

**Chair's Report on visit to the Australian Health Practitioner Regulation Agency (AHPRA) and lectures to AHPRA and HealthGov Australia in Melbourne and the HealthGov and Clinical Teaching and Advisory Committee at the University of Sydney**

Monday 30 January 2012 to Saturday 4 February 2012

**Introduction**

This 4 day visit was the outcome of an invitation from Professor Stephanie Short, the Convenor of HealthGov Australia - a division of the Australian Research Council. The invitation was to deliver presentations on the work of the HPC to colleagues in Melbourne and Sydney.

In addition, meetings with members of the Board, and Executive, of the Chinese Medicine Registration Board of Victoria and the Chinese Medicine Board of Australia were arranged in light of HPC's involvement in this area.

The report covers three main areas:

- 1 The work of the Australian Health Practitioner Regulation Agency (AHPRA)
- 2 The Australian experience of Chinese Herbal Medicine regulation
- 3 A statutory code of conduct for unregulated practitioners

**1 The work of the Australian Health Practitioner Regulation Agency (AHPRA)**

**Background and organisational structure**

The establishment of an Australia-wide system of health practitioner regulation in 2010 has been widely welcomed as a transformational change. AHPRA has replaced a state based system of regulation, each with different legislature, standards and processes. There are 10 national professional boards, supported by AHPRA (chiropractic, dentistry, medicine, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology). There are 530,000 names on the national register. AHPRA operates an online renewal process, which is now fully operational, and currently around 85% of registrants renew online.

The role of the Boards is to set standards, approve programmes, determine the requirements for registration, and oversee fitness to practise proceedings. There are five 'types' of registration: general, specialist, provisional, limited and non-practising. Although each Board operates independently, the standards

owned by each are similar in structure. For example the Physiotherapist Board registration standards cover:

- CPD (must maintain a portfolio, undertake sufficient CPD to maintain competence, 20 hrs per year relevant to scope of practise, self-declare upon renewal);
- criminal history (mandatory disclosure);
- professional indemnity insurance (mandatory);
- English Language skills (for overseas qualified applicants minimum IELTSs 7.0 in four domains and A/B in each domain of the Occupational English Test. Exemptions apply e.g. to UK graduates); and
- recency of Practise (must be in practise during the five year period immediately preceding application for registration).

AHPRA is self-funding, and is accountable to the Australian Ministerial Council. There is no cross subsidisation by Boards, and each Board sets its own fees (Average fees are £260 p.a). AHPRA has an office in every state, and is there to support the work of the Boards. It employs around 600 staff, and its Chief Executive was formerly CE of the English National Patient Safety Agency.

AHPRA hold a student register of approximately 100,000. This is not a public register and there is no fee, and no requirement on students to comply with the AHPRA registration standards. Education providers pass on student lists to AHPRA. If the student has either a health impairment or a criminal conviction (in previous 12 months) this triggers a mandatory reporting process. There have been 7 student registration cases considered by AHPRA to date.

In July 2012, 4 more Boards will be added to AHPRA (occupational therapy, medical radiation, Chinese Medicine, and Aboriginal and Torres Strait Islander health practitioners). To date, there have been 17,000 grandparenting applications to these new Boards.

### The Fitness to Practise process

Complaints and subsequent actions by the Board are assessed against a set of criteria relating to impairment, unsatisfactory practise or unsatisfactory conduct. Investigations are conducted by AHPRA staff and submitted to the Board, and the Board has the power to take a range of actions. The Board may decide to refer the case to a health or professional standards panel or a tribunal. It has the power to take immediate action on grounds of risks to personal or public safety.

Between July 2010 and July 2011, there were 8,139 complaints or 'notifications' (1.3% of all registrants). 52% of these were closed at the initial stage. More than half of the total complaints were about doctors, who represent 16% of the AHPRA register. Around 70% of notifications in 2010/11 were about conduct across all the professions.

AHPRA officials see the regulatory process as not about 'punishment', but about public protection. However, there is a need to raise awareness of this across Australia and AHPRA has been subject to criticism in the media for taking this position.

### AHPRA and English Language Testing

I met with an academic from the University of Melbourne who has been commissioned by AHPRA to look at the range of English language tests required for overseas trained health professionals with a view to making recommendations to AHPRA.

### AHPRA and governance

AHPRA staff were particularly interested in HPC's work on governance and Board recruitment and appraisal systems. The Board recruitment is via ministerial appointment.

### AHPRA and research

AHPRA works closely with Health Workforce Australia (equivalent to the Centre for Workforce Intelligence), and regularly issues health workforce surveys attached to the online renewal process. This data is analysed anonymously by HWA. The uptake of such surveys is around 90%.

AHPRA has recently made a commitment to taking a 'proactive' approach to research. It has set up an Information Committee to consider requests for data from outside sources, ensuring that these comply with privacy rights and AHPRA's public protection role. AHPRA would like to see the development of new research on, for example, CPD and language competence.

HealthGov Australia was established in 2007. It is a network of researchers, health professionals, regulators and policy makers with an interest in promoting best practice in workforce governance.

### Liaison with HEIs

At one of my meetings, a member of the Chancellors office at the University of Sydney was keen to speak to HPC about its work in liaising with the HEIs. The HPC workshops and ongoing liaison were perceived as a model that might be applicable in Australia.

- See [www.ahpra.org](http://www.ahpra.org) for more details across all these areas.

### **Reflections on AHPRA**

HPC was seen by several as 'a model for the future' - where AHPRA might be at some point. The groups I met in both Melbourne and Sydney welcomed the research undertaken by HPC and felt that this proactive approach to building the evidence base was commendable and unique in professional regulation

worldwide. Few other regulatory bodies have demonstrated this strategic approach to evidence building, although AHPRA was now becoming more proactive in this area.

The HealthGov concept might be of relevance in a UK context, as we currently do not have such a network of researchers, regulators and practitioners with a shared interest in regulation.

## **2 Chinese Herbal Medicine regulation**

I met with members of the Chinese Medicine Registration Board of Victoria and the Chinese Medicine Board of Australia, and its Executive Officer, as well as a member of the team in the Department of Health who had worked on the consultation document and the legislation over many years.

### **Background**

The process for regulating this group in Victoria began in 1995 with the publication of 'Towards a Safer Choice' (Bensoussan and Meyers of The University of Western Sydney). This report provided a comprehensive review of the field, and recommended statutory regulation. The report identified significant risks within the practice of Chinese medicine. These related to:

1. clinical judgement;
2. administration of medicines;
3. failure of handling and manufacture of products; and
4. use of acupuncture.

The report estimated that there were 2.8 million Chinese medicine consultations in Australia per year. 1,500 primary practitioners and 3,000 non primary practitioners e.g., GPs and other health professionals using Chinese medicine in their practice. The workforce was described as 'unevenly qualified', with courses varying from 50 – 3000 training hours. There were 23 professional associations representing different segments of the profession.

Key factors in driving forward legislation were:

- Increasing consumer usage
- Highly varied standards of education
- Multiple professional bodies with varying standards

However, there was a change of Minister in 1995 and progress was slow until 1997, when there was a public consultation and the Doyle Report was published, outlining the options in more detail. In 2000, the State of Victoria passed the Chinese Medicine Registration Act and in 2002 the register opened. Approximately 1,200 practitioners were grandparented in over the next two years, making up 70% of all applications. Approximately 10% of practitioners

had their registration application declined. The most common reasons were inadequate qualifications or lack of evidence of competence. Between 2003 and 2008, 170 applications were refused. Two decisions were appealed and neither was successful.

Some small training schools closed as a result of regulation. During the transition period, IELTS level 6 was accepted. The rationale for this was to enable 'as large a number of practitioners' to join the Register, following the example of Hong Kong. When regulation was set up in Hong Kong, all practitioners joined the register, and higher educational standards were introduced over time.

In July 2012, AHPRA will open the Chinese Medicine Register across all states and territories. It is estimated that 5,000 practitioners across Australia will join. There are three levels of registration - the highest level allows practitioners to dispense 'toxic' herbs. Registration fees will vary from \$550 to \$700 Australian dollars depending on the level of registration. Those whose language skills meet IELTS level 6 will be eligible for conditional registration during the transitional period.

### Complaints

Total number of complaints: 215 between 2002 and 2008.  
Number of complaints per 100 practitioners is around 2.

Data from Lin and Gillick (2011) *Does workforce regulation have the intended effect? The case for Chinese medicine practitioner regulation*  
Australian Health Review, 35 (4), p455-461.

Reasons include:

- Advertising violations (misleading testimonials)
- Clinical issues (poor management of adverse reactions, inadequate labelling, poor hygiene, inappropriate clinical management)
- Conduct issues (dishonesty, sexual misconduct, fraud, engaging unqualified staff)

Complaints from consumers were low in the first year (11%) but have risen steadily and are now at around 60%. Protection of title prosecutions: 24 successful

### **Lessons learned:**

1. Over the last ten years of experience in regulation - most TCM cases are conduct cases.
2. The economic imperative to regulate was strong.

3. Public safety, not medical opinion, was the key driver. The issue of efficacy was not the key factor in determining whether or not to introduce regulation - public safety was paramount.
4. Legislating for standards of competence was seen as key to raising educational level and through this improving safety. The incremental approach, ie registering the majority from the outset with less rigorous standards during the transitional period e.g., of language competence, was seen as important to the success of the scheme.

**Further observations taken from the consultation document:** *'Chinese Herbal Medicine: Options for the regulation of practitioners', Department of Health Victoria (1997)*

### 5. Risk

On average practitioners experience one adverse event every 8 months. These arise from the consumption of herbal medicines leading to toxicity or allergic reactions. A key finding is that the risk of adverse events 'is linked to the length of education, i.e., those graduating from 'extended' chinese medicine programs experience half the number of adverse events compared with those graduating from short programs'.

'Regulation must ensure that Chinese Medicine practitioners have adequate qualifications for safe and competent practice, accreditation of courses, and effective disciplinary processes'. This approach aimed to ensure that health choices remained 'as wide as possible' while delivery remained 'as safe as possible'.

### 6. Language requirements

Victoria stipulated that practitioners must have either a 'shared' language with their clients, or an interpreter present. Although this was not popular with practitioners initially it did achieve its objective to register as many practitioners as possible from an early stage.

### 7. Communication

A key component of successful implementation was communication. The Board worked closely with the professional associations to promote the benefits of registration.

### **Reflections on 'Chinese medicine regulation'**

- The experience of establishing regulation in Victoria suggests that it is both possible and in the best interests of the public.
- A staged approach which aims to get as many practitioners on to the register, and through this raise standards, would appear to be a constructive way forward.

### **3 A statutory code of conduct or 'Negative licencing'**

In November 2010, the Australian Health Workforce Ministerial Council began a process to 'consider whether there was a need to strengthen regulatory protection for those who use the services of unregistered health practitioners'. The Australian Health Workforce Ministerial Council is currently considering the outcome of a national consultation. A decision is likely in April 2012.

The 'problem' which the consultation was seeking to address was described as follows: There are a small number of practitioners who engage in unethical, exploitative or predatory behaviours that, if they were registered, would result in a decision to remove their right to practise (p5). These practitioners might be members of professional associations, or they might have moved from one jurisdiction to another. They might practise under a different name, having been removed from a register. They might have no formal qualifications at all.

The preferred solution emerging from the consultation, and 'the one which is considered likely to deliver the greatest net benefit to the community' (p7) is one based on an existing legal framework used in New South Wales since 2008 known as negative licensing (NL) This scheme contains a statutory code of conduct that applies to any practitioner who provides health services, and who is not on a statutory register.

#### The Process

There is a statutory code of conduct with enforcement powers for breach of the code. All those working in the health sector that is unregistered are subject to the Code. The New South Wales Health Care Complaints Commissioner (HCCC) can receive a complaint about any practitioner and take action under the scheme.

The HCCC investigate a complaint and if the practitioner has been found to breach the code of conduct or been convicted of a relevant offence, then the Commission can issue a prohibition order:  
prohibiting a person from providing health services for a period of time, placing limitations on the practitioner or stopping them from practising in health care altogether, or  
providing a warning to the public about the practitioner.

Breaches of the order are subject to prosecution through the courts.

#### Estimating the size of the problem

AHPRA data shows there is a wide variation in the rate of complaint for different professions. For doctors the rate is 72/1000, for nurses 5/1000, physiotherapist 4/1000. The average is 18/1000.

NSW is different from other states/territories in that complaints come to a central point, which allows for cross comparison of data rarely available in our field. The data shows that the HCCC received 79 complaints about unregistered

health practitioners compared with 2,170 about registered practitioners in 2009/2010 (n=2000 p.a.). This ratio is consistent over a 5 year period.

In NSW, there have been 200 complaints about unregistered practitioners since the NL scheme opened. 31 were investigated and 9 prohibition orders have been issued. The HCCC only investigates when there is a 'serious risk to public health or safety'. Examples include - practitioners removed from a statutory register and practising under another name, unethical behaviour, dishonesty, fraud, clinical mismanagement or neglect. These figures suggest that the numbers are relatively small.

### Costs

The estimated cost of administering each of these cases is \$43,000 (£28,000). The report estimates that the annual cost (excluding initial implementation costs) of the negative licensing scheme would be \$526,000 (£354,000) (with no increased costs to consumers of health services) compared with \$79 million (£53 million) p.a. if statutory regulation were extended across a wider range of professions and groups, and \$10 million (£6.4 million) if a voluntary accredited registration scheme were introduced. Implementation of the negative licensing scheme across Australia is estimated at \$600,000 (£400,000) (Further cost analysis data available).

### The benefits of this scheme are described as follows:

- it captures all those working in health care regardless of which title they are using or which professional association they belong to;
- it sets minimum standards of conduct regardless of profession or occupation;
- it targets enforcement action to those who avoid ethical standards;
- it is a relatively low cost method of addressing the most harmful conduct;
- it is expected to reduce the incidence of harm associated with services provided by unregistered practitioners;
- it provides a targeted mechanism for dealing with poor practitioners and those who currently avoid regulation; and
- it provides higher levels of public protection than other options, such as self regulation or accredited voluntary registration.

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