SUBMISSION ON
THE CHINESE MEDICINE BOARD OF AUSTRALIA
DRAFT REGISTRATION STANDARDS

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EXECUTIVE SUMMARY

This submission will analyse the Consultation Paper and its implications for the Chinese medicine profession and Chinese medicine practitioners in particular. It will also make recommendations, where appropriate, on the proposed standards with a view to improving the outcome for legitimate Chinese medicine practitioners applying under the grandparenting arrangements.

The intent of grandparenting, as stated in the Consultation Paper:

> 'is to ensure that practitioners who are legitimately practising the profession (particularly in those jurisdictions that did not require registration) are not unjustly disadvantaged because they are not automatically transitioned to the national registration scheme as a state or territory registrant or because they do not hold an approved qualification.'

The draft grandparenting standard requires major revision before being approved by the Ministerial Council.

As the standards to be put to Ministerial Council will determine eligibility for registration and whether existing Chinese medicine practitioners are able to earn a living through continuing practice in their chosen profession, it is incumbent upon the CMBA to make sure it deals with the issues submission, and to ensure that it has fully considered all the implications of its proposed standards and their impact on the profession in general and, in particular, practitioners.

The standard does not adequately provide a suitable mechanism for grandparenting of legitimate practitioners of Chinese medicine. If applied in its current form, it would result in many hundreds of legitimate Chinese medicine practitioners being denied the right to continue to practise in the profession and/or to use the scope of Chinese medicine services that they have been safely using for the many years.

This will occur through what appears to be the retrospective application of contemporary standards and the inflexibility in the criteria that a Chinese medicine practitioner may demonstrate in the practice of Chinese medicine.

The draft standard would mean that the qualifications of most Australian-trained practitioners would not be recognised for grandparenting purposes, despite those course meeting the standards that applied at the time. These practitioners would then be required to apply under the proof of competence and practice for five years in the period 2002 to 2012. This would result in a potentially unmanageable workload for AHPRA and the CMBA in trying to competently assess and process these applications before the 1 July 2012 deadline.

The inflexibility of the criteria for patient cards (under proof of competence section), while appearing thorough and reasonable on the surface, would actually result in many hundreds of legitimate Chinese medicine practitioners being denied registration in the divisions of acupuncture and/or Chinese herbal medicine. This will have significant negative financial and anti-competitive effects on affected Chinese medicine practitioners without any measurable improvement to public health and safety.

The draft standard also does not acknowledge the full range of legitimate practices within contemporary Chinese medicine practice in Australia.

Key information that significantly changes the interpretation of qualifications requirements was released as an Addendum less than two weeks before the close of the consultation period. This raises questions about providing an adequate consultation period when key information that stakeholders need to know is not made available at the commencement of consultations.

This process has resulted in significant unease, anxiety and insecurity in the profession about how they will be treated when they apply for national registration. With such an important process requiring the support of the profession, AACMA considers it imperative that the CMBA consider the impact of the grandparenting standards on the bulk of practitioners who make up the profession in Australia.

AACMA has made a number of recommendations that it believes would deal with the shortcomings in the draft standard. Adopting these recommendations will allow all legitimate Chinese medicine practitioners to obtain registration in divisions relevant to their current practice. These recommendations will not permit individuals who are not Chinese medicine practitioners from inadvertently being included in the scope of the grandparenting standards.

In relation to the five mandatory standards, the English Language Skills standard needs a major overhaul as the period of application of the exemptions for grandparented applicants makes the rest of the standard meaningless. As this is a mandatory standard, the CMBA is not required to match the exemptions period with the special rules for grandparented applicants. Therefore a shorter period can be set. AACMA has made recommendations that it believes allows the CMBA to meets its health and safety obligations to the public while allowing existing legitimate practitioners to continue to earn their living through practise in their profession. This includes a recommendation that that special rules under the English standard only apply to grandparenting applicants that are received before a certain date, such as 1 July 2012, or some other date not later than 1 July 2013.

The Recency of Practice Standard also needs some review, particularly in relation to the period of time allowed for new graduates to be exempt from recency of practice requirements. AACMA recommends a three year period, to bring it in line with the requirements for other practising registrants. AACMA has made some other recommendations that are outlined in the body of the submission. Some of the terminology related to ‘graduation’ and year of ‘award’ need to be tightened up to reflect what is actually meant.

AACMA recommends that the Professional Indemnity Insurance (PII) Standard be amended to require a minimum of $5,000,000 for a single claim, to bring it in line with the other health professions, as well as mandatory inclusion of legal expenses cover. The definitions of ‘Claims made’ and ‘Occurrence-based’ policies need to be revised.

In relation to the Continuing Professional Development (CPD) Standard, AACMA recommends a shift to a Credit Points system, rather than hours, and the preparation of Guidelines for CPD to supplement the Standard.

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SUMMARY OF RECOMMENDATIONS

The numerical references in this Summary of Recommendations correspond to the question numbers in the CMBA Consultation Paper and to the Chapters and Sections in this submission. It includes the major recommendations arising from from this submission.

1. CONTINUING PROFESSIONAL DEVELOPMENT

1.1 Number of hours specified

Recommendation: AACMA recommends a CPD Credit Points approach, where one hour of CPD activity equates to one CPD Credit Point. Activities that do not directly translate into hours can be allocated CPD Credit Points according to an agreed formula. The detail of CPD Credit Points could be included in a set of CPD Guidelines supplementing the registration standard.

Recommendation: That 20 hours is sufficient for a practitioners registered in one division, that practitioners registered in more than one division be required to complete an additional five hours per additional division and that practitioners be required to complete at least five hours CPD per division in activities directly related to that division.

1.2 Professional issues

Recommendation: that the minimum hours mandated for professional issues be reduced to two hours.

3. ENGLISH LANGUAGE SKILLS

3.1 Evidence requirements

AACMA objects to the proposed 1.5 years full-time equivalent for post-graduate studies. Unless there is solid evidence to show that post-graduate students have an innate ability to master English language faster than anyone else, to IELTS level 7, AACMA sees no justification in post-graduate students being given preferential treatment. The same full-time equivalent duration should apply to all applicants or they do the IELTS or other approved English language test. Furthermore, a post-graduate course may be conducted on-line or by distance education and not include any face-to-face or spoken component so it could not be used as evidence of English language competence.

Recommendation: That the CMBA more closely adapt the models used by the other health professions to apply to new applicants for registration received on or after 1 July, with a set of special rules or exemptions to apply to existing practitioners who apply by 30 June 2012 or such later date but not before 1 July 2013.

3.4 General exemptions

Recommendation: that an additional dot point be added under point 1:

- 'to perform a demonstration in clinical techniques'.

3.5 Exemptions for 'grandparented' practitioners

Recommendation – exemptions for grandparented applicants: That the period of application of the exemption for grandparenting applications apply only to applications received on or before 30 June 2012 or, if that is not technically or legally possible, not later than 30 June 2013.

Recommendation: That practitioners with a moderate to good level of English should be able to prove they meet a grandparenting standard through one of the following:

- an IELTS or other English test deemed adequate by the Board for grandparented applicants
- evidence of academic engagement where the language of communication is English; this could be in the form of a letter from the employing institution that the practitioner is/has been engaged in the teaching or clinical supervision of students where the language of communication is English
- evidence of professional engagement where the language of communication is English; this could be in the form of a letter from the professional body, committee, or other organisation involved in professional matters outlining the role of the practitioner has/had within the organisation and that the language of communication is/was English
- evidence of community engagement where the language of communication is English; this could be in the form of a letter from the community organisation outlining the role the practitioner has/had within the organisation and that the language of communication is/was English.
- evidence of having passed a Chinese medicine examination conducted in English; the assessing organisation should explain the nature of the examination and that the language of communication for the examination was English
- evidence of conduct of the practitioner's practice primarily in English; evidence could include:
    - a statutory declaration from the practitioner's practice manager that the practitioner has worked at the clinic for x years and conducts or primarily conducts their practice in English,
    - a statutory declaration from a professional colleague who is a native speaker of English with good knowledge of the practitioner's practice; this could be a colleague in the same or an allied practice, or a colleague with whom the practitioner has referred patients or vice versa.
    - a statutory declaration by the practitioner that they have conducted their professional practice primarily in English for x years, supported by 20 de-identified patient cards that are in English.

Recommendation: For public health and safety, practitioners who cannot provide evidence of moderate to good level of competence in English should have conditions placed on their registration and have their registration endorsed accordingly. This endorsement should be noted on the public register

3.7 Appropriate arrangements for emergency services

Recommendation: That the registered practitioner be required to hold a first aid certificate, level 2 workplace first aid, or equivalent in in-service training, and that the requirement for a first aid certificate be incorporated into the CPD registration standard.

4. PROFESSIONAL INDEMNITY INSURANCE (PII)

4.1 Minimum requirements for a single claim

Recommendation: The AACMA Board is of the view that a minimum $5,000,000 cover for a single claim is the appropriate level of cover for a registered health professional. We believe that registration brings with it a higher risk of litigation and thus the need for a higher level of cover.

4.3 Self-declaration about compliance

Recommendation: that the CMBA should required registrants to submit a copy of the Certificate of Currency or Cover Note on initial or renewal of registration.

4.4 Other issues

Recommendation: that legal expenses cover be included as a minimum requirement.

5. RECENCY OF PRACTICE

5.1 Three year period

AACMA is generally in agreement with a three year period for recency of practice. However, AACMA would not object to the period being extended up to five years. AACMA would not support the period being less than three years.

5.2 Exemptions

Recommendation: For consistency and fairness, AACMA recommends the period for new graduates be three years, in line with the requirements of all other applicants for initial or renewing registration.

7. TRANSITIONAL ARRANGEMENTS FOR QUALIFICATIONS (GRANDPARENTING)

7.1 Qualifications standards

Recommendation: that the standard to be presented to the Ministerial Council should clearly articulate how the three limbs of Section 303 will be applied.

Recommendation: that the heading referencing to pre-2008 qualifications be removed

Recommendation on 'adequate clinical hours': That 'adequate clinical hours' not be prescriptively defined in the document in relation to sub-degree programs. Instead, if any reference to or definition of adequate clinical hours is to be included in the grandparenting standard, then it should be stated as follows:

- adequate clinical hours will be considered in the context of the era when the course was delivered and the standards that prevailed at the time.

Recommendation: that the standard undergo a major review to recognise and acknowledge the past accredited and non-accredited Australian qualifications in acupuncture and/or Chinese herbal medicine that met the standards that applied at that time and these be included on a list of qualifications deemed adequate for grandparenting purposes (refer to Appendices A & B).

Recommendation – accredited Australian programs: Being a discrete group of applicants, it is reasonable and achievable to identify and publish a list of accredited Australian programs that are deemed adequate for grandparenting purposes. A list of accredited programs is included as Appendix A.

Recommendation – non-accredited Australian programs: Being a discrete group of applicants, it is reasonable and achievable to identify and publish a list of non-accredited Australian programs that are deemed adequate for grandparenting purposes. A list of non-accredited programs suitable for grandparenting purposes is included as Appendix B.

Recommendation: that legitimate practitioners of Chinese medicine who initially qualified in acupuncture and who have incorporated Chinese herbal medicine into their practices should be able to obtain registration in the division of Chinese herbal medicine and not be arbitrarily or unfairly precluded from continuing their Chinese herbal medicine practice.

Recommendation: That the qualifications of overseas-trained practitioners be considered according through qualifications equivalency assessment, overseas accreditation/registration, local examinations and the conditions that prevailed in the relevant country at that the time.

7.3 Types of competence evidence

Recommendation – acupuncture patient records: That the criteria for acupuncture patient records include a statement that accords with the following:

> 'When assessing competence in the practice of acupuncture through patient records, recognition will be given to diagnosis and treatment that is in accordance with the range of traditions/styles of acupuncture that have developed out of traditional Chinese medicine, such as meridian therapy, Korean oriental medicine, five element acupuncture, and other traditional oriental medicine styles of acupuncture.'

Recommendation – Chinese herbal medicine patient records: That the criteria for Chinese herbal medicine patient records include a statement in accordance with the following:

> 'For Chinese medicine practitioners who have demonstrated their eligibility for registration in the division of acupuncture who are also applying for registration in the division of Chinese herbal medicine, when assessing competence in the practice of Chinese herbal medicine through patient records, consideration will be given to diagnosis and treatment that is in accordance with the range of traditions/styles of Chinese herbal medicine that have developed out of traditional Chinese medicine. A formula-based prescription that accords with the diagnosis will be considered adequate even if does not show modification of a traditional formula.'

8. Board statement – grandparenting registration standard

AHPRA Principles The proposed standard does not fully meet the consultation requirements of the National law as key information necessary to appreciate and understand the impact of the draft standards was only published within two weeks of the close if consultations.

COAG Principles

AACMA does not agree with the Board's assessment against the COAG principles and believe that it fails to consider a range of anti-competitive and unnecessary adverse effects in aspects of the following::

- Unnecessary restriction of competition
- Unnecessary restriction of consumer choice

1. DRAFT MANDATORY STANDARD CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

Overall, AACMA is in broad agreement with the principles of the draft standard.

However the following issues should be considered and addressed before the standard is finalised for Ministerial approval

1.1 Number of hours

1.1.1 Hours or Credit Points

The standard needs to allow for a broad range of activities to fit under the definition of CPD.

Contact hours are not necessarily a reliable way to assess the extent or level of continuing professional development (CPD).

For example:

- how should hours be calculated where the practitioner is keeping up-to-date on the developments in research and practice through academic journals? A slow reader would be able to accrue more CPD hours than a person who is able to read and extract key information in a shorter time;
- how should hours be calculated for a self-directed learning activity? A slow learner would be able to accrue more CPD hours than a person who is able to process information in a shorter time.

Allocation of credit points rather than hours or providing a formula for determining hours equivalence for activities where an 'hours' allocation would result in inconsistency on how the standard is applied.

Recommendation: AACMA recommends a CPD Credit Points approach, where one hour of CPD activity equates to one CPD Credit Point. Activities that do not directly translate into hours can be allocated CPD Credit Points according to an agreed formula.

The detail of CPD Credit Points could be included in a set of CPD Guidelines supplementing the registration standard.

1.1.2 Additional CPD for two or more divisions

AACMA supports a minimum 20 hours (or CPD points) be required of all registrants in a practising category.

The CMBA also needs to set reasonable and achievable additional CPD requirements where a practitioner is registered in more than one division of the register, with a minimum number of hours/credit points for each division in which the practitioner is registered.

A practitioner registered in more than one division is expected to update their knowledge and skills in more modality-specific areas than a practitioner registered in only one division of the register. Because some of the knowledge, skills and attributes to be obtained are general or

transferrable between practice modalities, an additional five hours (or credit points) per additional registered modality would be reasonable and sufficient.

A minimum number of hours or credit points could be mandated for activities directly relevant to each division in which the practitioner is registered. AACMA suggests a minimum five hours (or credit points) per division for directly relevant CPD activities. This ensures practitioners are updating their knowledge and skills in the practice areas for which they are registered without unreasonably limiting the flexibility needed to enable practitioners to pursue CPD activities in areas of need or interest.

It is noted that the draft policy already mandates a minimum number of hours to professional issues as well as to scheduled herbs for endorsed practitioners and dispensers.

This underscores the importance accorded by the CMBA to ensuring some key elements of practice are being included in CPD activities. AACMA believes that the practices in which the practitioner is registered are also key elements of practice and should also be required to be included in the practitioner's CPD activities.

Recommendation: That 20 hours is sufficient for a practitioners registered in one division, that practitioners registered in more than one division be required to complete an additional five hours per additional division and that practitioners be required to complete at least five hours CPD per division in activities directly related to that division.

1.1.3 Suitable CPD activities

On page 9 of the Consultation Paper, reference is made to 'research and teaching' under Suitable Activities.

The intent of this phrase is unclear and ambiguous.

As the draft standard states that 'CPD activities should:…'include research and teaching', a narrow interpretation would be to limit the range of activities that practitioners could be reasonably claimed for CPD activities. This surely could not be the intent of the standard.

The CMBA needs to acknowledge in the standards that attendance at seminars or conferences is not the only mechanism for CPD accrual. A flexible approach is required that takes into account the range of practitioner circumstances (such as regional and remote), accessibility, flexible delivery methods, learning styles and availability of CPD activities.

1.2 Professional issues

AACMA does not object to a minimum number of hours being mandated for professional issues.

However, AACMA believes that four hours is too high and practitioners may have some difficulty in meeting these requirements each year.

While more CPD related to professional issues should be encouraged, the mandated minimum should be no more than two hours (or credit points) per year.

Recommendation: that the minimum hours mandated for professional issues be reduced to two hours.

1.3 Specific CPD for endorsed practitioners

AACMA does not object to two hours (or credit points) being allocated to scheduled herbs for endorsed practitioners. This is conditional on the CMBA ensuring that there actually are CPD activities specific to scheduled Chinese herbs.

As this is an area of practice not currently being provided by the organisations and individuals offering CPD to Chinese medicine practitioners, it would be up to the CMBA to take steps to ensure that there are sufficient CPD activities in this field in a range of formats to enable practitioners, wherever they are located, to access CPD in scheduled herbs.

1.4 Mandatory further education

AACMA agrees that mandatory further education, training, mentoring or supervision (which is remedial) should not be counted toward CPD calculations.

1.5 Exemptions

AACMA does not object to the exemptions outlined in the Consultation Paper.

1.6 Other matters

1.6.1 First Aid Certificate

As a matter of public safety, AACMA believes that all registered Chines medicine practitioners should hold a current first aid certificate (FAC) or equivalent, as the timely application of first aid may mean the difference between life and death.

Although the industry standard is to require a current FAC and that this has been taken up as a requirement by the private health insurers, there is no guarantee that practitioners will maintain their membership of a reputable association after they obtain registration. This means that the onus is on the CMBA, not the associations or the health funds, to ensure registered practitioners have a current FAC.

Finally, the onus should be on the registered practitioner to have the FAC, not some other person, registered or unregistered, to have the FAC. It is the responsibility of the registered practitioner to provide any first aid treatment, not their receptionist, practice manager, or clinical assistants.

Recommendation: That practitioners with practising registration be required to have a current first aid certificate (FAC), workplace FAC or equivalent in in-service training and that be renewed/refreshed every three years

1.6.2 CPD Guidelines

The standards should also include reference to Guidelines for CPD that can be developed over a longer period and involve a more comprehensive and meaningful consultation than has been the case with the current consultation process.

This is consistent with the approach taken by the other national boards.

AACMA would not object to some of the above issues being incorporated in Guidelines if they are considered too specific for the Standard. This would include how to deal with hours/credit points for activities that are not attendance at seminars, conferences or webinars.

2. DRAFT MANDATORY STANDARD CRIMINAL HISTORY

2.1 Ministerial Council approval

AACMA raises no objection to the Criminal History standard being submitted for Ministerial Council approval.

As stated in the consultation document, this standard is required to be consistent across the boards and has already undergone a consultation process.

3. DRAFT MANDATORY STANDARD ENGLISH LANGUAGE SKILLS

It is noted that this standard is a mandatory standard not a grandparenting standard. If applied without taking into account the circumstances of the existing practitioner cohort, an unjustifiable and unreasonable outcome will be accorded to a significant proportion of the existing profession.

As the purpose of registration is to protect the public and a purpose of the CMBA is to register the Chinese medicine profession in Australia, it is not unreasonable to expect registered practitioners to be sufficiently competent in English to be able to safely practise in Australia and to access and understand health information and health alerts in English.

English is the language of communication in Australia and the language of communication between health professionals as well as being the language of communication of most patients of health services in Australia.

However, Chinese medicine does have a different history of development in Australia, compared with the other registered health professions, which has included a large number of practitioners who qualified overseas and later migrated to Australia. Of that group, the largest sectors from non-English speaking backgrounds are those from Chinese, Korean and Vietnamese language backgrounds.

This creates a unique situation that needs to be carefully addressed in the grandparenting process, balancing the importance of protecting public health and safety against the right of practitioners to be able to continue to safely practise in their profession.

3.1 Evidence requirements

AACMA does not object in principle to evidence of completion of four years full-time equivalent of education taught and assessed in English.

AACMA does, however, object to the proposed 1.5 years full-time equivalent for post-graduate studies. Unless there is solid evidence to show that post-graduate students have an innate ability to master English language faster than anyone else, to IELTS level 7, AACMA sees no justification in post-graduate students being given preferential treatment. The same full-time equivalent duration should apply to all applicants or they do the IELTS or other approved English language test. Furthermore, a post-graduate course may be conducted on-line or by distance education and not include any face-to-face or spoken component so it could not be used as evidence of English language competence.

AACMA notes that no other board has approved 1.5 years post-graduate studies in English as adequate for English.

A more credible approach would be to more closely adapt the models used by the other health professions to apply to new applicants for registration received on or after 1 July, with a set of special rules or exemptions to apply to existing practitioners who apply by 30 June 2012.

A secondary, but important, issue arises in relation to practitioners grandparented under the Victorian scheme who will be transitioned into the national scheme. Victorian practitioners who do not have adequate English language to meet the national standard would still be able to obtain registration under the national scheme through the transitional arrangements. This would place them at a competitive advantage over other practitioners applying for the first time under the national scheme.

As the purpose of grandparenting is to ensure practitioners not already registered in Victoria are not unjustifiably disadvantaged because there was not a registration system in place in their jurisdiction, there do need to be special circumstances/rules applying to initial applicants for registration under the national scheme whose applications are received by the CMBA by 30 June 2012.

3.2 Minimum test results

The minimum test results are broadly consistent with the requirements of the other health professions.

3.3 Effective communication requirements

AACMA has no specific suggestions on this section.

However, we note that reliance on interpreters, while necessary, usually means that family members of the patient, including children who may not actually understand the meaning of medical terms or how to translate concepts and words outside their personal experience, will be providing the interpretation.

However, practitioners should not be limited to the use of professional interpreters and another adult with sufficient expertise in both languages should be adequate.

3.4 General exemptions

The minimum test results are broadly consistent with the requirements of the other health professions.

However, AACMA recommends that an additional dot point be added under point 1:

- ‘to perform a demonstration in clinical techniques’.

This would bring that section of the exemptions in line with the standards of the other health professions.

The extra paragraph related to IELTS tests and student registrants is acceptable.

3.5 Exemptions for ‘grandparented’ practitioners

The exemption for grandparenting applicants needs to be reworked to make what the CMBA expects clearer and to focus on safety.

It is noted that, according to the proposed exemptions for grandparented practitioners, the rest of the standard is meaningless as it will not actually apply during the period of the standard.

Period of application of the exemption

The draft standard states that the exemption for grandparented applicants applies until 31 December 2015.

It is not apparent in the Consultation Paper why the date of 31 December 2015 was selected and not 30 June 2015. Was it an error or was there some other purpose for that date? If there is some other purpose then transparency would require that it be clearly stated in the document.

AACMA considers that a 3.5 year period after the commencement of registration in which new entrants to the profession in Australia would not be required to demonstrate an adequate English language competency is too long. Such a long period is not in the interests of public health and safety.

AACMA is also emphatic that special rules should apply to existing practitioners so that they are not unjustifiably disadvantaged because they were not required to be registered in Victoria.

This can be fairly achieved by applying the special rules only to applications for registration received by 30 June 2012. This will enable special rules to apply to existing practitioners without compromising public safety for an additional 3.5 years. If there are legal or technical reasons why that date cannot apply, then a date no later than one year after the commencement of Chinese medicine registration should apply.

Furthermore, as this standard is not a grandparenting standard but a mandatory standard, the CMBA is not limited to a three year period when considering the special rules for existing practitioners. It is within the Board's scope to set a shorter period to apply this section if it is in the public interest

To ensure fairness, the grandparenting standard must also allow initial applications for non-practising registration that are received by 30 June 2012 to be assessed in the same manner.

Recommendation – exemptions for grandparented applicants: That the period of application of the exemption for grandparenting applications apply only to applications received on or before 30 June 2012 or, if that is not technically or legally possible, not later than 30 June 2013.

Standards applying to grandparented applicants

The CMBA needs to balance public health and safety risks of allowing practitioners who do not meet the English language standards against their rights to continue to earn their living through practising in the profession .

There are three basic groups of practitioners who may not be able to demonstrate competence in English to the level of IELTS 7 (Academic):

1. those with a moderate to good standard of English who effectively communicate with the patients in English; these practitioners most likely conduct their practices primarily in English

2. those with a poor standard of English who may have the ability to safely communicate in English but whose practices are conducted primarily in a language other than English
3. those with limited or no English whose practices are usually conducted in a language other than English.

Practitioners in Group 1 should be deemed to have an adequate level of English language competence for grandparenting purposes without the need for additional testing or conditions. For practitioners who primarily conduct their practices in English, imposing conditions such as the use of interpreters for English-speaking patients would destroy their practices and act in the same way as denial of registration.

In contrast, public health and safety would require that practitioners in Group 3 to have conditions placed on their registration and have their registration endorsed accordingly. Potential patients searching the public register for a registered practitioner need to know that the selected practitioner does not speak English. It is not good enough that they only find this out when they attend the clinic and find that the practitioner does not actually understand the complexity of their condition and cannot adequately explain the treatment and the risks or obtain informed consent. Such an endorsement would not necessarily adversely affect their practices as they are usually conducted in languages other than English and they would usually not expect to be treating English-speaking patients.

Practitioners in Group 2 are a bit more problematic as they may have been safely practising for many years and may be able to safely communicate with emergency services but their level of English may be not good enough for effective communication with patients in English. This group should be treated in the same way as Group 3 until their English language standard is sufficiently competent to not require conditions on their registration.

The question is the evidence that could be supplied to demonstrate moderate to good English competence to be deemed adequate for grandparenting:

- an IELTS or other English test deemed adequate by the Board for grandparented applicants
- evidence of academic engagement where the language of communication is English; this could be in the form of a letter from the employing institution that the practitioner is/has been engaged in the teaching or clinical supervision of students where the language of communication is English
- evidence of professional engagement where the language of communication is English; this could be in the form of a letter from the professional body, committee, or other organisation involved in professional matters outlining the role of the practitioner has/had within the organisation and that the language of communication is/was English
- evidence of community engagement where the language of communication is English; this could be in the form of a letter from the community organisation outlining the role the practitioner has/had within the organisation and that the language of communication is/was English.
- evidence of having passed a Chinese medicine examination conducted in English; the assessing organisation should explain the nature of the examination and that the language of communication for the examination was English
- evidence of conduct of the practitioner's practice primarily in English; evidence could include:

- a statutory declaration from the practitioner's practice manager that the practitioner has worked at the clinic for x years and conducts or primarily conducts their practice in English,
- a statutory declaration from a professional colleague who is a native speaker of English with good knowledge of the practitioner's practice; this could be a colleague in the same or an allied practice, or a colleague with whom the practitioner has referred patients or vice versa.
- a statutory declaration by the practitioner that they have conducted their professional practice primarily in English for x years, supported by 20 de-identified patient cards that are in English.

Written evidence submitted in support of a practitioner's English language competence should itself demonstrate a high standard of English language spelling, grammar and expression.

3.6 Appropriate arrangements for consultations/treatments

For public health and safety, practitioners who cannot provide evidence of moderate to good level of competence in English should have conditions placed on their registration and have their registration endorsed accordingly. This endorsement should be noted on the public register.

3.7 Appropriate arrangements for emergency services

The arrangements for emergency services are inadequate.

If, as implied by the draft standard, it is possible that practitioners may face an emergency situation where the difference between life and death may be the timely application of first aid, then it is necessary that registered practitioners be required to have a current first aid certificate.

Recommendation: That the registered practitioner be required to hold a first aid certificate, level 2 workplace first aid, or equivalent in in-service training, and that the requirement for a first aid certificate be incorporated into the CPD registration standard.

4. DRAFT MANDATORY STANDARD PROFESSIONAL INDEMNITY INSURANCE (PII)

4.1 Minimum cover for a single claim

The AACMA board is of the view that a minimum $5,000,000 cover for a single claim is the appropriate level of cover for a registered health professional. We believe that registration brings with it a higher risk of litigation and thus the need for a higher level of cover.

Should the CMBA determine that a minimum cover of $5M for a single claim apply, then the following should be incorporated into the standard for Professional Indemnity Insurance:

- existing policies for $2M cover for a single claim should be deemed adequate for initial registration for applications received before 30 June 2012; and
- a minimum $5M should be required only when those policies come up for renewal in the first year of registration.

The cost of upgrading existing $2M policies to $5M mid-way through the policy term would result in unreasonable additional costs for the insurer and the insured as each policy would need to be endorsed and reissued.

We note that the minimum level of cover required by the Chinese Medicine Registration Board of Victoria is $2M for a single claim. If the minimum $5M cover were to apply only to policies renewing in the first year of the scheme, Victorian practitioners would not be disadvantaged or put to added PII costs in the transition to national registration.

Furthermore, as $2M minimum cover has been widely accepted in the profession outside Victoria, applications for registration with only $1,000,000 cover should have to upgrade to $2M cover as a condition of registration. In this way, Victorian practitioners would not be placed in a position of competitive disadvantage in relation to the level of PII cover required.

In terms of the impact of a higher level of cover on AACMA members, over 36% of members already have $5M or higher cover. For the majority of members who are on the AACMA Master Policy, the cost of taking out $5M as opposed to $2M is marginal (under $20). This is because AACMA, in preparation for an expected minimum $5M cover for a single claim, has been working with our insurers to minimise the impact of mandatory higher levels of cover.

While we would not object to a mandatory minimum of $2,000,000 for a single claim, we think it is in the long-term best interests of the profession and the public to move to the higher level of cover. We believe that the CMBA should take a proactive stand and require $5M minimum cover in its initial standard rather than waiting for a situation to arise where $2M ends up being inadequate to cover a claim.

4.2 Other minimum requirements

AACMA recommends additional minimum requirements which we have addressed below under 5.4 (other issues).

Run-off cover

Practitioners should have run-off cover in the event of:

(a) ceasing to practise permanently
(b) temporary periods out of practice.

Registrants converting from practising to non-practising registration should be required to show evidence of temporary or permanent run-off cover for past events. Under the AACMA scheme, temporary run-off for a reduced fee applies to members temporarily ceasing practice and after two years it converts to permanent run-off cover at no additional cost.

While run-off cover may be incorporated into the wording of some group schemes, such as the AACMA facility, practitioners still need to take steps to convert their policies to run-off cover before the relevant cover expires.

Similar considerations apply to practitioners under individual cover (that is not part of a group scheme) – they will not automatically convert to run-off. The practitioner must take steps to convert to or arrange temporary or permanent run-off cover before the relevant policy expires.

While we are in agreement that run-off is required, it only becomes an issue when the person ceases practice. However, it is largely unenforceable if the practitioner permanently ceases practice and does not convert to or arrange run-off cover before the expiry of the relevant policy.

We suggest that the wording should change from 'run-off cover' to 'run-off cover following any period of practice'.

Self-assessment of the appropriate level of cover

In relation to the scope and extent of cover, the key issues are:

- does the PII policy cover the practitioner's scope of practice?
- Are policy exclusions clearly stated and do they interfere with the capacity of the practitioners to practise?

For example, does the policy have broad-form wording (that is covering the practitioner's scope of practice) or does it only cover specified practice modalities.

In the former (broad-form), the policy covers the scope of the practitioner's professional practice and it is the exclusions (such as home birthing or spinal manipulation) or policy conditions that narrow down the cover. This provides the best cover for practitioners and patients in the event of a claim. This is the type of cover that most registered professions adopt. The AACMA scheme is a broad-form policy.

In contrast, the latter type of policy covers only listed practice modalities, such as acupuncture, Chinese herbalism, naturopathy, etc. If the practitioner practises outside those specified modalities, even if qualified, they risk not having cover in the event of a claim. This is not in the interest of the practitioner or the patient in the event of a claim that may fall outside the scope of the cover.

AACMA believes it is in the best interest of practitioners and the public for the CMBA to recommend that policies have broad-form wording. This will address some of the issues listed under the first paragraph on page 26. This could be a longer-term strategy for the CMBA as it may take some years to bring about the transition.

4.3 Self-declaration about compliance

Professional indemnity insurance cover is mandatory under the national law.

For this reason, AACMA recommends that the CMBA require registrants to submit a copy of their PII cover note or certificate of currency on renewal of their registration.

We are aware from published reports of the of Chinese Medicine Registration Board of Victoria and information from professional standards hearings that some practitioners will sign a declaration about having PII cover when in fact they may not have that cover.

Preventive treatment is more effective than management of the injury: if a member of the public is left without remedy because the practitioner did not actually have the cover they declared they had, then the public has actually not been protected.

While we recognise that other national boards may accept a statement or declaration in lieu of evidence, it will take some years before the entire body of CMBA registrants are acculturated to the range of professional responsibilities under registration.

When the standard comes up for review in three years, the CMBA will have considerable data on compliance and can make a decision then about whether a declaration is sufficient evidence of compliance.

4.4 Other issues

Legal expenses cover

The key item missing from the minimum requirements is legal expenses cover, including but not limited to:

- coronial inquiries
- professional standards hearings and tribunals
- prosecutions.

This is touched on under clause 4 on page 26 as a matter practitioners should consider, but is not recommended or mandated.

It is in the interests of the profession and the regulator that we have a robust and accountable complaints process and this necessitates practitioners having competent legal advice in the event of a complaint or prosecution related to their professional conduct or practice.

The balance of power in a complaints process operates unfairly in favour of the regulator to the detriment of the practitioner if the practitioner does not have access to competent legal advice and may result in unjust and unreasonable outcomes for the practitioner.

Furthermore, a practitioner responding to a statutory complaint without the benefit of sound legal advice not only may be acting detrimental to their best interests but also may unnecessarily waste time and resources in pursuing avenues through which they have no hope of success. This can only result in higher PII premiums for the profession as a whole and increase the costs of registration.

While it may be argued that it is not up to the CMBA to protect the practitioner and that the practitioner needs to look after themselves, the CMBA should be taking a public interest view. It is in the public interest that practitioners have adequate legal expenses cover. This will assist with sound accountable decision-making and a robust complaints system.

AACMA recommends that the minimum cover for legal expenses be $250,000. It is noted that some insurers may exclude sexual misconduct cases or place a sub-limit on legal expenses of these cases.

Policy owner

Clause 3 on page 26 makes reference to third party PII cover, including 'cover through membership with a professional association'. Very few, if any, associations provide third party PII cover as part of their membership fee as is implied by the wording.

The rule is that the association negotiates a policy that it believes is appropriate for its members. The individual members then make a choice – take up their association's recommended policy or to take out some other policy that meets the association's requirements. Although the association negotiates the terms, it is technically not a third party PII policy. The association may determine the scope and terms of the policy, the members actually take out the cover.

The only exception to this would be an association that exists for the sole purpose of providing a PII facility. This would not be a professional association but would, for all practical purposes, be a PII club.

We therefore recommend that wording of this paragraph be amended to reflect the rule rather than the exception. Reference could be made to this type of policy as a 'group scheme' rather than 'third party cover'.

Definitions

Some definition under clause 9 on page 27 are poorly worded. AACMA suggests the following (or something similar):

Claims made policy This means that a policy must be in place at the time the claim is made or when the circumstances that gave rise to the claim were notified to the insurer. Prior events are picked up by continuity of cover, retroactive clauses, and/or run-off cover, whichever is applicable to the circumstances.

Occurrence-based policy This means that a policy must have been in place when the event which is the subject of the claim occurred, even if the policy has not been renewed. This type of policy relies on the past insurer being in existence at the time of the claim. Breaks in insurance cover will not be covered unless there is retroactive clause added to the policy.

5. DRAFT MANDATORY STANDARD RECENCY OF PRACTICE

5.1 Three year period

AACMA is generally in agreement with a three year period for recency of practice.

However, AACMA would not object to the period being extended up to five years. AACMA would not support the period being less than three years.

5.2 Scope of application

AACMA has no objection to the scope of application of the standard.

5.3 Exemptions

Paragraph (a) – New graduates

The proposed one year period for new graduates to apply for registration before having to demonstrate recency of practice is too short.

While it is necessary for new graduates to commence practice as soon as possible after graduation in order to consolidate their knowledge and skills, there may a range of valid reasons why that does not happen within one year of graduation.

For consistency and fairness, AACMA recommends the period be three years, in line with the requirements of all other applicants for initial or renewing registration.

The CMBA needs to ensure consistency in the use of terminology. Rather than referring to 'year of graduation' the standard should refer to 'year of course completion'. These phrases may mean different years. A student may not graduate until six or more months after they have met the requirements for graduation, based simply on the scheduling of awards ceremonies, whereas students at other institutions may be awarded their qualification soon after they are eligible for graduation.

The same issues apply to the definition of 'recent graduate' on page 32. The award of the qualification is a different meaning and event from a graduate meeting all the requirements for graduation and thus being eligible to apply for registration. We recommend that 'whose qualification for registration as awarded' should be changed to 'who became eligible to graduate with a qualification for registration' or similar.

5.4 Definition of practice

The definition of practice in the draft standard is broad enough to include registrants who may not be in clinical practice but are in a position to impact on the safe, effective delivery of health services.

This broader scope beyond clinical practice needs to be spelled out in more detail so that applications for registration do not inadvertently sign a statement that they genuinely believe

is correct at the time but later turns out to not satisfy the scope of what is considered practice in the profession.

While a registrant/applicant may be able to demonstrate current knowledge and skills relevant to practice, they may not be able to demonstrate recency of clinical practice. According to the definition of practice and the standards being about recency of practice, not recency of *clinica*l practice, this point needs to be made clearer in the standard.

Examples:

- Is the head of a Chinese medicine program who has ultimate but not direct oversight of the program and student clinic deemed to be in practice because they are in a position to impact on the delivery of services in the student clinic?
- how high up the management chain in a hospital or private clinic is a person deemed to be sufficiently distant from direct therapeutic contact with patients to be considered 'not in practice' or are they expected to be engaged in patient diagnosis and treatment in order to prove recency of practice in order to maintain their registration?
- Is an academic (lecturer or researcher) in a Chinese medicine program who is not in private practice deemed to be practising in the profession even if they do not run a private practice?

These issues need to be clarified in advance of the standard coming into effect.

See also AACMA comments under Scope about the inconsistent use of terminology.

6. BOARD STATEMENT OF ASSESSMENT MANDATORY REGISTRATION STANDARDS

AACMA has no comment on the Board Statement of Assessment against AHPRA's procedures for development of registration standards in relation to the mandatory standards.

7. DRAFT GRANDPARENTING STANDARD

Key information that significantly changes the interpretation of qualifications requirements was released as an Addendum less than two weeks before the close of the consultation period. This raises questions about providing an adequate consultation period when key information that stakeholders need to know is not made available at the commencement of consultations.

This process has resulted in significant unease, anxiety and insecurity in the profession about how they will be treated when they apply for national registration. With such an important process requiring the support of the profession, AACMA considers it imperative that the CMBA consider the impact of the grandparenting standards on the bulk of practitioners who make up the profession in Australia.

7.1 Qualifications standards

Although there are three limbs to the special rules under Section 303 of the national law, it is unclear how that is displayed in the draft standards.

For example, the first limb refers to an adequate qualification or training for grandparenting purposes and the third limb refers to five years practice between 2002 and 2012 (referred from now on as five years of practice). The Consultation Paper appears to outline how both of these limbs are proposed to be addressed by the CMBA. However, there does not appear to be any reference as to how the second limb will be addressed or, if it is present, it is not apparent to a keen reader.

AACMA proposes that the standard to be presented to the Ministerial Council should clearly articulate how the three limbs will be applied.

7.1.1 The first limb: Adequate qualifications – bachelor degree level qualification (or higher)

AACMA agrees that legitimate Chinese medicine qualifications at bachelor degree level should be adequate for grandparenting purposes.

The following current courses at bachelor degree level clearly fall within the scope of this part of the grandparenting standard:

- Endeavour College (all campuses): Bachelor of Health Science (Acupuncture)
- RMIT University: Bachelor of Applied Science (Chinese Medicine)/Bachelor of Applied Science (Human Biology) – double degree award
- RMIT University: Bachelor of Health Science (Acupuncture and Chinese Manual Therapy)
- Southern School of Natural Therapies: Bachelor of Health Science (Chinese
- Medicine)
- University of Technology Sydney: Bachelor of Health Science in Traditional Chinese Medicine

The following masters programs and combined bachelor/masters programs are on the list of CMRBV-approved courses and should be deemed adequate for grandparenting purposes:

- University of Western Sydney: Bachelor of Health Science/Master of Traditional Chinese Medicine
- RMIT University: Master of Applied Science (Chinese Herbal Medicine)
- RMIT University: Master of Applied Science (Acupuncture).

Previous versions of the above courses at the same academic level should be deemed adequate for grandparenting purposes.

AACMA has concerns that some graduate certificate, graduate diploma and masters programs may not be of a sufficient standard to merit inclusion under this part of the grandparenting standard.

Unacceptable post-graduate qualifications

However, AACMA has concerns that some graduate certificate, graduate diploma and masters programs may not be of a sufficient standard to merit inclusion under this part of the grandparenting standard.

There are some other post-graduate qualifications that, in the view of AACMA, would not meet an appropriate standard but may inadvertently fall under this part of the grandparenting standard. The following examples elucidate the problems.

Australian Institute of Holistic Medicine (AIHM)
The AIHM offers a *Vocational Graduate Diploma of Clinical Acupuncture* to practitioners of other health professions, including naturopaths. According to the organisation's website, students complete 8 academic units and 8 clinical/practical units. The duration is 2.5 years part-time which most likely represents a 1.25 years full-time equivalent duration. Students may be awarded a *Certificate in Fundamentals of Clinical Acupuncture* (non-accredited) after completing three academic units and 100 hours of clinical work.

Monash University
Monash offers a one year part-time *Graduate Certificate in Medical Acupuncture* made up of 4 academic units, corresponding to one semester full-time equivalent duration. There is no identifiable supervised clinical practice component.

Southern Cross University
SCU has, until recently, offered a two year Master of Acupuncture program by distance education. This course has never been approved by the CMRBV and does not meet AACMA entry criteria. This course should not be recognised as adequate for registration under this part of the standard.

The above post-graduate programs could, however, be dealt with under the second limb of the special rules – 'a qualification or training plus further study, training or supervised practice as required by the Board'.

Current sub-degree programs

According to the draft grandparenting standard, for qualifications awarded after 2007, only

bachelor degree or higher qualifications will be considered adequate qualifications for registration under grandparenting.

This means that recent graduates of accredited advanced diploma programs may not be eligible for registration on the basis of their qualification. They will be unable to apply under the third limb (five years practice) as they will not have had five years practice. The only alternative, based on the draft registration standards, is under the second limb, that is that they undergo further 'study, training, or undertake other requirements, approved by the Board'.

In contrast, the CMRBV continued to recognise sub-degree programs until three years after the end of grandparenting (that is, up to the end of 2007, six years after the commencement of registration). The CMRBV does not currently have any sub-degree courses on its list of Board-approved courses.

Grandparenting under the national scheme needs to take into account the current position and history of Chinese medicine Australia-wide, not just what has happened in Victoria. It also needs to ensure that practitioners outside Victoria are not unjustifiably disadvantaged because they were not required to be registered in their practice jurisdiction.

While AACMA no longer recognises advanced diploma programs and graduates must pass our entrance exam in order to be admitted to membership, grandparenting is not about applying the highest standard. It is about finding appropriate mechanisms to enable legitimate practitioners to continue to practise in the profession.

AACMA expects the post-grandparenting standard to be at minimum a bachelor degree qualification majoring in acupuncture and/or Chinese herbal medicine. Such standards would be consistent with AACMA current standards and the level of education one would expect from most other registered health professions. AACMA would not support recognition of sub-degree programs extending beyond the three year transition period. Institutions have had adequate notice of an expected bachelor degree standard and the transition period is sufficient time to demonstrate they meet the requirements for bachelor degree accreditation of their Chinese medicine programs.

7.1.2 The first limb: Adequate qualifications – qualifications before 2008

AACMA questions the relevance of 2007/2008 as a dividing timeline. We understand that the CMRBV ceased recognising sub-degree programs after 2007. The relevance of this year to the rest of Australia is unclear, especially since other state accreditation agencies continued to accredit advanced diploma programs in acupuncture and/or Chinese medicine after 2007.

The draft grandparenting standard defines an adequate pre-2008 qualification being:

> A course of study which is broadly consistent with a minimum Advanced-Diploma-level in the Australian Qualifications Framework (AQF) (assessed by NOOSR).

The document then goes on to outline what these courses must include and includes references to 'adequate clinical training' and 'adequate practical training' that courses must include in order to be on the list of courses deemed acceptable.

However, the definitions of adequate clinical/practical training were only released in an Addendum less than two weeks before the close of consultations.

Adequate clinical hours

The Addendum on 'adequate clinical training' proposes supervised practice hours to be:

- minimum 390 hours for undergraduate
- minimum 180 hours for post-graduate level studies by a person with an undergraduate qualification in the other area of Chinese medicine practice
- minimum 210 hours for post-graduate level studies by a person with a degree in medicine, chiropractic, nursing or other health care profession

The origin and rationale for the 'hours' listed above is unclear and certainly not transparent. It pre-supposes a one-size-fits-all approach that can be retrospectively applied to qualifications, regardless of when the qualifications were obtained and the educational standards that were deemed acceptable at that time.

This is concerning as the details of these additional criteria act to negate the possibility of most Australian advanced diploma programs from inclusion on the list of courses deemed acceptable for grandparenting purposes.

Without that Addendum, it would have been reasonable to assume that all pre-2008 advanced diploma programs, including programs broadly equivalent to an advanced diploma, would be considered adequate for grandparenting purposes. However, with the publication of the Addendum, this assumption is no longer possible.

The development of Chinese medicine education over the past four decades has been marked by the genuine common interest of professional and educational bodies to progressively develop and improve the qualification level of programs and the quality of program delivery. From the genesis of Chinese medicine education in Australia in the 1970s, we now have established bachelor and higher degree qualifications as the primary basis of entry to practice for most new practitioners. National registration would not have been possible without these educational developments.

The proposed grandparenting criteria for adequate clinical training do not appear to make allowances for the different clinical practice requirements for single as opposed to dual modality programs. They also mandate significantly less clinical practice hours for other health practitioners studying TCM.

Most single-modality sub-degree programs usually require/required 200 hours of supervised practice. Some dual-modality sub-degree programs may have had more clinical hours but not necessarily 390 hours. The increase in supervised clinical practice hours to at least 400 hours occurred only when courses were established at, or upgraded to, bachelor degree level.

Therefore, the application of the proposed definition of adequate clinical hours adversely affects every Australian-trained practitioner who does not have an accredited bachelor degree qualification—that is, almost everyone who qualified in acupuncture in Australia, other than graduates of the recent bachelor programs, and graduates of some dual modality sub-degree programs.

Recommendation on 'adequate clinical hours': That 'adequate clinical hours' not be prescriptively defined in the document in relation to sub-degree programs. Instead, if any reference to or definition of adequate clinical hours is to be included in the grandparenting standard, then it should be stated as follows:

- adequate clinical hours will be considered in the context of the era when the course was delivered and the standards that prevailed at the time.

Accredited Australian qualifications

The introduction of formal accreditation of courses delivered by private providers had the following impacts :

- it regulated the qualifications that could be awarded
- it commenced a process, through the VET system, of quality management in the structure and delivery of programs
- it enabled the accreditation of bachelor degree programs in the non-university sector through state higher education authorities.

At the same time, developments in the university sector saw the introduction of bachelor degree and post-graduate qualifications being offered by the self-accrediting institutions.

In 1993, AACMA commenced a national consultation project to develop a National Competency Standard (NCS) for Acupuncture. This project was concluded in 1995 with the publication of the Acupuncture NCS.

In 1998, AACMA commenced a national consultation project to develop minimum educational standards for Traditional Chinese Medicine programs. This resulted in the publication, in 2001, of *Australian Guidelines for Traditional Chinese Medicine Education*. This document may be downloaded from the AACMA website under 'Publications'.

These developments occurred in the context of the Australian Standards Framework (ASF) which evolved into the Australian Qualifications Framework (AQF). The introduction of Registered Training Organisation (RTO) status for non-self-accrediting institutions and Training Packages for VET level qualifications also developed in that period. The HTP for Complementary and Alternative Medicine (CAM), developed more than a decade ago, specifically excluded acupuncture and Chinese herbal medicine qualifications and providers of VET TCM programs had to apply for specific accreditation through the state VET accreditation authorities in order to continue to deliver these programs.

This means that all accredited programs that have been offered since the introduction of course accreditation through the VET system have been through a process of assessment and monitoring by the authorised VET accreditation agencies. Students have enrolled in these programs on the expectation that they will be adequate for unsupervised practice in Australia.

While AACMA did not recognise all accredited VET programs in acupuncture and/or Chinese herbal medicine, graduates are/were able to be admitted to membership by demonstrating their competence through an examination process. It is noted that all but five of these programs are no longer being offered and most graduates of the discontinued programs are likely to have been in practice for five years or more.

Recommendation – accredited Australian programs: Being a discrete group of applicants, it is reasonable and achievable to identify and publish a list of accredited Australian programs that are deemed adequate for grandparenting purposes.

A list of accredited programs is included as Appendix A.

Non-accredited qualifications

Prior to the introduction of accredited VET and higher education programs, all Chinese medicine education in Australia was delivered through the private sector. Quality and standards developed through cooperation with the professional bodies and their course approval processes.

Although there was a diversity in the duration and quality of unaccredited programs, the majority of these programs produced graduates who met professional association standards at that time.

It is noted that there was a reasonable period when some unaccredited programs continued to be offered after other programs had been converted to accredited program status. Graduates of these programs should be not subjected to differential treatment in terms of the grandparenting standard if they completed their studies prior to 2002 or if they passed an examination conducted by a professional body.

There was also at least one provider that allowed the accreditation of their Chinese medicine program to lapse at a date after 2002 while they continued to enrol and graduate students. Consideration needs to be given to those graduates when assessing eligibility for registration if they passed an examination conducted by a professional body.

The key issue is: did the course meet the standard that applied at the time? This can be determined by obtaining a list of courses recognised during that era by the major acupuncture/Chinese medicine associations, such as the Acupuncture Ethics and Standards Organisations, the Australian Acupuncture Association Ltd, Australian Acupuncture and Chinese Medicine Association Ltd, the Register of Acupuncture and Traditional Chinese Medicine and the Australian Natural Therapists Association Ltd, and others.

There is a small group of non-accredited programs that operated for a short time-frame and/or that may not have been recognised by anyone other than boutique/alumni associations. The majority of graduates of these programs may have been in successful professional practice for two or more decades.

A very small number of the very early Australian programs may not have required evidence of the bio-medical sciences having been undertaken. These bio-medical science studies may have been contemporaneously undertaken at another institution or subsequently completed under requirements of their professional association.

This means that the vast majority of Australian-trained practitioners will have completed a course of study in acupuncture and/Chinese herbal medicine that included studies in the bio-medical sciences and clinical training that met the standards at that time.

A major consideration is that graduates of unaccredited Australian programs are a discrete group. There will be no more possible applicants than the current cohort, most are qualification-based and most will have been in practice for over ten years.

For graduates of non-accredited Australian programs that met the standard that applied at the time, the public interest is not served by requiring these practitioners who have been in safe and competent practice, many for decades, to undertake further study or examination in order to continue to practise after registration.

Recommendation – non-accredited Australian programs: Being a discrete group of applicants, it is reasonable and achievable to identify and publish a list of non-accredited Australian programs that are deemed adequate for grandparenting purposes.

A list of non-accredited programs suitable for grandparenting purposes is included as Appendix B.

7.1.3 Chinese medicine practitioners undertaking add-on studies in another Chinese medicine modality

There are two groups of Chinese medicine practitioners under this category:

1. practitioners who initially qualified in Chinese herbal medicine and who have incorporated acupuncture into their treatment regime; and
2. practitioners who initially qualified in Acupuncture and who have incorporated Chinese herbal medicine into their treatment regime.

There is a small number of practitioners who trained in Victoria, New South Wales and South Australia who would fall under the first group. Most, if not all of these, will have been in practice for at least five years and AACMA expects they will be able to satisfy the criteria for acupuncture if they were expected to submit patient cards as evidence of their competence. This is because they should be able to provide a Chinese medicine differential diagnosis, based on their initial Chinese medicine training. By simply listing the points used in the treatment, they will be demonstrating 'individualisation' under the grandparenting criteria.

In contrast, there is a substantial number of practitioners outside of Victoria who fit under the second group. It is important when considering this group who will be initially applying under the national scheme that there is a very different educational history and ethnic make-up when compared to Victoria.

Until the last decade, there were very few undergraduate programs majoring in Chinese herbal medicine. There have also been no accredited post-graduate programs available outside of New South Wales and Victoria to provide a locally-based pathway to a formal qualification in Chinese herbal medicine. For this reason, practitioners in these jurisdictions have been forced to rely on a mixture of industry-based courses and training, undergraduate minors in Chinese herbal medicine, and continuing professional development. An industry-based course in this context refers to a structured program of study in the safe and competent use of Chinese herbal medicine based on Chinese medicine differential diagnosis which includes progressive and/or final assessment before the certificate of completion was awarded. Others may have also undertaken clinical training in China or elsewhere in order to develop their knowledge and skills in the practice of chinese medicine.

It is stressed that all practitioners in this group are qualified Chinese medicine practitioners and would be eligible for registration in the division of acupuncture and most, if not all, will be able to demonstrate five years practice in Chinese herbal medicine.

This cohort of Chinese medicine practitioners represents over 50% of Chinese medicine practitioners who will be applying for registration in the division of Chinese herbal medicine.

This group does not include other health practitioners such as medical practitioners, naturopaths and western herbal medicine practitioners who may have undertaken add-on industry training and/or CPD in the use of Chinese herbs in order to support their primary practice modalities. They are not considered Chinese medicine practitioners for the purpose of this discussion.

It is expected that a component of this cohort of Chinese medicine practitioners will be able to obtain registration in the division of Chinese herbal medicine under the approved qualifications section of the grandparenting standard.

Another component of this group will be able to obtain registration for Chinese herbal medicine by proving competence through submission of patient records.

The remaining component of this group of Chinese medicine practitioners will be able to demonstrate a Chinese medicine differential diagnosis and a treatment that accords with the Chinese medicine diagnoses but will be deemed incompetent simply because they have used a classical Chinese herbal medicine formula in a pre-manufactured form. Classical formulas have a long history of legitimate use in Chinese medicine– that is why they are called classical formulas. Their use in a pre-manufactured form, a popular method of administration due to high patient compliance, is not evidence that the Chinese medicine practitioner is not competent in the practise of Chinese herbal medicine. The issue is whether the pre-manufactured classical formula was appropriate for the patient's condition.

A practitioner who is not a Chinese medicine practitioner would not have the knowledge and skills to know if the classical Chinese herbal formula were appropriate for the patient.

AACMA estimates at least 300 legitimate Chinese medicine practitioners and possibly up to 1500 legitimate Chinese medicine practitioners fall into this third group of practitioners. If these Chinese medicine practitioners are denied registration in the division of Chinese herbal medicine, based on the criteria in the Consultation Paper, they will also be denied the right to prescribe and dispense Chinese herbal product that the TGA has determined is safe for unrestricted self-medication and for supply without prescription. This is because this particular group will, for all practical purposes, be deemed to contravene the holding out provisions of the national law, despite any unregistered practitioner or other registered health care providers being able to prescribe and supply these products with impunity.

A preliminary list of non-accredited Australian qualifications that AACMA deems adequate for grandparenting purposes is included under Appendix B.

7.1.4 Overseas-trained practitioners

For overseas-trained practitioners, it is not simply a matter of requiring equivalency to a program on the list of courses deemed adequate for grandparenting.

Overseas educational courses vary considerably in standards and across different eras.

However, for the majority of legitimate Chinese medicine practitioners in Australia who obtained their qualifications overseas, it may be a fairly straightforward process to determine eligibility for registration.

This could be as simple as Chinese medicine practitioners:

- with qualifications that have been assessed as equivalent to an Australian bachelor degree or an Australian Master degree - this would cover the bachelor degree and higher degree qualifications from China, Korea, Taiwan and North America
- with qualifications that have been assessed as equivalent to an Australian advanced diploma qualification - this would cover many of the sub-degree qualifications from China, Korea, New Zealand and Britain
- who have been licensed for the practise of acupuncture in Japan
- who have been certified by the North American Certification Commission for Acupuncture and Oriental Medicine
- who have completed a three year course approved by the British Acupuncture Council
- who have passed a formal examination in acupuncture and/or Chinese herbal medicine conducted by an Australian professional association.

A limited list of overseas qualifications that should be deemed adequate for grandparenting purposes is included under Appendix C. This list would require further development in the period leading up to the finalisation of the standard to ensure legitimate Chinese medicine practitioners are not unjustifiably required to individually prove their competence to practise under the third limb of the grandparenting standard.

7.1.5 References to NOOSR

References are made to qualifications being assessed by NOOSR. NOOSR stands for the National Office of Overseas Skills Recognition, a part of Education Australia. NOOSR, now called AEI-NOOSR, has nothing to do with assessing Australian qualifications; it assesses overseas post-secondary non-trade qualifications for equivalency against the Australian Qualifications Framework (AQF). It publishes Country Education Profiles and these are used by agencies to assess an individual qualification for equivalency to an Australian qualification. They assess the qualification level only; they do not provide advice on whether the qualification meets professional standards or the requirements for registration.

There are a number of agencies that are authorised to assess overseas qualifications for Australian equivalency. For example, state Overseas Qualifications Units (except NSW) will assess overseas qualifications of applicants for migration for equivalency against the AQF, usually for no fee. Vetassess, based in Victoria, will also provide this service for a fee. AEI-NOOSR also provides this services, but is it much more expensive and usually takes longer than the other agencies.

AACMA does not recommend each individual overseas-trained practitioner being required to obtain an equivalency assessment. Firstly, because it would be costly and would delay practitioners submitting their applications, and secondly because it is simply not possible for all equivalency statements to be given for every overseas qualification.

The CMBA should be able to take advice on these issues and prepare an internal document that it can use as an equivalency guide when assessing applications from overseas-trained practitioners. AACMA has considerable experience and expertise in the area of overseas qualifications and in the use of the NOOSR Country Education Profiles and is willing to assist the CMBA in this area.

7.1.6 The second limb: a qualification or training program plus further study, training or supervised practice as required by the Board

Practitioners who have completed a course of study (within the past five years) that the Board considers inadequate for grandparenting purposes could have limited registration based on further study or mandatory CPD being completed within a reasonable timeframe.

Practitioners who trained under an apprenticeship, who can prove competence to practise Chinese medicine, but can show no evidence of training in the bio-medical sciences, should be required to complete a bridging program in the basic bio-medical sciences or to undertake mandatory CPD in areas deemed necessary by the board.

7.1.7 The third limb: five years of practice within the profession between 2002 and 2012

There is a key issue that must be acknowledged and given weight when considering which qualifications will be approved for grandparenting purposes. This will determine the number of practitioners who will need to be assessed under the third limb – five years practice between 2002 and 2012 (five years practice). This will in turn determine the resources that will be required by the CMBA to process the applications.

If the draft standards are not substantially changed to acknowledge the legitimacy of past Australian qualifications for grandparenting purposes, then a large proportion of the profession will need to apply under the third limb. From a resource management perspective and the timeframes to apply, it is unlikely that the Board will be able to assess, process and deal with appeals before the 1 July 2012 deadline.

This will mean that practitioners whose applications cannot be completed on time for the 1 July 2012 deadline may be in breach of the holding-out provisions if they try to earn a living after 30 June 2012 by continuing to practise in their profession. Alternatively, severe financial hardship will result if practitioners are forced to cease practising because their applications were not processed on time.

In any case, practitioners will lose health fund provider status because the private health insurers are not permitted, by law, to pay rebates for services provided by unregistered practitioners if they are provided in a jurisdiction where a practitioner is required to be registered for the delivery of that service. This of itself will cause not only immeasurable financial hardship but also irreparable damage to the practitioner's reputation in the eyes of their patients.

Therefore, the interests of the public safety, the profession and the CMBA are best served by not placing unreasonable barriers on Australian and overseas-trained practitioners with adequate training from applying under the first limb of section 303 of the national law (that is, with a qualification deemed adequate for grandparenting purposes).

Practitioners who qualify for registration under one division but fall short in the requirements for registration in a second or third division may also be covered by this limb.

7.1.8 Non-practising applicants

In the interests of fairness and equity, the grandparenting standard should be flexible enough to allow persons who have a qualification on the list of qualifications deemed adequate for grandparenting, notwithstanding that they may not have practised within the past three years or for five years between 2002 and 2012.

Grandparenting under national registration is a one-off process that is intended to deal with existing practitioners.

The grandparenting standard should be flexible enough to enable legitimate members of the profession who hold a qualification that is on the list of qualifications deemed adequate for grandparenting purposes, to initially apply for non-practising registration under the national scheme.

It would be up to those practitioners to prepare a re-entry plan, in accordance with the recency of practice standards, to enable them to re-enter professional practice as registered practitioners.

7.1.9 Dispensers

The key issue is that there are no courses in Australia to train dispensers for the purposes of registration.

This means that unless the grandparenting provisions are flexible enough to enable bone fide Chinese medicine dispensers, most of whom trained overseas or under an apprenticeship of sorts, to obtain full or conditional registration, then Chinese herbal pharmacies around the county may be forced to cease providing dispensing services to third parties, that is for registered Chinese medicine practitioners.

Another issue that is not clear in the document is whether the CMBA will be adopting the policy of the CMRBV and deeming practitioners registered in the division of Chinese herbal medicine to be qualified as dispensers in relation to their own prescriptions dispensed directly to their patients as part of a consultation and treatment of the patient.

If the standard for dispensers is only applying to persons who dispense Chinese herbal product on prescription from a third party, namely a registered Chinese medicine practitioner, then this should be made clear in the standard.

7.2 Types of practice evidence

The types of practice evidence are broad enough to enable legitimate practitioners to prove practice. However, there are two items that need specific attention.

7.2.1 Premises registered for skin penetration

We are not sure that this is particularly relevant any longer.

Most jurisdictions, if not all, do not require a skin penetration licence. Some jurisdictions require the practitioners to notify the local council if skin penetration activities are being performed on the premises and the local council may or may not inspect the practice. Evidence may be difficult to provide if the council has not done an inspection or if the report does not specify that acupuncture is being provided at the premises (as opposed to skin penetration). Other jurisdictions simply set standards that the practitioner/premises must comply with.

It is only in Victoria that a skin penetration licence is required if the person is providing acupuncture, dry needling or other euphemism for acupuncture but is not registered with the CMRBV or other health board. As illegal practice could not be used as evidence of legitimate practice in the profession, a licence is irrelevant for those potential applicants.

Therefore, we recommend that this item be removed from the evidence list on the basis of irrelevancy. Alternatively, the details and explanation section should be contemporised.

7.2.2 Membership of a professional association

The statement from the professional association must identify the modalities for which the practitioner has been accredited, such as acupuncture and Chinese herbal medicine.

An accreditation in traditional Chinese medicine (TCM) or Chinese medicine as a generic term is not specific enough to be evidence of practice in the specific registrable modalities of acupuncture and Chinese herbal medicine. In some instances, reference to TCM may simply mean TCM remedial therapy (also called Tuina or Chinese manual therapy).

Therefore, we recommend that this be clarified in the details and explanations section.

7.3 Types of competence evidence

AACMA does not object to applicants without a qualification being required to prove competence.

7.3.1 Forms of evidence

Statement from a Chinese medicine professional association

AACMA agrees in principle that this is one acceptable way to demonstrate competence.

However, our support is predicated on a satisfactory answer to the following:

- what defines assessment of the practitioner's competence?
- what are the criteria that the Board will deem acceptable?

Is assessment of the practitioner's competence limited to a formal examination in some form (written, oral, practical, etc) or is it wide enough to embrace an association assessing the practitioner's qualifications and deeming them adequate for practice.

AACMA found that the CMRBV guidelines in this area were vague and non-specific which did not provide unambiguous guidance to a professional body as to what the CMRBV deemed to be 'assessment' for the purpose of a statement of competence. It should not be a matter of 'send it in and we will tell you if it is adequate'. That is not transparency.

As transparency is a principle that is supposed to underpin the scheme, transparency would require the CMBA to specify its 'criteria' and what it means by 'assessment' against those criteria. This would avoid unnecessary delays for applicants and unnecessary wasting of resources of associations where statements of competence provided may be outside of the Board's contemplated scope.

If the criteria to be applied to this item are too narrow, then it may end up becoming a meaningless option.

AACMA recommends that assessment be limited to assessment through some form of examination, including at least one of the following:

- written examination,
- practical assessment,
- clinical assessment,
- structured interview.

As a decision by a professional body to individually assess a practitioner is dependent on a range of variables (such as the level/year of qualification, the institution issuing the qualification, recency of practice, etc) the statement could include a short description about the basis for undertaking the assessment.

Statement from an Employer

Similar considerations should apply to this item as for the previous item. The person must have been actually assessed.

An interview for employment and discussion about the practitioner's treatment/practice methods and style is not an assessment.

Patient records – 20 de-identified patient records for each Division being applied for

AACMA accepts patient records being one method for a practitioner to prove competence, although not the most ideal method.

However, there are a number of pitfalls in the criteria proposed by the board.

Practitioners are expected to maintain contemporaneous notes that include various elements outlined in the Consultation Paper.

While on the surface the criteria for patient records appear to be thorough and focussed on the profession of Chinese medicine, they are more a test of the practitioner's record keeping skills than their competence to practise.

We also note the list of protected Chinese medicine titles in the national law and the inclusion of the title 'oriental medicine practitioner. This would imply that the intent of the national law was to include the range of legitimate practices of acupuncture and Chinese herbal medicine that have developed out of traditional Chinese medicine.

A grandparenting standard should be broad enough to recognise the range of styles of Chinese medicine practice that have developed out of traditional Chinese medicine. AACMA's concern is that it is not evident in the draft standard that the CMBA recognises or acknowledges that there is not one single way of practising Chinese medicine as implied by the draft standard.

This is not about what AACMA or others believe should be the current entry standard to the profession. It is about mechanisms to enable legitimate practitioners of Chinese medicine to continue to earn a living through practise in their profession after registration.

Criteria for acupuncture patient records

The issue is about inflexibility in the way Chinese medicine practitioners can demonstrate competence in the practice of acupuncture through their patient cards. The draft standard makes no allowance for the variations of style in the practice of acupuncture that developed out of traditional Chinese medicine, such as Korean oriental medicine, meridian therapy, five element acupuncture, 'classical' acupuncture, 'Japanese' acupuncture styles, et cetera. It is implied by inclusion of 'oriental medicine practitioner' in the list of protected titles that these legitimate styles of acupuncture would be recognised.

A grandparenting standard should be broad enough to recognise the range of styles of acupuncture that have developed out of the traditional Chinese medicine. The draft standard, as worded, does not allow for legitimate variations in practice style.

Another concern is that, if the criteria are too prescriptive, this will have the unintended effect of falsified records being submitted by some practitioners. While this is not encouraged by AACMA and would amount to a breach of our Code of Ethics, it is an inevitable outcome if practitioners are to be arbitrarily denied their rights to continue to earn their living through practice in their profession.

We think a short addition to the section will be adequate to demonstrate the Board's commitment to recognise legitimate practice/styles of acupuncture that developed out of traditional Chinese medicine and at the same time to reassure affected practitioners that they will not be arbitrarily prevented from continuing to practise in their profession.

Recommendation – acupuncture patient records: That the criteria for acupuncture patient records include a statement that accords with the following:

> 'When assessing competence in the practice of acupuncture through patient records, recognition will be given to diagnosis and treatment that is in accordance with the range of traditions/styles of acupuncture that have developed out of

traditional Chinese medicine, such as meridian therapy, Korean oriental medicine, five element acupuncture, and other traditional oriental medicine styles of acupuncture.'

Criteria for Chinese herbal medicine

The issue is about inflexibility in the way Chinese medicine practitioners can demonstrate competence in the practice of Chinese herbal medicine through their patient cards. The draft standard makes no allowance for the variations of style in the practice of Chinese herbal medicine that developed out of Traditional Chinese medicine, such as Korean oriental medicine and Kampo medicine, nor do they take into account modern developments in the types of products being utilised in contemporary Chinese herbal medicine practice.

We note that the draft standard states that processed or unprocessed forms of herbs can be employed. However, it really means that if practitioners show treatments that are primarily formula-based, using Chinese herbs in pre-manufactured pill-form or otherwise in a form that has not been manipulated, it will be impossible to demonstrate competence in the practise of Chinese herbal medicine. This will apply even if the Chinese medicine prescription is in accordance with the Chinese medicine differential diagnosis and appropriate for the patient's condition.

It is also unclear whether prescribing two different pill formulae to be taken concurrently would be considered individualisation, despite this being an accepted part of Japanese (Kampo) medicine.

The legitimate Chinese medicine practitioners who are unfairly and unreasonably affected by the inflexibility of the criteria are Chinese medicine practitioners who first qualified in acupuncture and undertook add-on studies or minor undergraduate studies in Chinese herbal medicine.

For patient compliance and safety considerations, many of these legitimate Chinese medicine practitioners may limit their prescribing and dispensing to TGA-listed classical Chinese herbal formulas and do not prescribe or dispense raw herbs which require herb identification skills and special preparation methods/instructions. This does not make them less qualified or less competent for grandparenting under the national scheme, it just makes them safer in the practice to Chinese herbal medicine.

A distinction needs to be made between a legitimate Chinese medicine practitioner practising both acupuncture and Chinese herbal medicine (as described above) from a person with no formal training in Chinese medicine who is also applying for registration under the five year practice limb.

The former is a qualified Chinese medicine practitioner who has extended their practice to safely incorporate another modality of Chinese medicine into their Chinese medicine practice. The latter could be a naturopath or western herbalist who utilises Chinese herbal medicine product as part of their naturopathic or western herbal practice and is seeking to legitimise the use of Chinese herbs through the CMBA registration process. It could also be a practitioner of Chinese medicine who has had little or no formal training.

These two groups are not the same and should not be treated in the same way under this section of the standard. The first group are qualified Chinese medicine practitioners with add-on or minor undergraduate studies in Chinese herbal medicine, the latter group are practitioners trying to prove their basic competence in the practice of Chinese medicine.

The issue for the former/first group should be: If an appropriate Chinese medicine differential diagnosis is recorded and formula prescribed that matches and accords with the diagnosis, this should be adequate evidence of competence in the practice of Chinese herbal medicine. This would allow these practitioners to continue to prescribe and dispense TGA-listed product without contravening the holding-out provisions of the national law.

For the latter group, the criteria outlined in the draft standard are more than adequate.

AACMA estimates over 300 legitimate Chinese medicine practitioners who have been safely practising Chinese herbal medicine for at least five out of the last 10 years may be adversely affected by this aspect of the grandparenting standard if it remains in its current form. This will have measurable financial impacts through loss of income, damage to reputation through loss of health fund provider status for Chinese herbal medicine services, and reduced level of service for patients.

Furthermore, if the criteria are not amended to recognise the legitimate practice of Chinese herbal medicine by Chinese medicine practitioners who initially qualified in acupuncture, the likely impact will be the creation of an unfair and unjustifiable anti-competitive advantage in favour of unregistered practitioners and other (non-TCM) health practitioners who will not be subjected to the same restrictions on their scope of practice. Those other practitioners will be able continue to prescribe and supply TGA-listed Chinese herbal product and single processed or unprocessed Chinese herbs without any penalty or sanction. Instead, it will be the legitimate Chinese medicine practitioners who initially qualified in acupuncture who will be subject to professional sanction and possible criminal prosecution for simply supplying product that can be supplied elsewhere without prescription or restriction by any organisation or person who is not a Chinese medicine practitioner.

Other likely impacts include:

- driving suppliers of traditional Chinese herbal product to develop markets outside of the Chinese medicine profession, and in so doing re-packaging product with naturopathic indications
- this will result in an increase in adverse events from Chinese herbal product because non-Chinese medicine practitioners are not trained in their safe and appropriate use
- the re-orientation of an industry that strongly identifies with the Chinese medicine profession as the main suppliers of quality TGA-listed product to Chinese medicine practitioners to an industry that supplies Chinese herbal product to practitioners without any formal training in Chinese medicine.

It is further noted that, because there were well-established courses teaching Chinese herbal medicine in Victoria, the proportion of practitioners adversely affected by this approach after the CMRBV was established in 2000 was small compared with the numbers and proportion of the profession that will be affected nationally. This cohort of legitimate Chinese medicine practitioners should not be denied the right to continue to use the range of Chinese medicine services that they have been safely and legitimately providing to their patients.

In the same way that the CMBA has proposed that legitimate Chinese medicine practitioners will not be refused registration on the basis of being unable to satisfy the English language criteria, the same consideration should be given to legitimate Chinese medicine practitioners who initially qualified in acupuncture and who primarily use formula-based pre-manufactured Chinese herbal product.

It is within the scope of the board's power to place conditions on Chinese medicine practitioners who are eligible for registration in the division of acupuncture and who can demonstrate the appropriate use of non-modified Chinese herbal formulas to restrict their practice to TGA-listed product. If these Chinese medicine practitioners were able to show modification of formulas through patient cards, then restriction or conditions would not be necessary.

The number of practitioners affected by this would be a limited cohort of Chinese medicine practitioners whose number would not increase. It would apply only to existing Chinese medicine practitioners with at least five years Chinese herbal medicine practice applying under the grandparenting arrangements that, technically, are supposed to provide a mechanism to enable them to continue to practise in their chosen profession.

Recommendation – Chinese herbal medicine patient records: That the criteria for Chinese herbal medicine patient records include a statement in accordance with the following:

> 'For Chinese medicine practitioners who have demonstrated their eligibility for registration in the division of acupuncture who are also applying for registration in the division of Chinese herbal medicine, when assessing competence in the practice of Chinese herbal medicine through patient records, consideration will be given to diagnosis and treatment that is in accordance with the range of traditions/styles of Chinese herbal medicine that have developed out of traditional Chinese medicine. A formula-based prescription that accords with the diagnosis will be considered adequate even if does not show modification of a traditional formula.'

7.4 Other issues – CMRBV-approved courses

According to the national law, educational programs that were approved for registration purposes by a participating jurisdiction will be deemed approved under the national scheme.

This means that, in addition to the courses approved as adequate for grandparenting purposes, the current list of courses approved by the CMRBV would be suitable for registration under the regular provisions of the law and only past version of currently approved courses that need to be added to the list of courses approved for grandparenting purposes.

8. BOARD STATEMENT OF ASSESSMENT DRAFT GRANDPARENTING STANDARD

8.1 AHPRA Principles

The proposed standard does not fully meet the consultation requirements of the National law as key information necessary to appreciate and understand the impact of the draft standards was only published within two weeks of the close if consultations.

8.2 COAG Principles

AACMA does not agree with the Board's assessment against the COAG principles and believe that it fails to consider a range of anti-competitive and unnecessary adverse effects.

Restriction of competition

The areas where this assessment falls short is in the anti-competitive effect on legitimate Chinese medicine practitioners who initially qualified in acupuncture who have incorporated Chinese herbal medicine into their practices. Based on the Victoria experience, the proposed criteria in relation to Chinese herbal patient records appears to intentionally target a sub-set of legitimate Chinese medicine practitioners who limit their practice of Chinese herbal medicine to TGA-listed classical Chinese medicine formulas.

The anti-competitive impact is that this sub-set of legitimate Chinese medicine practitioners will be prevented from continuing to provide the full range of Chinese medicine services that has been part of their treatment regime for many years. Based on the Victorian experience, these Chinese medicine practitioners will be potentially breaching the holding-out provisions of the national law if they continue to prescribe or dispense TGA-listed Chinese herbal products or if they display those products in their waiting rooms. This is despite these products being considered by the TGA as safe for use without prescription.

In contrast, unregistered health practitioners and practitioners registered with other boards will be able to display, prescribe and dispenses these products to their patients, without needing to prove competence in the practise of Chinese medicine and without breaching the national law.

Unnecessary restriction of consumer choice

The issue outlined above will also result in reduced consumer choice as patients of affected Chinese medicine practitioners will no longer be able to obtain their TGA-listed Chinese herbal formulas from their Chinese medicine practitioner of choice. They will either need to go to a different practitioner of Chinese medicine (if there is one in the local area), increasing the cost of treatment or they will simply go to their local naturopath or western herbalist for this service.

It is not in the public interest to reduce consumer choice in this way and may have the opposite effect on public health safety than was intended.

GLOSSARY OF ACRONYMS

AACMA..... Australian Acupuncture and Chinese Medicine Association Ltd
AQF..... Australian Qualifications Framework
ARTG ..... Australian Register of Therapeutic Goods
ASF ..... Australian Standards Framework
CAM ..... Complementary and Alternative Medicine
Chinese Medicine..... Traditional Chinese Medicine
CMBA..... Chinese Medicine Board of Australia
CMRBV ..... Chinese Medicine Registration Board of Victoria
HTP ..... Health Training Package
TCM..... Traditional Chinese Medicine/Chinese Medicine
TGA ..... Therapeutic Goods Administration
VET ..... Vocational Education and Training

APPENDIX A: LIST OF ACCREDITED PROGRAMS

This is a non-exclusive list of accredited Australian programs that should be considered sufficient for grandparenting purposes.

PROVIDING INSTITUTION	COURSE TITLE	FOR REGISTRATION IN THE DIVISION(S) OF
Academy of Traditional Chinese Medicine Australia	Advanced Diploma of Traditional Chinese Medicine	Acupuncture & Chinese herbal medicine
Acupuncture Colleges (Australia)	Bachelor of Applied Science (Acupuncture)	Acupuncture
Acupuncture Colleges (Australia)	Diploma of Applied Science (Acupuncture)	Acupuncture
Australian College of Natural Medicine (all campuses)	Bachelor of Health Science (Acupuncture)	Acupuncture
Australian College of Natural Medicine (all campuses)	Advanced Diploma of Applied Science (Acupuncture)	Acupuncture
Australian College of Natural Medicine (all campuses)	Diploma of Applied Science (Acupuncture)	Acupuncture
Australian Institute of Applied Sciences	Advanced Diploma of Acupuncture (on-campus studies only)	Acupuncture
Endeavour College (all campuses)	Bachelor of Health Science (Acupuncture)	Acupuncture
Gold Coast Institute of TAFE	Advanced Diploma of Applied Science (Acupuncture)	Acupuncture
Melbourne College of Natural Medicine	Bachelor of Health Science (Acupuncture)	Acupuncture
Melbourne College of Natural Medicine	Advanced Diploma of Applied Science (Acupuncture)	Acupuncture
Melbourne College of Natural Medicine	Diploma of Applied Science (Acupuncture)	Acupuncture
RMIT University	Bachelor of Applied Science (Chinese Medicine/Human Biology)	Acupuncture & Chinese herbal medicine
Perth Academy of Natural Therapies	Advanced Diploma in TCM	Acupuncture & Chinese herbal medicine
Southern School of Natural Therapies	Advanced Diploma in TCM	Advanced Diploma in TCM
Sydney College/Institute of TCM	Advanced Diploma of Traditional Chinese Medicine	Acupuncture & Chinese herbal medicine
Sydney College/Institute of TCM	Diploma of Traditional Chinese Medicine	Acupuncture & Chinese herbal medicine
University of Technology Sydney	Bachelor of Health Science in Acupuncture	Acupuncture
University of Technology Sydney	Bachelor of Health Science in TCM (Acupuncture)	Acupuncture
University of Technology Sydney	Bachelor of Health Science in TCM (Chinese Herbal Medicine Major)	Chinese herbal medicine
University of Technology Sydney	Bachelor of Health Science in TCM (Dual Modality)	Acupuncture & Chinese herbal medicine
University of Western Sydney Macarthur	Bachelor of Applied Science (Traditional Chinese Medicine)	Acupuncture & Chinese herbal medicine
Victoria University	Bachelor of Chinese Medicine (Acupuncture & Herbs)	Acupuncture & Chinese herbal medicine
Victoria University	Bachelor of Health Science - Traditional Chinese Medicine	Acupuncture & Chinese herbal medicine
Victoria University of Technology	Bachelor of Health Science in TCM (Acupuncture)	Acupuncture
Victoria University of Technology	Bachelor of Health Science in TCM (Chinese Herbal Medicine)	Chinese herbal medicine
Victoria University of Technology	Bachelor of Health Science in TCM (Dual Modality)	Acupuncture & Chinese herbal medicine
Victoria University of Technology	Graduate Diploma in Clinical Acupuncture	Acupuncture as an add-on

APPENDIX B: LIST OF NON-ACCREDITED PROGRAMS

This is a non-exclusive list of non-accredited Australian programs that should be considered sufficient for grandparenting purposes.

PROVIDING INSTITUTION	COURSE TITLE	FOR REGISTRATION IN THE DIVISION(S) OF
Academy of Traditional Chinese Medicine Australia	Diploma of Traditional Chinese Medicine	Acupuncture & Chinese herbal medicine
Academy of Natural Therapies (Gold Cost)	Bachelor of Applied Science TCM	Acupuncture & Chinese herbal medicine
Academy of Natural Therapies (Gold Cost)	Diploma of Acupuncture	Acupuncture
Academy of Natural Therapies (Gold Cost)	Diploma of Chinese Herbal Medicine	Chinese herbal medicine as an add-on
Acupuncture Colleges (Australia)	Practitioner Diploma of Acupuncture	Acupuncture
Acupuncture Colleges Australia (Brisbane)	Bachelor of Acupuncture	Acupuncture
Acupuncture Colleges Australia (Brisbane)	Practitioner Diploma of Acupuncture	Acupuncture
Australian Acupuncture College Inc	Practitioner Diploma of Acupuncture	Acupuncture
Australian College of Natural Medicine	Bachelor of Acupuncture	Acupuncture
Australian College of Natural Medicine	Bachelor of Traditional Chinese Medicine	Acupuncture & Chinese herbal medicine
Australian College of Natural Medicine	Practitioner Diploma of Acupuncture	Acupuncture
Australian College of Oriental Medicine	Diploma of Chinese Herbal Medicine	Chinese herbal medicine as an add-on
Brisbane College of Traditional Acupuncture (with name extension variations)	Bachelor of Acupuncture	Acupuncture
Brisbane College of Traditional Acupuncture (with name extension variations)	Bachelor of Traditional Chinese Medicine	Acupuncture
Brisbane College of Traditional Acupuncture (with name extension variations)	Practitioner Diploma of Acupuncture	Acupuncture
Brisbane College of Traditional Acupuncture (with name extension variations)	Diploma of Chinese herbal medicine	Chinese herbal medicine as an add-on
New South Wales College of Natural Therapies	Diploma of Oriental Medicine	Acupuncture & Chinese herbal medicine
New South Wales College of Natural Therapies	Diploma of Traditional Chinese Medicine	Acupuncture & Chinese herbal medicine
North Coast College of Acupuncture	Practitioner Diploma of Acupuncture	Acupuncture
Perth Academy of Natural Therapies	Advanced Diploma of TCM	Acupuncture & Chinese herbal medicine
South Australian College of Natural Therapies and Traditional Chinese Medicine	Diploma of Applied Science (TCM)	Acupuncture
Sydney College of TCM	Diploma of Traditional Chinese Medicine	Acupuncture & Chinese herbal medicine

Other courses that may be considered for grandparenting where the practitioner has more than 20 years practice

PROVIDING INSTITUTION	**COURSE TITLE**	**FOR REGISTRATION IN THE DIVISION(S) OF**
Melbourne College of Natural Medicine	Diploma of acupuncture (must also have bio-medical sciences or be a registered practitioner with another board)	Acupuncture
Nanjing College of TCM (private college based in Melbourne) in	Diploma of TCM (must have completed studies in the bio-medical sciences)	Acupuncture & Chinese herbal medicine

APPENDIX C: LIST OF OVERSEAS QUALIFICATIONS

A list of suitable overseas qualifications will be submitted separately.