is serious enough.

Appendix 12 provides a list of key events relevant to this national consultation. Nine consultation forums were held, one in each State and Territory capital city and Alice Springs, during the period from late March to early April. Invitations were issued by State and Territory health departments, with the invitation lists supplemented by internet searches to identify other stakeholder organisations.

Over 350 organisations and individuals attended the consultation forums (see *Appendix 13* for a list of attendees).

182 written submissions were received. *Appendix 14* provides a summary of the views expressed by participants and issues raised at each consultation forum.

Appendix 15 provides a list of those individuals and organisations that provided written submissions. A total of 182 written submissions were received. The submissions are available at the following website:

www.ahmac.gov.au/cms_documents/Submissions%20list%20for%20website.doc

Table 5 below lists the number of submissions received by the type of respondent. By far the largest group of respondents (approximately 68%) were individual practitioners or their representative bodies. Seventeen (17) submissions were received from consumers or consumer representative bodies.

Table 5: Number of submissions by type of respondent

Type of respondent	Number of submissions	% of total respondents
Professional associations and unions	74	41%
Individual practitioners	49	27%
Individual students	3	2%
Consumer representative bodies	6	4%
Individual consumers	11	5%
Health complaints entities	5	3%
Government departments and regulators	13	6%
Educational bodies and training organisations	6	3%
Health insurers	2	2%
Peak bodies/service providers/employers	14	7%
TOTAL	**182**	**100%**

3.2 Key themes from submissions and forums

Appendix 16 provides summary data on the views of respondents, drawn from the submissions. The main themes drawn from submissions and the consultation forums are summarised below.

It is difficult to estimate the size of the sector

Professional associations were asked to provide an estimate of the number of unregistered health practitioners believed to be practising in their respective professions. Most professional bodies advised that it was not possible to know with any accuracy how many practitioners were in active practice in their profession. Some provided details of their various data sources and the assumptions they had made in making their estimates. Some, notably the Australian Register of Naturopaths and Herbalists (ARONAH) and Naturopaths for Registration identified complexities such as:

- the proportion of practitioners who practise multimodalities and/or hold membership of more than one professional association
- the Australian Bureau of Statistics census data on self-reported occupation may provide a significant underestimate of numbers.

> There are number of associations representing hypnotherapists throughout Australia and an estimate of the numbers would be very difficult to provide.
>
> **Professional Hypnotists of Western Australia Inc (Submission 38)**
>
> Whereas there are approximately 40,000 Australians who have trained in Reiki at various levels (one, two, three/master/teacher), ARI estimates that there are approximately 1,000–2,000 working in the public arena as professional Reiki Treatment Practitioners.
>
> **The Australian Reiki Connection Inc (Submission 71)**
>
> The number of unregistered health practitioners practising as naturopaths and Western herbalists is unknown. Estimates range from 3,000 to 15,000.
>
> **Naturopaths for Registration (Submission 88)**
>
> The STAA is… a single modality organisation with 300 members. There are other qualified shiatsu practitioners who will be members of other organisations which may number another 150 practitioners… There would also be qualified shiatsu therapists who are not members of any association either because they are not currently practising or who chose not to join an association.
>
> **Shiatsu Therapy Association of Australia (Submission 133)**

Despite the shortcomings in the data, reported numbers from professional associations provides the most accurate estimate available of the numbers of practitioners within the scope of this RIS.

Self-regulation and co-regulation are key features of the regulatory landscape

Some respondents suggested that the consultation paper did not adequately describe or give sufficient recognition to:

- the self-regulatory arrangements put in place by many professional associations
- the co-regulatory arrangements that apply between governments and professional associations to set and enforce standards for provision of services funded by governments.

While many respondents made reference to the existing self-regulatory arrangements, most also noted shortcomings of self-regulation, compared with statutory registration.

While there is much anecdotal evidence of problems, there is little hard data

Respondents identified a range of risks associated with the practice of unregistered health practitioners and identified various factors they considered reduced or exacerbated these risks. While the range of factors identified was broad, approximately 15% of respondents identified 'lack of training and/or continuing professional development (CPD) as the single most significant risk factor. Approximately 7% or respondents identified 'remote or isolated practice' and 'vulnerable patients, for example, the elderly, juvenile or chronically ill' as risk factors.

With respect to incidence of risk, respondents generally confirmed the data already presented in the consultation paper and representation of the problem. Many respondents reported they knew of anecdotal evidence of a similar nature. A small number of submissions provided some concrete data including case studies.

The additional case studies provided were of the following main types:

- sexual misconduct and other improper relationships with clients
- failure to refer on appropriately or in a timely manner, resulting in delayed treatment and in some cases death
- false and misleading claims about the effectiveness of treatment
- financial exploitation
- incompetent or unethical counselling services

In two areas of practice, substantial material was submitted on cases of harm. These were:

- Naturopathy and Western herbal medicine
- Counselling and psychotherapy

Consumers reported serious harm and a lack of effective avenues for redress

Consumer submissions made a number of points. First, those families who have been affected by unethical, unqualified or 'rogue' practitioners, particularly in the counselling and psychotherapy field, reported acute levels of distress at the harm caused to their family members, and frustration at the lack of available avenues for seeking redress. These included reports about individual practitioners who are operating in a cult like environment, as well as religious organisations offering drug and alcohol and mental health services.

> The tragic experiences of AFMA members provide evidence… In many cases the lives of the clients as well as their families have been seriously affected or destroyed including instances of suicide. The families, as well as the clients, become victims of the harmful therapy.
>
> **Australian False Memory Association Inc (Submission 99)**

I am therefore led to conclude that the system for regulating unregistered health providers is broken. ….Even when I presented a compelling case that some religious groups formulate "treatment" that mixes medical/psychological terminology and exorcism, no satisfactory action has yet to be taken.

Confidential Submission 35

Submissions from a West Australian government MP and health complaints entities stressed the need for additional regulatory safeguards in this area.

Consumers of mental health services are often very vulnerable and open to exploitation and harm from their service provider and may not have the mental or emotional capacity to realise or deal with unethical behaviour on the part of that provider… It may also be easier for an unscrupulous practitioner to isolate these clients from other sources of emotional support such as families, workmates and friends.

The Hon. Alison Xamon, MLC East Metropolitan, Western Australia (Submission 132)

Respondents expressed the view that consumers are often uncertain about how to make a complaint and, in many instances, there are no effective avenues of redress available. The emotional as well as financial costs of court action can be prohibitive, but many consumers do not want financial recompense. Rather, they often seek an assurance that the same thing will not happen to others.

I sincerely trust that there will be protection and avenues for recourse for other families so that they do not have to experience the heartache our family continues to experience.

Confidential Submission 139

While complaints numbers are low, there is considered to be substantial under-reporting of unethical conduct

A common view expressed was that there is likely to be substantial under-reporting of unethical or unprofessional conduct either because consumers do not know of available avenues of complaint, or for various reasons are unable or unwilling to pursue the matter, or fear they will not be taken seriously. A few submissions documented studies that suggest under-reporting of complaints, notably ARONAH, Victorian Allied Health Leaders Council (VAHLC), and D. Sauvage.

It does take a bit of nerve to decide to make an official complaint. Often complaints can be made to bodies that seemingly have little power to address complaints adequately… the complainant needs to be dogged in their pursuit of a complaint and not be discouraged and worn down.

Consumer Submission 3 (name withheld)

I suspect there is considerable non-reporting in this field. The level of vulnerability is obvious.

Ombudsman and Health Complaints Commissioner Tasmania (Submission 148)

There is general consensus that most cases of harm go unreported. Most commonly the reason given is that patients and their family wish to move on from what has been a negative and sometimes traumatic experience… often exacerbated by the lack of legal recourse against such practitioners.

Australian Register of Naturopaths and Herbalists (ARONAH) (Submission 141)

There is strong support for further government action

Protection of the public from unqualified practice was a commonly reported objective, along with the need for a clear, well-publicised pathway for complaints and a public education program to better inform consumers and practitioners. Submissions made reference to a variety of other subsidiary objectives.

Over 90% of respondents supported further government action to strengthen regulation of unregistered health practitioners. Most respondents supported Option 3, to adopt nationally the regulatory model already in operation in NSW. While many professional associations reported that they already have in place a code of ethics and disciplinary processes, most saw their role as complementary to that of a Commissioner, with their association dealing with less serious complaints, and then referring the more serious complaints to the Commissioner. Many reported that they are powerless to deal with practitioners who breach professional standards but are not members of their association.

> Each year the Australian Register of Homoeopaths Ltd (AROH) receives a number of complaints about homeopaths or their practice. In many cases we are unable to investigate the complaint or take any action, as the practitioner is not registered with AROH, as in the tragic death of Gloria Sam in NSW. In these cases we direct the complainant to the appropriate State authority.
>
> **The Australian Register of Homeopaths Ltd (Submission 161)**

A small number of respondents supported Option 1, arguing that there is no case for government action in this area. Those opposed to further regulation were:

- the Pharmacy Guild submitted with respect to pharmacy assistants
- three counselling organisations (PACFA, ARCAP, and ACA) with respect to counsellors and psychotherapists.

PACFA and ACA submissions expressed the view that further government intervention was not warranted as they considered the risks associated with their profession were small and that any complaints were adequately dealt with by their internal processes.

> Given the low risk relating to Counselling and Psychotherapy, the potential costs of regulation and the effectiveness of existing regulatory mechanisms and self-regulation, it is difficult to argue there is a need for further regulation by government. However there is a need to build on existing self-regulation to ensure these more effectively manage risks to the community from unregistered health practitioners.
>
> **Psychotherapy and Counselling Federation of Australia (Submission 84)**

This view was not shared by consumer respondents who reported suffering harm at the hands of untrained counsellors (submissions 3, 35, 98,139 & 157).

Three submissions expressed the view that ‘pseudo medicine’ should not be legitimised through a regulatory scheme, and that CAM causes increased community mistrust of registered professions.

Statutory registration preferred by a sizeable minority of respondents

Of the respondents who opposed Option 3, most expressed the view that Option 3 would not provide sufficient protection to the public and that statutory registration was their preferred (and in some cases the only) option to satisfactorily address the risks associated with their profession. In total, 36 (20%) respondents identified statutory registration as their preferred option.

Table 6 below shows the professions where respondents nominated statutory registration as their preferred regulatory model.

Table 6: Respondents by profession who identified their preferred option as statutory registration

Profession	Number
Allied health	1
Social work practitioner/ association	7
Counselling/psychotherapy	1
Speech pathology	1
Cardiac/respiratory/sleep scientists	4
Anaesthetic technicians	1
Audiology	1
Orthotics/prosthetics	1
Sonography	3
Optical dispensers	1
Paramedics	1
Translators/interpretors	2
Oral health/dental technicians	5
Doulas	1
Personal care workers	1
Naturopaths	2
Medical practitioner (drug & alcohol services)	1
Health fund (multiple professions)	1
State registration board (Speech pathologists and dental technicians)	1
TOTAL	36

Some of these respondents appear to have an unrealistic expectation of what statutory registration can achieve, seemingly believing that if their profession were registered, there would be no more unethical or incompetent practice. The complaints data at Table 4 for the registered health professions does not bear out this view.

Strong support for a partnership with government to strengthen self-regulation

While most respondents supported Option 3, many also expressed concern about the reactive nature of the negative licensing model of regulation, particularly the absence of probity checking and minimum qualification standards for entry to practice.

Many national professional associations supported a combination of Option 2 (strengthened self-regulation) and Option3, stating that it would provide a safety net to protect the public from practitioners who choose not to participate in the profession's self-regulatory arrangements, or who had left the professional association to avoid disciplinary action.

> Speech Pathology Australia currently has strong self-regulation mechanisms, linked to membership, that ensure that speech pathologists have the appropriate qualifications and practice competencies; that they practise within the Association's code of ethics and scope of practice; and that their practice is recent and current… The Government through a national framework should recognise the robust self-regulatory mechanisms of those professions who can demonstrate they have these (the mandatory standards of AHPRA) in place.
>
> **Speech Pathology Australia (Submission 107)**

Where professional associations have robust structures of self-regulation in place, DAA sees little benefit and potential losses if these processes are removed in favour of additional intervention… DAA would like to see government agencies and others recognise the credentials such as Accredit Practising Dietitian in lieu of registration for professions with robust self-regulation.

Dietitians Association of Australia (Submission 117)

ATMS is therefore of the view that, whilst the government should not necessarily be the gatekeeper to professional entry, both Government and associations such as the ATMS should work in partnership to safeguard both the integrity of practice modalities, the health system more broadly and obviously the community, from rogue and unqualified practitioners.

Australian Traditional Medicine Society Ltd (Submission 52)

A number of professional associations provide detailed proposals for a 'co-regulatory model' and called for governments to support and endorse self-regulatory arrangements through an accreditation scheme for professional bodies and/or other incentives to encourage practitioner cooperation and compliance.

…Professionally trained practitioners, compliant with a genuine professional association set of rules and guidelines greatly reduce risk. The Australian Traditional Medicine Society Ltd (ATMS) believes that the government should simply set the "flags to swim between" but allow peak bodies such as ATMS to determine the standards for admission to the professions… ATMS strongly advocate the need for the Federal government to work with its State and Territory partners to establish a high-level principle of probity checks to be administered by official channels in partnership with professional associations. Moreover, ATMS holds the view that there should be an additional level of authentication by the Government to test any professional association's bona fides.

Australian Traditional Medicine Society (Submission 52)

Other respondents pointed to the conflict of interest in self-regulatory arrangements that provide for a professional association to investigate complaints against its members while also being responsible for representing its members and promoting their interests.

We are a small group of professionals who know all of our colleagues throughout Australia and new Zealand and would like to avoid accusations of collusion that could be managed if an investigation and subsequent action was administered by a different body.

Australian and New Zealand College of Perfusionists(Submission 87

The key purpose of the associations is to represent the interests of their member practitioners. A national register was seen as a necessary step towards the clear demarcation between roles, therefore, avoiding any potential conflict of interest, particularly in relation to disciplinary matters.

Australian Register of Homoeopaths (Submission 141)

A voluntary code of conduct is not in the best interests of the Australian public as it effectively asks professional associations to investigate complaints made by the public against their members whilst they are charged with upholding their members' best interests.

National Herbalists Association Australia (Submission 153

My experience as an unregistered healthcare professional is that professional associations who profess self-regulation tend to focus on continuing education and having a code of ethics as evidence of regulation. Such measures are preventative, but they do not constitute regulation of misconduct. When complaints are raised, professional bodies investigating their own members lacks credibility as there is a conflict of interest between retaining membership, prioritising one aspect of conduct over another, and objectivity and transparency are difficult to demonstrate.

Dr L. Collingridge (Submission 83)

Some also identified the challenges, including the costs associated with properly resourced complaints handling, and a complaints handling process that is managed primarily by volunteers without sufficient training or expertise.

> We believe that self-regulation provides less than adequate protection to the public. The executive of most professional associations is made up of volunteers. Investigation of complaints by the public, by those who are colleagues or competitors of the professional being complained about, introduces conflicts of interest and a perceived lack of objectivity.
>
> **Australian Association of Audiologists in Private Practice (Submission 177)**
>
> The complaints mechanisms that have been established by some professional associations are likely to be flawed because of a lack of clear process, a lack of experience in matters of fairness and the application of natural justice, and processes differ from one professional association to another…
>
> **Naturopaths for Registration (Submission 88)**

The benefits of extending regulation considered to outweigh the costs

Many respondents expressed the view that the cost to the community of doing nothing far outweighed the cost of extending regulation.

Few respondents addressed the question of what it might cost to comply with a national Code of Conduct. Those who did address this question expressed the view that they did not think they would incur any additional costs associated with complying with a statutory code of conduct, or if they did, the costs would be minimal, since they were already required to meet similar standards through membership of their professional association. The NHAA reported that cost increases to its members as a result of the introduction of the NSW Code of Conduct had been very minor.

> The experience of the introduction of the compulsory code of conduct in NSW presented no significant costs to practitioners. Minor costs were incurred from changes within practices regarding the display of materials relevant to the statutory code.
>
> **National Herbalists Association Australia (Submission 153)**

Who should fund extended regulation

The overwhelming majority of respondents who supported Option 3 expressed the view that since such a scheme was designed to protect the public, it should be funded by Commonwealth and/or State and Territory Governments.

A small number of submissions suggested various options for financing, including:

- a levy on professional associations to contribute to (but not solely fund) a national regulatory scheme
- a levy to finance strengthened self-regulation through government accreditation of self-regulatory bodies
- cost recovery could be achieved through the imposition of fines on those practitioners who breach the Code of Conduct
- a levy or tax on the industry.

Strong support for nationally uniform regulation

Of those who supported Option 3, approximately 2/3 supported a national administration for investigating breaches of a statutory Code of Conduct. The remaining 1/3 said that it would be acceptable for States and Territories to administer the enforcement of a National Code through existing State and Territory Health Complaints Entities. This was contingent on there being an effective mechanism for mutual

recognition of prohibition orders, to prevent practitioners from crossing state boundaries to avoid regulatory scrutiny. Few submissions showed an understanding that HCEs outside of NSW do not currently have prosecutorial powers and expertise.

A sizeable number of submissions supported locating the enforcement function within AHPRA, to provide a one stop shop for complaints, regardless of whether the practitioner is registered under statute or not.

A common theme in submissions was the need for a single portal of access for consumer and practitioner information. Many who expressed support for a centralised nationally administered scheme also expressed the view that if this were not possible, then there must be a single place for consumers to access details of prohibited practitioners and how to make a complaint – that is, a web based national register of prohibited practitioners.

Strong support for a single National Code of Conduct

Of the 104 respondents who addressed this question, most supported a single national code of conduct for unregistered health practitioners, rather than separate State and Territory codes.

This view was expressed particularly strongly by consumers, and by national professional associations who argued that to administer separate and different codes across eight States and Territories would add to their administrative burden, and increase the complexity of the communication task with their members.

There was a level of irritation expressed at State and Territory consultation forums with unnecessary fragmentation and duplication in regulation. In opposing separate state and territory codes, respondents raised concern about mutual recognition of prohibition orders and the fear that practitioners prohibited from practice in one jurisdiction would be able to re-locate their practice to another. Respondents emphasized the importance of a single place for consumers to access information on the scheme, including how to lodge a complaint and a register of practitioners who are subject to a prohibition order.

Two submissions expressed the view that a generic code would be too broad and that multiple codes targeted to specific professions were preferred.

A few respondents did not see the need for a code for their profession but supported a code for other professions and then emphasized that it should be a single national code. There were no respondents who opposed a code or codes of practice.

Strong support for the content of the NSW Code of Conduct

There was overwhelming support for the NSW Code of Conduct and its content. The general view expressed was that it provided a good model that captured all the minimum professional obligations that practitioners owe to their patients/clients.

A small number of respondents expressed concern that the Code is by its nature very broad, and sets minimum rather than optimum standards of conduct. Some noted that some professional association codes require a higher standard of professional conduct, in part because they provide profession specific guidance about practice that is absent from the generic code.

The main criticisms of the NSW Code, which are also criticisms of negative licensing as a regulatory approach, were that the Code does not set and enforce minimum qualification requirements for entry to practice in the health professions, and that regulatory scrutiny is triggered only when there is a complaint that the code has been breached.

A number of respondents suggested more clarity was needed in certain sections of the NSW Code, particularly section 11 that requires practitioners to ‘have an adequate clinical basis for treatments’. Respondents expressed the view that not only was this section open to interpretation, it presented

challenges for some CAM professions that operate under a different paradigm to that of Western biomedical science.

Increasing interest in cross profession regulatory approaches

With the commencement of the National Registration and Accreditation Scheme, there is increasing interest from professional bodies in cross-profession regulatory approaches (see Table 1). Initiatives include:

- Natural Medicine Register (previously known as the Inter-Association Regulatory Forum).
- National Alliance of Self-Regulating Health Professions.
- Allied Health Professions Australia.

This interest may stem from an increasing understanding that:

- to operate a comprehensive and robust system of professional regulation is likely to be beyond the resources of most professions alone, and
- cross profession regulatory structures such as the NRAS do not necessarily mean a loss of professional integrity or a loss of control over their own standards for participating professions, and
- the advantages in terms of economies of scale associated with joint regulatory arrangements may outweigh the disadvantages.

Strong support for more public education

Many respondents made reference to the need for strong public education, whatever option is adopted.

> A range of user-friendly information and education strategies, programs and initiatives be introduced to promote and enhance community awareness and understanding of processes and procedures to make complaints about unregistered health practitioners and regulatory mechanisms to improve reporting and investigation of unscrupulous unregistered practitioners.
>
> **Health Consumers Queensland (Submission 127)**
>
> The regulatory scheme should be accompanied by an adequately funded, effective consumer education campaign around the proposed code of conduct, the standards that unregistered health practitioners must adhere to, and recourse to address grievances.
>
> **Cancer Council Western Australia (Submission 111)**

3.3 Conclusions from the consultations

To summarise, the key themes that emerged from the analysis of submissions and the feedback from the consultation forums were as follows:

- It is difficult to estimate the size of the unregistered health practitioner workforce with no reliable sources of data.
- Voluntary self-regulation (by professional bodies) and co-regulation (a partnership between governments and professional bodies) are key features of the regulatory landscape, with a multitude of self-regulating professional associations and a range of government and non-government bodies that credential unregistered practitioners for various purposes (such as provider recognition for insurance rebates, eligibility to provide GST free services etc). However, there is:
  - considerable fragmentation of representative arrangements in some professions which undermines the efficiency and effectiveness of self-regulatory efforts
  - considerable duplication of effort is involved for government and non-government bodies that credential practitioners.
- While there is much anecdotal evidence of risks, there are a limited number of well documented cases of actual harm where causality has been established. In the professions of naturopathy and

Western herbal medicine the report *The Practice and Regulatory Requirements of Naturopathy and Western Herbal Medicine* commissioned by Victoria in 2005 and referred to in submissions provides extensive documentation of risks in practice.

- While complaints numbers are generally very low compared with registered health practitioners, many respondents maintain there is considerable under-reporting of unethical conduct. A small number of submissions (from both consumers and professional associations) provided some concrete data on risks, and further case studies were submitted in relation to the professions of social work, counselling and psychotherapy, naturopathy/Western herbal medicine (WHM) and homoeopathy.
- There is strong support for further government action, from consumers, practitioners and professional bodies. Option 3 (a national statutory code of conduct and power to issue prohibition orders for breaches) preferred by a substantial majority of respondents. Of the remaining respondents, most were opposed to Option 3 because they believed statutory registration offered greater public protection. Submissions opposed to Option 3 were few and primarily came from respondents who strongly support statutory registration for their profession.
- Option 3 is seen to provide a 'safety net' for self-regulating professions, supporting and reinforcing the role of professional associations. However, many respondents are critical that this regulatory model does not allow minimum qualifications for entry to practice to be enforced, nor does it provide for probity checking or protection of title, and regulatory action is triggered only when there is a complaint and (presumably) harm has already occurred.
- A substantial number of respondents who support Option 3 also support, in parallel, strengthened self-regulation, through government recognition or accreditation of professional association self-regulatory structures and disciplinary processes. Of those who support Option 3, there is overwhelming support for a single national code of conduct, rather than separate State and Territory codes. There is also strong support for the content of the NSW Code with very few suggestions for modification.
- With respect to administration of a negative licensing scheme, approximately 2/3 of respondents who support this option strongly support a single national body (with an administration in each State and Territory). Approximately 1/3 are comfortable with administration of a scheme by existing Health Complaints Entities (HCEs). Many respondents emphasized the need for mutual recognition of prohibition orders and a single website where consumers can go to access information on prohibition orders.
- Many respondents emphasized the need for governments to fund or support better community education about what consumers can expect of their practitioners and how to make a complaint.

4. Objectives and options

This section sets out the objectives of government action, describes the options under consideration and discusses the strengths and limitations of each of the options.

4.1 The objectives of government action

Given the nature of the problems identified in earlier sections, the objective of government action is to reduce the incidence of physical, psychological or financial harm to health consumers arising from unregistered health practitioners who are incompetent, impaired, or who breach their legal and professional obligations and are not fit and proper persons to provide health services. Any government action should also be cost-effective and designed to maximise efficiency of the health system while minimising any additional regulatory requirements on health practitioners and consumers of health services.

4.2 The options

Following feedback from stakeholders during the national consultation, the options presented in the consultation paper were revised with option 2 amended to include sub-options containing various measures intended to strengthen voluntary self-regulation and a new Option 4 included. The Options under consideration are:

- Option 1: No change to existing regulatory and non-regulatory mechanisms
- Option 2A: Strengthen self-regulation – Government monitored complaints handling
- Option 2B: Strengthen self-regulation – Government accredited voluntary registers
- Option 2C: Strengthen self-regulation – Voluntary national registration
- Option 3: Strengthen health complaints mechanisms – a national statutory code of conduct
- Option 4: Extend statutory registration to all health professions

Table 7 below provides a comparison of the key features of each option.

Table 7: Comparison of key features of Options

Option	1	2A	2B	2C	3	4
Description of option	No change, status quo	A voluntary code of conduct and State/Territory government measures to improve the effectiveness and efficiency of complaints handling	A national agency established or appointed by government to act as a national credentialing body for voluntary professional associations	A single national non-government agency to administer voluntary registers on behalf of multiple participating professions	A national statutory Code of Conduct & prohibition order powers	Extension of the National Registration and Accreditation Scheme to include all health professions
New or amended legislation required?	No	Some jurisdictions	No	No	Yes	Yes
Run by government?	Partly	Partly	Yes	No	Yes	Yes
Voluntary for practitioners?	Yes	Yes	Yes	Yes	No	No
Covers all unregistered practitioners?	No	No	No	No	Yes	No
National consistency?	No	No	Yes	Yes	Yes	Yes
Enforceable sanctions?	No	No	No	No	Yes	Yes

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

Under this option, it is assumed there would be no change to current regulatory and non-regulatory mechanisms through which the fitness to practise of unregistered health practitioners is assured and departures from accepted professional standards are dealt with. This means:

- the separate regulatory regimes for preventing or dealing with unethical or incompetent practice or impaired practitioners in force in each jurisdiction remain in place, and health practitioners and health service providers will continue to be subject to differing requirements depending on the State or Territory in which they practise
- there will continue to be costs to professional associations in developing and maintaining standards and educating their members about the differing legal obligations in each State and Territory
- there is no harmonisation of regulatory approaches to control risks
- there continues to be opportunity for practitioners to cross state boundaries to avoid regulatory scrutiny
- no change is anticipated in the level of harm to consumers arising from the practise of incompetent, impaired or unethical practitioners.

Inclusion of new professions in the National Registration and Accreditation Scheme

Option 1 does not preclude the possibility that the NRAS may be extended to include additional professions. 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 for amendments to be made to the National Law to extend the scope of the National Registration and Accreditation Scheme.

Unregistered health professions can make a case to governments at any time for statutory registration. For any profession to be considered for inclusion in the NRAS, a Regulatory Impact Assessment conducted in accordance with COAG requirements would need to demonstrate a net public benefit compared with the status quo and other options.

Currently, the paramedic profession is at an early stage of the process of consideration for possible inclusion in the NRAS.

Option 2: Strengthen self-regulation – Government monitored voluntary self-regulation

Under this option, there are three sub-options, each designed to strengthen the existing self-regulatory arrangements with respect to unregistered health practitioners, either through increased government provision of support, assistance or recognition of existing self-regulatory bodies (Options 2A and 2B), or through the establishment of a new national regulatory body (Option 2C)

Option 2A: Government monitored complaints handling

Under this option, a number of measures would be applied by governments to improve the effectiveness and efficiency of voluntary self-regulation of unregistered health practitioners. These measures would be over and above those powers currently available to HCEs and other regulators, and would include:

- development of a voluntary national code of practice, in cooperation with consumers, professional associations and other industry bodies that represent unregistered health practitioners;
- a strengthened role for existing State and Territory HCEs to provide information, education and support to professional associations and voluntary registers to assist them to improve their complaints handling mechanisms, compliance monitoring and reporting, including:

- provision of advice to professional associations and voluntary registers on best practice complaints handling procedures, including training for complaints officers and investigators
- preparation of community education materials and strategies to support professional association complaints handling, designed to inform consumers about:
  - what to expect from unregistered health practitioners, and what constitutes acceptable and unacceptable professional conduct
  - the importance of ensuring the health practitioners they choose are properly trained and qualified, and
  - the avenues available for dealing with any complaints that might arise
- monitoring the performance of professional association complaints handling mechanisms and reporting any issues of concern in HCE annual reports.

These measures would strengthen the role of State and Territory health complaints entities to support and assist professional associations and other self-regulating bodies in improving their quality assurance processes and handling of complaints about members.

Option 2B: Government accredited voluntary registers

Under this option, governments would lead the establishment of a self-funded body (or extend the role of an existing body) to act as a national standard setting agency for self-regulating professional associations and the voluntary practitioner registers they maintain. The role of the body would be to set governance and operational standards, and assess professional associations and voluntary registers against these standards, including assessing the effectiveness of their complaints handling and disciplinary processes.

The scheme would be voluntary, with professional associations and other self-regulatory bodies seeking accreditation for their self-regulatory arrangements. A fee would be charged for the accreditation process, in the same way that educational institutions are charged a fee for their programs to be accredited for registration purposes.

Modelled on the concept of ‘quality assured voluntary registration’ proposed by the United Kingdom Government (UK Department of Health, 2011), this option would provide some assurance to employers, government insurers (Medicare, workers compensation, traffic accident insurers), private health insurers, and consumers generally that the self-regulatory arrangements through which the quality of practitioners is assured are operating at an acceptable standard.

A professional association that achieves accreditation for its voluntary register could advertise this fact to the public, to potential practitioner members and to health payers. Employers and government and non-government health insurance funds might choose to employ or grant provider status only to practitioners who are registered with an accredited voluntary register. Incentives would thereby be created for practitioners to apply for and maintain registration with a voluntary register.

Option 2C: Voluntary national registration

Under this option, governments would, in cooperation with professional associations, lead the establishment of a national non-government agency that would administer voluntary registers on behalf of participating professions. This would be a body similar to AHPRA in that it would administer functions such as registration, program accreditation, complaints, discipline and practice guidance on behalf of multiple health professions. The key difference is that its operations would not be underpinned by statute, and registration on the registers that it administers would be voluntary for practitioners.

Governments would provide funding in the initial establishment phase, but once established, the agency would be self-funding, through registration fees paid by practitioners seeking entry to the voluntary registers and possibly levies on the professional associations that represent the participating professions.

The administrative functions assumed by the agency for each participating profession might include:

- registration functions – setting standards for registration and maintenance of a voluntary register of qualified practitioners for each participating profession
- accreditation functions – administration of processes of accreditation of programs of study that provide qualifications for entry to a voluntary register
- complaints handling functions – the receipt and investigation of complaints of unprofessional conduct, and conduct of disciplinary processes that may result in removal of a practitioner from a voluntary register
- practice guidance functions – publication of codes and practice guidelines for participating professions.

Incentives to encourage practitioners to seek and maintain voluntary registration could be offered through the institutional recognition of the voluntary registers by:

- employers who might seek to fill vacancies with practitioners who are on the voluntary register
- health insurers (both government and private) who might offer provider recognition only to practitioners on the voluntary registers
- a range of other institutions such as the Australian Taxation Office, Australian Education International who might rely on the agency and the voluntary registers it maintains as the trusted source of information on professional standards, qualifications assessment and provider recognition.

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

Under this option, a single national statutory Code of Conduct would set out mandatory practice for all unregistered health practitioners. The Code would apply in all States and Territories and would specify practice standards along the lines of those of the *NSW Code of Conduct for unregistered health practitioners* (see *Appendix 9*).

Consumers would be able to make a complaint that a 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, a court enforceable order could be made prohibiting the practitioner from continuing to provide health services, or limiting 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.

There are alternative administrative arrangements through which a national statutory code of conduct might be administered including State and Territory arrangements or a national body. The possible administrative arrangements are discussed in more detail in Section 7 Implementation.

Option 4: Extend statutory registration to all health professions

Statutory registration of a profession is designed to protect the public by reducing the risk of unethical or fraudulent behaviour. Under this option, a National Board for each unregistered health profession would be established under the National Registration and Accreditation Scheme. The Board's role would be specified in the National Law and would include:

- registration functions – setting standards for entry to the profession, and maintenance of a statutory register of qualified practitioners in the profession
- accreditation functions – administration or delegation of processes of accreditation of programs of study that provide qualifications for entry to the profession
- complaints handling functions – the receipt and investigation of complaints of unprofessional conduct or professional misconduct, and conduct of disciplinary processes that may result in cancellation of the practitioner's registration

- practice guidance functions – publication of codes and practice guidelines for participating professions.

4.3 Discussion of options

Option 1 – No change

Option 1 means continued reliance on existing laws and self-regulatory arrangements to regulate professional conduct and protect consumers. Important elements of the existing arrangements are discussed below.

Does consumer law provide sufficient protection?

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 have been a number of 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 and Hope Clinic for alleged breaches of the *Fair Trading Act* (Vic) (subject to appeal).

While consumer protection regulators have successfully prosecuted in some cases, results are mixed, and 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 May 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 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)

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, cases that involve the prosecution of health service providers 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 provides powers to issue banning orders and cease trading orders, these powers may not deal effectively or in a timely manner with 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 sometimes have a history of 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 task. It seems only the most serious cases have been prosecuted, and only then 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. Consumer law does not provide a suitable remedy in such circumstances.

Is reliance on self-regulation sufficient?

The effectiveness of self-regulation relies on voluntary compliance by members of the profession with the association's code of ethics, and effective complaints handling and disciplinary processes.

The websites and codes of ethics for 18 organisations were reviewed. Only two professions documented their national complaints handling process on their website – social workers and speech pathologists. All offered continuing professional education programs. The codes of ethics varied considerably in detail and scope, with the most comprehensive codes being for social workers, massage therapists and

paramedics. However, an area that was not addressed in many codes was physical or mental impairment for example, due to alcohol or drug use, with only 7 of the 18 codes addressed this issue.

Effective self-regulation often relies on considerable volunteer labour by members to administer the arrangements. Few professional associations are of sufficient size, with sufficient membership fee income to employ staff to carry out many of the association's functions.

Self-regulation works best when the risks of harm are low and there are sufficient incentives and/or sanctions within the industry to support compliance by association members with the self-regulatory arrangements. Since membership of self-regulating professional associations is voluntary, there may be no effect on a practitioner's business if they are expelled from the association for professional misconduct (NSW Parliament Joint Committee on the Health Care Complaints Commission 1998, p. 43).

In particular, the effectiveness of the disciplinary arrangements under voluntary self-regulation rely on the profession being highly cohesive and collegiate. Although extensive self-regulatory arrangements have been put in place by many professional associations, the extent to which these associations are able to regulate their respective professions depends largely on their 'market share'. Significant fragmentation occurs in the CAM professions, particularly among those without well-established educational pathways or a well-defined scope of practice. In the professions of naturopathy and western herbal medicine (WHM), a La Trobe University report (2005, p. 9) identified five major professional associations representing naturopaths and WHM practitioners in Australia and a large number of smaller groups.

> This sort of fragmentation in the representative arrangements for many unregistered health professions undermines the effectiveness of voluntary self-regulation. The La Trobe University report (2005, p.9) noted the tendency of groups to form and then split from federated arrangements and that this weakened their ability to represent unified professions to the policy and regulatory requirements of governments. Associations also had different entry criteria and recognition of qualifications and different approaches to the maintenance of ethical standards and investigation of complaints.

Although there is considerably less fragmentation in the smaller conventional professions than in the smaller CAM professions, the limited size of their membership base means that they have few resources available to devote to self-regulation. In particular, there are limited resources available for complaints handling.

There is also considerable duplication in the credentialing undertaken by employers, health payers and other bodies, thus increasing the administrative burden and costs for the health sector as a whole. For most unregistered health professions, there is no single trusted source of information for employers and health payers (as there is for registered practitioners) about the qualifications and probity of practitioners.

Is reliance on co-regulation sufficient?

The operation of co-regulatory schemes should, in theory, result in improved industry self-regulation and nationally consistent standards of education, professional conduct and quality service delivery. However, for many CAM professions, this is not the case. For instance, the La Trobe University report (2005, p. 162) identified over 20 associations for the professions of naturopathy and WHM that in 2004 had been formally assessed as meeting the ATO's definition of a 'professional association':

> Although these disparate arrangements have not been reconciled into a single, nationally consistent body of standards for each discipline, the ATO has nonetheless recognised, for GST purposes, multiple sets of standards for multiple associations. Consequently, a practitioner found to have breached the standards of one association can join another association and maintain his or her GST free status (La Trobe University 2005, p. 257)

National uniformity versus diversity

Under Australia's federal system of government, diversity is to be expected, and in some cases may be desirable to encourage local responsiveness, competition and innovation. 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.

The national consultation considered questions such as 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?

Under **Option 1**, a statutory code of conduct for unregistered health practitioners would 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 dealing with complaints against unregistered health practitioners. There would be limited mechanisms for prohibiting from practice those practitioners found not to be fit and proper persons 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 able to maintain their registration in one jurisdiction while ‘struck off’ in another.

Option 2: Strengthened self-regulation

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

However, 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 the practitioner is not prepared to enter formal conciliation via a state or territory health complaints commission, the main option for an aggrieved consumer 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 alone 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: An enforceable National Code of Conduct

A statutory code of conduct and prohibition order powers provides 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 relevant to their practice under another Act but is continuing to practise. Such a scheme is not designed to absolve consumers of the responsibility 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 is not able to be adequately dealt with through other means. In NSW, the HCCC's powers provide a relatively low cost, targeted complaints handling mechanism that complements other available remedies, including civil action.

An enforceable National Code of Conduct would draw together in one place the basic ethical and legal obligations of unregistered health practitioners. It would facilitate ethical discourse amongst members of the unregistered health professions about their professional and legal obligations.

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 (but not always) after some harm has occurred. Intervention by government is kept to a minimum, and only occurs when things go wrong and 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.

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:
  - receipt and investigation of complaints about breaches of the code of conduct
  - investigation and prosecution of breaches of code of conduct.

Strengths of this approach 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. This means that sanctions may be applied even where a criminal prosecution of the practitioner has been unsuccessful.

National uniformity versus diversity

To administer the arrangements at a State/Territory level would build on existing State and Territory health complaints arrangements, including the power to investigate complaints against unregistered practitioners. This would provide a synergy of function and economies of scale with the existing HCE functions. 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.

National administration would strengthen the move towards national systems of regulation. While the establishment of a new body might initially be more costly than extending the powers of existing entities such as state based HCEs, 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.

Where HCEs have been empowered to undertake this function (NSW and SA), the function could be transferred to the new body. Alternatively, if HCEs were to continue to carry out this function, the national body would need to liaise and work cooperatively with the HCEs in the same way that liaison currently occurs in relation to complaints against registered practitioners

It is possible that the national body could be supported administratively by AHPRA. Such a model would provide a synergy of function across all health professions and economies of scale. 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. AHPRA would also 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.

Option 4: Extend statutory registration to all health professions

The purpose of statutory registration for a profession is to protect the public, rather than to promote the interests of the profession. Statutory registration is the appropriate regulatory option when the risk of harm associated with the activities of a profession are high, and there is no other less restrictive means for addressing these risks.

Analysis of submissions indicates that many unregistered health practitioners and their representative bodies strongly believe that statutory registration is the most suitable regulatory response to the problems identified. The benefits were seen as protection of title, enforceable barriers to entry to practice, improved standards and reduced risk to consumers. Such submissions place emphasis on the need to protect the public, but do not often address the associated costs including the impact on competition and reduction in the range of services available to consumers.

Although statutory registration reduces harm through the imposition of barriers to entry and penalties for poor practice, it does not eliminate it. This is evident from the complaints data and disciplinary cases available on the AHPRA website about registered health practitioners. While statutory registration provides for probity checking of practitioners entering the regulated health professions, regulatory action is generally triggered by a complaint, in the same way that it is with a negative licensing scheme as in Option 3.

When the incidence of harm for a profession is low, the benefits of registration are also low, but the costs remain the same. In order for the National Registration and Accreditation Scheme to be extended to additional professions, a net public benefit must be demonstrated for each profession.

It is not considered possible for a registration scheme to capture every practitioner who provides 'health' services. This is because some practitioners do not identify with a particular profession and/or may not have formal qualifications in a given profession. The only way to prevent such unregistered practitioners from providing ‘health’ services would be to make it an offence to provide any ‘health’ service when not registered.

5. Impact analysis – costs and benefits

This section aims to identify the risks associated with the practice of unregistered health practitioners, and the type and level of impacts that each option will have on those groups most likely to be affected by regulation. Where possible, an estimation of the likely costs or benefits of these impacts is provided.

5.1 Affected parties

The parties likely to be affected by the proposals in this RIS are:

- consumers who use the services of health practitioners, and their representative bodies
- unregistered health practitioners and their representative bodies
- registered health practitioners, to the extent that they provide health services outside the usual scope of practice of their profession, and their representative bodies
- employers of unregistered health practitioners and employer representative bodies
- government regulators including:
  - HCEs
  - Consumer protection authorities
  - AHPRA and the National Boards
  - State, Territory and Commonwealth regulators of drugs and poisons, therapeutic goods, use of radiation equipment, infectious diseases etc
- health payers (insurers) including:
  - Commonwealth, State and Territory government health insurance schemes such as Medicare Australia, workers compensation schemes, transport accident compensation schemes, Department of Veterans Affairs
  - Private health insurance funds

Governments and the general public are also stakeholders to the extent that any adverse events associated with the practice of unregistered health practitioners undermine the trust of the public in the health system.

Table 8 below provides an estimated number of unregistered health practitioners, as at April 2011.

Table 8: Estimated number of unregistered health service practitioners in Australia (within scope)

Occupation	Number*	Data Sources
Ambulance services/ paramedics	19,000	Paramedics Australia, Council of Ambulance Authorities submissions
Optical dispensers	3,270	Australian Dispensing Opticians submission
Dieticians	4,500	Dieticians Association of Australia submission
Massage therapists	25,000	Australian Association of Massage Therapists and The Association of Massage Therapists submission
Shiatsu	850	Shiatsu Therapy Association of Australia
Naturopaths	10,000	Australian Naturopathic Practitioners submission
Western herbal medicine	3,000	National Herbalists Association of Australia
Speech therapists and pathologists	6,500	Speech Pathology Australia and Speech Pathologists Board of Queensland's submissions
Audiologists	2,000	Submission L. Collingridge
Audiometrists	500	Submission L. Collingridge

Occupation	Number*	Data Sources
Dental technicians	3,000	The Oral Health Professionals Association submission
Personal care assistance/ assistance in nursing	7,000	Australian Nursing and Midwifery Association
Anaesthetic technician	1,000	The Australasian Society of Anaesthesia and Paramedical Officers submission
Social workers	19,300	Australian Association of Social Workers submission
Reiki practitioner	1,000	Usui Reiki Network, Reiki Association of Australia, Australian Reiki Connection submissions
Arts therapy	4,200	Australian and New Zealand Arts Therapy Association submission
Exercise scientists and physiologists	3,000	Exercise and Sports Science Australia submission
Sonographers	5,135	Australian Sonographers Association submission
Reflexology	9,420	Reflexology Association of Australia and Association submission
Infant massage instructors	1,000	The International Association of Infant Massage Therapists submission
Cardiac scientists	300	Australian Professionals in Cardiac Science submission
Medical laboratory scientists	13,000	Australian Institute of Medical Scientists Association submission
Emergency medical technicians	10,000	The Australasian Registry of Emergency Medical Technicians submission
Homeopaths	700	The Australia Register of Homeopaths Ltd and Australian Homeopathic Association submission
Orthotists/ Prosthetists	320	The Australian Orthotic Prosthetic Association Inc submission
Orthoptics	223	Australian Orthoptic Board and Orthoptics Australia WA Branch submissions
Hypnotherapy	893	Academy of Applied Hypnosis submission
Medical photographers or illustrators	75	The Australian Institute of Medical and Biological Illustration
Counselling and psychotherapy	7,780	Psychotherapy and Counselling Federation Australia and Australian Counselling Association Australia submission
Music therapists	383	Australian Music Therapy Association
Respiratory scientists	900	The Australian and New Zealand Society of Respiratory Science
Sleep technologists	900	Australian Sleep Technologists Association submission
Pharmacy assistants	42,500	The Pharmacy Guild of Australia submission
Total	**206,649**	

Notes:

* To provide a conservative estimate where different numbers were provided, the lowest number is used except for counsellors and psychotherapists where a yellow pages analysis was utilised

Sources: Submission numbers 122, 162, 115, 117, 100, 68, 133, 70, 153, 107, 32, 177, 102, 158, 109, 21, 61, 110, 123, 156, 171, 44, 125, 164, 161, 163, 79, 131, 144, 51, 137, 84, 95, 114, 92, 128, 167 on AHMAC website.

Table 9 below lists the number of practitioners in each of the 14 professions that are regulated under the National Registration and Accreditation Scheme..

Table 9: Estimated number of health practitioners registered under the National Registration and Accreditation

Occupation	Number	Data Source
Chiropractors	4,462	AHPRA 2011 -12 annual report
Dental practitioners (dentists, dental specialists, dental hygienists, dental prosthetists, dental therapists & oral health therapists)	19,087	AHPRA 2011 -12 annual report
Medical practitioners	91,648	AHPRA 2011-12 annual report
Nurses and midwives	343,703	AHPRA 2011-12 annual report
Optometrists	4,568	AHPRA 2011-12 annual report
Osteopaths	1,676	AHPRA 2011-12 annual report
Pharmacists	26,548	AHPRA 2011-12 annual report
Physiotherapists	23,501	AHPRA 2011-12 annual report
Podiatrists	3,690	AHPRA 2011-12 annual report
Psychologists	29,645	AHPRA 2011-12 annual report
Aboriginal and Torres Strait Islander health practitioners	298	National Board statistics Dec 2012
Chinese medicine practitioners (acupuncturists, Chinese herbal medicine practitioners and Chinese herbal dispensers)	3,952	National Board statistics Dec 2012
Medical radiation practitioners (radiographers, nuclear medicine technologists, medical radiation therapists)	13,508	National Board statistics Dec 2012
Occupational therapists	14,255	National Board statistics Dec 2012
Total registered health service workforce	**580,541**	

5.2 Assessment of risk

Definitions

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 likelihood 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 problems, although there have been some high profile cases of unacceptable outcomes for consumers and for the health system.

> 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 (UK Working Group 2009, p.8)

Types of risk

Risks associated with the practice of unregistered health practitioners may be divided into three main categories:

- 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.
- risks associated with the competence of the practitioner in exercising clinical judgement:
  - misdiagnosis
  - inappropriate removal of therapy
  - incorrect prescribing or other application of treatment
  - failure to refer
  - failure to explain precautions or contraindications
- risks associated with the characteristics of the patients or clients, with increased patient vulnerability associated with:
  - life threatening or chronic illness
  - mental illness
  - intellectual or physical disability

The likelihood of harm to the public is expected to be greater when the practitioner:

- is unqualified or poorly trained
- suffers from a physical or mental impairment that impacts on their practice
- has a broad scope of practice that includes independent primary care practice
- fails to take adequate steps to ensure their skills, knowledge and practice remain up to date
- works with vulnerable or isolated individuals
- works in isolation from peer or supervisor support
- is highly mobile, a locum or on short tenure
- has a criminal history, falsified identity or false qualifications
- is of poor character with a willingness to place their own interests above those of their patients.

Risks associated with the type of procedure or activity

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.

Table 10 below identifies thirteen types of procedure or activity 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 be carried out only by registered health practitioners.

Table 10: Activities or procedures undertaken by health practitioners and that carry risk

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 conditions with potential for harm.
10. Setting or casting a fracture of a bone or reducing dislocation of a joint.
11. Provision of a primary care service to patients with or without a referral from a registered practitioner.
12. Treatment that commonly occurs without any other persons present.
13. Treatment that commonly requires patients to disrobe.

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

Using the ABS data, a list of health professions and occupations has been generated. *Appendix 1* identifies the extent to which these activities are typically part of the scope of practice of unregistered health 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 the 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 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 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 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).

Managing risk

The incidence of risks in practice depends in part on the institutional arrangements surrounding a practitioner's practice. Employers, peers and professional bodies all carry out important quality assurance roles by:

- setting and enforcing minimum qualification and other requirements for entry to the profession
- maintenance of professional competence
- detecting and dealing with unethical or incompetent practice before harm occurs
- providing an avenue to deal with consumer complaints against practitioners
- modifying systems in response to experience.

Risks are likely to be greater where:

- the institutional arrangements are under-developed or fragmented
- practitioners work primarily in independent private practice rather than in an employment relationship.

The stronger and more cohesive the institutional arrangements for professional representation, the more effective a profession is likely to be in enforcing minimum qualification standards for entry to practice and dealing with departures from acceptable professional standards.

Factors identified as likely to affect the extent to which theoretical risks are realised in practice include:

- whether a risky 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, for example, where 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
- the experience of the practitioner carrying out the act and whether their practice is guided by a strong professional (or employer) code of conduct
- 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 (UK Working Group on Extending Professional Regulation July 2009, p.21).

The likelihood of illegal or unethical practice may be greater in the emerging professions compared than in well established professions. This is because the established professions have stronger institutional arrangements that operate to contain risk, for example, by effectively enforcing 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 insurers, 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 may 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 prospective employers may fail to reveal adverse details from 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.

In every profession there is a small proportion of practitioners who wilfully do the wrong thing, and place their own interests above those of their patients/clients. No regulatory regime can eliminate all risk of harm arising from wilful illegal or unethical conduct or impaired or incompetent practitioners. However, where there is money to be made and no effective mechanisms for checking probity and qualifications before entry to practice, there is an increased risk that persons predisposed to exploit others will be attracted to the profession.

Consequences

Harm can be physical, mental and financial. For the purposes of this cost/benefit analysis, harm is defined as:

- death or serious injury that is attributable to a practitioner's impairment, incompetence or unethical conduct.
- loss of income associated with injury
- pain and suffering

5.3 Available data

There is limited data that can be used to quantify the likelihood of harm (serious injuries and deaths) arising from the practice of unregistered health practitioners. The following data sources have been identified:

NSW Health Care Complaints Commission

NSW Health Complaints Commissioner (HCCC) provided data on the costs associated with application of the NSW Code of Conduct. The NSW data was relied upon because it is the only jurisdiction that has fully implemented a statutory code of conduct and prohibition order powers.

Table 11 below sets out the data provided by the NSW HCCC on complaints received about unregistered health practitioners over a three year period, from 2009 to 2011.

Table 11: Number of complaints to the NSW Health Care Complaints Commission about unregistered health practitioners

	2009-10	2010-11	2011-12	Total	Average/year
Complaints received	80	104	88	**272**	90
Investigations finalised	11	14	15	**40**	13
Prohibition orders/public statements	4	6	7	**17**	6

During this period, the Commission has received over 270 complaints against unregistered health practitioners. Of these, 40 complaints were investigated, resulting in 17 prohibition orders or public statements.

The NSW HCCC conducts a formal investigation of a complaint only when its preliminary assessment indicates there is a serious risk to public health or safety.[16] Therefore, the number of investigations conducted has been taken as a proxy measure of the frequency of serious harm.

[16] Section 23 of the NSW *Health Care Complaints Act 1993* states:

(1) The Commission must investigate a complaint:

(b) if, following assessment of the complaint, it appears to the Commission that the complaint:

National Registration and Accreditation Scheme

Notifications data at Table 4 provided by the Australian Health Practitioner Regulation Agency for 2011–12 indicates an average of 14 notifications per thousand registered health practitioners (AHPRA 2012). The rate of notifications varies depending on the profession.

Complaints data included in the Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law indicated an average of 15 complaints per thousand registered health practitioners (AHMAC 2009).

Report on regulatory requirements for Naturopathy and Western herbal medicine professions

A report commissioned by the (then) Victorian Department of Human Services in 2005 titled *The Practice and Regulatory Requirements of Naturopathy and Western Herbal Medicine* documented the risks associated with the practise of naturopathy and Western herbal medicine, particularly:

- Risks associated with the clinical judgement of the naturopath or WHM practitioner, and
- Risks associated with the consumption of herbal and nutritional medicine. (La Trobe University School of Public health, 2005, p.5)

The report assessed the profession against the AHMAC Criteria for statutory registration, and recommended that an independent regulatory body be established to determine uniform minimum professional and educational standards and to provide effective complaints handling mechanisms and sanctions relating professional misconduct.

Other data sources

Wardle (2008) reported Adverse Drug Reactions Advisory Committee (ADRAC) data suggesting an average of 395 adverse reactions to complementary medicines reported each year, and 62 deaths associated with complementary medicine in the past decade. However, there are limitations with reliance on this data, including under-reporting of adverse drug reactions to complementary medicines, unrecognised adverse effects occurring, and lack of proven causal links with cases reported.

The case studies identified during the research, along with those submitted by respondents to the national consultation, suggest that deaths associated with the practice of unregistered health practitioners have been known to occur – see case studies in *Appendix 10*. While some of the cases identified involve coroners findings that have proven causal links, some cases involve patients who were suffering from terminal illnesses and it is unclear the extent to which their deaths may have been hastened by poor clinical care.

5.4 Cost–effectiveness analysis

This section sets out the assumptions that have been made and summarises the costs, benefits and the impacts of the various options. Table 14 summarises the costs and benefits of options 2–4. Table 20 summarises the assumptions and qualitative analysis that inform the results in Table 14.

Assumptions

In order to quantify and compare the costs and the benefits of each of the options, a number of assumptions have been made.

(i) raises a significant issue of public health or safety, or

(ii) raises a significant question as to the appropriate care or treatment of a client by a health service provider, or

(iii) if substantiated, would provide grounds for disciplinary action against a health practitioner, or

(iv) if substantiated, would involve gross negligence on the part of a health practitioner, or

(v) if substantiated, would result in the health practitioner being found guilty of an offence under Division 3 of Part 2A of the *Public Health Act 1991*.

Assumption 1: Scope of RIS – size of practitioner cohort

The number of unregistered health practitioners has been calculated from estimates provided in submissions from professional associations to the national consultation in March-April 2011. The total figure of approximately 206,650 practitioners is likely to be conservative this figure is unlikely to include all unregistered health practitioners, nor does it include practitioners who do not identify with a particular profession.

Assumption 2: Incidence of serious harm

As outlined above, the number of investigations undertaken by the NSW HCCC has been used as a proxy measure to estimate the frequency of serious harm Australia-wide. This is because the NSW HCCC only investigates a complaint if, following assessment of the complaint, it appears that the complaint raises a significant issue of public health or safety.

Between July 2009 and June 2012, the NSW HCCC investigated 40 complaints against unregistered health practitioners, an average of 13 investigations in NSW per year. An average of just under 6 prohibition order per year were issued.

Table 12 below extrapolates this Australia-wide using ABS population data (ABS, 2011b). This results in an estimate average of 40 investigations and therefore 40 incidences of serious harm or injury a year Australia-wide, associated with the practice of unregistered health practitioners.

Table 12: Estimated average number of complaints and investigations Australia wide

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Australia
Pop. weight	0.321391	0.24791	0.201031	0.072951	0.107139	0.022571	0.010351	0.016519	1
Complaints	90	69	56	20	30	6	3	5	**280**
Investigations	13	10	8	3	4	0.91	0.42	0.67	**40**

This data has been used to estimate the anticipated level of reduction in harm of various options (see assumption 4 below).

Assumption 3: Costs of complaints handling and the issuing of prohibition orders

Table 13 below sets out the estimated costs of complaints handling and prohibition orders, based on the average unit costs provided by the NSW HCCC, using salary data from NSW.

Table 13: NSW Health Care Complaints Commission costs associated with receipt, assessment and investigation of complaints against unregistered health practitioners

	Function	Average Unit cost
A	Assessment of a complaint - unregistered or registered practitioner	$676
B	Investigation finalisation of complaint	$16,279
C	Investigation of a complaint/breach of code by unregistered practitioner	$18,174
D	Issue of prohibition order to unregistered practitioner by a Commissioner following investigation	No additional cost
E	Issue of prohibition order by a state or territory tribunal - includes preparation and prosecution of case to either issue prohibition order prosecution of breach of a prohibition order before a court	$ 30,645

Under a model where the regulator (rather than a tribunal) has powers to issue a prohibition order, the cost of making such an order is included in the average cost of investigating a complaint. This is because the NSW HCCC has advised that it is no more expensive to issue a prohibition order at the end of an investigation than not to, given that the prohibition orders are issued by the Commissioner directly following consideration of the investigation of the report.

Under a model where the prohibition orders are to be issued by a tribunal following a hearing rather than directly by a regulatory body, the HCCC has estimated an additional cost of $30,645 for the preparation and presentation of each case before the tribunal. This figure excludes the costs of the tribunal itself, such as sitting fees for hearing panel members and tribunal overheads.

Productivity Commission data from the Steering Committee for the Review on Government Services has been used to estimate court costs to government.

Assumption 4: Reduction in serious harm

Assumptions have been made concerning the level of reduction in serious harm associated with each option compared with the base case (Option 1). Table 14 below sets out these assumptions and provides some explanation of how these assumptions have been applied to give a benefit rating. The benefits in terms of harm reduction associated with each option have not been allocated a dollar figure, due to insufficient available data. Instead, a rating scale has been applied, using the following ratings for the estimated level of reduction in serious harm as follows:

Rating for reduction in serious harm				
Very low	Low	Medium	High	Very high

Table 14: Assumed reduction in harm for each option compared with the base case Option 1

Option	Description	Assumed reduction in serious harm compared with Option 1	Comments
Option 2A	Strengthen self-regulation – government monitored complaints handling	Very low	While a voluntary code may assist in educating practitioners and consumers about accepted practice standards, the strengthened standards and improved complaints handling will only apply to those practitioners who voluntarily choose to participate in self-regulatory arrangements. This option is unlikely to deal any more effectively than Option 1 (no change) with practitioners who knowingly engage in exploitative and predatory behaviour towards their patients and choose to operate outside the collegiate arrangements of a professional association.
Option 2B	Strengthen self-regulation – government accredited voluntary registers	Very low	Professional associations may or may not be motivated to achieve government accreditation. For those associations that are successful in attaining accreditation, some improvement in quality assurance arrangements for their profession would be expected and this is likely to reduce harm to consumers. The increased institutional recognition (from employers, health payers) that may flow from government accreditation may create incentives for practitioners to join an accredited association. As a result, members who are subject to an accredited association's disciplinary process and might otherwise be tempted to let their membership lapse to avoid disciplinary action might reconsider, given the consequences (for example, loss of provider recognition). However, the estimated harm reduction associated with this option, while greater than Option 2A, is still limited because the option will not capture all practitioners and will have no impact on those who choose to operate outside the collegiate arrangements of an accredited professional association.
Option 2C	Strengthened self-regulation – voluntary national registration	Low	The level of harm reduction is expected to be higher than for Options 2A and 2B because this option is likely to be more effective in setting and enforcing nationally consistent standards for entry to and practise of unregistered health professions. This should provide greater quality assurance of practitioners than would otherwise apply. The harm reduction is expected to be lower than for Option 3 because this option will not capture all practitioners and will have no impact on those who choose not to join the voluntary register, or choose to let their registration lapse to avoid disciplinary action, but continue to practise.
Option 3	A national statutory code of conduct and prohibition order powers	Medium	This option will apply to all practitioners, whether they are members of a voluntary register or not. It provides a more direct and powerful tool that targets all of the problem practitioners. It enables the regulator to take immediate and effective action (via an interim prohibition order to prevent practice) in cases of threat to public health and safety. A national register of prohibition orders and mutual recognition between States and Territories would help to ensure that practitioners subject to a prohibition order in one jurisdiction could not resume practice in another. Prohibition orders issued by a single national agency would impose enforceable national sanctions on practitioners found to have breached the code.
Option 4	Statutory registration for all health practitioners	Medium	This option would set enforceable minimum qualifications for entry to the regulated profession, probity checking of new entrants and effective complaints handling. While it would be expected to address some of the risk, it is not possible for a registration scheme to capture every practitioner because many do not identify with a profession. The only way to prevent unregistered practitioners from providing 'health' services would be to make it an offence to provide any 'health' service when not registered. It would be very difficult to nominate a profession for all services that could be described as 'health' services. Registering all health professions would have serious consequences for consumers in restricting their choice of health practitioners and may result in an increase in harm due to lack of access to services.

Option 1: No change – rely on existing regulatory and non-regulatory mechanisms (base case)

Under this option, there would be no change to current regulatory and non-regulatory arrangements through which the fitness to practice of unregistered health practitioners is assured, and serious departures from accepted professional standards are dealt with.

Benefits

The main benefit of retaining the existing arrangements is that extra costs, to practitioners, governments or the community associated with additional regulatory measures are avoided. Existing regulators (such as consumer protection, therapeutic goods, radiation safety regulators) continue to carry out their functions of investigating and where necessary prosecuting illegal conduct by unregistered health practitioners, while professional associations continue to carry out their quality assurance roles.

Costs

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

- for individuals and their families who have suffered harm, costs associated with:
  - injuries caused by the unethical, incompetent or impaired behaviour of unregistered practitioners
  - pursuit of private actions for damages
- 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 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 community – costs associated with lost productivity of individuals unable to work due to injury and the impact of lost income on their families.

Qualitative estimates

Between July 2009 and June 2012, the NSW HCCC investigated 40 complaints against unregistered health practitioners, and as a result, conducted an average of 13 investigations in NSW per year.

Table 12 above extrapolates this Australia-wide using ABS population data (ABS, 2011b). This results in an estimate average of 40 investigations and therefore an estimated 40 incidences of serious harm or injury a year Australia-wide, associated with the practice of unregistered health practitioners. This may be conservative estimate, to the extent that these results incorporate the benefits of NSW strengthening its complaints mechanism and enforcement powers in 2008. On the other hand, the full benefits of the NSW system may increase over time.

There are also costs associated with obtaining redress through the courts. These costs are shared by the consumer who has suffered harm, the health practitioner against whom the action is brought, and governments that pay for the court system. These costs have not been quantified in this analysis.

Option 2A: Strengthen self-regulation – government monitored complaints handling

Under this option, the role of existing State and Territory health complaints entities would be formalised and strengthened to include working with professional associations and other self-regulatory bodies to put in place a voluntary code of conduct and best practice processes for handling complaints made against their members.

Benefits

This option would be expected to improve the quality assurance of unregistered health practitioners, and as a consequence reduce harm through the provision of guidance and education to practitioners and their associations about appropriate standards of practice and best practice complaints handling. Greater consumer trust and understanding of what constitutes acceptable professional conduct should serve a protective function for consumers. Flexibility to tailor codes of practice to the circumstances of each profession and to amend the codes over time could facilitate more responsive quality assurance. Increased dialogue about professional standards between professional associations and governments in the design and implementation of the code/s would be expected.

While this option would be expected to strengthen self-regulatory arrangements generally, it will not capture all unregistered health practitioners, but only those who are members of professional associations and are willing to participate in self-regulatory regimes. Given this option is unlikely to have any impact on those practitioners who choose to operate outside professional self-regulatory arrangements, it is assumed that this option will only have a limited impact on reducing harm.

Costs

This option is expected to increase costs to existing State and Territory health complaints entities and professional associations.

For State and territory health complaints entities, the increased costs are associated with:

- provision of advice and assistance to professional associations on development of voluntary codes of practice and on best practice complaints handling
- educating health service consumers about the voluntary code/s of practice and complaints mechanisms for unregistered health practitioners
- increased staff to deal with an expected increase in the number of complaints and investigations arising from greater awareness and reporting by health consumers of poor quality health services provided by unregistered health practitioners.

For the purposes of this analysis, it is assumed that implementing this option would increase the costs to state and territory complaints entities in working with professional associations, assessing and investigating an increased number of complaints referred from these associations, and in educating the public and professional associations about the voluntary code of conduct.

Data and costings provided by the NSW HCCC have been used to quantify the costs of this option (see Assumption 3: Costs of complaints handling and the issuing of prohibition orders, page 67).

Based on 2011-12 data, the NSW HCCC has advised that the average unit cost of assessing a complaint is $676, and $16,279 for each investigation for both registered and unregistered health practitioners. While only a small proportion of the total complaints received by the NSW HCCC relate to unregistered health practitioners, the NSW HCCC has advised that the cost of dealing with these complaints against unregistered health practitioners tends to be higher than average, as they often involve additional meetings with the practitioner and therefore more resources. For this reason, NSW HCCC has advised that an average cost of $18,174 for each investigation is more accurate (excludes cost of preliminary assessment of the complaint).

The costs will vary with the average salary costs of the complaints entity.

While some of the additional responsibilities associated with Option 2A may be incorporated into the existing activities and cost structures of state and territory HCEs, additional resources will be required. For the purposes of this analysis, it assumed that Option 2A would require an average of two additional staff in each large jurisdiction (NSW, Qld, SA, Vic & WA), assumed to cost on average $250,000 per year, and 1 staff member in each small jurisdiction (ACT, NT and Tas), assumed to cost an average of $125,000 a year. This gives a total estimated cost of $**1.625m** per year.

The additional costs for HCEs Australia-wide of assessing the anticipated increase in the number of complaints and undertaking additional investigations results in an additional cost of $0.627 million per year (including overheads). This calculation is presented in Table 15 below.

Table 15: Option 2A – estimated costs by state and territory of complaints assessment and investigation

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Australia	Australia excl. NSW
Pop. weight	0.321391	0.24791	0.201031	0.072951	0.107139	0.022571	0.010351	0.016519		
No. of Complaints	90	69	56	20	30	6	3	5	280	190
No. of Investigations	13	10	8	3	4	0.91	0.42	0.67	40	27
Costs										
Complaints Assessment (no. of complaints x $$676)	$60,840	$46,930	$38,056	$13,810	$20,282	$4,273	$1,959	$3,127	$189,276	$128,436
Investigations (no. of investigations by $18,174)	$236,262	$182,244	$147,783	$53,628	$78,760	$16,592	$7,609	$12,144	$735,023	$498,761
Total costs									$924,299	**$627,197**

Assumptions:

- Using NSW data, assumes an additional 90 complaints resulting in 13 investigations per year with population weighting (ABS,2011b)
- Cost per complaint assessment $676, cost per investigation $18,174
- Some complaint numbers have been rounded up but costs are done on weighted figures
- NSW costs excluded as already in operation, SA costs included as not yet fully operational.

Therefore the total additional costs for HCEs is $1.625 + $0.627 = $2.252m per year.

In the absence of any information about the increased cost to professional associations of working with health complaints entities to develop voluntary codes of practice and improve their complaints handling, it is assumed that the increase in costs will be similar to that experienced by the state and territory HCEs, or $2.252 m a year across Australia.

The increased costs to professional associations is likely to be passed on to their members in the form of increased membership fees and that this would be passed on by members in the form of higher prices for health consumers. The price increases have not been quantified, but are assumed to be minimal as these would be spread over a large number of consumers.

There would be one-off implementation costs to government to develop a Code of Conduct in consultation with consumers and professional associations. No legislative changes would be expected to be required for HCEs to take on this role, although jurisdictions may decide amendments are required to formalise these extended functions. It is assumed that the additional costs to government of implementing this option would be met from within existing State, Territory and Commonwealth government resources.

There is potential for strengthened complaints mechanisms to affect professional indemnity insurance premiums and therefore costs for unregistered health practitioners. While there might be an increase in complaints/claims against insurance policies within the early stages of the complaints mechanisms implementation, overall, insurers would be expected to see this as a positive risk management approach that should provide long term benefits in terms of the risk profile of this sector. As at July 2011, the availability of cost effective insurance policies for allied health practitioners was strong.

Option 2B: Strengthen self-regulation – government monitored voluntary registers

Under this option, governments would lead the establishment of an agency (or extend the role of an existing agency) to act as a national standard setting and accrediting body for self-regulating professional associations and the voluntary practitioner registers they maintain. The role of the agency would be to set governance and operational standards and assess professional associations and voluntary registers against these standards, including assessing the effectiveness of association complaints handling and disciplinary processes. The standards agency would charge associations and other bodies for the accreditation service on a user pays basis.

Benefits

For the purposes of this analysis, it is assumed that under Option 2B, benefits in terms of a reduction in the incidence of harm would by very low, mainly because the system is voluntary.

Under this option there may be benefits in terms of cost savings associated with a reduced administrative burden on government and non-government bodies that already credential practitioners for various purposes, notably employers, health payers (transport accident and workers compensation insurers), the Australian Tax Office and the Department of Veteran's Affairs. However, these benefits depend on changes to policy by these agencies to recognise only those associations (and their members) that have been accredited by the standards agency.

Another potential benefit of Option 2B is the reduction in court costs associated with reduced harm. It is assumed that the reduction in harm will be very low due to the voluntary nature of Option 2B.

Costs

The cost of Option 2B includes the costs of establishing a new agency, or extending the functions of an existing government or a non-government agency. The agency would set governance and complaints handling standards for professional associations and voluntary registers, audit against those standards and accredit organisations that meet the standards.

To estimate the increase in annual ongoing costs associated with an agency that sets accreditation standards, audits performance and accredits against these standards, several existing government and non-government bodies that undertake similar health care standard setting or accreditation functions were identified. These included the Australian Commission on Safety and Quality in Health Care (ACSQHC), the Reproductive Technology Accreditation Committee (RTAC) and National Association of Testing Authorities Australia (NATA).

The annual membership of $150 charged by the Fertility Society of Australia (that administers Reproductive Technology Accreditation Committee) has been assumed as indicative of the annual cost per member of an organisation accreditation function. It is assumed that half the number of unregistered health practitioners identified in Table 8 would be members of accredited voluntary registers, and that this cost would be passed on to members in the form of higher membership fees. Costs have been adjusted to remove NSW figures. See Table 16 below for full calculations.

Table 16: Option 2B – estimated costs associated with standard setting and accreditation agency

Component	Calculation	Subtotal
Cost of annual accreditation	Per professional association member	$150
Estimated number of accredited members of professional associations	0.5 x 206,649	103,324 accredited members
Subtotal	$150 x 103,324	= $15, 498, 675
Subtraction of NSW figures (using ABS population weighting of 0.321391)	0.321391 x 15,498,675	= $4,981,135
Total	$15, 498, 675 - $4,981,135	= **$10, 517, 540**

It is assumed that the cost to governments of establishing a new national standard setting and accreditation entity would be approximately $500,000 in the first year, or half that figure ($250,000) if an existing body were to assume the role.

No legislative changes would be expected to be required with this option.

Option 2C: Strengthened self-regulation – voluntary national registration

Under this option, governments would, in cooperation with professional associations, lead the establishment of a national non-government agency that would administer voluntary practitioner registers on behalf of participating professions. The non-government agency would be a body similar to AHPRA in that it would administer the full range of regulatory functions for a profession (registration, program accreditation, complaints, discipline, practice guidance) on behalf of multiple professions. The key difference would be that the agency would not have statutory powers and registration on a practitioner register it administers would be voluntary.

Benefits

Option 2C is expected to be more effective in reducing harm than Options 2A or 2B as it would include professional registration, formal disciplinary procedures and a complaints mechanism. However, its effectiveness in reducing harm would be expected to be lower than Options 3 and 4 because registration is voluntary.

Some of the potential benefits of this option include:

- economies of scale for participating professions in carrying out quality assurance of their members
- cost savings due to the reduced administrative burden on employers, health insurers (Medicare, transport accident and workers compensation insurers, etc) who currently have separate accreditation processes for practitioners or their professional associations
- a reduction in court costs associated with reduced harm due to improved quality assurance of practitioners
- national consistency in the application of standards for voluntary registration, for participating professions.

Costs

The cost of Option 2C includes the cost of establishing a new non-government agency or extending the role of an existing agency. The agency would perform similar functions to AHPRA for health professions and occupations that wished to have voluntary national registration arrangements.

Under Option 2C, it is assumed that the ongoing costs would be similar to those of AHPRA. The average annual registration fee charged to registered health practitioners is $377, calculated using AHPRA's 2011-12 data on general registration fees for the initial 10 professions, and the general registration fee for the four additional professions on entering the scheme in July 2012 (see Table 17 below).

Table 17: Annual registration renewal fee by registered health profession 2011-12

Registered health profession	Annual registration renewal fee	Registered health profession	Annual registration renewal fee
Chiropractic	$ 510	Physiotherapy	$ 196
Dental	$ 563	Podiatry	$ 362
Medical	$ 670	Psychology	$ 403
Nursing & Midwifery	$ 115	Chinese Med	$ 550
Optometry	$ 408	Medical Radiation	$ 325
Osteopathy	$ 496	Occupational Therapy	$ 280

Pharmacy	$ 305	ATSI Health Workers	$ 100
Average registration renewal fee across 14 professions	$ 5283 / 14 = $ 377		

Assuming that half of the professional associations for unregistered health practitioners agree to participate in a national registration system, the increase in annual costs would be $26.4m, assuming that current professional association fees are similar to the average AHPRA fee of $377[17]. See Table 18 below for calculations.

Table 18: Option 2C – estimated costs associated with voluntary national registration

Component	Calculation	
Cost of registration	Based on average registration renewal fee under NRAS	$377
Estimated number of voluntary registrants	0.5 x 206,649	103,324 vol. registrants
Total	$377 x 103,324	= **$38,953,148**

As health practitioner costs would increase with this option, it is likely that these would be passed on in the form of higher prices to health consumers. These price increases have not been quantified, but are assumed to be minimal as these costs would be spread over a large number of consumers.

It is assumed that the costs of establishing a new national entity would be $1,000,000 in the first year, or half that figure ($500,000) if an existing body undertakes the role.

No legislative changes would be expected to be required with this option.

Option 3: A national statutory code of conduct

Under this option:

- a single national statutory Code of Conduct made by regulation would set out mandatory professional standards of practice for all unregistered health practitioners
- serious breaches of the Code of Conduct could result in a prohibition order limiting the practitioner's scope of practice, or preventing them from providing health services altogether

While the Code of Conduct would be developed nationally, the receipt and investigation of complaints and issuing of prohibition orders would be undertaken either by existing State and Territory health complaints entities or a national body supported by State and Territory Offices. Prohibition orders would be imposed directly by the body or via a tribunal following a hearing.

Benefits

This option would be expected to protect the public and reduce harm by:

- alerting consumers to practitioners who are impaired, incompetent or who have behaved unethically
- preventing practitioners who are not fit and proper to practise from continuing to provide health services
- reducing the incidence of repeated misconduct by those practitioners who are disposed to engage repeatedly in criminal, exploitative or predatory behaviour towards their patients or clients.

In addition, the threat of a prohibition order may deter unregistered health practitioners from engaging in unethical conduct or setting up practice when they are not properly qualified.

[17] Based on website information on membership fees for six professional associations (AASW, DAA, SPA, NHAA, ATMS and ANTA) the average membership fee is $386 per annum (2011-12).

Under either implementation arrangement (a national body or state and territory complaints bodies), regulators would have powers to impose sanctions such as prohibition orders that would be expected to be more effective in reducing the incidence of harm than Options 1 and 2. This is because it would address harmful practices by health practitioners who are not members of a professional association or do not identify with a particular profession, and/or who choose to operate outside the collegiate self-regulatory arrangements of a professional association.

Court costs would be expected to be reduced due to the availability of an additional method of redress (prohibition orders).

Increasing community trust in unregistered health practitioners would be expected and in the health system generally, with reduced consumer anxiety about incompetent or unethical health practitioners.

Costs

The costs of Option 3 depend on the method of implementation: either using existing State and Territory health complaints entities or using a newly established national body, supported by staff in State and Territory offices.

The costs have been calculated based on the NSW HCCC estimates of average annual number of complaints, assessments and investigations between 2009–10 and 2011-12 (**$627,197** – see Table 19 below).

Table 19: Option 3 – estimated costs of dealing with complaints against unregistered health practitioners for breach of a mandatory Code of Conduct

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Australia	Australia excl NSW
Pop. weight	0.321391	0.24791	0.201031	0.072951	0.107139	0.022571	0.010351	0.016519		
Complaints	90	69	56	20	30	6	3	5	280	190
Investigations	13	10	8	3	4	0.91	0.42	0.67	40	27
Prohibition Order	5	4	3	1	2	0.35	0.16	0.26	16	11
Costs										
Complaints Assessment (no. of complaints x $$676)	$60,840	$46,930	$38,056	$13,810	$20,282	$4,273	$1,959	$3,127	$189,276	$128,436
Investigations (no. of investigations by $18,174)	$236,262	$182,244	$147,783	$53,628	$78,760	$16,592	$7,609	$12,144	$735,023	$498,761
Total costs*									$924,299	**$627,197**

* excludes cost of prosecutions for breaches of prohibition orders.

The costs of prosecutions for breaches of prohibition orders is added to this cost, applying the NSW experience of around one breach a year to the whole of Australia and a cost estimate of $$30,645 per prosecution. This results in an estimate of two prosecution breaches a year, excluding NSW (**$61,290**).

This results in a total Australia-wide cost estimate for investigating breaches of the Code of Conduct and issuing prohibition orders of **$688,487** a year, excluding NSW ($627,197 plus $61,290).

As legislative change would be required in all state and territories (except for NSW and SA), it is assumed that implementation would result in an approximate cost in the first year of $100,000 for six jurisdictions, and $50,000 for NSW and South Australia where minor amendments may be required to provide for mutual recognition of interstate prohibition orders, or **$700,000** Australia-wide. Note that these costs would be expected to be absorbed by each jurisdiction within their existing legislative programs.

Implementation costs for Option 3 would different depending on whether the arrangements are implemented by existing State/Territory HCEs or by a national body. It is assumed there would be additional implementation costs for a new national body, in the order of $500,000 in the first year. If this role were to be given to an existing national entity, the establishment costs are estimated to be half this amount ($250,000). Economies of scale are available with both models.

Should these functions be undertaken by existing state and territory HCE then $50,000 per jurisdiction (excluding NSW and South Australia) or **$300,000** in total has been estimated as required in the first year to assist with establishment.

Option 4: Statutory registration extended to all unregistered health professions

Under this Option, the National Registration and Accreditation Scheme would be extended to include the 34 unregistered health professions and occupations listed in Table 8. Registration functions would be administered by AHPRA.

Benefits

This option would be expected to improve the quality of practitioners by setting enforceable entry level standards for practice, requiring probity checking, and providing more effective mechanisms for monitoring practice and dealing with impaired, incompetent or unethical practitioners.

The risk profile for each health profession or occupation varies depending on a range of factors, notably the scope of practice and the extent to which it includes invasive or risky procedures or activities (see section 5.2 Risk Assessment). Where the incidence of harm is low for a profession, the benefits of registration will also be marginal.

Therefore, while registration of all the 34 unregistered health professions and occupations would be expected to lead to a reduction in harm, it would not eliminate all harm, and may have unintended consequences. For these reasons, the reduction in harm associated with this option is assumed to be of the same order as for Option 3.

An expected benefit would be reduced court costs due to the availability of an avenue of redress for aggrieved health consumers.

Costs

The cost of extending the National Registration and Accreditation Scheme has been estimated by applying the average AHPRA annual registration fee in 2011-12 of $377 to health practitioners from the 34 unregistered health professions listed in Table 8. An estimated 206, 649 unregistered practitioners paying $377 per year in registration fees gives a figure of **$77,906,673** per year.

As this option would require legislative change as well as grand-parenting of existing practitioners in all State and Territories, it is assumed that implementation would result in an average cost in the first year of $500,000 Australia-wide per profession. This figure has been estimated based on the costs that were associated with transitioning four health professions into the NRAS in July 2012. This results in the first year implementation cost Australia-wide of 34 professions x $500,000 = **$17 million**.

Tables 20 and 21 summarise the costs and benefits for all of the options.

Option 3 provides the greatest benefit for the least cost irrespective of the method of implementation. Implementation costs for Option 3 have been calculated at the highest level of establishing a new national body. Implementation costs would be reduced if implementation is through Health Complaints Entities.

Table 20: Impact summary – estimated Australia-wide annual costs and benefits of options

	Option 2A	Option 2B	Option 2C	Option 3	Option 4
Description of option	Strengthen self-regulation – Government monitored complaints handling	Strengthen self-regulation – Government accredited voluntary registers	Strengthen self-regulation – Voluntary national registration	Strengthen health complaints mechanisms – a national statutory code of conduct	Extend statutory registration to all health professions
Benefits*	Very low	Very low	Low	Medium	Medium
Costs					
Estimated additional health services complaints mechanism expenditure	$2,252,197	–	–	$688,487	–
Estimated increase in costs to health practitioners, or professional associations (costs recovered by membership fee increases)	$2,252,197	$10,517,540	$26,433,957	–	$77,906,673
Increase in professional insurance costs	no material increase	no material increase	no material increase	no material increase	no material increase
Increase in cost of health services to consumers	small increase	small increase	small increase	–	small increase
Estimated government implementation costs (first year only)	–	$500,000	$500,000**	$1,000,000***	$17,000,000
First year costs (including implementation costs)	**$4,504,394**	**$11,071,540**	**$39,453,148**	**$1,688,487**	**$94,906,673**
Annual costs excluding initial implementation costs	**$4,505,394**	**$10,517,540**	**$38,953,148**	**$688,487**	**$77,906,673**

Notes:

* Refer to Table 14 above

** Assumes existing entity takes on the functions.

*** Assumes legislative change required in eight jurisdictions ($700,000), and six out of eight state and territory HCEs take on new functions (excludes NSW and South Australia) ($300,000)

Sources: NSW HCCC data, ABS 2011b and Table 8 above

Table 21: Summary of costs and benefits of options compared with base case (Option 1)

	Option 2A	Option 2B	Option 2C	Option 3	Option 4
Harm reduction – Assessed reduction in annual cost of harm to health consumers	Very low benefits: Does not capture all practitioners, only those who are members of a professional association	Very low benefits: Does not capture all practitioners, only those who choose to participate in the voluntary quality assurance system	Low benefits: • Improves quality assurance of practitioners through national standard setting, accreditation of training and complaints management system BUT • does not capture all practitioners, only those who participate in the voluntary quality assurance system.	Medium benefits: • alerts consumers to incompetent and unethical behaviour. • provides sanctions for serious breaches by prohibiting from practice those who have been found to have breached the Code • may deter poor or unethical practice • has the benefits of a nationally consistent administration of investigations of Code breaches if administered through a national body	Medium benefits: • may deter poor or unethical practice due to greater monitoring of health practitioner performance and conduct, thereby reducing harm BUT • does not capture all practitioners
Estimated additional health services complaints mechanism expenditure	Costs: • assessing and investigating complaints Australia-wide, subtracting NSW costs. • educating the public about the voluntary code of conduct. .	None	None	Costs of: • assessing and investigating complaints Australia-wide, subtracting NSW costs. • educating the public about the mandatory code of conduct. • prosecuting breaches of prohibition orders. • imposing prohibition orders though a tribunal rather than by the complaints mechanism in jurisdictions that require this.	None
Estimated increase in costs to health practitioners or their professional associations (costs recovered by membership fee increases)	Costs: • to health practitioner associations assessing and investigating complaints • of educating members about the voluntary code of conduct.	Cost to professional associations and voluntary registers of obtaining accreditation	Increased cost to health practitioners who choose to register on voluntary national register	None	Cost of national registration fees
Increase in cost to consumers of health services	Minimal	Minimal	Minimal	None	Minimal
Estimated government implementation costs (first year only)	None as costs met within existing government resources	• $500,000 to establish a new national entity or half that if an existing body is used. • other costs met with existing government resources.	• $1m to establish a new national entity or half that if an existing body is used. • other costs met with existing government resources	• $100,000 for each state and territory to enact new legislation, excluding NSW and SA • $500,000 to establish a new national entity or half that if an existing body such as AHPRA is used if national administration.	$500,000 for each of the 34 professions to be included in AHPRA, totalling $17 million.

Sources: As for Table 20

5.5 Business compliance costs

This section considers the business impacts of complying with Option 3, in particular the increased cost of meeting requirements of the mandated code of practice. These costs may include any increases in insurance, maintaining competence and administrative costs.

The main impact on compliance costs of this option is the need for unregistered health practitioners to familiarise themselves with the mandatory code, and provide information to the state or national complaints mechanism if they are the subject of a complaint or investigation.

As discussed above, the options (including Option 3) are considered unlikely to have a material impact on professional insurance premiums and therefore costs for unregistered health practitioners. As most are already members of professional associations that require professional indemnity insurance, compliance costs will increase only to the extent that practitioners do not currently have such insurance.

Overall, it is arguable that Option 3 would have a substantial impact on compliance costs. This is because the Code of Conduct would combine many of the existing legal obligations that apply to unregistered health practitioners such as the duty of care all health practitioners owe to their clients under common law, as well specific requirements that apply under other health and consumer protection legislation. These include the costs of obtaining qualifications, maintaining competency, adopting standard precautions for infection control and keeping appropriate clinical records.

The Code of Conduct serves to expressly remind practitioners of their legal obligations to ensure their practice is compliant with various laws, rather than imposing new obligations. Therefore, in estimating business compliance costs, such costs of compliance cannot be considered extra costs attributable solely to the regulatory model.

The content of the Code of Conduct has yet to be developed, but it is anticipated that it will be based on the NSW model. Table 22 below provides a summary assessment of the possible compliance costs associated with Option 3 – a single national statutory Code of Conduct with powers to issue prohibition orders for breach of the Code.

Table 22: Business Compliance Cost Checklist for Option 3 – a National Code of Conduct*

Type of cost	Costs incurred	Comments
Notification costs (associated with requirements to report certain events)	Minimal	Minimal costs since no routine reporting required by practitioners, only exception reporting – when one practitioner identifies another has having breached the Code of Conduct.
Education costs (associated with keeping abreast of regulatory requirements)	Yes	Costs associated with obtaining details of the Code of Conduct and legal obligations, and communicating these to staff.
Permission costs (associated with seeking permission to conduct an activity)	No	
Purchase costs (associated with purchase of materials or equipment)	No	
Record keeping costs (associated with meeting requirements to keep records up to date)	No	No additional costs to those already required to operate a business and meet other regulatory obligations.
Enforcement costs (associated with cooperating with audits and inspections)	Minimal	Only for those practitioners who are the subject of a complaint for alleged breach of the Code of Conduct
Publication and documentation costs (associated with producing documents for third parties or displaying signs)	Minimal	Minimal costs, associated with obligation to display Code of Conduct and information about how clients may make a complaint.
Procedural costs (non-administrative costs for example, conducting fire drills)	No	
Other	Minimal additional costs	Depending on the content of and obligations imposed under the Code of Conduct, some practitioners may incur costs that they might otherwise have chosen to avoid, such as the cost of: • obtaining suitable qualifications in their field of practice • maintaining competency in their field of practice • ensuring a sound understanding of adverse interactions associated with their practice • ensuring appropriate first aid is available to deal with any misadventure during a client consultation • complying with privacy, infection control and record keeping laws • holding appropriate professional indemnity insurance.

* Assumption that content of Code of Conduct is based on content of *NSW Code of Conduct for Unregistered Health Practitioners*

5.6 Competition effects

This section estimates the impacts on competition in the health services industry that are expected to arise from implementing Option 3.

The number of health practitioners available to provide services will be affected by the number of orders issued that prevent health practitioners from practising or limit the range of services they are able to provide. The availability of prohibition order powers also may have a deterrent effect, discouraging some practitioners from providing health services. However, as Option 3 does not impose minimum practice standards or other hurdle requirements such as probity checks, it does not impose any restrictions on new practitioners who wish to enter the market. This contrasts with the strong workforce implications of Option 4, which would impose strict barriers to entry. The overall effect of Option 4 would be to significantly reduce competition, whereas Option 3 maintains the current open marketplace for unregistered health services.

Option 3 may even result in an increase in competition between unregistered and registered health practitioners, by increasing consumer confidence in the unregistered health professions. For example, a

consumer who would normally choose to see a psychologist may choose to see an unregistered counsellor, if he or she knows that the counsellor is bound by a statutory Code of Conduct. Changing patterns of consumer behaviour and increased market confidence may also result in an increase in the range of unregistered health services covered by private health insurers.

NSW HCCC issued 17 prohibition orders over the last three financial years or around 6 orders per year. This translates to around 19 per year Australia-wide based on demographic data (ABS 2011b). As a proportion of the estimated total population of unregistered health practitioners of 206,650 (Table 8), this reduction in the number of available health practitioners is negligible. Also, prohibition orders would be expected to apply only to those practitioners whose practice presents a serious risk to public health and safety. Practitioners have the option of challenging a prohibition order. The NSW Health Complaints Commissioner has advised that to date no appeals have been made in relation to prohibition orders issued in NSW.

As Option 3 is not expected to impact in any way on the membership fees paid by health practitioners to professional associations, it would have no impact on their costs and therefore prices charged to health consumers.

In conclusion, it is considered that Option 3 will not restrict competition in the health industry, or limit access to novel treatments that are yet to establish an evidence base. This is because prohibition orders would be issued in response to an assessment of harm associated with the incompetent or unethical behaviour of unregistered health practitioners. Based on the available information, the impact on the number and range of practitioners is assessed to be minimal.

6. Conclusions and recommendations

There are risks associated with any form of health care. The harm associated with the provision of health services by unregistered health practitioners is difficult to quantify 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. However, preventable deaths and serious injury associated with poor practice have been documented. This suggests that further action is required by governments.

This RIS has investigated a number of options to better protect health service consumers from harm arising from services delivered by unregistered health practitioners.

Table 20 summarises the key impacts of each of the options considered in this RIS. As discussed in the analysis of the impacts in Chapter 5 , all options have the potential to reduce the harm to consumers compared with Option 1, the base case.

Option 3, a single national Code of Conduct made by regulation, with enforcement powers for breach of the Code is considered likely to deliver the greatest net public benefit to the community. It is more effective in reducing harm than Options 1 or 2, and compared with all options, it can be implemented at the lowest cost to the health care sector, government and consumers.

In summary, the key benefits of Option 3 over the other options considered are:

- it captures all practitioners whether or not they choose to be members of self-regulating professional associations
- it sets common minimum standards of practice regardless of the profession or occupation or the nature of the practice
- it targets enforcement action to those practitioners who avoid their ethical responsibilities or who engage in predatory or exploitative behaviour towards their clients, and
- it presents a relatively cost effective method of addressing the most harmful conduct and, over time, is expected to lead to an overall improvement in standards, and a better educated and informed public.

While all instances of harm to health service consumers cannot be prevented, Option 3 is expected to reduce the incidence of harm associated with health services provided by unregistered health practitioners. It is also the option that was most strongly supported by the majority of respondents to the national consultation.

While Option 3 does not set minimum qualifications and probity requirements for entry to practice as a health practitioner, and regulatory action is generally triggered only on a complaint, it provides a targeted mechanism for dealing with practitioners who are found to have breached the Code.

On balance, Option 3 is the recommended option because it is the least cost option while effective in achieving the objective of protecting the public and reducing harm.

Harm associated with the current practice of unregistered health practitioners is estimated to result in around 40 incidents of serious harm per year across Australia. While there are costs associated with implementing Option 3, the estimated reduction in harm is expected to be in excess of the estimated costs to the community as a whole.

7. Implementation

Two alternative models for implementing a national negative licensing scheme (Option 3) are available:

- State and Territory administered schemes
- A single nationally administered scheme

State and Territory administered

Under this option, the powers of existing State and Territory bodies would be extended to empower investigation of breaches of the national code of conduct and to allow prohibition orders to be issued for breach of the code (where these powers do not currently exist). It would be up to each State and Territory Government to determine the body empowered to investigate breaches of the national code. Each jurisdiction would also determine whether prohibition orders are to be issued by the same body that investigates breaches (as in NSW and South Australia), or an independent tribunal as for registered health practitioners.

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 enforcement action.

To achieve national consistency across jurisdictions in the implementation of Option 3, an intergovernmental agreement could set out the policy parameters and the arrangements for agreeing the terms of the first National Code of Conduct, and any changes required from time to time.

Nationally administered

Under this option, the regulation of unregistered health practitioners under a statutory code of conduct would be administered by a national body. This body could be a new or existing entity, with the investigation of breaches of the National Code of Conduct carried out by staff located in State and Territory offices.

The body 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 and refer to HCEs where appropriate
- issue prohibition orders directly, or bring prosecutions for serious breaches forward to the responsible State or Territory Tribunal for hearing.

The difference in cost between these two approaches is small and unlikely to alter in any substantial way the overall net public benefit.

If National administration is preferred, then implementation would be through amendments approved by State, Territory and Commonwealth Health Ministers (sitting as the Australian Health Workforce Ministerial Council) to the *Health Practitioner Regulation National Law Act 2009* (Qld) and enacted by Queensland, with Western Australia passing complementary legislation. If State/Territory administration is preferred, then implementation could be achieved through any one of three mechanisms:

- **Adoption of laws** – As for national administration, Health Ministers, sitting as the Australian Health Workforce Ministerial Council under the *Health Practitioner Regulation National Law Act 2009*, would agree to amendments to the National Law to give effect to a negative licensing scheme, with Western Australia passing a corresponding law to give effect to the scheme in that state. The body responsible for administering the scheme in a jurisdiction would be determined by the jurisdiction and named in

either the amendments to the National Law, or in each jurisdiction's adoption law. Prohibition orders would automatically apply nationally, thus provisions to achieve mutual recognition of prohibition orders would not be required.

- **Template or mirror legislation** – A nationally consistent State and Territory-based negative licensing scheme, implemented through complementary legislation that is agreed by the Health Ministers, and enacted and administered in each jurisdiction, with provision for the following elements:
  - A single national Code of Conduct
  - Agreed scope of the scheme, statutory definitions, and grounds for issuing prohibition orders
  - A national register of prohibition orders, or separate State and Territory registers and arrangements for sharing of information between States and Territories
  - National application of prohibition orders.
- **Agreed policy** – A nationally consistent State and Territory-based negative licensing scheme, implemented in accordance with policy parameters agreed by Health Ministers that include provision for:
  - A single national Code of Conduct
  - A national register of prohibition orders, or separate State and Territory registers and arrangements for sharing of information between States and Territories
  - Mutual recognition of prohibition orders

An adoption of laws model is likely to be the most efficient legislative mechanism for achieving and maintaining either a single national scheme, or nationally consistent state based schemes. Whatever approach is adopted, agreement should be reached by jurisdictions on:

- the content of a National Code and how it is to be amended from time to time
- the scope of the scheme and who is to be subject to the Code
- common definitions applied under the scheme, such as the definition of a health service
- the grounds for issuing a prohibition order, such as serious risk of harm, and a fit and proper person test
- the nature of orders available, including interim orders
- the mechanism or mechanisms through which prohibition orders are issued, either directly by a Commissioner or by a tribunal following a hearing
- the arrangements for:
  - information exchange between jurisdictions, including during investigations, if separate state based Commissioners
  - national application and publication of prohibition orders
  - reporting of data on complaints received and investigated, and prohibition orders issued and any breaches prosecuted
  - funding of the scheme
- how the scheme is to be monitored and reviewed and changes made over time. In particular, reporting of complaints, investigations, prohibition orders issued and breaches of prohibition orders would provide useful data which could be used to review the overall effectiveness of the scheme.

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Appendices

Appendix 1

List of risky and invasive activities by health profession or occupation

× indicates that the practitioner's scope of practice typically includes the activity

	1. Putting an instrument, hand or finger into a body cavity[18]	2. Manipulation of the spine[19]	3. Application of a hazardous form of energy[20] or radiation	4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth	5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs	6. Administer-ing a scheduled drug or substance by injection	7. Supplying substances for ingestion	8. Managing labour or delivering a baby	9. Undertaking psycho-logical 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. Primary care practitioners who see patients with or without a referral from a registered practitioner	12. Treatment commonly occurs without others present[21]	13. Patients commonly required to disrobe
Registered Health Practitioners													
Aboriginal and Torres Strait Islander Health Practitioner[22]	×			×	×	×	×			×	×	×	×
Chinese Medicine Practitioner[23]	×	×		×	×	×	×	×			×	×	×
Chiropractor		×									×	×	×
Dental care[24]	×		×	×	×	×					×		
Medical Radiation Practitioner[25]			×	×		×					×	×	×
Medicine	×	×	×	×	×	×	×	×	×	×	×	×	×
Nurse and midwife	×		×	×	×	×	×		×		×	×	×

18 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.

19 Moving the joints of the cervical spine beyond the individual's usual physiological range of motion using a high velocity, low amplitude thrust

20 Electricity for aversive conditioning, cardiac pacemaker therapy, cardioverson, defibrillation, electrocoagulation, electroconvulsive shock therapy, electromyography, 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.

21 Includes practitioners who practice solo or treat with no others present, such as medical specialists and practitioners who may be solely responsible for clinical care overnight or in a remote community

22 Registration to commence 1 July 2012

23 Includes acupuncturist, Chjnese herbal medicine practitioner, Chinese herbal dispenser). Registration to commence 1 July 2012.

24 Includes dentists, dental prosthetists, dental therapists

25 Includes diagnostic radiographers, radiation therapists, nuclear medicine scientists/technologists

	1. Putting an instrument, hand or finger into a body cavity[18]	2. Manipulation of the spine[19]	3. Application of a hazardous form of energy[20] or radiation	4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth	5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs	6. Administer-ing a scheduled drug or substance by injection	7. Supplying substances for ingestion	8. Managing labour or delivering a baby	9. Undertaking psycho-logical 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. Primary care practitioners who see patients with or without a referral from a registered practitioner	12. Treatment commonly occurs without others present[21]	13. Patients commonly required to disrobe
Occupational therapist			×								×	×	×
Optometrist					×						×	×	
Osteopath		×									×	×	×
Pharmacist					×		×				×		
Physiotherapist	×	×	×								×	×	×
Podiatrists				×	×	×					×	×	
Psychologist									×		×	×	
Unregistered Health Practitioners													
Ambulance Officer/Paramedic	×		×	×		×		×			×		×
Anaesthetic Technician						×							
Anatomist or Physiologist												×	
Art Therapists									×		×	×	
Audiologist	×										×	×	
Audiometrist	×										×	×	
Biomedical Engineer												×	
Cardiac Technician						×							×
Counsellors									×		×	×	
Dance Therapist											×		
Dental Assistant	×												
Dental Hygienist	×											×	
Dialysis Technician				×		×							

	1. Putting an instrument, hand or finger into a body cavity[18]	2. Manipulation of the spine[19]	3. Application of a hazardous form of energy[20] or radiation	4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth	5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs	6. Administer-ing a scheduled drug or substance by injection	7. Supplying substances for ingestion	8. Managing labour or delivering a baby	9. Undertaking psycho-logical 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. Primary care practitioners who see patients with or without a referral from a registered practitioner	12. Treatment commonly occurs without others present[21]	13. Patients commonly required to disrobe
Dietitian											×	×	
Diversional Therapist													
Drama Therapist											×		
Drug and Alcohol Counsellor									×		×	×	
Electroencephalographic Technician													×
Environmental Health Officer													
Family and Marriage Counsellor									×		×		
Fitness Instructor											×	×	
Health Information Manager													
Health Practice Manager													
Health Promotion Officer													
Homœopath						×	×				×	×	
Hospital Orderly													
Hypnotherapist									×		×	×	
Medical Laboratory Scientist													
Medical Laboratory Technician													
Massage Therapist											×	×	×
Music Therapist											×	×	

	1. Putting an instrument, hand or finger into a body cavity[18]	2. Manipulation of the spine[19]	3. Application of a hazardous form of energy[20] or radiation	4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth	5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs	6. Administer-ing a scheduled drug or substance by injection	7. Supplying substances for ingestion	8. Managing labour or delivering a baby	9. Undertaking psycho-logical 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. Primary care practitioners who see patients with or without a referral from a registered practitioner	12. Treatment commonly occurs without others present[21]	13. Patients commonly required to disrobe
Naturopath						×	×				×	×	
Neurophysiology Technician												×	
Occupational Health and Safety Adviser													
Operating Theatre Technician													
Optical Dispenser											×		
Optical Mechanic													
Orthoptist											×	×	
Orthotic and Prosthetic Technician													
Orthotist or Prosthetist											×	×	
Perfusionist						×							×
Pharmacy Sales Assistant							×						
Pharmacy Technician													
Phlebotomist				×								×	
Psychotherapist									×		×	×	
Rehabilitation Counsellor												×	
Renal Technician													
Sleep Technician											×		
Sonographer													

	1. Putting an instrument, hand or finger into a body cavity[18]	2. Manipulation of the spine[19]	3. Application of a hazardous form of energy[20] or radiation	4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth	5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs	6. Administer-ing a scheduled drug or substance by injection	7. Supplying substances for ingestion	8. Managing labour or delivering a baby	9. Undertaking psycho-logical 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. Primary care practitioners who see patients with or without a referral from a registered practitioner	12. Treatment commonly occurs without others present[21]	13. Patients commonly required to disrobe
Speech Pathologist	×		×								×	×	
Sterilisation Technician													
Therapy Aide													
Weight Loss Consultant											×	×	

Appendix 2

Definitions of 'health service' contained in 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 2009 – 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 2009 – 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

State and Territory health complaints entities – summary of powers and functions

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; • Collecting information about operation of the Human Rights	**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 profession board and the commission cannot agree about

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
					Commission Act and related Acts, and publishing the information.	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 of action under the National Law (such as the referral of the health practitioner for performance	*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
				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 • any other person, or any body, that, in	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; That a provider or manager acted unreasonably in respect of a complaint made by a user about the	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 procedures; and • to detect and review trends in the delivery of health services 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
		the opinion of the Commissioner, should be able to make a particular complaint in the public interest	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.		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 services. Conduct inquiries if in the public interest or as directed by the Minister.	**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 services; and comply with any Commission standard.	For health quality complaints: • respond to health quality complaints, including by conducting investigations and inquiries; • recommend ways of improving health services; • identify and review issues arising from health complaints.		

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
				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 treatment, prognosis, further advice and education etc.	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 reports to registration authorities and to work with registration authorities to	**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
			• 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.		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 Commissioner, should be able	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 treatment, prognosis, further advice and education etc.	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 report to the Minister and the Health Minister on any matter relating to health services or the administration	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
		to make a particular complaint in the public interest	• 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.		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 the users 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

* Current arrangements. Although SA has enacted a negative licensing scheme similar to NSW which commenced operation in March 2013.

Appendix 6

Profile of selected professional associations for unregistered health professions

6.1 Professional associations with membership greater than 4,000 – information from websites

	Australian Association of Social Workers (AASW)	Australian Traditional Medicine Society (ATMS)	Australian Natural Therapists Association (ANTA)	Dietitians Association of Australia (DAA)	National Herbalists Association Australia (NHAA)	Speech Pathology Australia (SPA)
1. How many members?	6000 nationwide 10 branches	11,200	5900	> 4500	Not stated on web-site.	Not stated on web-site.
2. What are the membership fees?	$620 ($580 early bird option)	Accredited member $214.50 Associate member $110 Student member $77	$165.00 pa	$553.64 (for more than 20 hours full time per week)	Full member $250 Full ATSI member $65 Companion member /Herb Grower $160 Student member $65 Corporate member $3,000	Practising $467.50 Non-practising $324.50 F/T Post-grad student $242.50 Re-entry $324.50 Student $96.80 Alumnus $110.00
3. Is constitution or articles of association accessible on the website?	Yes	Yes	Yes	Yes	No	No
4. What is the stated purpose of the organisation?	To promote the profession of social work by enhancing the public and professional recognition and identity of social work through the establishment , monitoring and improvement of practice and ethical standards.	To promote and represent professional practitioners of natural medicine who are encouraged to pursue the highest ideals of professionalism in their natural medicine practice and education.	Promotes the health and safety of consumers of traditional medicine and natural therapy health services and possesses the infrastructure, systems, policies and procedures which enables the association to encompass all aspects of the profession.	DAA is the peak body of dietetic and nutrition professionals providing strategic leadership in food and nutrition through empowerment, advocacy, education, accreditation and communication.	To service and support our membership and promote and protect the profession and practice of herbal medicine.	National peak body for the speech pathology profession in Australia striving for excellence and recognition for the profession and representing the interests of members and their clients with communication and swallowing difficulties.

	Australian Association of Social Workers (AASW)	Australian Traditional Medicine Society (ATMS)	Australian Natural Therapists Association (ANTA)	Dietitians Association of Australia (DAA)	National Herbalists Association Australia (NHAA)	Speech Pathology Australia (SPA)
5. What is the make up of the board? Are there any non-practitioner members?	No National Board of President, 2 Vice Presidents and 6 directors. Also has branch management Committees at State and territory levels and specific committees, and practice and working groups.	No 18 directors including a President, 2 Vice Presidents and Treasurer. Also a number of honorary positions including State & Territory and Head of Department representatives.	Information is not on the website – Annual Report not on Website.	No National Board of president, vice-president and 7 directors. Also has branch committees. No non-practitioner members.	Not stated on webpage but directors can be found in Annual report. Webpage provides link to ARONAH (national register) which does detail board makeup and it has 3 non-practitioner members.	No President, 2 Vice presidents and 6 councillors.
6. Is the complaints process documented and accessible on the website? Is it clear how to make a complaint?	Yes Yes	Yes Yes	Yes Yes	Yes Yes	No – complaints to be handled by ARONAH but not yet fully operational.	Yes. Provides email to national office or Senior Advisor Professional Issues who will ring back.
7. Is there a searchable list of members on the website?	Yes	Yes	Yes	Yes	Yes	Yes
8. Are there any continuing professional development (CPD) requirements for members?	Yes	Yes	Yes	Yes – Accredited Practising Dietitians Program (ADP)	Yes	Yes for those wanting to be Certified Practising Speech Pathologists. Not required for other categories.
9. Are members required to hold professional indemnity insurance (PII)?	Yes – part of membership fee	PII required for members with health funds provider status. Applications for PII sent after membership accepted.	Yes – part of membership fee	Yes – part of membership fee	Yes min. of $2m for full practitioner members.	Appears to be not compulsory, however there is a preferred insurer with reduced rates for members and a range of covers depending on practice requirements.
11. Are there any practice guidelines on the website?	Yes – Code of Ethics, National Bulletin, Journal, CPD Program/Event	Code of conduct on website and professional conduct listed within membership application form.	Yes – ANTA's Scope and Standards of Practice	DAA Endorsed Practice Guidelines and Recommendations; National Competency Standards; Journal	Yes but member access only.	Yes but can only be accessed by members. Some flyers for the public.
12. Are annual reports published on the website, and if so, is complaints data published?	Yes but only through the members login	Listed on website but link not operating. Membership form states that complaints data is part of annual report.	Unable to find Annual Report on Website	Yes through their media section	Yes but these are annual financial reports. No complaints data.	No

	Australian Association of Social Workers (AASW)	Australian Traditional Medicine Society (ATMS)	Australian Natural Therapists Association (ANTA)	Dietitians Association of Australia (DAA)	National Herbalists Association Australia (NHAA)	Speech Pathology Australia (SPA)
13. Are there any paid staff? If so, how many?	Yes – 31 across 10 branches and national offices	Yes, 9 fulltime and 2 part-time.	Yes 6–8 (estimate)	Yes – at least 10	Not stated on web-site.	Yes. 6 F/T, 6 P/T and I external

6.2 Professional associations with membership less than 4,000 – information from websites

	Organisation					
	Australian Sonographers Association	Reiki Australia	Australian & New Zealand College of Perfusionists	Association of Massage Therapists	Reflexology Association of Australia	Australian Orthotic Prosthetic Association
1. How many members?	3000	Unknown	Unknown	1500	Unknown	300
2. What are the membership fees?	Membership without insurance: $385	Lay member – $60 Practitioner member – $115 Master – $115 Combined Master/Practitioner – $170 Reiki friend – $60	Fellow – $305 Clinical trainee – $225 Sustaining member – $255 Overseas member – $235 Corporate member – $450	General member – $165 Senior level 1 – $210 Senior level 2 – $240 Student – $50	General member – $240 Student – free	General member – $478.50 Student member – $110
3. Is constitution or articles of association accessible on the website?	Yes	No	Yes – in 'members only' section	Yes	No	Yes
4. What is the stated purpose of the organisation?	• To exclusively consider the issues confronting and challenging sonographers in the modern environment • To pursue high standards within the practice of medical sonography	To be a trusted resource for the personal, professional and community expression of Reiki, embracing students, masters, teachers and treatment practitioners.	• To provide a means of communication between clinical perfusionists • To provide a regulatory body to uphold the standards of perfusion • To obtain official recognition and acceptance as qualified practising clinical perfusionists	• Massage Therapy is recognised as a distinct profession • The Australian public recognises the benefits of Massage Therapy and has the information, knowledge and resources to choose a professional therapist • The Australian government recognises Massage Therapy as a legitimate health service	• To develop and promote an awareness and understanding of reflexology within the Australian community • To represent the interests of the reflexology profession within the public and political arena • To establish and maintain uniformity and high standards of training within Australia	AOPA aims to promote the training, education and professional status of orthotists and prosthetists throughout Australia.

	Organisation					
	Australian Sonographers Association	**Reiki Australia**	**Australian & New Zealand College of Perfusionists**	**Association of Massage Therapists**	**Reflexology Association of Australia**	**Australian Orthotic Prosthetic Association**
				• Practitioners of Massage Therapy are adequately skilled and well-educated • Practitioners of Massage Therapy are supported in clinical practice • The practice of Massage Therapy in Australia is supported by a sustainable model for governance and regulation.	• To maintain a high level of professional practice • To serve and protect the needs of all members within the national structure • To act as a central information and resource body for all members • To act as an advisory body within the jurisdiction of the national body • To promote co-operation with international reflexology bodies • To establish and maintain relevant national databases of practitioners • To provide ongoing professional development for members and a supportive network for reflexologists • To promote research and development which support reflexology	
5. What is the make up of the board? Are there any non-practitioner members?	Unclear	A five member board of directors.	A five member board	A Board of Directors and a number of committees: • Discipline • Finance • Education and Research • Ethics • Strategic Planning	Has a Board of Directors, and has branch committees in each State. All positions are honorary.	12 members: one from each Section, being the President or Vice President of each Section, plus the President, 2 Vice Presidents, Secretary, Treasurer, and Registrar.

	Organisation					
	Australian Sonographers Association	**Reiki Australia**	**Australian & New Zealand College of Perfusionists**	**Association of Massage Therapists**	**Reflexology Association of Australia**	**Australian Orthotic Prosthetic Association**
6. Is the complaints process documented/accessible on the website? Is it clear how to make a complaint?	Yes, very clear. Includes an online complaints form.	Yes – clear and easily accessible	Yes – referred to in the Regulations pdf. There is also a 'Perfusion Incident Reporting System' for incidents and accidents.	Yes. Easily accessible and includes a downloadable complaints policy	No	Yes, although it's quite difficult to find on the website. The complaints procedure forms part of the 'Rules and Statement of Purpose' document, which is in itself quite hard to find.
7. Is there a searchable list of members on the website?	No	Yes	No	Yes	No	No
8. Are there any continuing professional development (CPD) requirements for members?	Yes	Yes	Yes	Yes	No	Yes
9. Are members required to hold professional indemnity insurance (PII)?	No but strongly recommended. Can be included in membership, varying fees apply depending on type of employment (eg. self-employed).	Yes. Reiki Australia is accredited with OAMPS Insurance Brokers Ltd and insurance information is provided on the website	No	Strongly recommended but not required. Insurance information provided.	No	No, although AOPA has a partnership with Guild Insurance Ltd to provide (voluntary) insurance to AOPA members.
11. Are there any practice guidelines on the website?	Yes – code of professional conduct	Yes – code of ethics and code of professional conduct for practitioners	Yes –code of ethics and code of practice, which are also contained in the Regulations PDF.	Yes – brief Code of Ethics available on website.	Code of Ethics easily accessible	Yes – contained in the 'AOPA guidelines' and 'Competency Standards'.
12. Are annual reports published on the website, and if so, is complaints data published?	Yes. No complaints data published.	No	No	Yes. No complaints data published.	No	No
13. Are there any paid staff? If so, how many?	Unknown	Unknown	Unknown	Company secretary remunerated on a part-time basis	Unknown	Unknown

Appendix 7

State and Territory workers compensation schemes – arrangements for provider recognition

Jurisdiction	Authority	Legislation	Rehabilitation providers
C'wealth	Heads of Workers' Compensation Authorities (HWCA) www.hwca.org.au www.worksafe.com.au	National Harmonisation of OHS Laws, to be called Work Health and Safety (WHS) Act, due to come into effect on 1 January 2012	In June 2008, the HWCA endorsed the introduction of a Nationally Consistent Approval Framework for Workplace Rehabilitation Providers. The new Framework took effect in all Australian jurisdictions (except Queensland) from 1 July 2010. Organisations seeking to be an approved workplace rehabilitation provider must submit an application to the jurisdiction in which approval is sought demonstrating how they will meet the Conditions of Approval. Applicants also need to refer to the relevant Work Health and Safety authority in their jurisdiction for information about specific jurisdictional application requirements.
ACT	WorkSafe ACT www.worksafety.act.gov.au	*Work Safety Act 2008*	ACT has adopted the Nationally Consistent Approval Framework for Workplace Rehabilitation Providers. It will recognise, by mutual recognition, rehabilitation providers recognised in other jurisdictions (subject to an application by the provider). An approved workplace rehabilitation provider is an independent party who is authorized to liaise and negotiate with everyone involved in the worker's rehabilitation. The primary focus of the injury management process is the involvement of all 3 key parties (the employer, injured worker and nominated treating doctor). It is unclear which health professionals, other than medical practitioners, are covered by insurance to provide treatment to injured workers in the ACT.
NT	NT WorkSafe www.worksafe.nt.gov.au	*Workplace Health and Safety Act* Workplace Health and Safety Regulations	NT has adopted the Nationally Consistent Approval Framework for Workplace Rehabilitation Providers. The Work Health Authority, via its administration arm NT WorkSafe, administers and enforces the *Workers Rehabilitation and Compensation Act* which establishes the Northern Territory compensation scheme. Under section 50 of the *Workers Rehabilitation and Compensation Act*, the power to approve a person or persons as an accredited vocational rehabilitation provider rests with the Work Health Authority. The Work Health Authority may revoke such an approval. Only vocational providers require accreditation with NT WorkSafe. Treatment providers that are medical practitioners or allied health professionals who are covered by the *Medical Act*, *Dental Act*, *Health and Allied Pensions Registration Act*, who consult or provide treatment covered under that Act, do not require approval under the *Workers Rehabilitation and Compensation Act*.
Queensland	Q-Comp www.qcomp.com.au	*Workers' Compensation and Rehabilitation Act 2003*	All health professions which are registered in Queensland (including speech pathologists and occupational therapists) are qualified to deliver return-to-work and vocational rehabilitation services. Other 'non-registered' professional groups are also able to provide specific rehabilitation services. These 'non-registered approved providers' require insurer approval and are outlined below: **Exercise Physiologists** All exercise physiology services performed must be provided by a person with at least a tertiary degree in Human

Jurisdiction	Authority	Legislation	Rehabilitation providers
			Movement studies, Exercise Science or equivalent. An accredited exercise physiologist (AEP) with Exercise & Sports Science Australia (ESSA) is the preferred provider. If the practitioner is not an AEP, they must be eligible for accreditation as an AEP by ESSA. For services provided to workers outside Queensland, the treating exercise physiologist must be eligible for accreditation as an AEP by ESSA. **Rehabilitation counsellor** A person with a tertiary qualification in an accredited rehabilitation counselling course or other recognised counselling course and preferably a member of the Australian Society of Rehabilitation Counsellors – ASORC. Due to the diversity of backgrounds of rehabilitation counsellors, the qualifications and experience must be acceptable to the insurer for type of service being offered. **Social worker** A person with a tertiary degree in social work. **Diversional therapist** A person with a minimum of an Associate Diploma in Diversional Therapy. **Dietician** A person with a tertiary degree in dietetics.
Victoria	Worksafe Victoria www.worksafe.vic.gov.au	*Accident Compensation (Occupational Health and Safety) Act 1996* *Accident Compensation (WorkCover Insurance) Act 1993* Accident Compensation Regulations 2001	A provider of reasonable medical to a WorkSafe claimants must satisfy the relevant qualification requirements in the appropriate discipline as follows: **BOARD REGISTERED PROVIDERS** **Medical, Physiotherapy, Dental, Podiatry, Chiropractic, Osteopathy, Nursing, Optometry and Psychology:** Current copy of board registration **Acupuncture** Current copy of board registration AND Current copy of Professional Indemnity Insurance **NON BOARD REGISTERED PROVIDERS** **Dietary Analysis** Accredited Practising Dietician AND Current copy of Professional Indemnity Insurance **Remedial Massage** *Current registration as well as written confirmation from one of the associations listed below that qualifications entitle practitioner to full membership of either:* • Australian Assn. of Massage Therapists Ltd. (AAMT) • Association of Massage Therapists (NSW) Ltd. • Confederation of Massage & Myotherapists Australia (CMMA) • Australian Natural Therapists Association Ltd. (ANTA) • Australian Traditional Medicine Society Ltd.

Jurisdiction	Authority	Legislation	Rehabilitation providers
			• Institute of Registered Myotherapists (IRMA) AND Current copy of Professional Indemnity Insurance **Naturopathy** *Written confirmation from one of the associations listed below that qualifications entitle practitioner to full membership of either:* • Australian Natural Therapists Association (Naturopath) • Australian Natural Practitioners Association Inc or • Complementary Medicine Association AND Current copy of Professional Indemnity Insurance **Loss and Grief Counselling** *Written confirmation of eligibility to be an accredited counsellor with:* National Association of Loss and Grief (Victoria) AND Current copy of Professional Indemnity Insurance **Occupational Therapy** *Copy of proof of eligibility for full membership of:* OT Australia (Victoria) or Copy of Tertiary qualifications AND Current copy of Professional Indemnity Insurance **Social Worker** *Copy of proof of eligibility for full membership of:* Australian Association of Social Workers or Copy of Tertiary qualifications AND Current copy of Professional Indemnity Insurance **Speech Pathology** *Copy of proof of eligibility for full membership of:* Australian Association of Speech and Hearing or Copy of Tertiary qualifications AND Current copy of Professional Indemnity Insurance **Exercise Physiology** *Written confirmation from one of the associations listed below that qualifications entitle practitioner to full membership with:* Exercise and Sports Science Australia

Jurisdiction	Authority	Legislation	Rehabilitation providers
			AND Current copy of Professional Indemnity Insurance
South Australia	WorkCover Corporation of SA www.workcover.com	*Workers Rehabilitation and Compensation Act 1986* Workers Rehabilitation and Compensation Regulations 2010	A medical expert is defined under the *Workers Rehabilitation and Compensation Act 1986* as a provider who is registered with the relevant registration board in South Australia or in any other relevant jurisdiction if the services are delivered outside of SA, in one of the following disciplines: • medical practice (including general practice, specialist, physician and psychiatry) • dentistry • psychology • optical • osteopathy • physiotherapy • chiropractic • podiatry • occupational therapy • Speech pathology. Acupuncture treatment can only be provided by a legally qualified medical practitioner or other medical experts such as physiotherapists, chiropractors and occupational therapists. WorkCover recognises the following services delivered by non-medical expert providers: • physical rehabilitation (gymnasium) services • remedial massage services. To provide these services, physical rehabilitation providers and remedial massage providers must be registered with WorkCover. To become a registered physical rehabilitation (gymnasium) provider or registered remedial massage provider, a minimum set of qualification standards must be met.
NSW	WorkCover NSW www.workcover.nsw.gov.au	*Work Health and Safety Act 2011* *Workers Compensation Act 1987* *Workplace Injury Management and Workers Compensation Act 1998*	All allied health providers must follow administrative procedures developed by WorkCover in conjunction with the relevant professional association. **Osteopaths** Registered osteopaths can be approved by WorkCover, by completing an application form and the required WorkCover Training Program. **Chiropractors** Registered chiropractors can be approved by WorkCover after completing an application form and the required WorkCover Training Program. **Exercise physiologists** Exercise physiologists must be approved by WorkCover to deliver treatment services to injured NSW workers. All exercise physiologists providing treatment to injured workers must follow the procedures developed in conjunction with Exercise and Sports Science Australia.

Jurisdiction	Authority	Legislation	Rehabilitation providers
			Hearing service providers Any contracted hearing service provider with the Office of Hearing Services is eligible to apply for WorkCover approval as a hearing service provider. **Physiotherapists** Registered physiotherapists can be approved by WorkCover by completing the Physiotherapists application for WorkCover approval and the required WorkCover Training Program. All physiotherapists providing treatment to injured workers must follow administrative procedures developed in conjunction with the Australian Physiotherapy Association. **Psychologists and counsellors** Psychologists and counsellors must be approved by WorkCover to deliver treatment services to injured NSW workers. To retain their approval number, all WorkCover-approved psychologists and counsellors must attend training prescribed by WorkCover within six months of receiving their provider number. The Australian Psychological Society (APS) provides this training on behalf of WorkCover. **Remedial massage therapists** WorkCover has suspended processing of all remedial massage therapist applications for WorkCover approval until further notice. Only those remedial massage therapists who currently have WorkCover approval are eligible for payment for remedial massage therapy services provided to injured workers.
Tasmania	WorkCover Tasmania www.workcover.tas.gov.au	*Workers Rehabilitation and Compensation Act 1988* *Workplace Health and Safety Act 1995* Workplace Health and Safety Regulations	Tasmania has adopted the Nationally Consistent Approval Framework for Workplace Rehabilitation Providers. It will recognise, by mutual recognition, rehabilitation providers recognised in other jurisdictions (subject to an application by the provider). Rehabilitation is manage by: • Medical providers • Workplace rehabilitation providers • Injury management co-ordinators Workplace rehabilitation providers are organisations accredited to deliver workplace rehabilitation services to help injured workers return to work. They have the qualifications, experience and expertise appropriate to provide timely intervention, with services based on the assessed need of the worker and the workplace. Injury management co-ordinators ensure the injury management process runs smoothly. They co-ordinate and oversee the entire process, including medical treatment, return to work, and all aspects of return to work plans and injury management plans. It is unclear which health professionals, other than medical practitioners, are covered by insurance to provide treatment to injured workers in Tasmania.
Western Australia	WorkCover WA www.workcover.wa.gov.au	*Workers Compensation and Injury Management Act 1981*	Allied health providers include: • Chiropractors • Clinical Psychologists • Counselling Psychologists • Exercise Physiologists • Occupational Therapists

Jurisdiction	Authority	Legislation	Rehabilitation providers
			• Osteopaths • Physiotherapists • Speech Pathologists • Workplace Rehabilitation Providers These groups are recognised by WorkCover WA and contribute towards the agency's common goal of ensuring that an injured worker can return to, or remain at, work following an injury. **Other professions** Other professions not listed above who would to be recognised as an approved treatment provider within the Western Australian workers' compensation system must submit an application to the WorkCover WA Board with a statement addressing the following criteria: • demonstration that a governing body or an association exists with licensing ability • regulatory powers and an accepted code of ethics, plus dispute resolution and complaints handling procedures • demonstration that as a minimum, the proposed treatment providers professional qualification at degree level of at least three years undergraduate study; and • explanation of where the proposed treatment providers would fit within the workers' compensation system, and importantly, what unique skills and services they add which are not already covered by existing treatments. It is a legislative requirement that applications for approval as a treatment provider be approved by the Hon Minister for Commerce on recommendation of WorkCover WA.

Appendix 8

State and Territory motor accident compensation schemes – arrangements for provider recognition

Jurisdiction	Authority	Legislation	Rehabilitation providers
ACT	NRMA Insurance Ltd www.nrma.com.au/insurance	*Road Transport (Third Party Insurance) Act 2008*	No information is available on who is approved to provide rehabilitation services.
Northern Territory	NT Government Motor Accidents Compensation Scheme www.tiofi.com.au	*Motor Accidents (Compensation) Act 2007*	Injuries sustained in the Northern Territory is supported by a Scheme, The Motor Accidents Compensation Act (MACA). The Territory Insurance Office (TIO) is in charge of the MACA scheme on behalf of the Territory Government. Lodging a claim for injuries sustained in the Northern Territory, the MACA Scheme may provide compensation benefits for: • medical and rehabilitation costs; • loss of economic expenses; • personal care • Lump sum compensation payout for individuals who may suffer some sort of permanent disability. No other information is available on health service providers.
Queensland	Motor Accident Insurance Commission www.maic.qld.gov.au	*Motor Accident Insurance Act 1994*	Rehabilitation may include one or more of the following services: • Physiotherapy including in rooms treatment, hydrotherapy, gym strengthening programs and home programs • Chiropractic • Psychological including counselling/therapy, neuropsychological assessments • Occupational therapy including work site visits, ergonomic assessments, functional capacity evaluations, driving assessments and home assessments • Vocational assessments • Work trial programs • Job placement assistance • Retraining assistance • Pain management programs • Multi disciplinary programs • Aids and equipment to improve the claimant's independent function • Home/vehicle modifications • Domestic or carer assistance

Jurisdiction	Authority	Legislation	Rehabilitation providers
			Rehabilitation services must be 'reasonable and appropriate evidence based services'. Under the Act, the insurer is only obligated to fund reasonable and appropriate medical and rehabilitation treatment once liability is accepted. The provider should set goals, have measurable outcomes, be able to demonstrate an objective rationale for instituting and continuing treatment and have a time frame for achieving goals. Intervention should also reflect current research findings and encourage self-management of a condition. From time to time the insurer may need to obtain independent advice about the appropriateness and benefits of a particular rehabilitation program. At other times, the insurer or solicitor may arrange an independent assessment for claims purposes. When reviewing medical reports, the provider should consider whether the report is for rehabilitation or claims purposes.
Victoria	Transport Accident Commission www.tac.vic.gov.au	*Transport Accident Act 1986*	**Allied Health Assistance services** Allied health assistance provided by a qualified Allied Health Assistant, with the appropriate personal indemnity insurance, acting under the supervision and direction of a Physiotherapist, Occupational Therapist or Speech Pathologist. Allied health assistants must hold a Certificate 3 in Health (Allied Health Assistant). **Audiological services** Audiological services provided by a qualified and accredited audiologist. Eligible for full membership of the Audiological Society of Australia and/or accreditation by the Australian Hearing Service (AHS). **Dietitian services** Dietitian services provided by a qualified and accredited dietitian, Eligible for accreditation as an 'Accredited Practicing Dietitian' in the state or territory in which the service is provided. **Drug and Alcohol services** Drug and alcohol services provided by agencies contracted to the Department of Human Services – Drug Treatment Services, Aged, Community and Mental Health Division and complying with its Framework for Service Delivery and quality improvement program. **Exercise Physiology services** Exercise physiology (also referred to as physical education) is a rehabilitation service that uses exercise as a form of therapy. The role of the exercise physiologist is to apply the principles of exercise for rehabilitation to the specific needs of the client and his/her injuries. The exercise physiologist will also aim to equip the client with the necessary skills and knowledge to progress his/her own exercise program independently. An exercise physiologist is defined as a person who has obtained accreditation by the Australian Association of Exercise and Sports Science, as an exercise physiologist. **Occupational Therapy services** Occupational therapy (OT) services refers to clinical assessment and treatment services provided by an occupational therapist to assist an individual to maximise his/her independence in activities of daily living and productive activities including paid work, study, volunteering and childhood play. OT services may include: • prescribing exercises to maximise a TAC client's function and promote the recovery of or rehabilitation from his/her injury • prescribing adaptive and/or alternative techniques to make it easier for a TAC client to perform activities, e.g. breaking strenuous tasks into smaller more manageable tasks • prescribing equipment that will facilitate and/or maximise a TAC client's independence and participation, e.g. installing a rail in a bathroom and

Jurisdiction	Authority	Legislation	Rehabilitation providers
			• conducting assessments to assist in establishing what support services that a TAC client may require as a result of his/her injury/illness, e.g. attendant care. • OT Services can be provided by OTs and Network OTs. All OTs must have met the following TAC criteria in order to provide OT services: • must be a qualified occupational therapist who is eligible to be a full member of OT Australia (Australian Association of Occupational Therapists) and • where applicable be registered with the appropriate state registration board • In addition to the requirements above, a Network OT is an occupational therapist who: • has a minimum of 3 years demonstrated, relevant clinical experience in occupational therapy • has met specific selection criteria in a TAC tender process for the provision of Network OT services • has signed a contract with the TAC to provide Network OT services. The TAC authorises occupational therapy clinical and assessment services to be an approved rehabilitation service. **Orthoptic services** Orthoptic services provided by a qualified and accredited orthoptist, eligible for membership of The Orthoptic Association of Australia. **Orthotic services** Orthotic Equipment refers to a support, brace or splint used to support, align, prevent or correct deformities in weakened joints or muscles and improve the function of the body. Orthotic services authorised by the TAC includes the prescription manufacture, and fitting of orthotic equipment. A person who is authorised to provide orthotic services must be eligible for full membership of the Australian Orthotic Prosthetic Association Inc. The TAC authorises orthotic services to be an approved rehabilitation service. **Social Work services** Social work services can be funded by the TAC when provided by a qualified social worker who is eligible for full membership with the Australian Association of Social Workers (AASW). All social work services require referral from a medical practitioner and prior written approval from the TAC. **Speech Pathology services** Speech pathology services provided by a qualified speech pathologist, Eligible for full membership of the Speech Pathology Association of Australia Ltd.
South Australia	Motor Accident Commission www.mac.sa.gov.au	*Motor Vehicles Act 1959* *Civil Liability Act 1936* *Motor Accident Commission Act 1992*	No information is available on who is approved to provide rehabilitation services.
NSW	Motor accidents authority www.maa.nsw.gov.au	*Motor Accidents Compensation Act 1999*	The MAA provides treatment guidelines for: • Psychologists and counsellors • Chiropractors

Jurisdiction	Authority	Legislation	Rehabilitation providers
			• Physiotherapists • Osteopaths • Therapists • Neuropsychological assessment • Anxiety management No other information is available on who is approved to provide rehabilitation services.
Tasmania	Motor accidents insurance board www.maib.tas.gov.au	*Motor Accidents (Liabilities and Compensation) Act 1973* Motor Accidents (Liabilities and Compensation) Regulations 2010	Health practitioners wishing to register as a provider with the MAIB need to provide the following details: 1. Name of provider 2. Practice/company name 3. Postal address 4. Practice/company address 5. Email address 6. Practice/company phone number 7. Practising speciality (eg GP, physio etc) 8. Medicare provider number (if applicable) 9. Australian Business Number (ABN) 10. Bank details (MAIB transmit payments by Electronic Funds Transfer (EFT)) To register as a provider, practitioners must complete a Provider Application Form.
Western Australia	Insurance Commission of Western Australia – MVPI division www.icwa.wa.gov.au/mvpi	*Motor Vehicle (Third Party Insurance) Act 1943*	No information is available on who is approved to provide rehabilitation services.

Appendix 9

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 10

Case studies of harm associated with the practice of unregistered health practitioners

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 was prosecuted unsuccessfully in 2010–11 by the Consumer Affairs Victoria for alleged breaches of the *Fair Trading Act 1999* (Vic). The case is now at appeal.

Case 11

In the past 14 months the Speech Pathologists Board of Queensland has had dealings with 12 practising speech pathologists for issues complaints and 9 breaches of the Registration Act of Queensland (practicing unregistered).

During the past 18 months there has been an average of 5 applicants each month seeking registration where either *Fitness to Practise* or *Recency of Practice* issues have been in question.

Over the past 3 years the board has required 12 applicants to complete further training to ensure *Recency of Practice* (7 completed to date) and 10 registrants are currently registered with conditions limiting scope of practice.

Case 12

Springham, N. (2008) Through the eyes of the law: What is it about art that can harm people? *International Journal of Art Therapy: Inscape.* Vol 13 (2) December. UK: Routledge

This paper describes a case in the UK where a serious injury was sustained by a client as a result of an art activity in a clinical setting. This led to legal action and the establishment of negligence on the part of the practitioner and the organisation. The act of negligence centred on the vulnerability of the client to discern the imaginary from the real and the responsibility of the practitioner and the organisation to competently assess the client's vulnerability and respond accordingly.

Case 13

A social worker in the disability sector was charged after driving dangerously under the influence of heroin addiction. The Supreme Court transcript states, "Ms C was 23 years old then and 24 when sentenced. She had no prior criminal history. She had worked as a personal care assistant with the Paraplegic and Quadriplegic Association of Queensland from 2000, and with Madison Community Care since mid-2004 as a disability and youth worker. Ms C took heroin well-knowing that the drug would affect her capacity to drive carefully. Her conduct demonstrated a high degree of social irresponsibility but was consistent with a powerful heroin addiction. She drove dangerously in moderately busy traffic at 12.25 pm on Saturday, 11 September 2004 along Annerley Road near Fairfield Street, Brisbane. It seems she momentarily dozed off. Her vehicle which was travelling at about 60 kms per hour traversed onto the incorrect side of the road, hitting the oncoming vehicle of the unfortunate M family which was travelling at about the same speed The appeal hearing indicated that Ms C had pleaded guilty and realised she needed rehabilitation and support. R vs Cocaris, DC No 2138 of 2005, District Court at Brisbane, 4 November 2005

Case 14

In 2006, the Coroner's Court of Tasmania investigated the death of an elderly gentleman, associated with the improper application of a halo brace, by an Orthapaedic Team and a Plaster Technician. In this case, the clinical decisions were not based on current evidence practise and the pins were inappropriately applied and over-torqued, resulting in skull perforation.

Case 15

A Cairns naturopath treated a man with a head injury as a result of falling off a horse. For six weeks she ineffectively treated the patient with a herbal poultice and dietary recommendations and failed to refer the patient even when the injury had progressed to a massive erosive lesion measuring 11x10 cm. At the behest of his wife, the patient finally sought medical treatment, where it was found that the lesion had eroded through the skull, soft tissue and down to the meninges of the brain. Careful observation showed a pulsatile area through which was percolating frank blood (Mackinnon, M. In General Practice, always expect the unexpected. *Australian Family Physician*, 2008, April 37 (4) 235–6)

Case 16

A Brisbane massage therapist who ran a large clinic in the CBD area employing several other therapists was convicted of two counts of sexual assault and one of rape, and sentenced to two years and six months imprisonment, suspended after serving a period of 9 months. The massage therapy association removed his membership but he is able to continue to practise.

Case 17

The ABC Four Corners program (05 April 2010) and a subsequent West Australian newspaper article (10 April 2010) featured the story of an unqualified practitioner who provides counselling and residential retreats in Western Australia. Family members made submissions to this national consultation detailing alleged psychological damage and financial exploitation of family members attending the counselling sessions and retreats run by the practitioner and the damage to family relationships.

Case 18

For 20 years a NSW social worker used his professional role and position of trust as a lure for young victims. During this time a number of allegations of improper sexual contact with children were made, but were never properly investigated. When the social worker was confronted with the complaints he would resign from his position and begin work as a social worker with a new employer. During this time, his employers included the Department of Child Welfare as well as various hospitals and schools. His crimes against children were not addressed until they were publicly broached during the Royal Commission into the NSW Police Force (Wood Royal Commission into the NSW Police Force 1997).

Case 19

The WA Coroner investigated the death of Penelope Dingle (nee Brown) in June 2010and found that her death on 25 August 2005 was a result of complications of metastatic rectal cancer.

He found that while the deceased may have been receptive to alternative approaches to medicine, she was not ideologically opposed to mainstream medicine. She did however decide to not undertake the surgery recommended by her medical specialist and relied on the treatment offered by her homeopath. The Coroner noted that this case highlighted the importance of patients suffering from cancer making informed sound decisions in relation to their treatment. In this case the deceased paid a terrible price for poor decision making, the Coroner noting that she was surrounded by misinformation and poor science. Although her treating surgeon and mainstream general practitioner provided clear and reliable information, she received mixed messages from a number of different sources which caused her to initially delay necessary surgery and ultimately decide not to have surgery until it was too late. He found her homeopath was not a competent health professional and that she had minimal understanding of relevant health issues, but unfortunately that did not prevent her from treating the deceased as a patient.

Case 20

Thomas Sam, 42, a homoeopath, and his wife, Manju Sam, 37, were convicted of manslaughter by gross criminal negligence in June 2009. Their daughter, Gloria, died of malnutrition and septicaemia, complications of severe eczema. They were accused of "gross criminal negligence" by failing to get conventional medical treatment for Gloria, who died three days after being taken to a Sydney hospital on May 5, 2002.

Born in July 2001, Gloria thrived until November when a nurse noticed her eczema and told the mother to see a skin specialist. Instead of doing this, the mother took Gloria to a GP who was extremely concerned at the eczema, saying it was the most severe case he had ever seen. Although the GP wrote a referral and made an appointment to a skin specialist, the parents never saw him. The parents spent months trying to treat her eczema with homeopathic remedies instead of mainstream medications.

At the trial the prosecutor, Mr Tedeschi said Gloria's skin would break when her clothing and nappy were changed and she became thinner and weaker, which allowed infections to enter her body.

The eczema and infections placed "an enormous toll on her body" which meant all the nutrition she took in was spent on fighting this off, instead of being used to grow. At four months, she weighed 6.5kg but at nine months she was down to 5.3kg and died of septicaemia.

Appendix 11

Complaints data from health complaints entities (HCEs) in relation to unregistered health practitioners

Appendix 11.1: NSW Health Care Complaints Commission

Complaints received about registered and unregistered 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 practitioners										
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 practitioners										
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

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	Total No.	Total %
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**

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[26]	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

[26] 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.

Outcome	Health practitioner														Total	
	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 11.2: QLD Health Quality and Complaints Commission 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 11.3: Victorian Health Services Commission complaints data

Types of unregistered practitioners and numbers of complaints made to the Health Services Commission 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%	

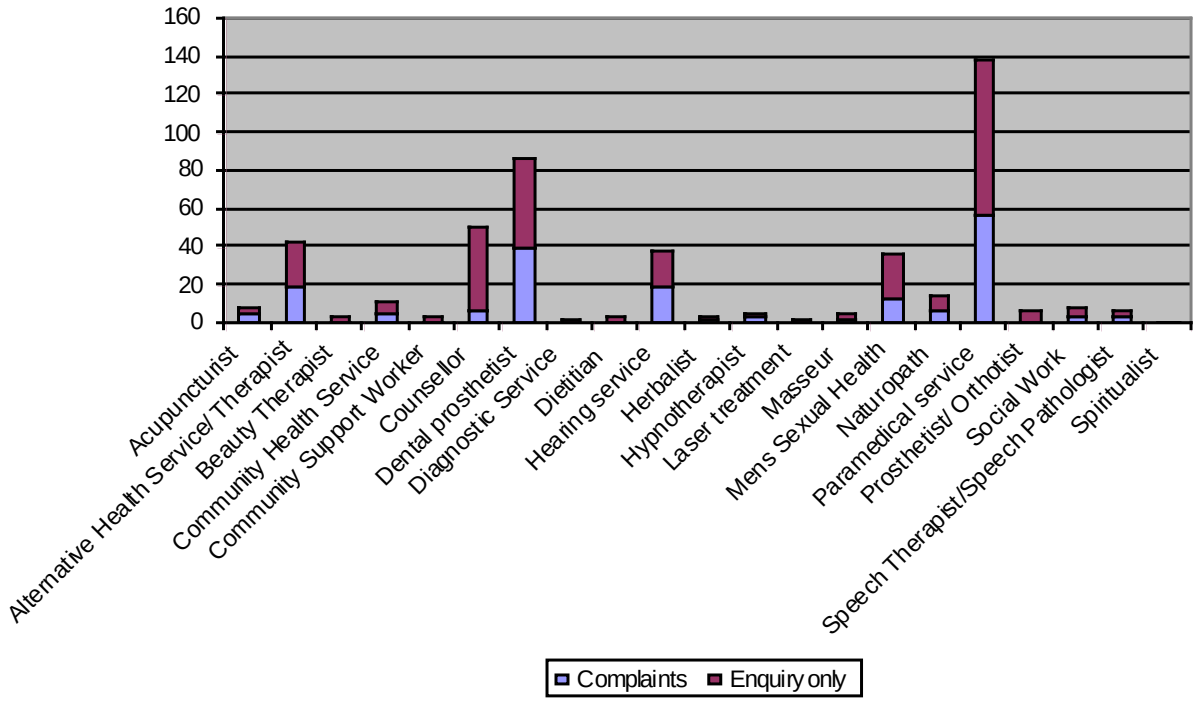
Appendix 11.4: Western Australian Office of Health Review complaints data

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

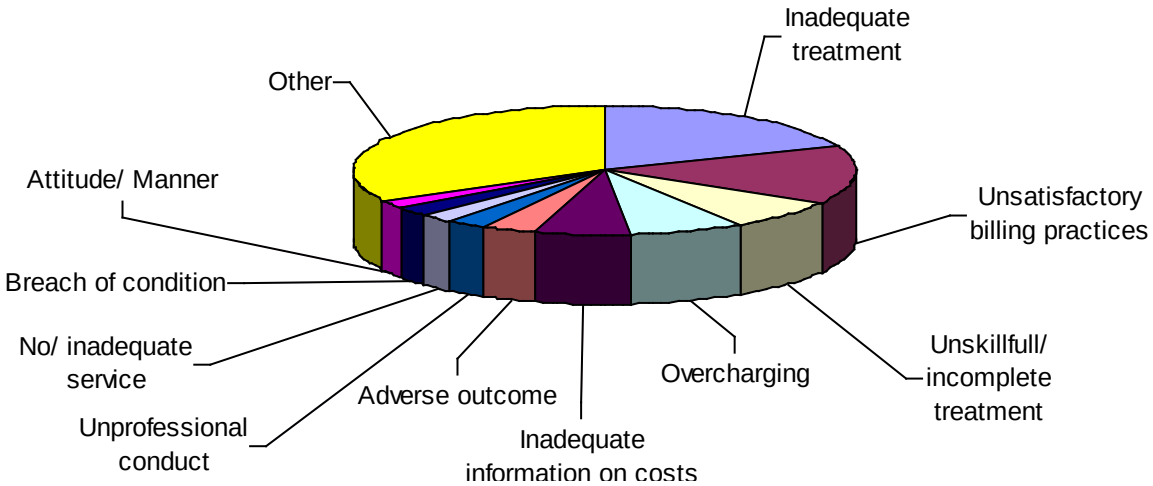
Non registered service	Total enquiries and complaints	Written complaints	Enquiry only
Hearing service	38	20	18
Herbalist	3	2	1
Hypnotherapist	5	3	2
Laser treatment	2		2
Masseur	5	2	3
Mens Sexual Health	36	13	23
Naturopath	15	7	8
Paramedical service	139	57	82
Prosthetist/ Orthotist	7		7
Social Work	9	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



Appendix 12

Events relevant to national consultation on options for strengthening regulation of unregistered health practitioners

Date	Key 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
28 February 2011	Consultation Paper available on AHMAC website
23 March 2011	Consultation Forum Melbourne
24 March 2011	Consultation Forum Adelaide
25 March 2011	Consultation Forum Brisbane
28 March 2011	Consultation Forum Darwin
29 March 2011	Consultation Forum Canberra
30 March 2011	Consultation Forum Hobart
1 April 2011	Consultation Forum Perth
4 April 2011	Consultation Forum Sydney
6 April 2011	Consultation Forum Alice Springs
15 April 2011	Closing Date for Submissions

Appendix 13

Attendance lists for consultation forums

Melbourne, 23 March 2011		
Trisha Hughes	Australian Association of Massage Therapists	CEO
Tammy Jones	Reiki Association of Australia	President
Dr Grant Davies	Office of Health Services Commissioner	Deputy Commissioner
Megan Rule	Individual	
Elaine Trevaskis	Australian Sonographers Association	CEO
John Coleman	Australian Reiki Connections	President
Vivien Watmo	Shiatsu Association Australia	
Paul Gilbert	Australian Nursing Federation (Vic)	Assistant Secretary
Leigh Clarke	Australian Orthotic & Prosthetic Association	EO
Elizabeth Foley	Australian Nursing Federation (National)	Federal Professional Officer
Gail Mulcair	Speech Pathology Australia	CEO
Barry Cahill	Chronic Illness Association	Consumer
Lynn Jordan	Australian Kinesiology Association	Sub-committee member
Tony Hoare	Massage Association of Australia	EO
Elizabeth Thuan	Council of Australian Reiki Organisations	Chair
Don March	Hypnosis Council	
Noelle McArthur		Training Consultant
Bevianne Finch	Reiki Australia	
Sarah Bird	Department of Health – Workforce Innovation	Policy Officer
Cristina Giacominato	Department of Health – Workforce Innovation	Policy Officer
Kath Phillip	Department of Health – Workforce Innovation	Policy Officer
Max Towns	Consumer Affairs Vic	Senior Policy Officer
Tony Carroll	Council of Reiki Organisations	
Ingrid D"Anrdrea	Council of Reiki Organisations	
Michael Tomlinson	Australian Register of Homeopaths	Secretary
Grace McAllister	False Memory Association	Consumer
Catherine Itsiopolous	Dietitians Association of Australia	
Bernard Agius	Ambulance Victoria	
Kerren Clark	HSU East	
Peter Hartley	Paramedics Australia	Secretary (Vic)
Denise Guppy	Health Services Union	
Karl Chariker	Australian Association of Social Workers	Senior Manager
Alison Brown	Australian Pilates Association	President
Michael Whitburn	Australian & NZ College of Perfusionists	President
Alison Horton	Australian & NZ College of Perfusionists	Chair, Regulation Sub-committee
Tania Strager	Orthotics Association	
Adelaide, 24 March 2011		
Lucy Avard	Office of the Health & Community Services Complaints Commissioner	
Carolanne Barkla	Aged and Community Services SA & NT Inc	
Heather Baron	Allied Health Professions Australia – SA Branch	
Rob Bonner	Australian Council of Private Education & Training	
Jennifer Buckseall	SA Medical Scientists' Association	
Cathy Clark	Speech Pathology Aust SA Branch	
Marion Croser	Australian Association of Social Workers – SA Branch	
Sue Cummins	Public Service Association	
Elizabeth Dabars	Australian Nursing and Midwifery Federation (SA Branch)	
Vicki Dodd	SA Health Aboriginal Health Division	
Julie Dundon	Dietitians Association of Australia	
Rachel Edwards	Public Service Association	
Rob Elliot	SA Ambulance Service & Paramedics Australasia	
Oliver Frank	The University of Adelaide	
David French	Society of Natural Therapies & Researchers Inc	
Nanette Hill	SA Medical Scientists' Association	
Sue King	University of SA	
Scott King	Australian Council of Private Education & Training	

Richard Larsen	SA Ambulance Service & Paramedics Australasia	
Traudi Lespse	Australian Homoeopathic Association Inc	
Jess Lock	SA Health Workforce Division	
Herb Mack	SA Health Aboriginal Health Division	
Heather McAllister	St John Ambulance SA	
Paul McCann	Australian Association of Massage Therapists	
Rebecca North	The Aust Orthotic Prosthetic Association Inc	
Diana O'Neill	Health Consumers Alliance	
Annette Raynor	University of SA	
Susan Rennison	Australian Kinesiology Association	
Jeanette Rouley	SA Health Allied & Scientific Health Office	
Etinne Scheepes	SA Health Workforce Division	
Ingrid Scolten	Flinders University of SA	
Helen Stevens	SA Health Workforce Division	
Leena Sudano	Health & Community Services Complaints Commissioner	
Kate Thomas	SA Health Workforce Division	
James Thompson	Flinders University of SA	
Andrew Thornton	SA Medical Scientists' Association	
Ian Todd	Pharmacy Guild of Australia – SA Branch	
Charlotte Trenter	Australian Association of Social Workers – SA Branch	
Catherine Turnball	SA Health Chief Allied & Scientific Health Advisor	
Julia Twohig	Australian Register of Homeopaths	
Helen van Eyk	SA Health Policy & Intergovernment Relations	
Alexis Watts	Australian Council of Private Education & Training	
Lee Wightman	SA Health Policy & Intergovernment Relations	
Allison Young	Australian Nursing and Midwifery Federation (SA Branch)	
Debbie Crump	Calvery	
Joe Hooper	Australian Medical Association SA	
Tania Axelby-Blake	CYWHS – Aboriginal Health	
Brisbane, 25 March 2011		
Adrian Hellwig	Australian Counselling Association	
Angela Doolan	Australian Register of Naturopaths & Herbalists	
Alisa Hall	Health & Community Services Workforce Council	
Amanda Hammer	Workforce Design & Liaison Unit – Queensland Health	
Amie Steel	Network of Researchers in the Public Health of Complimentary and Alternative Medicine	
Andrew Torney	Australian Orthotic Prosthetic Association	
Anita Hobson-Powell	Exercise & Sport Science Australia	
Ann Fitzgerald	Clinical Workforce Solutions –Queensland Health	
Anna Willis	Clinical Education Q – Queensland Health	
Annette Byron	Dietitians Association of Australia	
Barbara Lindsbergs	Australasian Society of Anaesthesia Paramedical Officers	
Brian Millis	Christian Heritage College	
Bronwyn Nardi	Clinical Worforce Planning & Development – QH	
Brooke Roberts	HQCC	
Cathy Boyle	Reflexology Association of Australia	
Christine King	Reflexology Association of Australia	
Chris Eldridge	QAIHC	
David Draper	The Society of Natural Therapists and Researchers Inc	
Dawn Harris	Australian Reiki Connections Inc	
Denise Edwards	Bluecare	
Don Martin	PSQ – CHI – Queensland Health	
Ellen Whittaker	Ramsay Healthcare	
Felicity Hall	Cancer Council Queensland	
Gai Rowlings	Allied Health Workforce Advise & Coordination Unit -QH	
Jane Caldwell	Office of the Adult Guardian	
Jan Gerhardt	United Voice Industrial Union of Employees	
Jane Evans	Dental Technicians Board of Queensland	
Jim Olds	Australian Natural Therapy Association	
Jeanette Temperley	United Voice Ambulance Union	
Julie Hulcombe	Allied Health Workforce Advise & Coordination Unit – QH	
Kathryn Beacham	Older Peoples Health and Extended Care Unit -QH	
Liesel Higgins	ClinEdQ – Queensland Health	

Lindsay Irons	Office of the Public Advocate	
Liz Ward	Speech Pathologists Board of Queensland	
Loretta Marron	Consumer	
Margaret Smith	Office of the Chief Dental Officer – Queensland Health	
Marissa Ker	Legislative Policy Unit – Queensland Health	
Mark West	Oncology Physicians (PAH)	
Megan Harbourne	Statewide Clinical Education Program, Clinical Measurement Disciplines – Queensland Health	
Meredith Liddy	Australian Institute of Medical Scientists	
Miles De Lacy	Workforce Design & Liaison Unit – Queensland Health	
Naomi Hebson	National Workforce Agenda – Queensland Health	
Neil Noble	Paramedics Australia	
Paul Sheehy	Legislative Policy Unit – Queensland Health	
Paul Stephens	Workforce Units – Queensland Health	
Penny Neller	Health Consumers Queensland	
Ray Bange	Australian College of Ambulance Professionals	
Rhys Straw	Allied Health Workforce Advise & Coordination Unit QH	
Rob Royal	Queensland Health	
Robert Rule	People and Culture Strategic Services – Queensland Health	
Ruth Gatehouse	Office of the Chief Health Officer – Queensland Health	
Sarah Carter	Australian Orthotic Prosthetic Association	
Sharron Mackison	Reiki Australia	
Sharyn Hopkins	QNU	
Stephen Gough	QAS	
Sue Cumming	Australian Association of Social Workers	
Susan Gair	Australian Association of Social Workers	
Susan Hunt	Australian Association of Social Workers	
Tim Heywood	General Practice Queensland	
Tina Hamlyn	Medical Imaging Ultrasound – Queensland Health	
Toni Halligan	Allied Health Clinical Education & Training Unit QH	
Tony Martin	Qld Mental Health Voices	
Virginia Thorley	The Listening Space	
Wendy Watson	Reiki Australia	
Cathie Nesvadba	Queensland Health	
Darwin, 28 March 2011		
Linda Blair	Dept Health – Strategic Workforce Planning	Senior Consultant
Des Bredhauer	Tropical Sports Massage	
Lisa Brindell	Optical Dispenser	
Karen Buckingham	Dept Health – Strategic Workforce Planning	
Sam Chow	Darwin Dental Technicians	
Judy Clisby	Community Visitor Program	
Lisa Coffey	Health Complaints –Health & Community Services	Health Complaints Commissioner
Sandra DosSantos	Sullivan Nicolaides Pathology	Phlebotomist
Yvonne Faulch	Australian Nursing Federation NT	
Kaye Griffin	Dept Health – Strategic Workforce	
Tiffany Haritos	Dept Health – Strategic Workforce	
Anne Holleley	Darwin Hypnotherapy	
Jon Hordern	Reflexology Assoc	
Jane Johnson	Lifeline	
Tracy Jonas	Optometric Dispenser	
Pat King	Sids & Kids	
Wendy Kingshott	Association of Massage Therapist	
Celina Lai	Royal Darwin Hospital	Speech Therapist
Susan Loudan	Sullivan Nicolaides Pathology	Phlebotomist
Renae Moore	Dept Health – Allied Health	
Peter Munks	St Johns Ambulance	
David Nebauer	Royal Darwin Hospital Pathology	Phlebotomist
Jenny Norris	Dept of Health & Ageing	
Judith Oliver	Pharmacy Guild	
Rebecca Orr	DHF	
Michelle Pinto		Consumer
Susanna Polan	Royal Darwin Hospital	Manager Dietitics

Margaret Rollings	Integrated Health Solutions – Naturopaths	
Caroline Rorh		Optometric Dispenser
Tony Rutter	Dept of Health & Ageing	
Vivienne Savill	Body Mind & Soul Health Care	
Thalila Thavaseelan	Speech Pathology Australia – Childrens Development Team	
Rodney Thomson	RDH Pharmacy	
Abigail Trewin	Paramedics Australia	
Felicity Wardle	Happy High Herbs Darwin	
Canberra, 29 March 2011		
John Baxter	National Herbalists Association of Australia	President
Tony Blattman	Population Health Executive Office, ACT Health	President
Matthew Boylan	Australian Traditional Medicine Society	CEO
Emma Burchell	Complementary Healthcare Council of Australia	Technical officer
Stephen Carter	St John Ambulance Australia	National First Aid Services Manager
Kim Crawley	DAA	Director
Megan Curran	Calvary John James Hospital	Director, Clinical Services
Carrie Fowlie	Alcohol, Tobacco & Other Drug Association ACT	
Dr Sean Geoghegan	Australian College of Physical Scientists & Engineers in Medicine	Chair, Professional Standards
Leah Hechtman	National Herbalists Association of Australia	Vice President
Karen Hocking	Complementary Healthcare Council of Australia	Standards & Compliance Officer
Michelle Hookham	Australian Homeopathic Association	National President
Leonie Hunt	Therapeutic Goods Administration	
Garry Lavis	Australian Association of massage Therapists	President
Lorraine Lawrence	Allied Health, ACT Health	
Leanne MacKinnon	National Capital Private Hospital	Deputy Director of Nursing
Mary Miles	Western Herbalist	
Jenny Miragaya	Australian Nursing Federation, ACT	
Will Mollison	Australian Association of Social Workers	Public Affairs Officer
Monica Persson	Audiology Australia	CEO
Christine Pope	Australian Homeopathic Association	National Treasurer
David Tassicker	Paramedics Australia ACT Chapter	
Faye Thornhill	Western Herbalist	
Felicity Martin	OPA	
Kelly Gourlay	The Pharmacy Guild of Australia	
Matt Hingston	Human Rights Commission	
Mary Durkin	Health Services Commissioner	
Hobart, 30 March 2011		
Jean Symes	Nutrition and Dietetics, Royal Hobart Hospital	Manager
Amanda Vallance	Pharmacy Guild.	Branch Director
Monica Persson	Audiology Australia.	CEO
Noel Dalwood	Ambulance Tasmania.	Acting Director of Clinical Services
Steve Trewin	Ambulance Tasmania.	Clinical Support Officer
Peter Morgan	Paramedic Australasia, Tasmania.	Vice Chair
Carol Dorgelo	Australian Association of Social Workers, Tasmanian Branch.	President
Tracey Tasker	Diabetes Tas (North)	Health Service Manager,
Ruth Chalk	Allied Health, NWAHS.	Co-director
Stuart Haggie	Environmental Health.	State Manager
Bill Pearson	Australian Traditional Medicine Society	Vice President
Pam Claxton	Australian Association of Massage Therapists	Board of Directors
Kevin Marriot	TasCAHRD.	CEO
Carolyn Hay	TasCAHRD.	Hepatitis Program Coordinator
Dr. John Walduck	Australia Dental Association.	ADATB Councillor
Lynda Kidd	Reflexology Association of Australia Ltd.	Tasmanian Branch Secretary
Gundrun Peacock	Speech Pathology Services, STAHS	Manager
Lee McGovern	CNAH.	Principal Allied Health Advisor
Richard Dyson-Holland	Australian Orthotic Prosthetic Association.	President
Francine Douce	CNAH	Director of Nursing and Midwifery
Karin Cuff	CNAH	ADON Workforce Development
Dr Andrew Williams	Exercise and Sports Science Australia	

Sharon Tay	Reflexology Association of Australia Limited	
Johannes Kelder	Professional counselling Association	
Jill Curtis	Speech Pathologist	
Berry Dunston	Counsellor/Psychotherapist	Private Practitioner
Colleen Neuman	Pharmacy Guild	Training Manager
Natasha Meeridirg	Dietitian	
Perth, 1 April 2011		
Trudi Marchant	Australian Association of Social Work	AASW National Registration C'ttee
Cynthia Thom	Australian Association of Social Work	
Andrew Waddell	Australian Labour Party	Member for Forrestfield
Paul Prague	Australian Orthotic Prosthetic Association	President
Robyn Collins	AHPRA	State Manager
Ella Davies	AUSIT	
Sharon Zaunmayr	Australian Association of Massage Therapists	Associate
Sue Strutt	Australian Institute of Medical Scientists	Chair, WA Branch
Catherine Wilmot	Australian Music Therapists Association	Chair, Government Relations Committee
Robyn Tsapazi	Australian Sign Language Interpreters' Association	President
Rebecca Johnson	Cancer Council	Policy Coordinator
Sandy McKiernan	Cancer Council	Director, Information Services
Margaret Cook	Children of Mentally Ill Consumers WA	Consumer
Carline Humfrey	Community	Consumer
Anne Zekas	Community	Consumer
Hope Alexander	Community	Consumer
Steve Pratt	Dietitians Association of Australia	Nutrition and Physical Activity Manager
Sue Peden	Disability Services Commission	ED, Statewide Specialist Services
Rachel Barron	Disability Services Commission	A/Regional Manager, Metropolitan Specialist Services
Steve Johnston	Edith Cowan University	Senior Lecturer, Paramedical Sciences
Assoc. Prof. Moira	Edith Cowan University	Head of Postgraduate Medicine. Faculty of Computing, Health and Science
Florence Miller	Edith Cowan University	Health and Lifestyle Lecturer
Michele Kosky	Health Consumers' Council	Executive Director
Tim Benson	Health Consumers' Council of WA	Health Consumer
Gio Terni	Health Consumers' Council	Senior Advocate
Steve Ashburn	Department of Health	Director, Legal and Legislative Service
Luci Bertoli	Department of Health	Senior Policy Officer
Anne Cooper	Department of Health	Senior Policy Officer, Legal & Legislative Service
Kevin Cropper	Department of Health	Transition Manager – Paramedics
Jenny O'Callaghan	Department of Health	Manager, Office of the Chief Medical Officer
Neil Keen	Department of Health	Chief Pharmacist
Kate Lenton	Department of Health	A/Senior Policy Officer, Workforce Policy, Planning & Reviews
Heather Roberts	Department of Health	A/Policy Officer
Sue Brooks	Department of Health	A/Director Workforce
Cathy Campbell	Department of Health	Manager, Workforce Policy, Planning & Reviews
Anne Donaldson	Health and Disability Services Complaints Office	Director
Kate Diamantopoulos	Homeopathy WA	President
Sergio Cooper	Independent Practising Interpreters' Association	President
Gabrielle Crofts	James Crofts Hope Foundation	
Linda Long	King Edwards Memorial Hospital	Clinical Nurse Specialist
Susan Nye	Mental Health Commission	Senior Project Manager. Service Purchasing and Development
Wynne James	Mental Health Commission	A/Assistant Director Mental Health Commission
Tony Martella	Optometrists Association of Australia – WA Div'n	Chief Executive Officer
Nigel Pierson	Oral Health Professionals Association	Chairperson

Lisa Briggs	Orthoptics Australia	President
Olga Frazer	PACAWA	President
Rosemary Watkins	PACAWA	PACFA Delegate
A/Prof Richard Brightwell	Paramedics Australasia	Director WA Chapter Paramedics Australasia
Phil Townsend	Paramedics Australasia	Chair, WA Chapter
Anne Young	Reflexology Association of Australia	President
Tyna King	Reflexology Association of Australia	Chairperson
Delwyn Klevenow	Reiki Association (WA)	Treasurer
Roy Wyatt	Royal Perth Hospital	Anaesthesia Technician Manager
Frances Phillips	Royal Perth Hospital	Chief Dietician
Melita Brown	Royal Perth Hospital	Chief Speech Pathologist
Roger Cook MLA	WA Parliament	Shadow Minister for Health
Jonathon Rafols	Speech Pathology Australia	Professional Standards Portfolio
Joe Cuthbertson	St John Ambulance (WA)	Manager Clinical Governance
Dr Anna Patterson	Solaris Care Foundation	Research Fellow
David Edwards	Solaris Care Foundation	CEO
Corina Della-Posta	Workfocus Australia	General Manager
Sydney, 4 April 2011		
Kate Adams	NSW Nurses Association	Manager Professional Services
Ireen Allanson	Association of Remedial Masseurs	Office Manager
Peter Baker	Australasian Dispensing Opticians Association	Committee member
Rebecca Barnett	Association of Massage Therapists	Company Secretary
Matthew Boylan	Australian Traditional Medicine Society Ltd	Chief Administrative Officer
Gloria Bradley	Australian False Memory Association	Vice-President
Linda Brookes	Workforce Development & Innovation, NSW Health	Project Officer
Louise Coe	NSW Dept of Fair Trading	Manager Investigations, Compliance & Enforcement
Louise Collingridge	Australian Association of Audiologists in Private Practice	Exective Officer
Anne Connolly	Workforce Development & Innovation, NSW Health	Manager
Brian Corless	Australian Shaolin Temple	Clinical Pyschologist
Suzanne Crowle	NSW Dept of Fair Trading	FTC Regional Manager
Gary Disher	Australian College of Physical Scientists & Engineers in Medicine	General Manager
John Dixon-Hughes	NSW Medical Services Committee	Chairperson
Matthew Fisher	Australian Dental Association NSW	Chief Executive Officer
Gary Gibbs	Australasian Society of Anaesthesia Paramedical Officers	Education Officer
Brett Holmes	NSW Nurses Association	General Secretary
Eithne Irving	Australian Dental Association	Policy and Media Relations
Peter Jackson	Australasian Dispensing Opticians Association	President
Iain Martin	Legal and Legislative Services , NSW Health	Assistant Director
Connie McNamee	Association of Remedial Masseurs	Committee Member
Lyn Oliver	Australian College of Physical Scientists & Engineers in Medicine	Committee Member
Colin Rossie	Association of Massage Therapists	Vice-President
Tamsin Rossiter	Association of Massage Therapists	President
Megan Shiell	The Australian and NZ Art Therapy Association	Vice President
Gretal Spiegel	Reflexology Association of Australia Limited	Chairman
Jon Wardle	Network of Researchers in the Public Health of Complementary and Alternative Medicine	Director – Research Capacity Stream
Roger Woolnough	Australian False Memory Association	Committee member
Grahame Forrest	Australian False Memory Association	
Carpet Hughes	Paramedics Australasia (NSW)	
Ryan Lovett		
Michael Smith		
Alice Springs, 6 April 2011		
Jennifer Mostran	Department of Health Senior Coordinator Office	CEO
Denise Brewster-Webb		Exec. Director of Nursing
Jane Boughen	Diabetes Educator Healthy Living NT	
Glynis Crack	Alice Springs Reiki Centre	
Bernie McDonald	Alice Springs Hospital	Radiology
Carolyn Enthoven	Alice Springs Hospital	Radiology
Virginia Loy	Alice Springs Hospital	Radiology

Margaret Schilds	Reiki Centre for Wellbeing	
Narayan Kanthan	Alice Springs Hospital	Speech Pathology
Kevin Konigs	NT Medical Imaging	
Simone Lewer	Dept Health	
Michelle Foley	Dept Health	
Karen Harris	Alice Springs Hospital	Director of Allied Health
Christen Munday	Cerneral Practice Network	
Karen Buckingham	Department of Health -Strategic Workforce Planning	

Appendix 14

Summary of views expressed and issues raised at consultation forums

Melbourne 23 March 2011

32 attendees, 5 apologies

Do you think there is a problem?

Yes

- No barriers to entry/no mechanism to enforce minimum standards re education and competency (no qualification requirements).
- No title protection.
- Fragmentation in current regulation across professions and States/Territories.
- Practitioners practice without Association membership (outside of voluntary codes)
- Lack of power to impose set requirement for professional association membership for some professions.
- Practitioners working outside of their professional boundaries.
- No public protection – no avenues for consumer complaints.
- Consumer vulnerability.
- Lack of current powers of HSC and other public entities, consumer bodies, professional associations etc.
- Need better knowledge of complaints/problem

Do you think there is a need for further protections for consumers?

Yes

- Complaints mechanism/minimum standards/ CPD/Scope of practise (competency based)
- Clear avenues of complaint
- Third party complaints not just patient/consumer
- Clear expectations of consumer of professional
- Need mechanism to ensure it is not a vexatious claim

What do you think of the three options? Are there other options?

Option 1. Status Quo: Increase number of professions within NRAS.

Option 2. Self Regulation:

Professional Associations

- Set/Standards for qualifications, CPD, etc
  - Govt need to consider other self-regulatory options currently in operation.
- Code Of Ethics
- Scope Of Practise
- Professional Development
- Separate investigations from associations/group

Limitations

- Non-members
- Cancelled memberships
- Very fragmented for some health practitioners
- Regulation required as associations cannot prevent person from practising

Option 3. Statutory Code of Conduct

- Best of the 3 options for serious complaints.
- Prefer national code of conduct.
- Nationally consistent prohibition orders.
- Associations to be made aware of de-registrations.
- Public access to prohibition orders.
- Minimum level of protection for the community.

Do you have a preferred option?

Combination of 3 options

Option 1

- Entry of other professions into NRAS

Option 2

- Credentialing of professional associations
- Deal with less serious cases.
- Govt required entry qualifications/accreditation standards – method for strengthening minimum professional standards.

Option 3

- National code to deal with worst cases – however intervention is reactive rather than proactive
- National scheme avoids mutual recognition issues
- Uniformity important

How important is national uniformity?

Agree on national uniformity

Should there be a single national Code of Conduct for unregistered health practitioners?

Yes – National Code of Conduct

Should there be separate State and Territory regulatory schemes, or a single nationally administered scheme with State and Territory based enforcement?

- Single nationally administered scheme with State/Territory based enforcement – could be APHRA or Health Complaints Commissioners (HCC). If APHRA same complaints mechanism for both registered/unregistered practitioners.
- Don't want another tier of protection.
- AHPRA have investigation/complaints role, not all HCC have this role.

Do you have any other comments or issues you wish to raise?

- Term unregistered – possible alternatives – independent, licensed, self-regulated, Health Care Providers
- Further consideration of self-regulatory models available/in operation
- Consideration of contractual arrangement between client and practitioner (Californian Model).

Adelaide 24 March 2011

36 attendees

Do you think there is a problem?

Yes

- Beyond the scope of professional associations.
- Practitioners able to transfer to another State if prohibited in one State.
- People are being exploited and harmed.
- People are vulnerable when ill and not necessarily well-informed.
- Not satisfactory to have professions investigating their own practitioners in terms off governance – need expertise and independence.
- Need to improve reporting of complaints/breaches, regulation and management.
- Often have recurring bad behaviour and current processes inadequate in terms of prosecution and consequences.
- Need education of the public and other professional to report inappropriate behaviour.

On current statistics, level of complaints is negligible.

Do you think there is a need for further protections for consumers?

Yes

- Self regulation does not compel practitioners to be registered within their professional association.
- Need to address where current protections are failing.
- Using legal sanctions is very difficult and costly for the individual.
- Education of the consumer is important.

What do you think of the three options?

- None of the options offer front end protection
- Should there be graded levels of regulation depending upon risk.

Option 1

- Need greater protection.
- Doing nothing is not acceptable.

Option 2

- Self Regulation: Works for some associations but who benchmarks them.
- Inadequate as some practitioners will remain outside of their professional association.
- Some professional groups have multiple associations.
- Strengthen accreditation of associations/professional bodies and include specific requirements such as PII.

Option 3

- Prefer proactive rather than reactive but need national code of conduct as minimum.
- Covers practitioners who do the wrong thing.
- May be too generic and fail to address occupational/professional standards.
- Already happening in SA

Do you have a preferred option?

Blend of 3 options

- Option 1 – More professions admitted to NRAS
- Option 2 – Government accredited professional associations with benchmarked standards.
- Option 3 – National code of conduct standard administered locally with a National Commissioner.

How important is national uniformity?

- Very important:
  - Prevents people going interstate and avoiding sanctions
  - Consumers move from State to State and expect to get the same service and protection.
  - Inappropriate conduct and register should be maintained nationally.
- National uniformity important but there are concerns relating to practical application/operation.
- Could use 'mirror' legislation in State/Territories but with nationally consistent principles.
- Important to have national standard, local administration acceptable as long as investigation is common nationally.
- National system for registered health practitioners so any system for unregistered should also be national to enable consistency, mutual recognition/prohibition.
- Management at a State/Territory level important so that local issues can be dealt with adequately.

Should there be a single national Code of Conduct for unregistered health practitioners?

Yes

- Common minimum standard but capacity for professions to add specific requirements.
- Very important not to have differences between States.

Should there be separate State and Territory regulatory schemes, or a single nationally administered scheme with State and Territory based enforcement?

- Single National Health Complaints entity with some State/Territory based enforcement.
- National body but administered at State level.
- Primary issue is useability for consumers and practitioners.
- View corrupted due to poor experience with AHPRA.
- National body may be expensive and unwieldy.
- Require collaboration and coordination between jurisdictions if State based.
- How would legal appeals impact on national consistency if using State Courts.

Do you have any other comments or issues you wish to raise?

- Consultation must be robust and seriously take into account alternative options.
- Engagement with other key groups
- Issue of workers not working in a health setting but providing a health service e.g. social workers.
- Issue of cost has not been addressed.
- Need to address the issue of business owners who are not practitioners but who influence practices within a group.
- Need for public education campaign re code of conduct and complaint process.
- Definition of health – Aboriginal people define health holistically and want spiritual, social, emotional and physical incorporated in the definition. This would mean that the regulation would apply very broadly.
- 'Bottom of the cliff' approach.
- Need to raise standards of practice/education e.g. aged care and child care workers work with most vulnerable populations but minimal educational qualifications.
- Need to have cultural input into complaints decision-making given covers range of practitioners including Aboriginal and other cultural healers.
- Need to change language – term unregistered health practitioner does not reflect level of self-regulation and registration systems.
- Ideal reform would be:
  - Minimal entry requirements
  - National list of approved practitioners

- Appropriate code of conduct
- Disciplinary actions for those who do not comply
- Appropriate requirement for ongoing professional development

Brisbane 25 March 2011

65 attendees, 1 apology

Do you think there is a problem?

- Issues related to where service delivered – metro/rural, isolated practice, no choice for consumers.
- Any amount of regulation cannot solve every issue.
- Fraud, misleading and deceptive conduct can be dealt with under other provisions, but not always provide solutions.
- Complaints mechanisms need to be made easier.
- Vulnerable people don't have the ability to complain.
- Need definitive list of who comes under these provisions & reasons, but others saw need for broad definitions to encompass new professions.
- Need to both ensure high quality services & take action if there is a problem, may need different mechanisms.
- Yes where there are untried regulatory practices, but these aren't necessarily 'rogue' practitioners.
- Non members of a voluntary regulatory system are problematic.
- Ideally look for a regulatory system which incorporates a code of conduct and safety and quality systems, to stop unqualified practitioners operating.
- Non-membership may limit practice in relation to Medicare but won't stop practice.
- Most codes of conduct are "no harm" but may not apply to some practitioners
- Education standards across States are not consistent.
- There will always be a problem with rogue practitioners who do not join any professional associations.
- At present there are public safety issues and an inability to take any action in a regulatory fashion.
- The issue is not profession specific it is about the safe practice of individuals.
- It is very important for the current workforce to:
- Transition to work across States and Territories
- One national Body per profession.
- A new regulatory scheme is important for the smaller less well resourced associations
- A number of practitioners even in the hospital system are using titles for which they are not qualified – consistent accreditation process required.
- The Workforce Council have conducted mapping across a large range of organisations.
- Discussion on who belongs – threshold for inclusion?

Do you think there is a need for further protections for consumers?

- Overregulation could result in "closed shop" mentality
- How do consumers know if practitioners are providing acceptable service.
- Regulation is preferred where consumers have little information and choice about a profession.
- Need transparency and processes to address problems.
- TGA only deals with certain issues, can it stop practice?
- There is a need to see natural justice built in to any regulatory system.
- The challenge is to inform the public.
- To safeguard against rogue operators.
- There is a need for title protection and recognition of credentials.
- If self regulating option was pursued Qualification checks, Criminal history checks and CPD requirements would need to be built in.

- Costs (of regulation) considered for smaller professions.
- Some form of regulation would track practitioners who have high mobility across jurisdictions.
- Yes but some incidents are conducted in ignorance by practitioners who are unaware they have done anything wrong.
- Yes clarity around which are accredited Qualifications.
- Code of conduct should include standards on level of service, duty of care and accreditation.

What do you think of the three options? Are there other options?

- Consider incorporating a complaints resolution panel into whichever option is chosen – an easy and cheap alternative.
- Take care not to 'regulate out' caring people (i.e. deter people from delivering a service).
- Option 3 allows national cover and prevents people hiding across borders.
- TGA mechanism works – just expand it to cover services.
- One group has an international presence and would be unwilling to usher in a national system.
- A voluntary code could contain definitive standards and State/national practice level.
- A voluntary code could contain a check list for good behaviour.
- A statutory code would have safeguards based on minimum standards.
- Practitioners may have to adhere to three codes; a national statutory code, an association code and a profession code.
- There are issues of consistency across such a diverse range of professions with a statutory code.
- Should be a national code administered by States and Territories (HCC's) (no national office).
- First option does not safeguard public.
- Alternative is option 2 with government prohibition order included.
- Some professions have yet to be represented by a national association (eg: AIN's).
- Option 3 has legislative power behind it but smaller groups want to avoid the 'big stick' approach needs to have a positive spin.

Do you have a preferred option?

- Option 3 was the unanimous choice by all groups, provided:
  - Does not stop associations from developing the profession;
  - Associations needed for each role.
  - One group did have a concern with negative licensing in not stopping rogue operators practising offshore, thought their own association's internal processes would be better.
- Option 3 is the safety net and should be the 'bottom line'.
- Association's own processes for dealing with rogue operators also need to be acknowledged.

How important is national uniformity?

- Important in terms of Codes of Conduct, but in terms of administration, State based HCC's could deal with it.
- In relation to national, cross jurisdictional reporting – very important.
- Not all associations have the ability to create interstate records.
- There has to be national consistency to stop similar health practitioner breaches in the past, happening again.
- One national body per profession.
- With enforcement, how would State based associations communicate decisions if there was not at a national framework, would mutual recognition be a viable alternative? Would it promote consistency, limiting movement of practitioners?
- Uniformity provides portability across states and territories avoids skipping to other professional groups.

- Significant cohort of overseas trained practitioners needs to be regulated.
- How are standards, qualifications and accreditation assigned to national associations?
- AIN's do not have a national assn, could they be licensed (along with other nursing cohorts) under NRAS (eg similar to the Dental Board process).

Should there be a single national Code of Conduct for unregistered health practitioners?

- The code of conduct needs to be broad enough to accommodate all professions – the NSW model can accommodate a broad range of professions.
- The NHS has mapped out a negative licensing model – should research this model and their benchmarks.
- There is a public perception that the self regulatory process has failed the public in some professions.
- Education of public about regulatory systems is paramount.
- There has to be national consistency to stop similar health practitioner breaches in the past, happening again.
- Yes

Should there be separate State and Territory regulatory schemes, or a single nationally administered scheme with State and Territory based enforcement?

- State level would be the most cost effective. Need to balance cost to public benefit.
- Setting up new national body and information system may be cost prohibitive.
- Support for national negative licensing scheme, monitored nationally for consistency, and offices in each State and Territory.
- Relationship between AHPRA, Police, government body (HCC), clear communication.
- Given the cost of setting up a national body to administer option 3, this function could be taken on by HCC's.
- Health ministers at the AHWMC would need to agree on code of conduct and subsequent (Queensland lead) state based legislation.

Do you have any other comments or issues you wish to raise?

- Need to heed any lessons learnt from setting up NRAS (expensive and time consuming, requiring many changes in legislation)
- Lessons learnt from NSW negative licensing scheme.
- Explore whether the option of utilising the processes of the NSW and SA models would be more efficient in designing a national program to facilitate option 3.
- Option 3 would be effective for health professions which are not coordinated (represented by an Association) and have no specified code in force or standards developed.
- A public education program is essential.
- Have professions education programs accredited by a government agency.
- Set up a database for nationally identified associations for the public to access.
- Need for national support or framework for professions wanting to form national associations (eg: AIN's)
- Need for establishing a benchmark for national associations, support for mechanism to accredit education programs.
- A register to enable members of the public to find practitioners.
- Limited choice of alternative professions for public in rural and remote areas.
- Mechanism to track 'rogue' practitioners who have left a registered workforce and are now working in an unregulated environment.

Darwin 28 March 2011 *29 attendees*

Do you think there is a problem?

Yes

- Confusion for consumers – where do I go if I have a problem, don't know who is registered who is not or levels of qualifications etc.
- Independence for practitioners through registration rather than employer-based recognition (paramedics).
- Gatekeeping of entry into National Registration scheme prevents other health practitioners from entry.
- No minimum standard at present.

Do you think there is a need for further protections for consumers?

- Need to protect consumer.
- Need to accredit/regulate professional associations.
- Self-regulation works for some health practitioners but disciplinary action can be difficult.
- Need to strengthen complaints mechanisms.
- How to deal with people outside of the self-regulation system.
- Remote issues:
  - Lack of access to services and complaint system may further limit access.
  - Complaints process may not translate across cultures.
  - Cultural competence should be a part of the code of conduct.

What do you think of the three options? Are there other options?

Option 1

- Only if more entry into registration system.

Option 2

- Self-regulation may be appropriate for some practitioners who already have strong associations however it does not deal with those who do not belong to associations.
- Not enough on its own.
- Professional associations need to separate membership and complaints/disciplinary process.

Option 3

- National code of conduct.
- Similar administration to AHPRA.

Do you have a preferred option?

- Support national scheme.
- National level preferred for codes of conduct and complaints.

How important is national uniformity?

Important

Should there be a single national Code of Conduct for unregistered health practitioners?

- National code of conduct and national prohibition orders with State/Territory base.

Should there be separate State and Territory regulatory schemes, or a single nationally administered scheme with State and Territory based enforcement?

- Should have same process/entity as registered health professions.

- Stream-lined and clear for consumers – current notification process at AHPRA not clear.
- Processing at state/region but national umbrella and continuity as well as national code of conduct and national public register of prohibition orders.

Do you have any other comments or issues you wish to raise?

- Why have two scheme – registered/unregistered practitioners?
- Need for practice managers/practice owners to also be held accountable.
- Issue of funding and vulnerability to cutbacks if government funded

Canberra 29 March 2011 *30 attendees*

Do you think there is a problem?

Yes

- Practitioners who do the wrong thing, quacks and charlatans.
- Different standards of education across the range of practitioners and the level of association involvement.
- Unqualified practitioners, poor case management, over-servicing, poor practice.
- Extent and magnitude of the problem is not really known, however potential for high risk behaviour such as sexual assault, physical, emotional and psychological damage.
- Problem with dealing with practitioners who are deregistered from their professional association but may still practice.
- Employers can also direct practitioners to do the wrong thing, so they should also be considered.
- Problem around use of title and who can practice – 3 yr courses versus 3 day workshop but both can use same title.

Do you think there is a need for further protections for consumers?

- Association membership does not avoid ‘dodgy’ practitioners and issue of governance with associations – what legal standing do they have?
- Issue with no entry criteria even if a negative licensing scheme is developed.
- With negative licensing there is no requirement for entry level qualifications, membership of an association or if associations themselves are bona fide.
- Need for better education for consumers regarding good service and how to make complaints.
- Associations need to do more public education as to what there membership stands for re qualifications, standards of practice and so on.

What do you think of the three options? Are there other options?

Option 1

- Not an option

Option 2

- Professional associations good but need to be backed up by greater intervention for major breaches.
- Need regulation/government accreditation of peak bodies and associations if meet standards of governance and have accredited complaint handling mechanisms. Would give for legitimacy and kudos for self-regulation.
- National code should for the base for all professional association standards which they could then make additions to for specific profession needs.
- Potential conflict of interests for professional associations – they represent their profession and this may impinge on their ability to also discipline members.
- However option 2 will not capture the real problem people.

- Would need to build in mechanism that requires people to be a member of a professional body/association.
- Natural therapies have about 165 professional associations – how would this be viable for accreditation?
- What happens with small professional associations with only minimal numbers in their profession (cardiac perfussionists)?
- Would need national body to handle serious complaints or where associations do not have the resources to manage complaints.

Option 3

- If there is going to be a code of conduct it should be national and administered nationally.
- Query whether same level of intervention need for all fields of practice – look at whether there are higher risk health practices and include these rather than low level risk.
- Best for consumer but may be difficult to implement.
- What level of complaints will they investigate – all or only high order?

Do you have a preferred option?

Option 4 with components of Option 2 & 3:

- National code of conduct.
- National administration but State based offices (possibly existing organisation).
- National database and mutual recognition of prohibition orders.
- Mix of professional associations and process for worst cases may be a good option.
- Public register of accredited practitioners.
- Where professional associations are doing the right thong need to reinforce this but need to have national code and body to deal with high order problem practitioners.

How important is national uniformity?

National uniformity is important.

Should there be a single national Code of Conduct for unregistered health practitioners?

Yes, single national scheme recommended.

Should there be separate State and Territory regulatory schemes, or a single nationally administered scheme with State and Territory based enforcement?

- National code of conduct.
- National administration but State based offices (possibly existing organisation).
- National database and mutual recognition of prohibition orders.
- National code of practice and body assures continuity and consistency and does not impose higher costs on smaller states.
- Separate State/Territory enforcement may lead to problems with mutual recognition of prohibition orders which places the public at risk and allows problem practitioners to move from State to State.
- Increasing level of internet services also mean that State boundaries are irrelevant.

Do you have any other comments or issues you wish to raise?

- What is the articulation point between registered and unregistered practitioners?
- Need for education of both consumers and practitioners around code of conduct and good practice.
- Training being through universities rather than private colleges to ensure competency.
- Negative licensing still does not legislate for minimal qualifications and education standards and therefore a barrier to entry.

Hobart 30 March 2011

26 attendees, 2 apologies

Do you think there is a problem?

Yes

- Potential for harm varies but it is significant.
- Have associations but no regulation and some practitioners have limited education/training and no self-regulation. Need qualifications to be appropriate to professional title.
- Limited capacity of professional associations to deal with problem practitioners.
- Minimum training requirements need to be articulated and strengthened.
- Lack of complaints process and recourse – need to protect the public.
- Consumers need more information about standards and how to complain.
- Limited consequences if complaints are raised.
- Cannot control people who are not members of professional associations.
- Employers are employing people who do not have adequate qualifications or recency of practice.
- Anyone can set themselves up as a psychotherapist/counsellor with minimal or no qualifications. Some people have considerable personal/psychological problems and use the workplace to deal with their own issues rather than clients.
- Some practitioners effectively regulated by employer (pharmacy assistants, paramedics) – can lead to problems because of employment relationship.
- Lack of protection of title and scope of practice.
- Need security within the system – should not just rely on consumer complaints.
- Health fund fraud.

Do you think there is a need for further protections for consumers?

- Need more teeth to deal with rogue/bogus practitioners.
- Develop/support associations as additional protection.
- Some unregistered health practitioners should have national registration (for example paramedics)
- Need minimal standards across all jurisdictions.
- Need to identify health practices that have the highest risk of harm and have stronger control for these. National scheme for these and perhaps a local scheme for others.
- Code of conduct is one component of minimal national association.
- Need for further education of general public to know what are acceptable standards, service, what to expect from a practitioner and how to identify a good practitioner as well as how to make a complaint.
- Lack of appropriate referral when problem is beyond the practitioner.
- Natural/herbal therapies may interfere with existing medications.
- Consumers are disempowered especially vulnerable clients.

What do you think of the three options? Are there other options?

Hard to see one solution, given the range of health practitioners covered by the scheme.

Need:

- Certification of self-regulating associations.
- National code/organisation
- Protect the vulnerable and uninformed through Option 3.
- National scheme to enable portability with enforcement/prohibition at national level but local State administration.
- Negative licensing does not have capacity to monitor practitioners, restrict entry, ensure qualifications and build public confidence.

- Should be looked at from a risk perspective – a true risk analysis to identify high risk practitioners, rather than decisions largely driven by professional size or likely cost of appropriate registration.

Option 1

Not an option.

Option 2

- Only appropriate if low risk or existing rigour.
- Essentially no change from current practice as many fields of practice already have self-regulation.
- Need improvements in self-regulation.
- Need national self-regulation not numerous State associations.

Option 3

- Good starting point.
- Enforcement is the issue – protection of most vulnerable.
- Financial incentive and reassurance for consumer.
- Need clear roles for prosecution and conciliation – Federal prosecution and local conciliation or vice versa.
- Reactive approach that waits until something serious has happened.
- No competency assessment.
- Need for public education to encourage and accept public complaints.

Do you have a preferred option?

Prefer 4th option:

- Professional associations strengthened with codes of conduct and standards (if they do not already exist) and need to be consistent with national code of conduct given government will need to enforce standards.
- Minimum qualifications requirement.
- National generic mandatory code of conduct.
- Code of conduct for those who do not have a professional association.
- Professional development/CPD requirements via professional associations or code.
- Clarity on the responsibilities of practice owners/managers of practices.
- Need robust solution not substandard reform.
- Complaints to be able to be made by range of people – other practitioners, consumer, family etc.

How important is national uniformity?

Important:

- National uniformity with State, rural and regional voice.
- Continuity across Sates important.

Should there be a single national Code of Conduct for unregistered health practitioners?

- Minimal national standard for those without professional associations and the code would form the basis of all professional association codes of conduct.
- Code of conduct should be national.

Should there be separate State and Territory regulatory schemes, or a single nationally administered scheme with State and Territory based enforcement?

- Need national scheme but State/Territory/region based enforcement.
- See potential for national body along lines of AHPRA but general consensus fro Health Service Complaints at State level to deal with complaint. However need some form of national entity to enforce standards across all professions and for national prohibition orders.

- National consistency, State-based complaints.

Do you have any other comments or issues you wish to raise?

- Issue of compensation for malpractice/breach of code.
- Access to online learning to upgrade skills/qualifications if this is required.
- Implementation plan must include a community education plan.
- Need for broader professional practices outside of serious complaints such as record keeping, patient information, mandatory reporting by other practitioners.
- Lesser protection for the public for practitioners outside of NRAS which allows practitioners who would never be allowed to practice if practitioners were included in the scheme to continue to practice.
- Code should include some level of mandatory requirement such as membership of professional association.

Perth 1 April 2011 *60 attendees*

Do you think there is a problem?

- Safety and quality of service to the consumer and they not be aware of the problem.
- Regulation may be through the employer but they may employ people who do not have the correct qualifications (pathology practices).
- Quasi health practitioners who do not have proper educational standards or belong to professional association (shopping centre booths).
- Problem dealing with people who do the wrong thing – no power to enforce decisions.
- Problems with supply/demand can create people with lesser qualifications being employed (interpretors, OHS officers on remote sites).
- Small but serious breaches of behaviour by some practitioners in complementary medicine.
- Under complaining – difficult for people in fragile situations, their families or those in an employment arrangement to complain.
- People may not realise they have had poor treatment.
- No restriction or minimal qualification so people may be working beyond their competency level.
- National code of conduct gives scope to take action.

Do you think there is a need for further protections for consumers?

- Protection for the consumer.
- Protection for those practitioners doing the right thing whose reputation is also lost when the public lose faith when encountering poorly trained or rogue practitioners.
- Education for the consumer about how and where to complain, however where action has had a major impact on the consumer they may be too fragile and unable to complain and progress the action themselves.
- Need support and resources to underpin any new regulations.

What do you think of the three options? Are there other options?

The three options do not cover all needs – 4th option needed.

Option 1

Not sufficient.

Option 2

- Many professional associations run on a volunteer basis and do not have the resources or necessarily the skills to undertake a monitoring/complaints role.

- Good to strengthen associations in terms of education, CPD, code of ethics etc. but not to take on regulation.
- Would need some government support.
- Should be government regulation.

Option 3

- National register of prohibition orders.

Do you have a preferred option?

- Combination of 2 & 3
- Option 3
- Option 4 (a new option)

How important is national uniformity?

National uniformity is important.

Should there be a single national Code of Conduct for unregistered health practitioners?

- Single national code of conduct is imperative.
- Would mandatory reporting for other practitioners be included in the code of conduct?
- Should employers be liable for conduct of staff?
- Should the code include a minimum level of qualification

Should there be separate State and Territory regulatory schemes, or a single nationally administered scheme with State and Territory based enforcement?

- A national scheme with State offices and a central registry.
- Needs to be consumer focused.

Do you have any other comments or issues you wish to raise?

- Working definition of health practitioner?
- How do you protect employees when the employer regulator has their own interests at heart rather than the profession?
- Can complaints come from employer, other professional, family as well as the consumer.?
- What happens where there are multiple organisations/associations in a particular profession? How would they be recognised in an accreditation process?
- Increased oversight of practitioners will benefit the professions as well as the public.
- Need for a public education campaign including forums, talk-back radio, print media etc.

Sydney 4 April 2011

40 attendees

How well is the NSW Code of Conduct working?

- Good experience with the code. Only problem is that it is not a national code so practitioners who have breached the code in NSW have gone to other States to practice.
- No protection of title and practitioner will only come to notice of authority once a problem has occurred.
- Code of conduct working well in educating the next generation of practitioners.
- Code is broad so it allows broad action.
- Relationship with court system – recently took down prohibition order after court action cleared practitioner.
- Requires public awareness to be successful – need to display code of conduct and public education.

What do you think of the three options? Are there other options?

Option 2

- Some professional associations only run by volunteers so do not have the capacity to under monitoring or complaints process.
- Need another body for investigation, judgement and enforcement.

Do you have a preferred option?

- Option 3 but need some probity checking
- Option 3 or perhaps Option 4 that allows for some co-regulation with professional associations with some accountability standards for associations.

How important is national uniformity?

- Would like to see a national code of conduct and a register of offenders.
- National uniformity is important.
- Practitioners should have the same standards across all jurisdictions.
- Unifying if it is a national code of conduct.
- Standardises practice which is useful where there are a large number of associations in the one practice modality.

Should there be a single national Code of Conduct for unregistered health practitioners?

- Complementary legislation across Australia – mutual recognition does not work.
- Adopt membership of a professional association into the code of conduct ?(already done for health insurance rebate).

Should there be separate State and Territory regulatory schemes, or a single nationally administered scheme with State and Territory based enforcement?

- Single national health complaints entity such as AHPRA or health complaint entities with some national coordination.
- National body but local administration.
- Complaints for all health practitioner registered or otherwise should be in the one place – cheaper, already exists and means all practitioner are treated the same way.

Do you have any other comments or issues you wish to raise?

- How do we add ethical issues specific to professions.

Alice Springs 6 April 2011 *10 attendees*

Do you think there is a problem?

Not as much as else where, because in a small community when and if there is a problem with a practitioner everyone knows about it and is able to make an informed decision.

Do you think there is a need for further protections for consumers?

Yes

What do you think of the three options? Are there other options?

While national continuity may be important in terms of having the same standards for all practitioners, it is difficult in small remote communities to get qualified staff and the loss of staff may mean that there is no service at all, So it is difficult to weigh up whether having a less than ideal service is better than having no service at all. A national standard may impact unfairly on a small remote community.

Do you have a preferred option?

Preferred option 3

How important is national uniformity?

More concerned with making sure that the nature and specific needs of remote communities are taken into account and that national uniformity does not diminish the services they are able to provide.

Should there be a single national Code of Conduct for unregistered health practitioners?

Yes, but need to be aware that remote areas have difficulty attracting qualified staff and that any standards need to be able to encompass this.

Should there be separate State and Territory regulatory schemes, or a single nationally administered scheme with State and Territory based enforcement?

Emphasised the need for administration at a regional level whatever the nature of the regulatory scheme.

Do you have any other comments or issues you wish to raise?

No

Appendix 15

Submissions to the national consultation on Options for Regulation of Unregistered Health Practitioners

Submission no.	Submitting entity	Profession
	Professional Associations	
13	A1 Australian Dental Association, WA	Dental Technicians
26	A2 Australian Assoc of Clinical Hypnotherapy & Psychotherapy	Clinical Hypnotherapy
31	A3 Australian Homeopathic Association (WA)	Homeopathy
38	A4 Professional Hypnotists (WA) (PHWA)	Hypnotherapy
44	A5 Australian Professionals in Cardiac Science	Cardiac Science
52	A6 Australian Traditional-Medicine Society	Natural Medicine
54	A7 International Bioresonance Practitioners Assoc Inc	Sonography
59	A8 Society of Natural Therapists & Researchers Inc	Natural Therapy
60	A9 Victorian Allied Health Leaders Council	Allied Health
61	A10 Reiki Association of Australia Inc	Reiki
62	A11 Australian & NZ Arts Therapy Association	Arts Therapy
68	A12 Association of Massage Therapists Ltd	Massage Therapy
69	A13 Australian Natural Therapists Association	Natural Therapy
71	A14 Australian Reiki Connection Inc	Reiki
73	A15 Australian Dental Prosthetists Association Ltd	Dental Prosthetics
75	A16 Australian Medical Association	Medical Practitioners
76	A17 Australian Sign Language Interpreters Association WA	Sign Language Interpreters
78	A18 Australian Institute of Interpreters & Translators WA Branch, Independent Practising Interpreters Association	Language Interpreters
79	A19 Australian Orthotic Prosthetic Association Institute	Orthotics & Prosthetics
84	A20 Psychotherapy & Counselling Federation of Australia	Counselling
86	A21 Australian Hypnotherapists Association	Hypnotherapy
87	A22 Australian & NZ College of Perfusionists	Perfusion
88	A23 Naturopaths for Registration	Naturopaths
92	A24 Australian & NZ Society of Respiratory Science Inc	Respiratory Science
93	A25 Queensland Professional in Cardiac Sciences	Cardiac Science
95	A26 Australian Counselling Association Inc	Counselling
100	A27 Australian Association of Massage Therapists	Massage Therapy
101	A28 Reiki Association, Wellspring Clinic, Australian College of Vibrational Healing, The Reiki Alliance, International Reiki Jin Kei Do & Buddho/Enersense Training Institute, SA Healing & Teaching Centre, Gendai Reiki Network Australia	Reiki
102	A29 Oral Health Professional Association	Oral Health
103	A30 Pharmaceutical Society of Australia	Pharmacy Assistants
107	A31 Speech Pathology Australia	Speech Pathology
109	A32 Australasian Society of Anaesthesia Paramedical Officers	Anaesthetic Technicians
110	A33 Exercise & Sports Science Australia	Sports Science
113	A34 Australian Register of Counsellors & Psychotherapists	Counselling
114	A35 Australian Music Therapists Association	Music Therapy
115	A36 Australian Dispensing Opticians Association	Opticians
117	A37 Dietitians Association of Australia	Dietitics
118	A38 Australian Physiotherapy Association	Physio Assistants
121	A39 Australian Society of Ultrasound In Medicine	Sonography
122	A40 Paramedics Australia	Paramedics
123	A41 Australian Sonographers Association	Sonography
125	A42 Australian Institute of Medical Scientists	Medical Science

Submission no.	Submitting entity	Profession
126	A43 Psychotherapists & Counsellors Assoc of WA	Counselling
128	A44 Australian Sleep Technologists Association	Sleep Technologists
129	A45 Australian Association of Social Workers	Social work
133	A46 Shiatsu Therapy Association of Australia	Shiatsu
134	A47 Australian Usui Reiki Association	Reiki
136	A48 Australian Acupuncture & Chinese Medicine Association Ltd	Acupuncture/Chinese Medicine
137	A49 Australian Institute of Medical & Biological Illustrations	Medical Illustration
138	A50 Health Services Union East	Health Workers
141	A51 Australian Register of Naturopaths & Herbalists	Naturopathy/Herbal Medicine
142	A52 South Australian Society of Hypnosis	Hypnosis
143	A53 Western Australian Institute of Translators & Interpreters Inc	Interpreting
144	A54 Orthoptics Australia Western Australian Branch	Orthoptics
145	A55 Complementary Medicine Association	Naturopaths
42	A56 Lactation Consultants of Australia & New Zealand	Lactation Consultants
153	A57 National Herbalists Association of Australia	Western Herbal Medicine & Naturopaths
154	A58 Australian Association of Professional Hypnotherapists & NLP Practitioners	Hypnotherapy & NLP
156	A59 Reflexology Association of Australia	Reflexology
158	A60 Australian Nursing & Midwifery Federation (SA Branch)	Personal Care Workers
159	A61 Audiology Australia	Audiology
160	A62 Australian Dental Association Inc	Dental Technicians
161	A63 The Australian Register of Homeopaths Ltd	Homeopaths
163	A64 Australian Homeopathic Association Inc	Homeopaths
164	A65 Australian Registry of Emergency Medicine Technicians	Paramedics
166	A66 Royal College of Nursing, Australia	Personal Care Workers
167	A67 The Pharmacy Guild of Australia	Pharmacy Assistants
170	A68 Australian Nursing Federation	Nursing
175	A69 Australian Dental Industry Association Ltd	Dental technicians & assistants
177	A70 Australian Audiologists in Private Practice	Audiologists
179	A71 Cosmetic Physicians Society of Australasia Inc	Unregistered Health Practitioners/Beauty therapists
178	A72 Audiology Australia NSW	Audiologists
70	A73 Australian Naturopathic Practitioners Association	Naturopaths
171	A74 International Association of Infant Massage	Infant Massage
	Consumer Representative Bodies	
99	B1 Australian False Memory Association	Counselling
106	B2 Consumer Health Forum of Australia	Unregistered Health Practitioners
127	B3 Health Consumers Queensland	Unregistered Health Practitioners
149	B4 Queensland Consumer Association Inc	Dental Technicians/Speech Pathologists
173	B5 Public Interest Advocacy Centre	Unregistered Health Practitioners
	Government Departments & Regulators	
4	G1 Confidential	Dental Technicians
34	G2 Australian Pain Management Association	Unregistered Health Practitioners
66	G3 Medical Radiation Practitioners Board of Victoria	Sonographers
94	G4 Disability Service Commission of WA	Disability Workers
97	G5 Confidential	Allied Health
130	G6 Dental Technicians Board of Queensland	Dental Technicians
131	G7 Australian Orthoptic Board	Orthoptics
147	G8 Confidential	Health
150	G9 Australian Competition & Consumer Commission	Unregistered Health Practitioners
32	G10 Speech Pathology Registration Board of Queensland	Speech Pathology

Submission no.	Submitting entity	Profession
165	G11 Consumer Affairs Victoria	Unregistered Health Practitioners
174	G12 Australian Health Practitioner Regulation Agency	Health Practitioners
176	G13 Consumer Protection Western Australia	Consumers
	Health Complaints Entities	
57	H1 NSW Health Care Complaints Commission	Unregistered Health Practitioners
148	H2 Ombudsman& Health Complaints Commissioner Tasmania	Unregistered Health Practitioners
152	H3 Health Service Commissioner Victoria	Unregistered Health Practitioners
155	H4 Qld Health Quality & Complaints Commission	Unregistered Health Practitioners
169	H5 Health & Community Services Complaints Commission NT	Unregistered Health Practitioners
	Individual Consumers	
3	C1 Name Withheld	Counsellors/Psychotherapists
8	C2 Confidential	Disability workers
9	C3 Bruce Arnold	Unregistered Health Practitioners
17	C4 Susan Monti	Personal Carers
33	C5 Name Withheld	Unregistered Health Practitioners
63	C6 Name Withheld	Sonography
98	C7 Name Withheld	Counselling
132	C8 Alison Xamon	Counsellors/Psychotherapists
139	C9 Confidential	Counselling
157	C10 Carline Humfrey	Counselling
35	C11 Confidential	Counsellors/Psychotherapists
	Individual Practitioners	
1	P1 Name Withheld	Aged Care Workers
6	P2 Confidential	Dietitians
5	P3 Brian Masters	Unregistered Health Practitioners
7	P4 Meah Robertson	Naturopathy
10	P5 Amanda Mannes	Nutrition & Dietetics
11	P6 Name Withehld	Unregistered Health Practitioners
12	P7 Confidential	Orthotics
14	P8 Confidential	Social Work
15	P9 Name Withheld	Social Work
21	P10 Jack O'Connor	Social Work
16	P11 Jeanne Lorraine	Social Work
18	P12 Jeremy Sweeting	Social Work
19	P13 Stephen Graham Brown	Social Work
20	P14 Janette Kostas	Social Work
23	P15 Name Withheld	Social Work
24	P16 Elizabeth Rocha	Social Work
25	P17 Charles Westheafer	Social Work
27	P18 David Nielsen	Aged Care Workers
28	P19 Michelle Moulos	Social Work
29	P20 Name Withheld	Unregistered Health Practitioners
30	P21 Lulu Langford/Kenzig	Natural Therapy
105	P22 Melita Brown	Speech Pathology
36	P23 Veronica Griffin	Natural Medicine
37	P24 Adam Arthur	Cardio Physiology
39	P25 Emily McKeough	Counselling
40	P26 Sharon Crimmins	Social work
41	P27 Carolyn	Medical Ultrasound
45	P28 Mary Higgins	Personal Carers
47	P29 Tina Hamlyn	Medical Ultrasound
48	P30 Name Withheld	Kinesiology

Submission no.	Submitting entity	Profession
50	P31 Michael Vagg	Unregistered Health Practitioners
53	P32 Zoe	Counsellors/Psychotherapists
55	P33 Name Withheld	Unregistered Health Practitioner
64	P34 Confidential	Audiology
74	P35 George Dimitriadis	Homeopathy
77	P36 Name Withheld	Social work
81	P37 Kerryn Pennell	Social Work
82	P38 Confidential	Church of Scientology
83	P39 Louise Collingridge	Audiology
85	P40 Sue Nesham	Social Work
90	P41 Confidential	Education
91	P42 Kate Puls	Unregistered Health Practitioners
96	P43 Katrina Fischer	Cardiac Science
104	P44 Name Withheld	Speech Pathology
112	P45 Mark Whitman	Cardiac Science
116	P46 Sue Cummings	Social work
119	P47 Confidential	Social work
120	P48 Trudi Marchant	Social work
140	P49 Name Withheld	Social Work
	Individual Students	
2	S1 Name Witheld	Naturopathy
46	S2 Confidential	Paramedics
72	S3 Deborah Sauvage	Social Work/Counselling
	Education & Training Organisations	
21	E1 Usui Reiki Network	Reiki
43	E2 National College of Neuro-Linguistic Communication	Hypnotherapy
51	E3 Academy of Applied Hypnosis	Hypnotherapy
56	E4 Nature Care College Ltd	Natural Medicine
58	E5 Australian & Pacific College of Clinical Hypnotherapy	Hypnotherapy
135	E6 Asia Pacific Reiki Institute	Reiki
	Health Funds	
65	F1 nib Health Fund	Unregistered Health Practitioners
172	F2 Medibank Private	Unregistered Health Practitioners
	Peak Bodies/Service Providers/Employers	
49	O1 NSW Medical Service Committee	Unregistered/Deregistered Health Practitioners
67	O2 Services for Australian Rural & Remote Allied Health	Peak Body
80	O3 Aged Care Queensland Inc	Aged Care Workers
151	O4 Aged Care Association Australia	Aged Care Workers
108	O5 Metro South Health Service District	Dental Technology/Speech Pathology
89	O6 Complementary Health Care Council	Unregistered Health Practitioners
111	O7 Cancer Council of Western Australia	Unregistered Health Practitioners
124	08 Private Hospital Assoc Qld, Australian Private Hosp Assoc, Catholic Health Aust, Ramsay Health Care	Hospitals
146	O9 United Voice – Ambulance Section	Paramedics
162	O10 Council of Ambulance Authorities Inc	Paramedics
168	O11 Bupa Australia	Aged Care Workers
180	O12 United Voice – Aged Care Union	Personal Carers
181	O13 Hearing Care Industry Association	Audiology
182	014 Statewide Anaesthesia & Perioperative Care Clinical Network	Anaesthetic Technicians

Appendix 16

Summary data of views of respondents

Question	Response	Number of responses	Organisation
Please estimate of the number of unregistered health practitioners practising in your field.	Between 1000 and 2000 Reiki practitioners	4	URN, RAA, ARC, RA
	1408 Speech Pathologists registered in QLD	1	SPBQ
	2209 International Board Certified Lactation Consultants	1	LCANZ
	11,413 members with 15,000 (est.) in industry	1	ATMS
	60 members with another 35 non-members (est.) in Australia	1	IBPA
	Around 1200	1	ANZATA
	Over 3000 members nationally	1	ESSA
	Approximately 5500 sonographers (including trainees)	1	MRPBV
	942 members	1	RAoA
	30,000 massage therapy practitioners Australia-wide	1	AMT
	5900 members	1	ANTA
	Approx 2000 audiologists and 500 audiometrists	1	HCIA
	Between 100–200 unregistered cardiac scientists in QLD	2	QPCS
	Between 18,000 and 20,000 social workers	3	AASW
	Approximately 7000 personal care assistants in SA	1	ANMFSA
	Approximately 19,000–20,000 paramedics Australia-wide	2	PA, CAA
	Nearly 2000 audiologists	1	AA
	Between 3000 and 15000 naturopaths and western herbalists	2	NRF, ARONAH
	4,540 accredited sonographers and 595 sonography students (Nov 2010)	1	ASA
	Approx. 700 homeopaths registered with professional associations	2	AHA, AROH
	Est. 320 Orthotist/Prosthetists in Australia	1	AOPA
	Est. up to 600 sleep technologists in Australia	1	ASTA
	Est. 15,000 full time and 27,500 part-time pharmacy assistants	1	PGA
	Approx. 75 to 100 medical photographers and illustrators	1	AIMBI
	Approx. 850–900 shiatsu massage therapists in Australia	1	STAA
	At least 600 practising orthoptists in Australia	1	AOB
	117 clinical members and 140 working towards it	1	PACAWA
	27,000 counsellors Australia wide (includes some registered practitioners)	2	PACFA, ARCAP

Question	Response	Number of responses	Organisation
	Up to 900 respiratory scientists working in Australia	1	ANZSRS
	Approximately 13,000 medical laboratory scientists practice in Australia	1	AIMS
	Approximately 650 members	1	AHyA
	3,189 unregistered dental technicians	1	OHPA
	84,746/60,000 personal care workers in residential/community aged care	1	ACQ
	157 certified infant massage instructors	1	IAIM
	3,270 optical dispensers (2006 census data)	1	ADOA
	4,500 members, representing 85% of the profession	1	DAA
	2650 dental technicians in Australia	1	ADPA
	383 registered music therapists	1	AMTA
	1000 – 1500 anaesthetic technicians nationwide	1	ASAPA
	Approx. 7000 counsellors/psychotherapists in Australia	1	ACA
	8,197 massage therapists practising in Australia	1	AAMT
	Between 4,000 and 5,000 naturopaths practising in Australia	1	CMA
What do you think are the risks associated with the provision of health services by unregistered health practitioners?	Incorrect or damaging information/advice	7	VAHLC
	Inconsistent, non-evidence based practice	6	SPA, AFMA, HSC
	Practitioners without tertiary training	1	
	Lack of practice standards/inconsistent standards	7	MRPBV, PACAWA, HQCC, HSC
	Lack of appropriate training/barriers to entry	21	NCC, RAA, ANZATA, ANZCP, AA, SPA, ASTA, AACMA, BUPA, ANZSRS, AIMS, AMTA, ASAPO, NHAA, HQCC
	No complaints process	6	MRPBV, NFR, DAA, ADPA, HSC
	No professional standards/organisation to guide practice	6	RAA, ESSA, ARONAH, PACAWA
	Lack of title protection	6	SPBQ, AASW
	Lack of professional ethics/ethics issues	4	SPA, PACFA, IBPA
	Misleading clients in potential results of treatment	12	URN, RAA, ANZATA, ARC, AA, AHA, AACMA, RA, CMA
	Consumers unable to pursue malpractice compensation	1	
	Improper or no follow-up care even when referred	1	
	Practitioners not accountable	7	DAA, AMTA, HQCC, HSC
	Practitioners abusing position of power and trust	1	SPBQ
	Unqualified practitioners	5	ATMS, TOHCC, NFR, AFMA
	Practising outside scope of practice	9	VAHLC, AMT, NFR, ASA, AIMS, ADPA, RA
	Practising with a lapsed qualification	1	

Question	Response	Number of responses	Organisation
	Incorrect use of medical devices	5	ASTA, ANZSRS
	Risks are low [for my profession]	6	PACFA, ARCAP, AHyA, ACA, HCIA
	Increased community mistrust of established professions	2	AIMBI
	Breaches of privacy	1	VAHLC
	Failure to refer	6	VAHLC, AHA, RA, NHAA, CMA
	Inappropriate interactions with clients/professional boundary issues	2	VAHLC, AMT
	Improper infection control	5	VAHLC, PA, ASA, AACMA, ADPA
	Failure to address mental health needs e.g. psychosis	2	ANZATA, HSC
	Volunteer organisations	1	
	Alternative medicine	1	
	False positive or false negative results	2	MRPBV, CCWA
	Sexual assault/misconduct	8	AMT, ARC, TOHCC, ASA, AHA, AACMA, RA, AAMT
	Unsafe work environment	1	ARC
	Professional reputations are at risk by unregistered practitioners bringing profession into disrepute	2	
	Undetected or overlooked underlying medical conditions/deterioration in conditions	5	AHA, AOB, QPCS, CPSA, CMA
	Misdiagnosis/inaccurate interpretation of results	9	ASA, ASTA, AOB, QPCS, ANZSRS, NHAA
	Failure to avoid drug interactions or to observe contraindications	2	CHCA
	Financial loss/exploitation	5	ARONAH, AHA, CCWA, HSC
	Additional burden/cost for community due to delayed/incorrect diagnosis	2	ARONAH
	Unscrupulous practitioners isolating clients from other sources of emotional support	2	AFMA
	Exploitation of mental health consumers/vulnerable clients	7	SPA, AASW, SASH
	Harm to new clients by known offenders/unethical practitioners who continue to practice	1	
	Psychological risks and PTSD potentially affecting fitness to practice	1	PA
	Environmental risks in EMS environment	1	PA
	Risks associated with supply of ingestible substances such as herbs	3	NFR, NHAA, CHCA
	Lack of cooperation/distrust between registered practitioners and CAM therapists	1	NFR
	Physical, mental or financial harm	2	DSCWA, AASW
	Unregistered practitioners performing restricted procedures	1	APA
	De-registered practitioners who continue to work in a similar area as an unregistered practitioner.	6	APA, HSUE, AACMA, PACAWA, ARCAP, SASH
	Unprofessional and predatory conduct	1	HSUE
	Poor quality materials	1	ADPA
	Poor quality/accuracy of work	1	ADPA

Question	Response	Number of responses	Organisation
	Suicide as a result of harmful psychotherapy techniques	1	AFMA
	Failure to request or verify informed consent	2	RA, NHAA
	Fraudulent documents with no practitioner registry to verify	1	ASAPO
	Direct damage (burns, scarring) cause by IPL or lasers	1	CPSA
	Similar to registered practitioners (for strong self-regulated professions)	1	CMA
To what extent have the risks associated with these activities been realised in practice?	Patients advised to follow unnecessarily restrictive/faddish diets	2	DAA
	More evident in private practice than public health system	1	
	Patient dissatisfaction with outmoded treatment by unqualified practitioners	1	
	Serious harm done to hospital and community based children by unregulated social workers	1	
	The true extent of the damage is unknown	1	
	The AASE can provide this data	1	
	Unprofessional unregistered practitioners identified as such can move from state to state	1	
	Very little	1	
	Fraudulent product claims/promotion	2	AHA
	Obstetric ultrasound transgressions including tardy reporting to medical practitioners (resulting in loss of pregnancy) and injury to patients	1	MRPBV
	Cases of sexual assault/misconduct	8	AMT, TOHCC, NFR, SASH, HSC
	Untrained counsellors and therapists have inflicted irreparable damage	2	AFMA
	Inaccurate interpretation of results leading to lengthened hospital stays	1	
	Practitioners with mental health problems	1	
	Harm caused by laser machines used by beauticians	1	TOHCC
	Failures to protect children in state care	1	
	Practitioners working under the influence of drugs or alcohol	1	ANZATA
	Unproven treatments for children with Autism Spectrum Disorder	1	DSCWA
	Complaints of unqualified practitioners undertaking ophthalmic procedures	1	AOB
	The risks are generally not realised in practice	1	PACFA
	Incorrect labelling/identification of samples	1	AIMS
	Significant financial cost for no positive health outcomes	1	DAA
	Estrangement, mental breakdown and suicide due to false memory syndrome	1	AFMA
	Improper infection control practices have been associated with death and injury	1	ASAPO
	Using fraudulent documents to seek employment	1	ASAPO
	Theft and sale of medical products	1	ASAPO
	Self-medication with controlled and restricted drugs	1	ASAPO
	Inappropriate or dangerous uses of IPL	1	CPSA

Question	Response	Number of responses	Organisation
Do you know of any instances of actual harm or injury?	Hypoglycaemic episodes in diabetic patients put on low-carb diets	1	
	Non-referral to medical practitioners for serious or potentially serious medical conditions	2	NFR
	Fracture caused by unqualified orthotists	1	
	Unqualified people offering counselling services	1	
	Professional neglect of patients in need	1	
	Physical, psychological and sexual abuse	3	ARONAH
	Professional Standards complaints in QLD	1	SPBQ
	Patients exploited by unproven cancer ‘cures’	5	NFR, CCWA, HSC
	Misconduct performing transvaginal ultrasounds	2	ASA
	Patients seriously financially disadvantaged with life threatening or fatal outcomes esp. cancer treatments	2	MSC, HSC
	Seminars/retreats by unqualified practitioners using Cognitive Psychotherapy techniques	2	IBPA, CPWA
	Untrained/unqualified retailers offering training	1	
	Counsellors failing to address safety issues in domestic violence situations	1	
	Harm caused by untrained arts therapists	1	ANZATA
	B17 poisoning	1	
	False positive or false negative results	2	MRPBV, AIMS
	Failure to refer to a specialist/medical practitioner/monopolisation of care	2	ARONAH
	False memories have destroyed families and caused irreparable psychological damage	2	AFMA
	Financial exploitation/loss	1	
	Damaging 'counselling' services by exploitative practitioners in a cult-like environment	3	CPWA
	Lack of specialised care causing major morbidity or death	1	ANZCP
	Infant fatality due to rice milk diet	1	NFR
	Cases of paediatric mismanagement of diabetes and cerebral palsy	1	NFR
	Patients advised to cease conventional medical treatment	3	ARONAH, AHA, NHAA
	Manslaughter by gross criminal negligence (case study provided)	1	AHA
	Inquest into death of bowel cancer patient by WA coroner (case study provided)	1	AHA
	Prothesis failure	1	AOPA
	Financial detriment in excess of $35,000	1	CPWA
	Depression, anxiety and suicidal thoughts due to false memory therapy	2	CPWA, AFMA
	Unqualified practitioners offering 'cosmetic' homotoxicology	1	AACMA
	NSW social worker using position of trust to lure young victims	1	AASW
	Social worker in public hospital engaging in sexual relations with rehab patient	1	AASW
	Death caused in SA by wrong blood issues following cross-matching	1	AIMS
	Unnecessary procedures undertaken as a result of false positives	1	AIMS

Question	Response	Number of responses	Organisation
	Reiki Australia has acted in two states as an expert witness in sexual assault cases	1	RA
	Patient harm and death associated with poor practice	1	ASAPO
	Burns due to calibration error made by an untrained beauty therapist	1	CPSA
	Patient given false negative result by unproven breast screening technique	1	CCWA
	Failure to detect underlying mental health condition	1	HSC
What evidence is available on the nature, frequency and severity of risks?	Patient feedback/testimony	3	
	Without professional regulation there is no mechanism to accurately monitor.	1	
	Anecdotal	1	
	Websites promoting the use of unscientific diagnostic devices and disproven practices	1	
	Court cases	1	
	ATMS complaints committee processes complaints	1	ATMS
	Incidents are often under reported	8	VAHLC, TOCHCC, ANMFSA, PA, ARONAH, RA
	Indemnity insurance claims	3	AMT, AA, CMA
	HCCC/State complaints data	4	AMT, ARC, SPA, NHAA
	There are a number of research papers into suggestive therapy techniques	2	AFMA
	Overseas data can be extrapolated	1	
	Government service providers' annual reports	1	PA
	Online Perfusion Incident Reporting System	1	ANZCP
	No real mechanism to accurately monitor or record risks	1	AASW
	Cosmetic Surgery Report to the NSW Minister for Health October 1999	1	CPSA
	OHSC data	1	HSC
What factors increase or reduce the risk that individuals will suffer harm as a result of the activities of unregistered health practitioners?	Lack of medical management of medical conditions by unregistered practitioners	1	
	Poor health literacy/ lack of patient knowledge	5	
	Complexity of the condition/number of options for treatment	1	
	Not registering practitioners increases risk	5	ANMFSA, OHPA
	Excessive workload/under staffing	6	AASW
	Lack of training and/or CPD	28	ATMS, NCC, ESSA, ANZATA, ARC, VAHLC, RAA, AOPA, ASTA, AASW, OHPA, DAA, CPSA, HQCC, CMA, AURA
	Lack of accountability	9	ESSA, AMT, AASW, DAA, SASH
	Non-protection of title	10	ESSA, AOPA, AASW, CMA
	Lack of legal structure/recourse	9	AMT, AASW, AFMA, HCQ, HSC
	Lack of remedial/complaints process	8	AASW, CMA, SASH

Question	Response	Number of responses	Organisation
	Practice that occurs in situations of crisis	1	
	No set criteria/framework/scope of practice	3	SPBQ, VAHLC, ASTA
	Vulnerable patients e.g. the elderly, juvenile or chronically ill	12	TOHCC, ACAA, ARONAH, AASW, ACQ, AURA, HCQ
	No requirement for unregistered practitioners to use therapeutic goods that are on the ARTG register	1	
	Professional organisations reduce the risk, but don't eliminate it	1	
	Remote/isolated practice	11	VAHLC, AMT, AASW, PACFA, ANZSRS, HCQ
	Access to certain medications, such as Schedule 1 herbs	1	ATMS
	Potential financial gain from vulnerable clients	1	VAHLC
	Unsupervised practice	7	VAHLC, MRBV, ANMFSA, AASW, PACFA
	No requirement for practitioners to join professional associations	9	RAA, ANMBSA, AOPA, OAB, HQCC
	Strong university accreditation programs decrease risk	1	ESSA
	No barriers to entry/ease of entry	5	AMT, TOHCC, ARONAH, NHAA, HQCC
	Mandatory training grounded in evidence-based studies into memory formation for all mental health providers decreases risk	2	AFMA
	Failure to inform medical practitioner about CAM therapy being undertaken	1	
	Lack of or inadequate peer support	2	TOHCC, PAFA
	Inability to prevent unfit people from practising	5	ASTA, BUPA, AMTA, RA
	Contracting out of government social services	1	
	Reduced risk: access to information; community and peer engagement; transparency in reporting, procedural processes and investigation.	1	PA
	Requirement to hold a current Certificate of Clinical Practice reduces risk	2	AA, AIMS
	Professional or employer codes of conduct reduce risk	5	DSCWA, DAA, RA, CMA, AURA
	Membership of professional associations reduces risk	7	PACFA, DAA, IBPA, NHAA, CHCA, CMA, AURA
	Appropriate training standards for practitioners and supervisors reduces risk	3	PACFA, AIMS, ASAPO
	Informed consent reduces risk	1	RA
	A national registry of practitioners would reduce risk	1	ASAPO
	Appropriate levels of indemnity insurance decreases risk	3	CMA, AURA
	Probity checking decreases risk	1	HQCC
What do you think should be the objectives of government action in this area?	National registration	16	VAHLC, SARRAH, BUPA, QPCS, ANZSRS, ADPA
	Protection of the public from unqualified practitioners	9	AHA, ANZSRS, NHAA, AURA
	Safer practice through more information and training	3	

Question	Response	Number of responses	Organisation
	Ensure standards and protect the public	20	ANZATA, AA, DSCWA, AASW, ANZSRS, RA, HCSCC, HQCC, CMA
	Title protection	6	ESSA, SPA, AODA, CMA
	Set standards of tertiary education	1	
	Develop a national code of conduct and complaints handling mechanism/body	5	URN, RAA, SASH
	Review and assessment to accredit practitioners	1	
	Protect the public /(esp. vulnerable patients)	5	SPBQ, TOHCC
	Controls on what can and cannot be claimed by practitioners	2	
	Immediate response/deregistration for certain offences	1	
	A clear well publicised pathway for public complaints	16	RAA, MRPBV, NIB, AHA, AOPA, STAA, AOB, ADPA, AFMA, RA, AAMT, NTDH
	A minimalist, low-cost, consistent system to protect public and the professions	3	LCANZ, NATCOM, HCIA
	Support national professional bodies/ self-regulation	10	RAA, RAoA, AHyA, DAA, IBPA, ACA, HCIA
	To help unregistered practitioners become recognized for prior learning	1	
	Public education program	13	AMT, AA, STAA, AMTA, AFMA, RA, ACA, CCWA, HCQ, NTDH
	Strengthen TGA and ACC powers to crack down on unlawful claims and deceptive advertising	1	
	Transparent and unbiased safety net for consumers	2	AAMT
	Probity checks administered in partnership with professional organisations	2	ATMS
	Government authentication/support of professional associations	6	ATMS, NCC, NIB, SPA, AHA, ARCAP, AIMS
	Legal recourse for patients who suffer through malpractice or negligence	1	ATMS
	National registration for counsellors and social workers	1	
	Regulatory boundaries and a transparent, consistent regulatory framework	2	NCC, AMT
	Require all government health employees to belong to peak professional body	1	ESSA
	Certainty for consumers that service will be of a high quality/certain standard	4	MRPBV, NIB, AMTA, NTDH
	Require practitioners claiming a health benefit to belong to peak professional body	4	NIB, SPA, AHA, CMA
	Require practitioners to display their local health care complaints process for consumers/patients	1	NIB
	Ensure all mental health practitioners have compulsory training	2	AFMA
	Requiring doulas who are effectively practising midwifery to be registered	1	
	Protect health, safety and wellbeing of Australian public	9	SPA, ARONAH, ASA, AOPA, HSUE, AAMT, HSC
	Maintain a wide range of services while ensuring minimum standards are met	1	
	Develop a process by which unfit persons can be banned from delivering a health service	4	ACAA, HSUE, AURA
	Ensure the ongoing viability of the health sector	2	ASA, CMA

Question	Response	Number of responses	Organisation
	Protection of the public from inappropriate treatments and financial exploitation	2	CPWA, DAA
	Ensure that all 'health professionals' follow a recognized code of conduct	1	AIMBI
	Ensure that deregistered practitioners don't continue to provide health services in a similar area	2	AACMA, ARCAP
	Provide limited registration for registered practitioners practising out of scope	1	AACMA
	Prevent practitioners from practising interstate if malpractice is proven in another state	1	STAA
	Include components and materials of dental prostheses in the TGA	1	
	Prevent harm to mental health clients, their families and communities through regulation, supervision and intervention.	1	AFMA
	Reduce client exposure to questionable health practices and protect public assets	1	ASAPO
	Ensuring anyone using IPL/laser technology meets minimum standards of training	1	CPSA
	Clear articulation of minimum standards to be met by unregistered providers.	2	HSV, NTDH
	A national database about complaints made against unregistered practitioners	1	NTDH
	Adopt a sensible definition of a health service	1	HCIA
	Avoid duplication of existing consumer protection	1	HCIA
Do you think there is a case for further regulatory action by governments in this area?	Yes	52	URN, ATMS, NCC, ESSA, ANZATA, MRPBV, RAoA, AMT, TOHCC, PA, ANZCP, AA, ARONAH, ASA, HSUE, AOB, AASW, BUPA, AIMS, DAA, AMTA, ASAPO, NHAA, CPSA, AAMT, CCWA, CMA, AURA, SASH, HSC, NTDH
	No	4	PACFA, IBPA
What do you think of the various options?			
Option 1: No change	This option is negligent of Health Ministers	1	
	Changes need to be made to protect the public	2	ATMS
	This option will perpetuate the problem	1	
	Appropriate for our profession which has standard international certification	1	LCANZ
	Best option	3	ARCAP, ACA
Option 2: A voluntary code of practice for unregistered health practitioners	Has not been shown to work in other industries	1	
	Would not have any effect/unenforceable	13	SPBQ, ATMS, RAA, ANZATA, MRPBV, ARONAH, DSCWA, EREMT, HCSCC, HQCC, HSC
	Difficult as some professions have multiple professional bodies	1	
	Yes	6	AAH, AAPHAN, PACFA
	Does not provide clear, transparent guidelines	1	NCC
	Unregistered professional bodies should be required to have code of practice	1	ESSA

Question	Response	Number of responses	Organisation
	This option does not offer adequate protection to the public	2	HSC
	Self-regulatory codes already exist within the pharmacy structure	1	PBA
	Government could work with professional associations to reduce the number and severity of cases that require a stronger intervention	1	AASW
	This option asks professional associations to investigate complaints made against their members while trying to uphold member interests	2	NHAA, NTDH
Option 3: A national statutory code of conduct for unregistered health practitioners	This should be implemented at the absolute minimum	9	SPBQ, SARRAH, ADPA, ASAPO, NHAA, CMA
	Yes	73	URN, AACHP, APMA, NATCOM, ATMS, NCC, APCCH, HCCC, SNTR, VAHLC, RAA, ANZATA, RAoA, ANTA, AAPHAN, TOHCC, ACAA, PA, ANZCP, AA, ARONAH, AREMT, AROH, AMA, CPWA, AANSW, HSUE, AIMBI, AACMA, LBHCC, ACQ, AHPRA, IAIM, MBK, PIAC, AFMA, RA, CHCA, AAMT, HCSCC, HQCC, CHF, CCWA, UV, HCQ, HSC, NTDH
	Better but not ideal	1	AAH
	Should apply to unregistered practitioners who have not joined professional body	1	ESSA
	Will not improve matters without public education and training standards	2	MRPBV, AMT
	Option 3 only addresses the most serious cases of poor and negligent practice	1	AASW
On balance, do you have a preferred option? What are your reasons?	National codes have a consistent approach	4	DSCWA
	Option 3 will provide better public protection	5	VAHLC, CCWA
	National registration	12	AASW, BUPA, OHPA, ANF, AAMT, CMA
	Option 3 would standardise codes across [state and territory] borders	2	URN, RAA
	Option 3 could be augmented through probity checking	1	ATMS
	National registration	9	SARRAH, MRPBV, NFR, ASTA, QPCS
	Option 3 provides the most relevant option	1	NCC
	A combination of options 2 & 3	5	ESSA, RAoA, AMT, AAPHAN, ANZCP, APA, AHA, STAA, AHyA, DAA, NHAA, AURA, SASH, HCIA
	Option 3 should be further developed to include accreditation of training	2	ANZATA
	Option 3 would assist in the accumulation of data and contribute to community awareness	1	
	Government certification of self-regulating professions who form the National Alliance of Self-Regulating Professions	2	AA, ASA
	Option 3 with further consideration of additional professions for inclusion in the national scheme	7	ARONAH, ANZSRS, PIAC, CHCA, HCQ, CHPO, NTDH
	A statutory code of conduct will complement the Australian Consumer Law to strengthen health complaints	1	CAV

Question	Response	Number of responses	Organisation
	mechanisms.		
	A combination of options 2 & 3 with further consideration of additional professions for inclusion in the national scheme	2	AOPA, AIMS
	A national statutory code endorsed by AHMAC	1	CPWA
	Option 2 with additional requirement of compulsory registration with national professional organisation	1	PACAWA
	Option 2	3	PACFA, APDA, IBPA
	Option 2 – restrictively regulating counselling and psychotherapy removes consumer choice	1	ARCAP
	Option 3 with all unregulated mental health practitioners being regulated under the National Scheme	1	AFMA
	Option 3 plus a national database of health practitioners who meet minimum standards	1	ASAPO
	Option 1	1	ACA
	Option 3, with 'services provided using laser or IPL technology' specifically included in the code	1	APSA
What do you think are the costs and benefits of the three options?	The costs of doing nothing are already more than the cost of doing something	6	PA
	The benefits outweigh the costs to the patient/clients	5	VAHLC, APA, ASAPO
	Costs are justified if they provide consistency and quality for the profession	1	
	Costs would be small	5	NCC, ANZATA, MRPBV, CMA
	There would be a bureaucratic cost for little benefit	5	
	There would be an initial set up cost	2	URN
	Initial set up costs for registration would be large but over time system would run itself	1	
	Unsure of costs	1	
	Benefits would be safer practitioners and increase in consistency	2	ATMS
	Costs would be endless	1	
	Option 3 would be the highest cost but best benefits	4	TOHCC, HSC
	A panel to investigate complaints would be cost effective	1	
	Routine cost of maintaining a national register and government enforcement of Code	9	ATMS, NCC, PA, ANZCP, AOB, AIMS, ASAPO, NHAA
	An annual fee linked to a national register and professional association membership	1	RAA
	Subsidising existing work of professional organisations	1	AMT
	Duplication of existing State and Territory functions	1	AMT
	Initial establishment cost of code – could form part of function of AHPRA	1	
	Regulation of unregistered therapists will lower the cost of mental health care in the long run	1	
	Costs of investigating alleged breaches	4	DSCWA, APA, AOB, IBPA
	Development and implementation of regulatory framework	1	APA
	Education campaign to inform public and health professionals	1	APA
	The scheme should be cost-neutral for practitioners, unless they are sanctioned	1	HSUE

Question	Response	Number of responses	Organisation
	Cost should be measured in more than just money eg. loss of patient trust	1	AIMBI
	Cost of Option 3 would be less than statutory registration of all practitioners	1	CHCA
If you are a practitioner, can you advise of what additional costs you think you would incur with the introduction of a statutory code?	Legitimate practitioners already pay membership fees	6	AA, AASW
	National association fees would rise	5	SASH
	Membership, renewal, training, insurance.	1	URN
	First aid training	1	URN
	No additional costs on top of current membership fees	2	
	CPD	5	AIMBI, AIMS, RA
	Attaining unnecessary qualifications to satisfy statutory requirements	1	
	Professional Indemnity Insurance/other insurance	4	VAHLC, ACAA, AMTA
	Insurance and membership fees would rise	1	RAoA
	Accreditation costs	1	AIMS
	Experience with NSW code is that cost increases have been very minor	1	NHAA
Do you think there should be a nationally uniform code of conduct?	Yes	103	AACHP, APMA, NATCOM, MSC, ATMS, NCC, APCCH, SNTR, VAHLC, RAA, ANZATA, MRPBV, NIB, RAoA, AMT, ARC, AAPHAN, TOHCC, ACAA, PA, ANZCP, AA, NRF, SPA, ARONAH, DSCWA, APA, AREMT, AHA, ASTA, CPWA, AANAW, HSUE, AIMBI, AACMA, STAA, AOB, AASW, BUPA, QPCS, ANZSRS, AIMS, AHyA, OHPA, ACQ, AHPRA, MBK, AODA, DAA, IBPA, ADPA, AMTA, AFMA, RA, ASAPO, NHAA, CPSA, CHCA, AAMT, APHA, CHA, PHAQ, RHC, HCSCC, HQCC, CHF, CCWA, CMA, SASH, HCQ, HSC, NTDH, HCIA
	Separate codes would be acceptable but not desirable	1	
	More practical to use existing processes in States and Territories	1	
	Professional bodies should develop and administer their own codes of conduct [initially]	2	AHyA
Should there be nationally uniform or nationally consistent arrangements for investigating breaches of the code?	Yes	58	URN, NCC, RAA, AMT, ARC, TOHCC, ACAA, PA, ANDCP, AA, NFR, ARONAH, ASA, AREMT, ASTA, AIMBI, AOB, AASW, BUPA, QPCS, ANZSRS, AIMS, OHPA, DAA, AMTA, AFMA, RA, ASAPO, NHAA, CHCA, HQCC, PSA, CCWA, CMA, SASH, HCQ, HSC, NTDH
	Unsure	1	
	States could enforce national code within current structures	26	NATCOM, MSC, ATMS, APCCH, SNTR,

Question	Response	Number of responses	Organisation
			VAHLC, ANZATA, SARRAH, ANTA, AAPHAN, DSCWA, APA, AHA, AOPA, CPWA, HSUE, AACMA, STAA, APHA, CHA, PHAQ, RHC, HCSCC, HCIA
	Professional associations should have the right to deal with complaints in the first instance	2	RAoA, IBPA
Should there be a centralised administrative body that administers the regulatory scheme?	Yes	41	ATMS, NCC, SNTR, RAA, ESSA, AMT, ANCP, NFR, ARONAH, APA, ASTA, CPWA, AAAPP, AIMBI, AOB, BUPA, QPCS, AIMS, OHPA, AODA, AFMA, RA, ASAPO, CHCA, CHF, HCQ
	Unsure	1	
	Should be administered by the states and territories	18	URN, ARC, DSCWA, AACMA, AHPRA, MBK, ADPA, AMTA, NHAA, APHA, CHA, PHAQ, RHC, HCSCC, HQCC, CMA, SASH, UV, HSC, HCIA
	No	4	NATCOM, MSC, HSUE
	Administration should be as efficient as possible with information nationally accessible	1	VAHLC
	Professional bodies should submit code breaches to central administration	2	ESSA, AA
	A national body with State boards/administration	7	PA, ANZSRS, CCWA, NTDH
If a statutory code of conduct were to be enacted, to whom should it apply?	All people giving information in a health field.	2	
	All allied health disciplines/(and other unregistered practitioners)	2	VAHLC, HSC
	Prosthetists/Orthotists	1	
	Social workers, psychotherapists, counsellors, community workers, youth workers, drug and alcohol workers, financial and employment counsellors, rehab counsellors, naturopaths, homeopaths, massage therapists	1	
	As for the NSW scheme	7	RAA, ANTA, TOHCC, RA, CCWA
	Any practitioner giving treatment where outcome relates to physical, mental or emotional health	8	URN, CPWA, AIMBI, AFMA
	All practitioners that deliver care or intervention	1	RAoA
	All practitioners and should include manufacturers of [therapeutic] products	1	
	All health professionals	18	ARC, ANZCP, NFR, SPA, ARONAH, AOPA, STAA, AASW, ACQ, CMA, SASH
	All who are broadly defined as health practitioners, not already covered by another scheme	10	ATMS, NCC, MRPBV, DSCWA, ASA, AHA, ASTA, AOB, AHyA, HQCC
	Anyone practising as a therapist/counsellor/social worker	2	
	All unregistered practitioners who are not members of their professional body	4	ESSA, AA, APA, DAA
	All arts therapists trained to the minimum standards	1	ANZATA
	Any practitioner claiming a health benefit from treatment	2	NIB, AMT
	Anyone employed as a cardiac scientist and anyone performing a similar role	3	QPCS

Question	Response	Number of responses	Organisation
	Doulas, lay birth attendants, lay midwives	1	
	All health and welfare professionals	2	AIMS
	Owners or operators of businesses providing pre-hospital care services	1	AREMT
	All staff of institution recognised as a health care provider	1	ANZSRS
	All natural therapists	1	IBPA
	All self-regulating or unregistered professions requiring mandatory education/qualifications	2	AMTA, ASAPO
	As per NSW code, with IPL/Laser use added to scope	1	CPSA
Which practitioners, professions or occupations should be included?	Naturopaths, homeopaths, personal trainers	1	
	Dieticians, nutritionists, social workers and speech pathologists	2	HSC
	Prosthetists/Orthotists	2	AOPA
	Social workers, psychotherapists, counsellors, community workers, youth workers, drug and alcohol workers, financial and employment counsellors, rehab counsellors, naturopaths, homeopaths, massage therapists	1	
	All health practitioners in the widest interpretation	10	LCANZ, ACAA, ARONAH, AOB, AASW
	Any practitioner giving treatment where outcome relates to physical, mental or emotional health	4	URN, ATMS, ANZATA, ANCP
	All professions that require a qualification to practise	1	
	None	1	
	Anyone practising as a therapist/counsellor/social worker	6	AFMA
	All allied health professionals and other unregistered practitioners	1	VAHLC
	As per the NSW scheme	4	RAA, TOHCC, HSUE
	All health professions not recognised by Medicare	1	ESSA
	All who are broadly defined as health practitioners, not already covered by another scheme	7	MRPBV, AHA, AMA, AHyA, RA, NHAA, HCQ
	Any practitioner who claims to be providing a health service	4	AMT, ARC, AURA
	All registered and unregistered health professionals	2	
	All health practitioners who perform duties of cardiac scientist	3	QPCS
	Those being paid for caring for women during pregnancy, labour or birth	1	
	Personal care workers	1	
	Myotherapists	1	
	Anyone entering a therapeutic relationship	1	
	Religious organizations offering counselling services/health programs	2	
	Non-government allied health professionals providing health services to people with disabilities	1	DSCWA
	Medical scientists and technicians, paramedics and ambulance officers	1	AIMS
	Qualified optical dispensers trained to Certificate IV level	1	ADOA
	All natural/complementary/alternative therapists	2	IBPA, HSC

Question	Response	Number of responses	Organisation
	Beauticians/beauty therapists	1	HSC
Should it apply only to practitioners who deliver health services? If so, what should be the definition of a health service?	Any service potentially affecting the mental or physiological health of individual	6	AA, AFMA, CMA, SASH
	Yes, using the WHO definition	2	PA
	Any service that will increase a patient's quality of life	1	
	Not just medical situations, should also include child safety, aged care, mental health	1	
	Those who work one-on-one in a treatment/consultation context	2	URN, ARC
	No	1	
	Yes, all who are broadly defined as health practitioners/(not already covered by another scheme)	6	ATMS, NCC, VAHLC, ANZATA, HSC
	Anyone advertising 'therapy' including under the guise of educational seminars	2	RAoA
	Anyone delivering a health, community or educational service	6	ESSA
	Should include advertising, selling and distribution of 'health products'	1	ESSA
	All health care workers recognised by Medicare and any private health fund	1	
	All practitioners who have direct contact with patients or who interpret data to make clinical decisions, directly or indirectly (i.e. through research)	2	ASTA
	Health Complaints Act 1995 (Tas) definition is good, but national uniformity would be better	1	TOHCC
	Yes, using the Australian Law Reform Commission Report-108 definition	1	ARONAH
	Yes, as defined in the WA Health and Disability Services (complaints) Act	1	DSCWA
	Health Services (Conciliation and Review) Act 1987 (Vic), Health and Community Services and Complains Act 2004 (SA), Human Rights Commission Act 2005 (ACT)	2	AIMBI, AIMS
	Practitioners providing advice on management/prevention of chronic conditions	1	AOB
	Health Service' needs to be defined more broadly, as per Ottowa Convention	1	AASW
	The provision of services, advice and information designed or claiming to assess, maintain or improve the physical, mental or emotional health of an individual, and/or diagnose, treat, prevent or manage an illness, disability, disorder, possible disorder or condition of an individual.	1	BUPA
	Any health or wellbeing service encompassing physical, psychological, emotional, cognitive and social needs.	1	AMTA
	As per NSW scheme	1	ASAPO
	Any service intending to improve health (and wellbeing) which may also have an unintended detrimental outcome (thus proving public risk)	1	NTDH
	The WA definition is appropriate	1	HCIA
Should it apply to registered practitioners who provide health services that are unrelated to their registration?	Yes	70	URN, ATMS, NCC, VAHLC, RAA, ESSA, ANZATA, MRPBV, RAoA, AMT, ARC, TOHCC, PA, AA, ARONAH, DSCWA, APA, AREMT, AHA, CPWA, AIMBI, AACMA, STAA, AOB, AASW, BUPA, ANZSRS, AIMS, AHyA, AHPRA, DAA, IBPA, AMTA, AFMA, RA, ASAPO, NHAA, HQCC, CCWA, CMA, AURA, SASH, HCQ, HSC

Question	Response	Number of responses	Organisation
	No	4	AMA
	Disciplinary action could also affect the offender's registration status	1	APA
	A de-registered practitioner must be prevented from returning to work as an unregistered health practitioner	1	APA
Should it only apply to practitioners who directly deliver services, or should it also apply to businesses that provide health services?	Should apply to all	41	ACC, RAA, ESSA, ANZATA, ARC, PA, ANZCP, ARONAH, DSCWA, AREMT, AHA, CPWA, AIMBI, AACMA, ANZSRS, AIMS, AHPRA, DAA, IBPA, AFMA, CPSA, CMA, AURA, SASH, HCQ, HSC
	Should apply only to those who directly deliver a service	33	URN, MRPBV, TOHCC, AOPA, AOB, AASW, BUPA, AHA, ADOA, AMTA, RA, ASAPO, NHAA, CCWA
	Should apply to practitioners but owners of business who ignore breaches could be held accountable	1	VAHLC
	Would depend on the code/practicality	1	AMT
	Should only apply to owners/operators who have contact with the public	1	
	Sanctions should apply to business owners only when they are found to have directly influenced the practitioner to break the code of conduct	2	HQCC
Do you have a preferred option for the legislative and administrative arrangements?	As per current NSW arrangements	6	URN, ARC, TOHCC, AACMA, ASAPO, CPSA
	It should be a national body – for consistency/one point of contact	7	APA, AOB, AASW, QPCS
	The TGA legislation could be expanded to include services	1	
	Existing State or Territory complaints and disciplinary processes	6	LCANZ, SARRAH, DSCWA
	Self-regulation by a national body – this is the best way to govern a profession	1	
	Amendment to the existing National Law or supplementary legislation	2	ATMS, AHyA
	As per current national registration	4	VAHLC, ANZCP
	Should be nationally consistent, robust and adequately funded	1	ANZATA
	Anyone practising as an Arts Therapist should be required to join ANZATA	1	NIB
	National registration for therapists who have or can get a Medicare provider number	1	NIB
	A peak health care complaints agency structure in each State or Territory	2	NIB, AMTA
	Administrative arrangements need to be in cooperation with Professional Associations	3	RAoA, SPA, RA
	As close as possible to national registration, as the public is not aware of the difference	1	
	A centralised administrative body and legislation to ensure that statutory powers are clear	2	SPA
	Should be administered nationally through DOHA	1	ASA
	Nationally uniform but state based administration/legislation with mutual recognition	6	AOPA, AMA, ACQ, NHAA, CCWA, HSC
	The UK HPC code of conduct is a good model	1	ASTA
	Professional organizations should be responsible for setting standards and investigation of complaints should be done by an independent third party	1	AAAPP

Question	Response	Number of responses	Organisation
	A national complaints commissioner	1	AIMS
	Self-regulation by professions with a strong national body and government agency for all others	2	DAA, IBPA
	Where feasible, could be included within the scope of existing consumer law	1	AURA
What do you think should be included in a national statutory code of conduct?	A relevant tertiary qualification/required level of training	2	ANZATA
	Minimum training requirements, ethical practice standards, complaints management process, practice standards	4	AIMS, AURA
	As with the NSW code	24	URN, ATMS, ARC, NFR, ARONAH, DSCWA, ASA, AHA, CPWA, STAA, AOB, AHyA, ACQ, DAA, RA, ASAPO, NHAA, HQCC, CCWA
	Issues relating to health prevention strategies, including vaccination	1	
	Ethics, expected behaviour, patient privacy and confidentiality	1	
	Duty of care, infection control, CPD, 'good character' requirement	1	
	Whatever is in a professional association's code of conduct	1	
	An updated list of modalities it refers to	1	RAA
	A version should be available for practitioners to display	2	RAA, CPWA
	A specified code of practice and required education and training needed	1	MRPBV
	Provisions for evidence from traumatised/affected third parties to be taken into consideration	2	AFMA
	Obligations on the practitioner and obligations in respect of patients' rights	1	
	Should capture employers' responsibility for their directly supervised practitioners	1	PA
	Should include membership of a professional association	2	NFR, AIMBI
	Advertising guidelines e.g. what can and can't be claimed	1	APA
	Protection of title	2	AHA, AFMA
	As per the UK HPC code of conduct	1	ASTA
	Provision for health insurers to reserve the right to audit and access a health practitioner's records	1	BUPA
	A requirement that practitioners keep records in English	1	BUPA
	As per the NSW code with the addition of IPL/laser services	1	CPSA
	A combination of various other professional codes of conduct e.g. APS, AMA, ADA	1	SASH
Do you have any comments on the NSW Code of Conduct for Unregistered Health Practitioners?	It's good/effective	22	MSC, VAHLC, RAoA, ANTA, TOHCC, PA, ANZCP, DSCWA, AOPA, AMA, DAA, AMTA, ASAPO, CMA, SASH, HSC
	Our organisation has adopted the NSW Code of Conduct for its members	1	AACHP
	It is ineffective against false and misleading claims	1	
	You should not need more than one instance of professional misconduct for it to be considered a breach of the code	1	ESSA

Question	Response	Number of responses	Organisation
	Name should be changed from 'unregistered' to 'self-regulating' or other term	4	ANZATA, RA, AURA
	Complementary therapy should be differentiated from alternative therapy	1	ARC
	It is very broad and pitched at a lower standard than many professional codes	1	AMT
	It is not sufficient for speech pathology	1	
	Should not be considered a substitute for registration	5	ARONAH, AASW, BUPA
	Has limited capacity for active monitoring and feedback	1	PA
	It has been largely ineffective to date	1	BUPA
	Some elements are not relevant for counselling/psychotherapy	1	PACFA
	Content has not been validated against the mitigation of potential risks	1	ANZSRS
	Medical laboratory scientists should be added to the list	1	AIMS
	Code should be amended to specifically refer to the supply of cosmetic contact lenses	1	AHPRA
What do you think are the strengths and weaknesses of the NSW Code?	Section 11 is open to misinterpretation and requires re-wording/clarification	2	URN, ARC
	No mechanism to stop false and misleading claims if "no serious patient care issues"	1	
	No option for anonymity of complainant	1	
	Section 5 should be expanded to include all forms of serious illness/chronic pain	2	APMA, HCQ
	It fails to address the issue of religious organisations who offer harmful/exploitative counselling/psychological services	2	
	Only comes into effect 'after the event'	13	NFR, ARONAH, AHA, ASTA, AASW, QPCS, ANF, AFMA, ASAPO, AAMT
	Needs to encourage professions to become self-regulating	1	
	Consumers need to be made more aware of their choices/ability to complain	3	MSC, ARONAH, ASTA
	Addition of probity checking is desirable	5	ATMS, NCC, NFR, ARONAH, HCQ
	Replace the word 'Alternative' with 'Complementary'	1	RAA
	'Adequate clinical basis' needs to be reworded/clarified	5	RAA, AOPA, AMTA, AFMA, CCWA
	Does not protect the public from someone who hasn't done the required amount of training	16	ANZATA, NFR, AHA, AOPA, ASTA, QPCS, DAA, AFMA, NHAA, CMA, HCQ, HSC
	Does not cover owner/operators	1	RAoA
	It is too broad/generic	6	AMT, ARONAH, AOPA, BUPA, AODA
	The specificity of the code to a particular profession could be made clearer by working through professional associations	1	
	Should include some provision for notifiable conduct	1	
	Some terms require further definition/specificity e.g. 'suitable period'	1	
	Strength: it is low cost and all encompassing	2	NFR, ANZSRS
	No profession-specific provisions	2	NFR, ARONAH
	No working with children check	1	NFR

Question	Response	Number of responses	Organisation
	No provision for student practitioners	1	NFR
	Lack of attention to minor offences/only deals with major issues	1	ARONAH
	Jurisdictional confusion between criminal and regulatory action	1	ARONAH
	Should ensure protection against claims to cure long term disabilities	1	DSCWA
	The definition of Health Professional needs to be monitored/expanded	2	AOPA, AOP
	All key terms in the Code need to be clearly defined	1	BUPA
	It's a minimalistic approach with components of risk management missing	1	ANZSRS
	Strength: the language is easy to understand for consumers	1	AIMS
	Strength: it is all-encompassing and mentions ethical considerations	1	AIMS
	The definition of masseur does not reflect current professional titles used	1	AAMT
	No protection of title	1	CMA
	Doesn't cover CPD	1	HCQ
	Section 10 (financial exploitation) should be strengthened	1	HCQ
	Section 16 (insurance) should be strengthened	1	HCQ
Do you think it provides a good model?	It's a good starting point	12	URN, RAoA, PA, AOPA, RA, ASAPO, AAMT, CHF, CMA
	Yes	17	ATMS, NCC, ANZATA, ARC, ACAA, ARONAH, DSCWA, AIMBI, AACMA, AIMS, AHyA, AMTA, NHAA, AURA, SASH
	It doesn't go far enough as a regulatory framework	2	AMT
	It's good but public awareness of the system needs to increase	1	
	No, as it doesn't address the issue of minimum standards	7	QPCS, ANZSRS
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?	Tribunal –	17	SARRAH, PA, NFR, ARONAH, DSCWA, AHPRA, PIAC, IBPA, AMTA
	- it would provide a more rounded decision	2	ANZATA
	- it would allow for natural justice	1	
	No real preference as long as there are adequate avenues for appeal	3	ASAPO, SASH
	System similar to TGACRP for minor breaches that can be elevated for major breaches – cost effective, timely, transparent and anonymous	1	
	An administrative order process through a commissioner	21	ATMS, NCC, HCCC, URN, SARRAH, PA, NFR, DSCWA, ASA, AHA, AACMA, AIMS, AFMA, NHAA, CCWA
	Anyone accused of misconduct should have the opportunity to defend themselves	1	
	Same as the system applying to registered practitioners	7	ESSA, AMT, ARC, ANZCP, STAA, ANZSRS
	Court hearing	1	

Question	Response	Number of responses	Organisation
	Professional Organisations should deal with complaints in the first instance	4	RAoA, AA, SPA
	Should be managed by a clinical board /(with direction from the Ministerial Council)	2	ASTA
	Tribunal hearings with the power to 'name and shame' lying with the commissioner	1	TOHCC
	As per NSW scheme	3	ACAA, ACQ, ADPA
	A Commissioner in the first instance and a tribunal for more serious breaches/appeals	5	CPWA, CPSA, HSC
	Practitioners should have a right of a appeal before prohibition order is made	2	AOPA, HCQ
	Orders issued through State and Territory HCEs, except in jurisdictions where HC does not have power to issue orders	1	HSUE
	Tribunal hearings, with the possible exception of repeat offenders	1	AIMBI
	Peak bodies are best placed to hear complaints about its members	1	ACA
	Through existing formal mechanisms	1	AURA
	Should be a separation of powers between the investigating and prosecuting functions	1	HCQ
What 'relevant offences' (if any) should provide grounds for a prohibition order to be issued?	Non-communication or failure to refer	2	AAMT
	Providing information that is not evidence-based	2	DAA
	Any offences that normally apply to a registered practitioner	4	URN, PA, AREMT
	Any proven harm to a person either physical or mental	5	RAA, CMA, SASH
	False and misleading claims	7	RA, AAMT, CCWA
	Discouraging conventional and life saving treatments	1	
	Providing services without a valid qualification	2	ASA
	Gross misconduct/sexual offences/fraud	10	ASA, CPWA, AASW, RA, AURA, SASH
	Financially profiting from useless/dangerous treatments/financial misconduct	3	SARRAH
	As per NSW code	6	ATMS, NCC, ANTA, TOHCC, AIMS
	All offences which cause (or potentially cause) harm to the public	4	VAHLC, AMT, ARONAH
	Those defined in the Public Health Act, Fair Trading Act or Australian Consumer Law	3	ESSA, ANTA, ARC
	Risk to public safety	5	SARRAH, ANZCP, ANZSRS, DAA
	Failure to maintain professional standards	2	ASA
	The practice of types of unproven therapy known to cause harm	1	
	Any breach of the code of conduct	4	ANZCP, DSCWA,NHAA
	Should include offences that don't necessarily pose a direct threat to public health and safety	1	AIMBI
	As per NSW code, but broadened to include criminal offences	1	AOB
	Prohibition orders should be a last resort after supervisory and educational activities	1	ACA
What other grounds should apply before a prohibition order may be issued?	Unethical behaviour	4	ASA
	Sexual misconduct	6	SARRAH, AMT, AAMT, SASH
	Practising under the influence of drugs/alcohol	4	AMT, ASA, CPWA

Question	Response	Number of responses	Organisation
	Financially exploiting clients	4	CPWA, NHAA, SASH
	Misinforming clients/making false claims	3	CPWA, AAMT
	Keeping poor patient records	1	
	Providing harmful/potentially harmful treatments to the public	5	AMT, AIMS
	Any grounds that would normally apply to a registered practitioner	3	LCANZ, URN, CHF
	Should be possible to issue prohibition orders pre-emptively, subject to procedural fairness, as a result of a professional association's findings	2	ATMS, NCC
	Working outside scope of practice	6	AMT, ARONAH, APA, AMA
	Failure to comply with statutory requirements e.g. privacy laws	1	AMT
	Should be possible to issue interim prohibition orders during an investigation if there is a serious risk to health and safety.	2	AREMT, CHF
	Practitioner being found guilty of a criminal offence	4	AOPA, CPWA, STAA, AAMT
	Practising while suffering from certain physical or mental conditions	2	CPWA, ANZSRS
	Breaching code should be sufficient, not necessary to demonstrate risk to health and safety	1	CCWA
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?	Federally	17	RAA, NFR, AOPA, AIMBI, STAA, AASW, AHPRA, RA, CMA
	Funded through professional organisations and paid for by members	4	ANZCP
	Partially federally and partially by national associations/practitioners	10	ATMS, NCC, AHA, CPWA, QPCS, ANZSRS, DAA, ASAPO
	Professional indemnity or other type of insurance	3	
	A new scheme would protect the public (thus should be partially funded by taxes) and improve professional standards (thus partially funded by professions)	1	
	Commonwealth should see public protection as a duty not an option	5	
	It should form part of current national scheme	5	URN, OHPA, AAMT
	It would need to be publicly funded which may limit services available through complaints mechanism	1	SPBQ
	Recovery costs should be sought if a practitioner is disciplined	6	LCANZ, NFR, HSUE, ANZSRS, AIMS, SASH
	Medicare should be increased .5% to cover dental and complementary health care	1	
	The self-medication/vitamin industry should be required to pay a levy/tax	2	
	Registration fees/license to practise	3	ASA
	Should be borne by practitioners	2	VAHLC, AOB
	Commonwealth and/or State and Territory governments	28	ESSA, ANZATA, SARRAH, RAoA, AMT, ARC, ACAA, PA, AA, SPA, ARONAH, DSCWA, AMA, ASTA, HSUE, AACMA, PACFA, ACQ, IBPA, AMTA, AFMA, NHAA, HQCC, CCWA, SASH, HCQ, HSC

Question	Response	Number of responses	Organisation
	As per NSW scheme	1	MRPBV
	By several jurisdictions	1	TOHCC
Do you have any other comments to make about these proposals?	Non-evidence based practice is a large problem, especially when anyone can provide health advice. It is impossible for consumers to differentiate between good and poor advice.	1	
	Naturopaths should be registered under the National Scheme.	4	ANPA, ARONAH, NFR
	Social Workers should be registered under the National Scheme	12	
	There needs to be a more integrated approach to treating abused children and adults and those with a mental health diagnosis	1	
	I would like national registration and protection of title	1	
	Everyone should be registered	1	
	Speech pathologists should be registered	4	SPBQ, LBHCC, QCA
	TGA should become Therapeutic Goods and Services Administration	1	
	The term 'health practitioner' can be misleading. There needs to be a clearly defined work role and job description.	1	
	Pseudo-medicine should not be legitimised through a regulatory scheme	3	
	The German and/or South African models should be followed.	1	
	Religious organisations purporting to offer health/counselling services should be included under the scheme.	1	
	Emergency Medicine should be registered	1	
	Sonographers should be registered	2	
	Tooth whitening and bleaching should only be done by registered dentists	2	ADA
	Family members/concerned other should be able to make complaints	1	
		2	
	A database of professional bodies should be made publicly available	1	
	Governments should only accredit professional bodies if they confirm qualifications and require criminal history checks	1	
	Prohibition orders should be published	1	MSC
	New category of 'health coach/counsellor' should be created	1	
	Probity checking should be introduced to insure any professional association is bona fide and effective	1	ATMS
	Practitioners should be required to be members of a peak professional association	2	SNTR, RAA
	The term 'unregistered' health practitioner has negative connotations and should be changed	8	RAA, ANZATA, RAoA, ANZCP, SPA, AROH, AOPA, AASW
	Online and TAFE courses in Audiometry should be stopped	1	
	The generic approach will not significantly improve standards of practice	1	MRPBV
	Therapists who engage in recovered memory therapy must be held accountable	1	
	Cardiac scientists should be registered	1	

Question	Response	Number of responses	Organisation
	The Church of Scientology (which offers counselling and distributes drugs) should be included on list of practitioners under consideration		
	Personal care workers/assistants in nursing should be registered	2	ANMFSA, ANF
	A nationally endorsed practice framework for personal care workers/assistants in nursing should be developed		
	A separate consultation process on the content of the Code of Conduct should be undertaken to ensure that viewpoints of all pre-hospital care practitioners are in included.	1	AREMT
	Paramedics should be registered	1	CAA
	Unregistered health professionals who are subject to a prohibition order should lose Medicare status	1	AMA
	The proposals are minimalistic and focus on ethical conduct	1	ASTA
	Pharmacy assistants are not health professionals and should be not included in any health regulatory scheme	1	PBA
	There needs to be a distinction in legislation between established professions and 'quacks'	1	HSUE
	The consultation should have included details of current self-regulation programs	1	AASW
	Consideration needs to be given as to how the proposed code will fit in with existing association codes	1	BUPA
	A national code of conduct should be an interim measure only, pending full registration	1	BUPA
	The NSW Coroner's recommendations from the report into the death of Rebekah Lawrence (8 December 2009) regarding psychotherapists/counsellors should be actioned.	1	PACAWA
	Dental technicians should be registered	3	LBHCC, CPSA, QCA
	The unregulated use of psychotherapy may warrant further investigation	1	AHPRA
	Specific measure should be implemented to protect children who are receiving services from a health professional, over and above working with children checks	1	IAIM
	Dental prosthetists should be registered	1	APDA
	It is of serious concern that anyone can legally practise counselling or psychotherapy with no qualifications whatsoever.	1	AFMA
	Consideration needs to be given to how the code would apply to unregistered personnel working under direct supervision	1	APHA, CHA, PHAQ, RHC
	The options provided are too broad to apply to various categories of unregistered professions.	1	PSA
	Consideration should be given to positive action and support for minor breaches	1	HCQ
	Personal care workers and community care workers should not come under any regulatory scheme	1	UVAC

Key

URN	Usui Reiki Network
AACHP	Australian Association of Clinical Hypnotherapy
SPBQ	Speech Pathologists Board of Queensland
APMA	Australian Pain Management Association
ADA	Australian Dental Association
LCANZ	Lactation Consultants Australia New Zealand
NATCOM	National College of Neuro Linguistic Communication
MSC	Medical Services Committee
AAH	Academy of Applied Hypnosis
ATMS	Australian Traditional Medicine Society
IBPA	International Bioresonance Practitioners Association
NCC	Nature Care College
APCCH	Australian and Pacific College of Clinical Hypnotherapy
HCCC	NSW Health Care Complaints Commission
SNTR	Society of Natural Therapists & Researchers
VAHLC	Victorian Allied Health Leaders Council
RAA	Reiki Association of Australia
ESSA	Exercise and Sports Science Australia
ANZATA	Australian and New Zealand Arts Therapy Association
SARRAH	Services for Australian Rural and Remote Allied Health
MRPBV	Medical Radiation Practitioners Board of Victoria
NIB	nib Health Funds
RAoA	Reflexology Association of Australia
AMT	Association of Massage Therapists
ANTA	Australian Natural Therapies Association
ANPA	Australian Naturopathic Practitioners Association
ARC	Australian Reiki Connection
AAPHAN	Australian Association of Professional Hypnotherapists & NLP Practitioners
TOHCC	Tasmanian Ombudsman and Health Complaints Commissioner
ANMFSA	Australian Nursing and Midwifery Federation (SA branch)
ACAA	Aged care association of Australia
ASUM	Australian society for ultrasound in medicine
PA	Paramedics Australasia
ANZCP	Australia and New Zealand College of Perfusionists
AA	Audiology Australia
NFR	Naturopaths for Regulation
SPA	Speech Pathology Australia
ARONAH	Australian Register of Naturopaths and Herbalists
DSCWA	Disability Services Commission of WA
RCNA	Royal College of Nursing
CAV	Consumer Affairs Victoria
ASA	Australian Sonographers Association
AREMT	Australian Registry of Emergency Medical Technicians
AHA	Australian Homeopathic Association
CAA	Council of Ambulance Authorities
AROH	Australian Register of Homeopaths
AOPA	Australian Orthotic and Prosthetic Association
AMA	Australian Medical Association
ASTA	Australian Sleep Technologists Association
CPWA	Consumer Protection West Australia
AANSW	Audiology Australia NSW
AAAPP	Australian Association of Audiologists in Private Practice
HSUE	Health Services Union East
AIMBI	Australian Institute of Medical and Biological Illustration
AACMA	Australian Acupuncture and Chinese Medicine Association
AOB	Australian Orthoptic Board
STAA	Shiatsu Therapy Association of Australia
PGA	Pharmacy Guild of Australia
AASW	Australian Association of Social Workers
BUPA	Bupa Australia Group
PACFA	Psychotherapy and Counselling Federation of Australia

ACCC	Australian Competition and Consumer Commission
PACAWA	Psychotherapists and Counsellors Association of Western Australia
ARCAP	Australian Register of Counsellors and Psychotherapists
QPCS	Queensland Professionals in Cardiac Science
LBHBB	Logan-Beaudesert Health Community Council
ANZSRS	Australian and New Zealand Society of Respiratory Science
AIMS	Australian Institute of Medical Scientists
AHyA	Australian Hypnotherapists' Association
OHPA	Oral Health Professionals Association
ACQ	Aged Care Queensland
AHPRA	Australian Health Practitioner Regulation Agency
ANF	Australian Nursing Federation
IAIM	International Association of Infant Massage
MBK	Medibank
PIAC	Public Interest Advocacy Centre
ADOA	Australian Dispensing Opticians Association
DAA	Dietitians Association of Australia
ADPA	Australian Dental Prothestists Association
AMTA	Australian Music Therapy Association
AFMA	Australian False Memory Association
ASLIAWA	Australian Sign Language Interpreters Association – WA branch
ASLIA	Australian Sign Language Interpreters Association
RA	Reiki Australia
ASAPO	Australasian Society of Anaesthesia Paramedical Officers
NHAA	National Herbalists Association of Australia
ACA	Australian Counselling Association
CPSA	Cosmetic Physicians Society of Australasia
DTBQ	Dental Technicians Board of Queensland
CHCA	Complementary Health Care Council of Australia
AAMT	Australian Association of Massage Therapists
APHA	Australian Private Hospitals Association
PHAQ	Private Hospitals Association of Queensland
CHA	Catholic Health Australia
RHC	Ramsay Health Care
HCSCC	Health and Community Services Complaints Commission (NT)
HQCC	Health Quality and Complaints Commission (Qld)
PSA	Pharmaceutical Association of Australia
CHF	Consumers Health Forum
CCWA	Cancer Council WA
CMA	Complementary Medicine Association
AURA	Aura Inc (Reiki)
WAITI	West Australian Institute of Translators and Interpreters
SASH	South Australian Society of Hypnosis
UV	United Voice Ambulance Section Queensland
QCA	Queensland Consumers Association
HCQ	Health Consumers Queensland
HSC	Health Services Commissioner (Victoria)
CHPO	Chief Health Professions Office WA
NTDH	Northern Territory Department of Health
UVAC	United Voice Aged Care
HCIA	Hearing Care Industry Association