Aboriginal and Torres Strait Islander Health Practice
Chinese Medicine
Chiropractic
Dental
Medical
Medical Radiation Practice
Nursing and Midwifery
Occupational Therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

Response template: Public consultation - revised *Guidelines for advertising regulated health services*

National Boards and the Australian Health Practitioner Regulation Agency (AHPRA) are seeking feedback about the revised *Guidelines for advertising regulated health services.*

This response template is an alternative to providing your response through the online platform available on the consultation website.

IMPORTANT INFORMATION

Privacy

Your response will be anonymous unless you choose to provide your name and/or the name of your organisation.

The information collected will be used by AHPRA to evaluate the revised guidelines. The information will be handled in accordance with AHPRA's privacy policy available here.

Publication of responses

Published responses will include the name (if provided) of the individual and/or the organisation that made the response.

You must let us know if you do **not** want us to publish your response.

Please see the public consultation papers for more information about publication of responses.

Submitting your response

Please send your response to: AHPRA.consultation@ahpra.gov.au

Please use the subject line: Feedback on guidelines for advertising regulated health services

Responses are due by: **26 November 2019**

General information about your response

Are you responding on behalf of an organisation?	
Yes	What is the name of your organisation? **CMASA (Chinese Medicine and Acupuncture Society of Australia)**
No	Are you a registered health practitioner? **Yes**/No If yes, which profession(s)? [redacted] Are you a student? Yes/No If yes, which profession?
We may need to contact you about your response. Please write your name and contact details below. **(Skip if you wish to remain anonymous)**	
Name (optional)	[redacted]
Contact details (optional)	[redacted]

1. How clear are the revised guidelines?

Document integrity/clarity of purpose:

With the expansion of coverage of types of health service providers by AHPRA to 16 health sectors, the Guidelines need to be sufficiently robust to meet the information needs of the public for all types of regulated health services. While the Guidelines seem to have been initially based on medical practice (which is well established within the community and government), the Guidelines would benefit from a fresh lens being applied to ensure the approach provides:

- equitable measures for all regulated health services
- does not inadvertently impose any anti-competative measures on particular service sectors, and
- in providing for cross-sector crossover arrangements, removes provisions that do not adequately provide protection for public safety.

Apart from this problem with perspective, and with the exception of several vague/fragmented pieces of information, the document is generally well structured and clearly expressed. However, there are a number of matters that could be expanded in the introductory area, to provide a better explanation of the regulatory framework and to indicate up front what advertising is considered to be. Some of these matters were dealt with in the 2014 Guidelines and seems to have fallen through the cracks.

The document is of a reasonable length given the complexity of the issue across such a broad area of service provision. The number of links to other documents is reasonable, but to improve transparency, it would benefit from inclusion of an Appendix with a list of links to all related supplementary papers by the National Boards as well as to any AHPRA and Board/s' review findings and/or subsequent variations made.

CMASA considers that some of the provisions and interpretations in the Guidelines pose problems for emerging Health systems that still have some way to go before being properly understood by the Australian public and/or integrated into Government programs, as is the case for Chinese Medicine (CM).

This means that greater flexibility is needed in some areas to meet public information needs, to foster a level playing field for competition, and to allow emerging Allied Health sectors to grow and help meet the growing demand in areas of often unmet need, such as in aged care, disability care, chronic illness and pain management.

Competative disadvantage: bias towards established professions and against emerging health sectors

A weakness of the Guidelines is that it has not taken into account the special circumstances of CM as a newly emerging system of health. This situation means that the Chinese Medicine sector does not have a large pool of research findings to confirm efficacy across the broad range of conditions it treats as a holistic form of medicine, and is likely to continue to attract a small share of research funding. It is somewhat problematic for its practitioners to try to explain the effectiveness of the holistic approach when restricted to single conditions with proven efficacy.

While CMASA strongly supports evidence based medicine, and is keen to see the removal of false and inaccurate claims in order to protect the reputation of its registered practitioners, it recommends that **consideration be given to allowing emerging medicines like CM to use have a standard statement about how their system of medicine works for inclusion in written materials/advertising materials, to supplement the current evidentiary requirements.**

Competative disadvantage: anticompetitive restrictions on discounting

Emerging health systems are similarly disadvantaged by the restriction on discounting and bulk purchases arising from the interpretation of ***section 4.5 Encouraging indiscriminate or unnecessary use of health services***, particularly under the second dot point:

" *Advertising may be unlawful when it:*

- *Indirectly encourages indiscriminate or unnecessary use through financial incentives such as prizes, bulk purchases, discounts, bonuses, gifts or without an option to exit the arrangement, to encourage consumers to use services regardless of clinical need or therapeutic benefit".*

CMASA has built the principle of practitioners not encouraging indiscriminate or unnecessary services into its own Member Code of Conduct, so it strongly supports this objective of not drawing patients into unnecessary treatment sessions.

While the Guidelines appear to have imposed a restriction on discounts because an assumption has been made that it may incentivise unnecessary treatments, CMASA considers this to be a narrow reading of the scope of discounting and one which is anticompetitive in nature because it does not apply evenly across regulated health service providers. General Practitioners have the option of providing a discount rather than charging a market rate by simply charging the government reimbursement level under Medicare, which amounts to a form of discounting.

CMASA argues strongly that AHPRA should create a level playing field and allow other regulated health practitioners the same opportunity as general practitioners to offer discounts, and to consider the consumer need aspect of other affordability options, so long as the requirements of the Act are met in that the terms and conditions are spelt out.

This is an important means of making health services more widely available to those in need. Pensioners and others on low fixed incomes would benefit from greater access to services, and may be more likely to seek timely treatment prior to conditions becoming chronic and imposing much higher costs on the health system. The **NSW Council of Chinese Medicine** recently advised CM practitioners not to advertise discounts to pensioners because of the exposure under this provision. This is the very group whose access to health services is recognised as being so constrained that the Federal Government issues them with a **Health Care Card** and gives entitlement to **Pharmaceutical Benefits Scheme**. It can only be interpreted as an overly cautious reaction/interpretation. The limits on pensioner income are known to be the greatest barrier to effective use of health services, let alone overuse. This is except for medical practices, where there is no upper limit on the amount or frequency services used under Medicare arrangements.

Again on competitive neutrality grounds, the restriction on bulk purchasing discounts should be removed, except for when there is clear evidence that patients are being locked into a preset treatment package which does not take account of their individual needs, and does not allow them to exit if they find they are not happy with the quality of treatment. **CMASA considers it would be beneficial to emphasise the measures that make this type of arrangement compliant.**

A person needing multiple treatments should also be able to be assisted to access regulated health services at an affordable rate which reflects the frequency of treatment needed through package or bulk pricing arrangements, if the practitioner is prepared to offer such discounts. It is noted that CM practitioners, although regulated, do not have access to Medicare reimbursement.

CMASA would like to see this dot point in 4.5 reworked to give a better and more reasonable balance between patient affordability considerations (currently not covered) and the objective of preventing unnecessary treatments, It would also like the matters raised to be communicated to all players, particularly the Boards and State organisations to prevent the perpetuation of this overly narrow interpretation. It would also like to see greater clarity around the avenues for taking up any such policy concerns, through inclusion of relevant review processes (possibly in an additional Appendix).

2. How relevant is the content of the revised guidelines?
In addition to the comments made above about the need for a broader lens to be applied to meet the diverse needs of the public for information about AHPRA regulated health services, CMASA has concerns about the following aspects of the guidelines: **Continuation of policy inconsistency and uncompetative arrangements – title protection anomaly:** The legislative intent of regulating the sector by providing **title protection** is eroded in the case of acupuncture through provisions which afford an entitlement to use of the title by those in other regulated sectors (?medical practice and physiotherapy) under certain conditions. This is an exceptional arrangement that is not applied to other regulated services (presumably because it undermines title protection), and regulated acupuncturists do not have the benefit of similar opportunities across other regulated sectors. If AHPRA recognises the principle that regulated health service providers can provide services from another sector under terms set by a National Board, then it should make that opportunity available across all regulated sectors, and ensure appropriate management systems are in place. Under the current arrangement, registered acupuncturists fail to obtain the benefits of protection of their title, where-as all other regulated sectors do have protection of their titles. This watering down of the legislative intent (albiet the problem lies within the legislation itself), seems to reflect that there may have been a built-in bias originally to accommodate a pre-existing activity within the medical profession, the dominant player at the time. This now needs to be reviewed and adjusted to provide equity of arrangements across service providers and to ensure that the public safety needs are being met. No rationale has been provided for why the National Board responsible for Chinese Medicine and acupuncture registration, remains uninvolved in the process of authorising practitioners in other regulated fields to practice acupuncture. **A standard policy position needs to be adopted by AHPRA to allow cross-sector arrangements to be developed across all regulated services, with the relevant Board given responsibility to work out the training needs and provider qualifications, equivalency standards and clinical practice requirements needed for practitioners outside the sector to be able to safely deliver that sector's health services**. CMASA considers there is likely to be greater growth in integrated medicine in the future, and that AHPRA should ensure it establishes the principles that support productive and safe integrated service delivery. It remains unclear why the public, under a regulated system of acupuncture with title protection, remains unable to be certain that it is receiving high quality acupuncture from a suitably qualified practitioner, and when dissatisfied, maybe uncertain as to how to/where to voice their concerns/complaints. This is likely to result in substantial under-reporting of problems so the extent of the safety risk remains hidden. The greatest concerns lie in the fact that both regulated and unregulated practitioners (other than regulated acupuncturists) are doing acupuncture (whether calling it acupuncture, dry needling or another term) after minimal training by trainers of unknown / untested qualifications and skills. This demonstrates that title protection is not being delivered for registered acupuncturists, and should be remedied. While this situation damages the reputation of the profession of acupuncture, the greatest concern is that it potentially harms patients, who the regulatory system is set to protect, including through title protection. Anecdotally, regulated acupuncturists are saying that patients are coming to them for long term unresolved musculoskeletal problems after treatment by other regulated practitioners doing dry needling, and are often highly reticent about acupuncture because of the pain of their previous treatment and the fact that it was slow to improve their condition. While-ever this inconsistent arrangement remains in place, It is reasonable to expect that the relevant National Board, the CMBA would have final say over the standards of training and the equivalency provisions for practitioners in other health service fields seeking endorsement from their own Board to practice acupuncture. National Boards should be working co-operatively with CMBA to ensure that their practitioners have adequate training and skills to deliver safe and effective treatment to patients. This type of arrangement would ensure that the reputation of

‘acupuncturist’ based on four years of fulltime tertiary study and supplemented by extensive clinical experience is not diminished, and to restore to some extent the title protection that is supposed to be in place.

Competative disadvantage: bias towards established professions

As noted above, emerging regulated health systems such as CM do not have access to the pool of evidence available to general practitioners and some other service sectors, and this places constraints on their ability to communicate the holistic whole-of-body-and-mind approach which is a central tenent of the CM diagnostic and treatment approach. **CMASA is recommending AHPRA agree to a standard set of information being developed (by CMBA in conjunction with professional associations) to overcome this limitation.**

Competative disadvantage: inconsistent decisions amongst Boards

The general level of disadvantage faced by emerging sectors within the Australian context such as CM, has been exacerbated by the actions of individual Boards like CMBA, through its imposition of more onerous restrictions on the type of evidence that is considered ‘acceptable’. In the case of CMBA, the imposition of a 5 year upper limit on research effectively crippled particular areas of specialisation/integration, such as the Fertility/IVF area, where earlier research had provided sound evidence of effectiveness. The reason for this might have had to do with the fact that research methods in the CM field are still evolving, which reinforces the fact that CM practitioiners are at a significant disadvantage because of the limited research undertaken in their areas.

The earlier research in the fertility area formed the basis of a now thriving co-operative arrangement between IVF and CM practitioners, with evidence of an ongoing dynamic interaction between the two fields of service that is beneficial to patients.

It is noted that AHPRA’s audit process’s implementation of this condition in 2019 caused substantial disruption to established and reputable CM practitioners. It is understood that the restriction was eventually able to be removed, although CM practitioners generally remain confused about why this rule was put in place and whether it still applies.

3. Please describe any content that needs to be changed or deleted in the revised guidelines.

Foreword p 4:

Sentence 1: update the number of Boards from 15 to 16.

Paragraph 3: clarify AHPRA’s role and whether it covers only health service provision or also product/pharmacology sales and ensure coverage in the definitions aligns with the position indicated (***p17 Product: a Therapeutic good within the meaning of the Therapeutic Goods Act 1989 (Cth)… and does not apply to the advertising of other products that are not associated with the provision of regulated health services’)***. Coverage in these Guidelines needs to be checked against the content of the 2014 Guidelines.

Last paragraph: indicate that Appendix 1 lists other relevant legislation and agencies

Additional paragraph: indicate APHRA’s role is regulatory and not advisory (lead into the information set out further in 1.1 on page 6).

Additional/expanded information: In order to set up a firm basis of understanding by practitioners of the regulatory framework within which the Advertising Guidelines function , expand the explanatory information to cover –

- AHPRA & National Boards' roles/ approaches in relation to advertising of regulated health services, and protection of regulated titles

- The division between AHPRA regulated health services and State/Territory regulated health services and how this impacts on special arrangements, particularly protected titles, but which does not place unregulated persons outside the offence provisions of the Act

- The enforcement approach is risk based and AHPRA sees its role as more educative than punative, and seeks to foster compliance. However, there are severe penalties in place for non-compliance where other measures fail to deliver compliance.

- The balance between Advertising '**offences/breaches**' and the use of '**misleading information**' for which regulatory action can be taken on ***health, conduct or behaviour grounds.***The 2014 Guidelines provided better coverage of this matter.

Additional flow chart: Consider adding a flow chart to show how advertising breaches are identified, the action taken by AHPRA (as spelt out on page 7), how the proceedings progress through either a Court or a Tribunal, and the severity of penalties that may be imposed, or the alternate pathway of action being taken by the regulator on grounds of health, conduct or behaviour. Alternatively, add the Appendix from the 2014 Guidelines which sets out in a table the various regulatory options.

P5. ***1 Advertising must not be false, misleading or deceptive, or likely to be misleading or deceptive.***

2nd dot point: make it clearer that the problem lies with the use of terms that claim the treatment can '***assist with***' or '***treat***' particular symptoms/conditions but which cannot be substantiated with acceptable evidence. Make it clearer that the problem lies with the unsupportable claim rather than with list making.

P.5. 2 .Any terms and conditions must be included when advertising offers a gift, discount or other inducement.: This clearly permits the offering of gifts, discounts and other inducements but appears to be contradicted on **page 15 in 4.5** in the 2nd dot point: ***"Advertising may be unlawful when…indirectly encourages indiscriminate or unnecessary use through financial incentives such as prizes, bulk purchases, discounts, bonuses, gifts or*** (??missing word???) ***without an option to exit the arrangement, to encourage consumers to use services regardless of clinical need or therapeutic benefit.***

As the foreword indicates that the Guidelines will constitute the standard against which practitioners will be held in Court or Tribunal proceedings, it is essential that this apparent contradiction be clarified. CMASA considers a more balanced approach needs to be taken, between the need for practitioners to be competitive and the need to prohibit advertising that promotes inappropriate take up of health services. The Guidelines seem overzealous in their efforts to prevent inducement, to the extent that it impedes normal competition and pricing arrangements. This has a stronger impact on emerging sectors that are trying to build business, particularly where they do not have access to government funding sources.

As outlined elsewhere, regulated health providers should be able offer discounts (eg. to those on low incomes such as pensioners) and offer bulk purchasing discounts for those requiring frequent treatment. These fall within normal business practices and are expected to be provided by the public, especially the offering of discounts for those on low incomes. Indeed, the need for discounted fees for low income earners is a core concept of Medicare, and provides medical practitioners with a built-in option for providing discounts. The same principles should apply across regulated health service providers in order to promote a level playing field and competitive

arrangements.

P5. 4. ***Advertising must not create in unreasonable expectation of beneficial treatment.***

***"… in a way that <u>may not be realistic, likely or possible</u> "**..*

While **page 14** expands on the types of advertising that are problematic in **4.4**, there is no indication of who makes the judgement of what is **realistic, likely or possible**, the grounds for such determination, and the options the practitioner/advertiser has to challenge any apparent misinterpretation of their advertising as generating unreasonable expectations. Given the reliance on this document in legal proceedings, this needs to be clearly stated.

P.8 - 4.1.1. ***Evidence required for claims about the effectiveness of regulated health services***

As noted above, CMASA strongly supports the use of evidence to verify efficacy, but that emerging health sectors are at a disadvantage in terms of the size of the pool of evidence they can access to validate claims. As this constrains the capacity of emerging holistic health systems to adequately describe their system of medicine or medical approach, **<u>CMASA recommends that an agreed description of the system of medicine be permitted. This could be a standard prepared by the relevant Board in conjunction with professional bodies, and would be in addition to the existing evidentiary requirements. This section needs to be amended to indicate that Boards can do this.</u>**

The sentence explaining **figure 1** is meaningless as the figure fails to provide any additional information about how the lack of acceptable evidence might be used to identify a breach.

Figure 1 simply illustrates/restates the arrangement and is unhelpful to the end user, the practitioners.

Page 7/8 – 3.2 Who is an advertiser?

Last sentence at bottom of page: '***A regulated health services is***' : this has an inappropriate page break which takes the focus away from the meaning set out in the dot points. This is significant as these definitions seem confusing and contradictory:

- ***'Any service provided by a registered health practitioner, or***
- ***A service that is usually provided by a registered health practitioner (but is provided by a non-registered practitioner)'.***What was this intended to mean? It needs to be reworded (and checked against the earlier Guidelines).

It is particularly problematic that the intended meaning is not clear for a matter that lies at the centre of regulatory purpose. It also raises the issue of whether this inadvertently (?or intentionally?) provides a defence for dry needling by unregistered practitioners.

This definition of a regulated health service also differs from the explanation in the ***Definitions*** pa**ge 17**, which defines it as '***A service provided by, or usually provided by, a health practitioner (as defined in the National Law). A health service is one that aims to prevent or ameliorate a person's specific health condition***'.

Perhaps inclusion of the definition from the Act is needed. There is a need for clarity about the two tiered regulatory structure of health practitioners within Australia. This needs to be covered in the introductory section.

Page 8 - 4.1.2 what is acceptable evidence? **Sentence 1** is convoluted and should be stated more plainly. For example. '***AHPRA and the National Boards rely on standards of evidence common to the wider scientific and academic community when assessing claims made by practitoiners in advertising. Practitioners are thus required to meet those high standards***.'

Reference is made to the ***Guide to assessing the evidence for advertising claims*** but it is not indicated whether this document also forms part of the standard to be considered by Tribunals and Courts. **It would be useful for the full set of related documents to be listed in an Appendix**. This also applies to the paragraph immediately before Figure 1, which directs readers to '***further information' about acceptable evidence***'. While this provides a helpful set of information about a core area of complexity of the arrangement, the layering of information in this way through hyperlinks, can have the effect of fragmenting information, and making it harder for practitioners to put the full picture together.

Page 10. 4.1.3 Titles and claims about registration, competence and qualifications.

This section is of great concern to CMASA and fails to adequately outline the arrangements. The concept of '**protected title**' is not a term in common usage and needs to be stated in **Sentence 1**, along with a reference to the relevant section of the Act.

It would be useful to indicate in this section the number/range of titles that are protected, and to bring out into the open the irregular provision for acupuncturist which CMASA considers to undermine the protected title for this health service alone.

As stated above, CMASA would like to see the principle behind this being uniformly applied across all regulated health sectors, with appropriate Board controls as outlined elsewhere. Otherwise, it suggests an inappropriate protection for certain categories of regulated practitioners, without suitable levels of training and clinical experience having been required, and while not providing the same opportunity to acupuncturists and most other regulated groupings. CMASA is concerned that AHPRA's failure to enforce title protection for acupuncturists damages the reputation of registered acupuncturists, and places members of the public at risk of harm.

Page 11 Qualifications

Paragraph 3 changes voice and directly instructs practitioners rather than informing them of the requirements. The sentence should begin with ***'Practitioners should…'***to be consistent (rather than starting with '***Take care that…'***..

CM has many practitioners with overseas obtained qualifications in addition to those obtained in Australia. There is no indication here of whether it is permissible to include such where the place of issue is clearly indicated. Patients seem to seek out this information as it gives them an indication of the background and experience of the practitioner.

Page 11/12. Gifts, discounts or inducements.

The Act clearly allows for the offering of discounts as long as the terms and conditions are stated. It is of concern that this may not have been the position adopted in the 2019 AHPRA audits of CM practitioners in terms of offering discounts. Similarly, the advice recently given by the NSW Council on Chinese Medicine is to not offer discounts in advertising to pensioners, which aligns with the focus taken in the Guidelines in **section 4.5** ***Encouraging indiscriminate or unnecessary use of health services.***' **CMASA is strongly of the view that AHPRA has been overzealous in this area and that it needs to redress this matter and restore competition to the regulated health sector by allowing discounts to be offered (as long as the terms and conditions are indicated).**

Page 16 Definitions

Introductory paragraph should refer to **Appendix 1 Associated Legislation and Agencies**.

The number of Boards should also be updated.

The coverage under Definitions is very limited, with omission of some terms with special meaning under this arrangement. Functional terms like '**specialist titles**', '**endorsements**' and '**protected title**' need to be explained somewhere in the document, but particularly should appear in the **Definitions** section.

There may also need to be provision made for mixed health service providers in line with the growth of integrative medicine.

P16.Advertising:

This section (or part of it) may be better placed in the introductory section of the Guidelines to give the reader/practitioner an understanding of the scope of materials the arrangements apply to.

From the list of what constitutes advertising, care needs to be taken on several points from a CM perspective:

- ***books (if the book is promoting a particular health service provider)-*** in CM as a style of treatment is often identified through the practitioner who developed it or is teaching it to others, but their role is educative rather than one of self promotion.

- Similarly, **media dealings** also could be vulnerable to misinterpretation about whether the intent is educational or service marketing.

Regulated health service. The beginning of the sentence should specify that "***A service***…' is '***A <u>health</u> service…***'.

Pages 18/19 APPENDICES

- Appendix 1 covers related legislation and agencies but there is a need for an additional Appendix to cover **AHPRA** and the **National Boards** in terms of:
    - All supplementary materials that form part of the 'standard' taken into consideraton by Courts and Tribunals
    - **All supplementary documents** produced by AHPRA and each Board, along with
    - **Any action taken** by Boards to give endorsement for one of their own practitioners to use the protected title of acupuncturist, and the conditions under which such have been allocated.

- **APPENDIX 2 Title protection**: this document needs to have greater transparency about the anomaly which allows the protected title of acupuncture to be given to other regulated practitioners without meeting the requirements set out by CMBA for registered acupuncturists (nor equivalent standards). AHPRA needs to indicate the rationale and background to this arrangement, in light of the high level of ongoing concern within the CM sector about erosion of the protected title, the damage to the reputation of registered acupuncturists, and of the potential safety risks for patients treated by those with unknown levels of skill or experience. Some clarity is also needed on AHPRA's regulatory action against misuse of the protected title by unregulated practitioners and individuals who provide acupuncture services.

4. Should some of the content be moved out of the revised guidelines to be published in the advertising resources section of the AHPRA website instead?

If yes, please describe what should be moved and your reasons why.

Both the website and the Guidelines should include a flow chart for AHPRA and National Board decision making processes, and the processes for taking up issues arising out of auditing action, where felt to involve a matter of principle or policy or competition anomaly.

Care should be taken not to over-fragment information provision by separating out different bits of information in the Guidelines and on the website.

CMASA considers the Chinese Medicine sector benefits from highly useful website resources provided by CMBA, particularly around the sample expressions permitted for certain circumstances. However, as far as possible, it is advisable that there be consistency of materials across regulated health sectors. Information should be communicated as simply and succinctly as possible to avoid information overload on practitioners/employers/educators.

5. How helpful is the structure of the revised guidelines?

The structure could be improved by expanding the information at the beginning to provide a more comprehensive picture of the regulatory framework and what is seen to constitute advertising/be excluded (as outlined in the Definitions at the end of the Guidelines).

In some instances, information is scattered in unrelated places, making it difficult to locate or to put together as a whole picture.

The Guidelines lack a section on the processes that are put into effect if a practitioner is found to be in breach of the Act on Advertising Standards, and there is no mention of the auditing system. The document could be made more practitioner friendly through the addition of information, such as:

- Expansion of the foreword to state that the Advertising Guidelines apply to service delivery **and to clarify whether they apply to pharmaceuticals/products or not**.
- How breaches are identified and the fact that cases are heard in Courts or Tribunals, with high penalties, which can apply not only to practitioners but also to individuals/corporations who fall outside of the regulated framework.
- It should also flag here that AHPRA's role is not advisory, and clarify whether Boards etc offer assistance to the sectors they are involved with.

6. Are the flow charts and diagrams helpful?

Please explain your answer.

The flow charts are generally unhelpful for practitioners as they seem to be designed to explain the regulatory framework rather than as an aid for practitioners, and/or are statements of the obvious and do not add any simplification or clarification.

It may be useful to show a flowchart of the processes which lead to identification of a potential breach, the action taken by AHPRA, and the processes by which a breach would pass through Tribunals and Courts, along with any alternative or subsequent action by AHPRA/relevant Board.

7. Is there anything that needs to be added to the revised guidelines?

Decision making structure and accountabilities:

The Guidelines need to show AHPRA's processes for oversighting the Advertising arrangement and the materials produced by individual Boards, particularly as the number and diversity of health service sectors grows. It should also indicate the processes in place for review of identified policy and principle problems, including as arise within the auditing process. CMASA suggests this be done through an additional appendix.

Better recognition of the particular issues affecting emerging health sectors, such as Chinese Medicine:

Chinese Medicine would like to see a more flexible approach within the evidence area while the sector catches up to WM in terms of the scope of practices it covers, through the development of a standard statement about CM, to supplement the current evidentiary arrangements. CMASA suggests this could be facilitated by CMBA in conjunction with the CM professional associations.

Proper coverage of the Protected title arrangements and the associated problems:

CMASA would like to see greater coverage of the arrangements for title protection as they affect acupuncturists, and changes to ensure that the relevant Board controls the educational levels, training skills, equivalence provisions and clinical experience of practitioners in other regulated fields who seek to gain endorsement for the practice of acupuncture. Similarly, AHPRA should signal that equivalent opportunities can be provided across other health sectors. CMASA would also like to see a statement about AHPRA's auditing resources being used to identify abuse of the protected title of acupuncture by anyone who is not a registered acupuncturist (or a registered practitioner with an endorsement to practice acupuncture).

It may be useful to show a flowchart of the processes which lead to identification of a potential breach, the action taken by AHPRA, and the processes by which a breach would pass through Tribunals and Courts, along with any subsequent action by AHPRA/relevant Board.

8. It is proposed that the guidelines will be reviewed every five years, or earlier if required. Is this reasonable? Please explain your answer.
AHPRA needs to ensure its arrangements keep abreast of the pace of change, particularly as the shape of the health system evolves, and medical practice becomes less dominant, albiet it will always hold the central position. Five years is a reasonable timeframe but should be flexible, and earlier review prompted by, for example, newly identified policy challenges, new research findings and new technology. Similarly, developments such as integrated medicine will generate new issues to be addressed. A Review of the core assumptions behind the legislative structure may be needed at the 10 year mark (2022). This response has identified a number of policy and procedural concerns.
9. Please describe anything else the National Boards should consider in the review of the guidelines.
The guidelines, while protecting public safety in the use of AHPRA regulated services, MUST also reach a balance in order to meet the information needs of the public and to avoid repressing beneficial competition. As the public is increasingly seeking to use Allied Health services, it is clear that the permitted scope of advertising lags far behind the information needs of the public, particularly for emerging sectors such as Chinese Medicine. It is considered better to provide the public with a standard type of explanation of the scope of treatment (with a qualification that it is yet to be supported by clinical studies), than for the public to have to fall back on word of mouth advice from friends and acquaintances. AHPRA and the Boards must reach a better balance on the pull between business activities of offering discounts and the need to avoid offering inducements for unnecessary treatment, and must communicate this to all players in the health sector.
10. Please add any other comments or suggestions for the revised guidelines.

Thank you!

Thank you for participating in the consultation.

Your answers will be used by the National Boards and AHPRA to improve the Guidelines for advertising regulated health services.