

# Regulation of TCAM Professions in New Zealand

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In New Zealand, “Traditional, Complementary and Alternative Medicine” (TCAM) is largely unregulated. As opportunity arises for increased TCAM participation in mainstream healthcare services, there is a growing perceived need for regulation.

Regulation can involve the setting of scopes of practice, standards of practice, codes of ethics, handling of complaints and other standards.

This document is not proposed as an authoritative study, but as a stimulus for fruitful discussion; through which TCAM can eventually establish its rightful place in the national healthcare services. This is entirely a personal view of the discussion, and I take responsibility for any errors made.

## 1 The case for regulation

1. Improve public safety
2. Standardise practices and delivery, and improve professionalism
3. Improve public image of TCAM
4. Gain recognition from government and healthcare services
5. Gain funding or subsidisation of client costs
6. Protect professional titles and modalities

## 2 Regulation pathways

There are currently two perceived pathways for regulation:

1. Statutory regulation under the Health Practitioner Competence Assurance Act (HPCAA) 2003.
2. Self-regulation under a body recognised by practitioners as well as the government.

### **3 Statutory Regulation under HPCAA**

This is a pathway that has been taken by Osteopaths and Chiropractics. Currently, applications are being processed for Acupuncturists and Western Medical Herbalists.

The commonly-expressed rationales for regulation under HPCAA are:

1. Recognition by government
2. Recognition and acceptance by medical establishment
3. Improvement in “mana” and status of modality and its practitioners
4. Access to ACC and other funding
5. Protection of title
6. Prevention of “rogue” unqualified and/or incompetent practitioners
7. Access by TCAM education providers to higher levels of course funding

#### **3.0.1 Recognition by government**

The government has not stated that it will only “recognise” modalities through the HPCAA or any other mechanisms. The National government appears interested in grass-roots or “bottom-up” development of integrated healthcare; i.e. collaborative clinics between medical and TCAM practitioners. There has been no indication that registration under the HPCAA is a significant factor.

#### **3.0.2 Recognition and acceptance by medical establishment**

While there is increasing evidence of medical-TCAM collaboration, there is no evidence that this is based on HPCAA-registration. In fact, the current Integrative Medicine clinic models include Naturopaths whom are not HPCAA-registered. Medical practitioners have indicated that collaboration is on the basis of mutual trust and perceived professionalism.

#### **3.0.3 Improvement in “mana” and status of modality and its practitioners**

The perception of increased mana and status was addressed in the Director-General’s report to the Ministry of Health 2009. There is no evidence that such has been the case for, e.g. Osteopaths and Chiropractors. The good general perception of these modalities could more readily be attributed to the clinical standards and professionalism of these modalities, and due to high education standards and good organisation of the professional associations.

### **3.0.4 Access to ACC and other funding**

While modalities may look to registration under the HPCAA as a pathway to public funding for clients, the HPCAA specifically excludes this. Funding to Osteopaths and Chiropractors was established under ACC, independently of HPCAA registration.

### **3.0.5 Protection of title**

The HPCAA does protect titles by legally prohibiting the use of legislated titles by unregistered parties. However, the HPCAA does not prevent unregistered practitioners from practising under other titles not protected by legislation.

### **3.0.6 Prevention of “rogue” unqualified and/or incompetent practitioners**

The HPCAA is a mechanism to protect the public from risk of harm from registered practitioners. However, it does not protect the public from unregistered practitioners; in such cases, the public is currently protected by criminal law relating to causing of injury or death.

### **3.0.7 Access by TCAM education providers to higher levels of course funding**

Currently, education providers of medical courses receive higher levels of funding than providers of TCAM courses. It is perceived by some education providers that HPCAA registration of relevant modalities will bring higher funding equivalent to medical courses. It is unclear whether this line of reasoning is true; however it would incumbent on education providers to negotiate better funding levels through other criteria than HPCAA-registration; especially if a self-regulation model could be shown to be equally or more effective.

## **3.1 Arguments against HPCAA regulation**

There is a growing body of practitioners that are not in favour of regulation under the HPCAA. Even the Director-General of Health expressed concern in a 2009 review of the HPCAA, that there is a “proliferation of registration authorities.” He recommended that the Ministry of health review the criteria it uses to advise the Minister whether regulation of a modality is justified.

### **3.1.1 Proving “risk of harm”**

The HPCAA was enacted specifically to protect public safety where registered health professions posed a “risk of harm.” This could include:

1. Invasive procedures (such as cutting under the skin).
2. Clinical intervention with the potential of harm.

3. Making decisions or exercising judgement which can substantially impact on patient health or welfare, including situations where individuals work autonomously, i.e., unsupervised by other health professionals.

Thus, a modality applying for registration under the HPCAA needs to show that it poses a significant danger to the public through its practices. This is not the reality for TCAM, which is largely benign due to its natural practices, methods and medicines. TCAM has an excellent record of safety relative to mainstream medical healthcare. It does not appear to be in its longterm best interests for a TCAM modality to go out of its way to prove that it is dangerous; as it might pave the way for increased control, regulation and restriction of that modality.

Canaway (2009) suggests that making efforts to prove “risk of harm” when in actuality the risk is very low, could lead to that “proof” being used to raise insurance premiums.

### **3.1.2 Costs of application for registration and administration**

The cost of submitting an application for registration under the HPCAA is prohibitive to most TCAM modalities. The costs of administration and annual licence fees, etc, are high, and would be prohibitive for part-time practitioners, who, in the case of Medical Herbalists constitute about 90% of their total practitioners.

### **3.1.3 Application of principles**

New Zealand, the UK, Ontario and Australia apply similar principles when considering statutory regulation of health occupations:

1. The benefits of statutory regulation should outweigh the costs.
2. Statutory regulation should only be considered if it is necessary to protect the public.
3. Statutory regulation should be the most appropriate way to regulate the occupation.
4. The risk posed by those health services cannot be addressed by other mechanisms.
5. Statutory regulation should be both practical and possible.

Most of the above principles do not appear to have been met in the case of TCAM; thus it is unlikely that statutory regulation would be favoured by the present government.

## **4 Voluntary self regulation**

Many industries in New Zealand are self-regulating. The National government is tending to favour less bureaucracy and administrative costs; and would therefore be in favour of self regulation. There are forms of registration of TCAM professions in New Zealand, such as membership of the Natural Health Council, or being chartered by the NZ Charter of Health Practitioners. However, these are mainly mechanisms of membership, and do not involve significant regulatory mechanisms.

### **4.1 Benefits of self regulation**

Self regulation of TCAM modalities and practitioners may offer a number of advantages:

1. Self-determination
2. Flexibility
3. Cost savings

#### **4.1.1 Self regulation and self-determination**

The potential benefits and potential risks of TCAM are best known by TCAM practitioners themselves. Thus it is most likely that TCAM associations would be in the best position to create regulation that optimally served the public as well as the professions.

The HPCAA was created for medical professions that statistically have high risk of causing harm. Therefore the kind of regulation required to mitigate that risk would not be appropriate for professions statistically carrying low risks, such as TCAM practitioners.

Self regulation would help assure independence of TCAM.

#### **4.1.2 Self regulation and flexibility**

Statutory regulation is notoriously inflexible and difficult to change. It would be in TCAM practitioners' interests to have the flexibility offered by self regulation. This would allow the self regulation to be a work-in-progress; to be developed as situations indicate particular needs. Such flexibility is more suited to relatively low-risk professions that have so far shown a good safety record.

#### **4.1.3 Self regulation and cost savings**

By reducing unnecessary bureaucracy and onerous regulations, self regulation could potentially minimise administrative costs. It would enable smaller groups to organise themselves and register their practitioners, at minimal cost. This would encourage greater participation, further sharing the cost load.

## **4.2 Problems with self regulation**

As history has shown, organised self regulation rarely happens until there is pressure to do so. With the increased profile of TCAM - and increased exposure to attack from vested interests - it is incumbent on TCAM practitioners to be regulated; to protect their profession as well as to protect public safety.

Forseeable problems arising from a move towards self regulation include:

1. Agreement on regulatory authorities
2. Agreement on standards and regulations
3. Legal enforcement
4. Lack of recognition

### **4.2.1 Agreement on regulatory authorities**

Some TCAM modalities have many practitioners, and there may be a number of representative professional associations. There is a history of friction and division. There may be difficulties in practitioners and associations agreeing on which body should become the regulatory authority for that modality. Such a decision may have to be negotiated between them and the umbrella bodies such as the Natural Health Council and the NZ Charter of Health Practitioners. The NHC and/or the Charter could become the regulatory authorities for their respective affiliate members.

### **4.2.2 Agreement on standards and regulations**

There may be difficulties agreeing on what the standards and regulations should be. This could be solved by creating a universal set of standards and regulations that is maintained and administered by an umbrella body such as the NHC or Charter. Modalities with particular requirements could have additional regulations added to the universal set. The Ministry of Health could be consulted during creation of standards, to ensure they are appropriate for the Ministry's expectations and requirements.

### **4.2.3 Legal enforcement**

A self regulation model would not have the legal clout of statutory regulation. Enforcement could be achieved through other means of applying pressure; for example by deregistering and shaming "rogue" practitioners, or by negotiating with distributors that "practitioner only" products be made available only to registered practitioners.

### **4.2.4 Lack of recognition**

It is feared by some that self regulation would not bring the "mana" and recognition that statutory regulation could. However, the reality is that recognition would proba-

bly develop from mutual trust, high standards of practice, and ongoing dialogue with government and other authorities.

Thus, it is foreseeable that recognition would develop from professions being easy to work with, and providing consistent results.

## 5 Conclusion

Government statistics show that injury and death due to natural healthcare and therapeutic products is negligible (Law, 2004). Using the HPCAA - legislation intended to regulate professions capable of high risk of harm - to regulate TCAM, seems an inappropriate mechanism which may ultimately not be in the best interests of TCAM.

While alternative statutory legislation may be a solution, the government may be disinclined to embark on such a route. Even if it did, the process would take a long time. It appears that the quickest, most flexible solution would be voluntary self regulation.

There are three possible means of creating self regulation:

1. Use a "shadow" version of the HPCAA, or deconstruct the legislation and reconstruct it to suit TCAM purposes.
2. Create new regulation from the ground up, on the basis of needs and requirements.
3. Adapt self regulation from other industries, or from TCAM professions in other countries.

The ascendancy of the medical professions was aided by the legal protection and recognition bestowed by medical registration acts (Canaway, 2009). The perception among a number of TCAM practitioners is that such legislation would thus confer TCAM similar protection and recognition. However, the political climate is changing; with public opinion playing a stronger role due to wider availability of information. There is an increased understanding among the public of the shortfalls of the medical system, and the potential benefits of TCAM. This might engender sufficient recognition to push government for increased participation of TCAM in the national healthcare services, and for funding of TCAM treatments.

It is suggested that TCAM, rather than making lengthy and uncertain applications for registration under HPCAA, would benefit more from resolving their differences and putting their "house in order," i.e., creating credible standards of practice and self regulation. The two major umbrella bodies, the Natural Health Council and the NZ Charter of Health Practitioners, have already established dialogue with the government, and have agreed to collaborate for the benefit of the TCAM profession. They are in the best position to become regulatory authorities for many TCAM professions, and are already considering strategies for creating self regulation in consultation with the Ministry of Health.

For the first time in the recent history of organised healthcare, there is a real opportunity for TCAM to have greater involvement in the healthcare services. This opportunity

has been hinted by the Ministry of Health and has led to discussions with the NHC and the Charter. It is now time for all TCAM professionals, part-time or full-time, to engage in the process of creating a logical, effective and sustainable healthcare system for New Zealand.

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