

Australian Natural Therapists Association

Submission to

Chair, Health Workforce Principal Committee

Registration of Remedial Massage and Myotherapy

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Introduction

This submission prepared on behalf of Australian Natural Therapists Association (ANTA)¹ presents evidence for the statutory regulation of remedial massage and myotherapy (RMM) in Australia under the National Registration and Accreditation Scheme for the Health Professions (NRASHP). The term RMM encompasses both therapies unless otherwise specified as outlined in the definitions below.

This submission applies the process outlined in Attachment B of The Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (IGA), which outlines six criteria to be met before registration of any health profession is considered.² The IGA states ‘it was envisaged that other health professions would be added over time.’³ This submission will focus on all of these criteria with a special focus on Criterion 2 which requires that the occupations’ practice presents a serious risk to public health and safety which could be minimised by regulation. This submission seeks to demonstrate that registration of this health profession is justified and will provide evidence of the risk to public health and safety that may arise for RMM and the reasons why current regulatory mechanisms are insufficient in minimising this risk. Risks associated with clinical judgments are inherent in any health profession. This submission will outline some of the documented examples of any type of injury that has been reported to have occurred in relation to RMM in Australia and Canada.

In achieving that goal, this submission will be cognisant of the COAG Best Practice Regulation Guidelines (COAG guidelines)⁴ which requires any regulatory response to first find a case for action, any decisions made should consider self-regulation, co-regulation and non-regulatory options and it should provide the greatest net benefit for the community which is proportional to the issue being addressed.⁵

Although this submission is primarily focussed on the Australian context, information has been accessed from other jurisdictions such as the USA and Canada. The use of international evidence is justified on the basis that the types of therapies used in RMM in Australia are also applied in these other jurisdictions and evidence of harm reported in those jurisdictions provides lessons about the potential risks in the provision of RMM in Australia and insights into the optimal regulatory structure that could apply in Australia.

Definitions for Remedial Massage and Myotherapy:

Remedial Massage

¹ View the profile of ANTA under Schedule C of this submission.

² Criterion 1: It is appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?

Criterion 2: Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

Criterion 3: Do existing regulatory or other mechanisms fail to address health and safety issues?

Criterion 4: Is regulation possible to implement for the occupation in question?

Criterion 5: Is regulation practical to implement for the occupation in question?

Criterion 6: Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

³ The Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (26 March 2008), p 22, 1.1

⁴ Council of Australian Governments, *Best Practice Regulation Guidelines: A Guide for Ministerial Councils and National Standard Setting Bodies*, October 2007.

⁵ *Ibid* 4-6.

Remedial Massage has been defined as:

- i) the application of a range of diagnostic techniques to identify clients and their conditions as suitable for remedial massage therapy and to enable adaption of remedial massage therapy techniques to suit the needs of individual clients; and
- ii) the use of a range of basic and advanced massage techniques (e.g. Trigger points, myofascial release and lymphatic drainage) to treat a variety of musculoskeletal and other system conditions.⁶

Myotherapy

‘A Myotherapist is a health practitioner specialising in the assessment, treatment and prevention of specific musculoskeletal conditions and somatic dysfunction. Treatment may involve various modalities that enhance the restoration and recovery from these conditions via treatment of soft tissues. For example; muscle, fascia and associated structure. Myotherapy is a manual therapy with a scope of practice aimed at treating and managing the soft tissues of the body. Soft tissues include muscular and connective tissues and their within and between system interactions.

A Myotherapist uses underpinning knowledge of anatomy, physiology, kinesiology, biomechanics and pathology to understand the relationships between the myofascia (muscles and related connective tissues), but also how the muscles and connective tissues relate to other systems of the body. Myotherapists use clinical examination skills, to locate the sources of symptoms and identify dysfunctions. They also use high level communication, clinical reasoning, problem solving and planning skills to design and implement treatment and management programs.

Where symptoms or dysfunctions exist, treatment aims to normalise sensation and function. Additionally, where no symptoms exist, management aims to optimise function, posture and movement. Normalising includes assisting the relief of pain and the return of normal sensation, posture and movement. The Myotherapist can function as the first point of treatment with an expert knowledge of the function and dysfunction of the soft tissue of the body in relation to movement. The Myotherapist can also function as a specialised member within an interdependent multi-disciplinary team of health professionals.⁷ Sports injury management, nutrition, exercise therapy and rehabilitation add a broader scope to learning and career outcomes at AQF Level 7 (bachelor degree).⁸

Criterion 1:

Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?

Complementary and Alternative Medicine (CAM)⁹, a sizeable part of which would involve expenditure on RMM, now constitutes a significant part of the Australian health care sector. A 2007 study suggested that the estimated number of patient visits to CAM practitioners is similar to the number of visits to conventional medical providers (69.2 million v. 69.3 million) with national out-

⁶ Grace S & Deal M, *Textbook of remedial massage*, (2012) Elsevier Australia 1-2.

⁷ 22316 VIC Advanced Diploma of Myotherapy 1 January 2017 to 31 December 2021.

⁸ <https://www.endeavour.edu.au/courses/bachelor-of-health-science-myotherapy>. Refer also to Brian Tritton, *Massage and Myotherapy*, (2nd edit 1996) RMIT Publishing 44-46.

⁹ The World Health Organization (WHO) defines CAM as a “broad set of health care practices that are not part of that country’s own tradition and are not integrated into the dominant health system”
<http://who.int/medicines/areas/traditional/definitions/en/>

of-pocket expenditures on CAM products of over \$4.1 billion.¹⁰ In some areas of Australia, CAM practitioners providing primary care services out number conventional primary care physicians.¹¹ Accordingly, it is important that, along with orthodox medicine, the regulation of CAM is given careful consideration. As the use of CAM is a multi-billion-dollar industry in Australia and is providing a substantial level of health services to Australians alongside orthodox medicine, it is appropriate for Health Ministers to exercise responsibility for these occupations rather than the occupations being regulated by another Ministry. If the IGA is appropriately within the portfolio of the Health Ministers, then there is no reason why the regulation of these occupations should fall within any other Ministry domain. While the number of RMM practitioners in Australia is not clear, there are in excess of 11,800 therapeutic massage therapists in Australia and perhaps approximately 15,100 practitioners by 2020 based upon government statistics.¹² Although the type of therapies, substances and health philosophy applied in the provision of RMM may be different from orthodox medicine, the focus is upon client health and it is appropriate that Health Ministers consider regulation of these occupations.

Criterion 2:

Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

The following should be considered when assessing whether there is significant risk of harm to the health and safety of the public:

- the nature and severity of the risk to the client group;
- the nature and severity of the risk to the wider public; and
- the nature and severity of the risk to the practitioner.

Areas which could be explored to identify a risk to public health and safety are:

- to what extent does the practice of the occupation involve the use of equipment, materials or processes which could cause a serious threat to public health and safety;
- to what extent may the failure of a practitioner to practice in particular ways (that is, follow certain procedures, observe certain standards, or attend to certain matters), result in a serious threat to public health and safety;
- are intrusive techniques used in the practice of the occupation, which can cause a serious, or life-threatening danger;
- to what extent are certain substances used in the practice of the occupation, with particular emphasis on pharmacological compounds, dangerous chemicals or radioactive substances; and
- is there significant potential for practitioners to cause damage to the environment or to cause substantial public health and safety risk.

¹⁰ Charlie C Xue et al, 'Complementary and Alternative Medicine Use in Australia: A National Population-Based Survey' (2007) 13 (6) *Journal of Alternative and Complementary Medicine* 643, 643.

¹¹ Jon Wardle et al, 'Distribution of Complementary and Alternative Medicine (CAM) Providers in Rural New South Wales, Australia: A Step towards Explaining High CAM Use in Rural Health?' (2011) 19(4) *Australian Journal of Rural Health* 197, 199.

¹² Department of Employment Job Outlook Aust Gov Website Massage Therapist: Statistics <http://joboutlook.gov.au/occupation.aspx?search=&tab=stats&cluster=&code=4116> accessed 29/11/2017

Risks associated with RMM

There is a substantial body of scientific papers about both the effectiveness of RMM and its risks. Research literature suggests that RMM is generally safe but mild to very serious adverse events have been documented.¹³ This submission will document both the reports of adverse events and the discussion of the frequency and nature of those adverse events which suggests the need to consider statutory regulation for RMM practitioners to ensure that the education, training and probity of RMM practitioners is such as to reduce those negative outcomes. In addition, this submission will discuss some of the risks for clients based upon the association that historically and currently exists between the sex industry and RMM. This association and the reliance upon self-regulation for the professional has resulted in the provision of RMM by unqualified practitioners with potential risks for clients. Statutory regulation will greatly assist in excluding those who do not have a professional focus through not permitting their use of restricted titles and provide a market signal of safe practice.¹⁴ The association between RMM and the sex industry and the regrettable record of sexual assault and rape of clients of some RMM practitioners should be seen as adverse events in terms of the impact on clients of RMM practitioners.

Inagraham suggests that massage therapy is generally safe but RMM can:¹⁵

- ‘Directly cause new injuries - most are minor but not all
- Aggravate existing injuries and chronic pain problems
- Distract patients from more appropriate care
- Mildly stress the nervous system’

A leading CAM researcher Professor Ernst has documented examples of adverse events (AEs) associated with RMM.¹⁶ In significant detailed research Ernst noted the low number of AEs and the safety of RMM but noted this could be based upon under-reporting and noted that in a related area (spinal manipulation) the under-reporting was very high.¹⁷ Ernst’s article documented 20 examples of significant adverse events associated with RMM involving outcomes such as a ruptured uterus, pulmonary embolism, ulceration of the leg and infection leading to amputation of the leg, hematoma, pseudoaneurysm of the popliteal artery requiring arterial reconstruction, colon rupture and deterioration of hearing.¹⁸ Other examples where remedial massage was seen to impact on patients included.¹⁹

- Neck massage causing a number of cases of acute deterioration of hearing²⁰
- Vigorous massage of left calf for 10 minutes leading to pulmonary embolus
- Vigorous massage for acute swelling over left back leading to haematoma related also to warfarin

¹³ E Ernst, ‘The Safety of Massage Therapy’, (2003) 42 *Rheumatology*, 1101-1106; Paul Ingraham, ‘Poisoned by Massage in, What could possible go wrong with Massage’, *Pain Science dotcom*, <http://www.painscience.com/articles/whats-the-harm.php,1>; K Kraft, S. Kanter and H Janik, ‘Safety and Effectiveness of Vibration Massage by Deep Oscillations: A prospective observational study’, (2013) *Evidenced Based Complementary and Alternative Medicine* 5.

¹⁴ Michael Weir, ‘Regulation of Complementary and Alternative Medicine Practitioners’, Law in Context special issue vol 23 in *Regulating Health Professions* (Ian Freckelton, edit 2006 Federation Press) 188, 189.

¹⁵ Inagraham, above n, 13; Keith Eric Grant, ‘Massage Safety: Injuries reported in Medline related to the practice of therapeutic massage 1965-2003’, (2003) 7 (4) *Journal of Bodywork and Movement Therapies*, 207-212.

¹⁶ E Ernst, ‘The Safety of Massage Therapy’, (2003) 42 *Rheumatology*, 1101-1106.

¹⁷ Ibid 1105.

¹⁸ Ibid Table 2 and Schedule A.

¹⁹ Ibid 1102-1105; James Trotter, ‘Deep tissue massage leading to haematoma of the right hepatic lode’, (1999) 341, *N Engl J Med*, 2019-2020.

²⁰ Ernst, above n 13, Table 2, 1104.

- Vigorous shiatsu massage leading to diagnosis of herpes zoster perhaps related to nerve or nerve root damage
- Rolfing massage resulting in displacement of ureteral stent
- Shiatsu massage on neck causing nasal half of visual field to be impaired and slight left hemiparesis in the upper extremity. Investigation showed multiple branch occlusions of central artery and multiple small infarctions in right frontal lobe
- Popliteal Aneurysm complicating a distal femoral osteochondroma caused by repeated massage by traditional medicine practitioner (sinseh) requiring vein graft.²¹

These outcomes arose both from therapists, non-practitioners and self-treatment. Ernst noted ‘that massage by non-professional and forceful techniques like shiatsu, urut, and Rolfing are relatively often associated with adverse events.’²² Ernst concluded that ‘massage therapies are not totally devoid of risks. The incidence of adverse events is unknown but probably low.’²³

Ernst and Posadzki provided an update to Ernst’s 2003 article in 2013.²⁴ This review identified a further 17 examples of AEs associated with RMM including acute paraplegia, abdominal distension, bladder rupture and bilateral cerebellar infarction. The majority of the AEs were not associated with qualified therapeutic massage suggesting that attention to training and qualified practitioners may be a means to avoid many AEs.²⁵ It was noted that electric massage devices were responsible for many AE’s. Some details about the AEs includes:

- After a vigorous neck massage by a professional masseur a 19-year-old man presented with a left supraclavicular mass causing an injury of the thoracic duct leading to a leakage of lymph. Treatment led to a complete recovery.²⁶
- A 53-year-old woman presented with a worsening shortness of breath having received a vigorous calf massage at a beauty salon. At the end of that session, she experienced pain for 2 weeks and shortness of breath. A deep venous thrombosis in the left leg and extensive acute pulmonary emboli was diagnosed. Treatment led to almost complete recovery.
- A 47-year-old man had a history of numbness in all fingers and bilateral paraesthesias and carpal tunnel syndrome received 2 months of in-patient rehabilitation therapy followed by massage at a private massage clinic. The massage therapist applied passive range-of-motion exercises to his arms, followed by compression of the anterior thorax and neck. The man then experienced acute weakness of all limbs. Clinical examination showed bilateral motor weaknesses, sensory impairment, generalised hyperreflexia and disc herniation due to compressive myelopathy. After treatment a significant deficit in hand function and gait coordination persisted.²⁷
- Fifty- year- old woman received face massage including left rotation of the head, placed shin on woman’s shoulder and posterior to anterior pressure against forehead with that repeated on the right side. Sharp pain in left side revealed to be caused by dissection of carotid and vertebral arteries.

²¹ Kalinga MJ, LO NN, Tan SK, ‘Popliteal Artery pseudoaneurysm caused by an osteochondroma traditional medicine sequelae’, (1996) 37 *Singapore Med J*, 443-445.

²² Ernst above n 13, 1105, Paul Ingraham, ‘Poisoned by Massage in What could possible go wrong with Massage’, Pain Science dotcom, <http://www.painscience.com/articles/whats-the-harm.php>.

²³ Ernst, above n 13, 1105.

²⁴ P Posadzki and E Ernst, ‘The Safety of Massage Therapy: An Update of a systematic Review’, (2013) (1) 18, *Focus on Alternative and Complementary Therapies*, 27-32.

²⁵ Ibid 32

²⁶ Ibid 28

²⁷ Ibid 29

- Patient with history of polycystic kidney disease, coronary heart disease, and other conditions received vigorous massage in a massage chair leading to subcapsular haematoma.²⁸
- Ernst and Posadzki describe examples of use of mechanical electric massage device leading to left sided hemiparesis leading to right extracranial internal carotid artery and large ischaemic stroke in middle cerebral artery.²⁹

There is evidence that the practice of RMM requires training in regard to the impact of medications on clients to avoid potential adverse events caused its impact on the metabolism of the client. This can occur in situations where:³⁰

- a client is taking analgesics or depressants which may result in the client not providing accurate feedback about the impact of massage therapy as the medications may alter their pain response. This could result in a client consenting to deeper massage potentially causing more tissue damage or bruising.³¹
- Massage around injection sites, skin patches and implanted devices may potentially alter the pharmacokinetics of the drug being administered.
- Massage may increase blood glucose and could trigger a hypoglycemic episode.³²
- Potential AEs have been identified with massage for clients undergoing chemotherapy, HIV or AIDS treatment and antipsychotics.³³
- Massage therapy is also contraindicated for some pregnant women, persons with bleeding disorders or low blood platelets and forceful and deep tissue massage should be avoided or where there is evidence of a tumour or cancer.³⁴

Ingraham has discussed a number of examples of AE's with RMM.³⁵

- After a strong two-hour session of massage therapy an 88-year old man collapsed caused by too much myoglobin in his blood causing kidney problems. Likely caused by massage.³⁶
- Report of a spinal accessory nerve injury being a case of spinal accessory neuropathy associated with deep tissue massage leading to scapular winging [the shoulder blade sticking out] and droopy shoulder as a result of weakness of the trapezius muscle.³⁷
- Apparent brain artery damage (extracranial internal carotid artery dissection) involving a 38-year-old woman who gave herself a stroke after use of a vibrating massage tool on her neck.³⁸
- Evidence a massage can dislodge blood clots, impacting on the lungs, brain or other tissues. Most relevant on fairly vigorous and careless massage on people at risk. It is probably an under-reported complication.³⁹

²⁸ Ibid 28

²⁹ Ibid 28. Report of Woman suffered stroke after facial massage Beauty therapy', UK Daily Mail 3 December 2015.

³⁰ Wendy Smith, Lincy Lal, (2009), ' Massage Therapy: Implications for Pharmaceutical Care', *Pharmacist*, 1-20
<https://www.uspharmacist.com/article/massage-therapy-implications-for-pharmaceutical-care>

³¹ Ibid 6.

³² Ibid 7-8.

³³ Ibid 12-16.

³⁴ National Center for Complementary and Integrative Health, *Massage Therapy for Health Purposes*,
<https://nccih.nih.gov/health/massage/massageintroduction.htm>

³⁵ Paul Ingraham, 'What could possible go wrong with Massage', *Pain Science dotcom*,
<http://www.painscience.com/articles/whats-the-harm.php>

³⁶ Lai MY, Yang SP, Chao Y, Lee PC, Lee SD, 'Fever with acute renal failure due to body massage-induced rhabdomyolysis,. (2006) 21 (1) *Journal of Nephrology, Dialysis and Transplantation*, 233-4.

³⁷ Aksoy IA, Schrader SL, Ali MS, Borovansky JA, Ross MA, 'Spinal accessory neuropathy associated with deep tissue massage: a case report', (2009), 90 (11) *Arch Phys Med Rehabil*, 1969-72.

³⁸ Grant AC, Wang N, 'Carotid dissection associated with a handheld electric massager, (2004) 97 (12) *South Med J*, 1262-3.

³⁹ Jabr FI, 'Massive pulmonary emboli after legs massage', 2007 86(8), *Am J Phys Med Rehabil*, 691.

- Warren documents a case report about a woman who suffered massive pulmonary emboli after extremely vigorous massage to her legs. The author speculates that it's also possible for RMM to actually *cause* blood clots. "The incidence is very minimal, considering the popularity of massage therapy, but there is likely underreporting."⁴⁰
- Case report of an elderly woman who developed a lung embolus after her husband vigorously massaged her leg, which had a known deep vein thrombosis — a serious contraindication to massage which any competent massage therapist would certainly avoid.⁴¹
- Posterior Oval mass shown continuous with the ligamentum flavum at c3-c4 after traditional massage therapy - required surgery to resolve.⁴²

A Medline citation search from 1965-2003 by Grant for cases associated with significant injury caused by RMM noted 11 case studies of apparent adverse events associated with RMM.⁴³

- Myositis ossificans traumatica (MOT) in a hockey player. A 20-year-old hockey player was subjected to an acute blow to the lateral thigh. The player was inappropriately treated with deep-tissue massage and heat at the time of injury. It is believed that this led to the fulmination and advanced degree of MOT development. Immobilization allowed for resorption of the calcific density of the ossified structure. Conclusion: Proper care of acute trauma is essential in disorders of this nature. Ice, immobility and recognition of when a possible MOT lesion is developing is essential when dealing with contact sports.⁴⁴
- Posterior interosseous syndrome resulting from deep tissue massage.⁴⁵
- Shiatsu massage-induced injury of the median recurrent motor branch.⁴⁶
- Ureteral stent displacement associated with deep massage.⁴⁷
- Case of acute unilateral neurosensory hearing loss caused by massage of the trapezius muscle.⁴⁸
- Zoster after Shiatsu.⁴⁹
- Eight cases of extracranial vertebral artery dissection.⁵⁰
- Massage-related perforation of the sigmoid colon in Kelantan.⁵¹
- Massage therapy on neck: a contributing factor for destructive thyrotoxicosis?⁵²
- Hepatic hematoma after deep tissue massage.⁵³

⁴⁰ Warren SE, 'Pulmonary embolus originating below knee', (1978) Jul *Lancet*, 272–3.

⁴¹ Mikhail A, Reidy JF, Taylor PR, Scoble JE, 'Renal artery embolization after back massage in a patient with aortic occlusion', (1997) 12 (4) *Nephrol Dial Transplant*, 797–8.

⁴² Kuo-Chin Huang, Pang-Hsin Hsieh, Kam-Fai Lee, Robert Wen-Wei Hsu, 'Rapidly enlarging thigh swelling after manipulative therapy: an unexpected response to therapy', (2009) 15(1) *Manual therapy*, 130-2.

⁴³ Keith Eric Grant, 'Massage Safety: Injuries reported in Medline related to the practice of therapeutic massage,' 1965-2003, (2003) 7 (4) *Journal of Bodywork and Movement Therapies*, 207-212.

⁴⁴ Danchik JJ, Yochum TR, Aspegren DD, (1993) 16 'Myositis ossificans traumatica', *Journal of Manipulative and Physiological Therapeutics*, 605–614.

⁴⁵ Giese S, Hentz VR, 'Posterior interosseous syndrome resulting from deep tissue massage', (1998) 102 *Plastic and Reconstructive Surgery*, 1778–1779.

⁴⁶ Herskovitz S, Strauch B, Gordon MJ, 'Shiatsu massage-induced injury of the median recurrent motor branch,' (1992) 15 *Muscle & Nerve*, 1215.

⁴⁷ Kerr HD, 'Ureteral stent displacement associated with deep massage', (1997) 96 *Wisconsin Medical Journal* 57–58.

⁴⁸ Medvedev EA, 'Case of acute unilateral neurosensory hearing loss caused by massage of the trapezius muscle', (1994) 3 *Vestnik otorinolaringologii*, 38–39.

⁴⁹ Mumm AH, Morens DM, Elm JL, Diwan AR, 'Zoster after Shiatsu massage', (1993) 341 *Lancet*, 447.

⁵⁰ Pego R, Marey J, Lopez-Facal MS, Marin-Sanchez M, 'Eight cases of extracranial vertebral artery dissection', (1996) 24 *Revista de Neurologia* 172–175.

⁵¹ Rahman MN, McAll G, Chai KG 1987, 'Massage-related perforation of the sigmoid colon in Kelantan', (1987) 42 *The Medical Journal of Malaysia*, 56–57.

⁵² Tachi J, Amino N, Miyai K, 'Massage therapy on neck: a contributing factor for destructive thyrotoxicosis?' (1990) 2 *Thyroidology*, 25–27.

- Massive haematoma from digital massage in an anticoagulated patient.⁵⁴
- Popliteal Artery pseudoaneurysm caused by an osteochondroma – a traditional medicine massage.⁵⁵

An article by Yin et al provides three further examples of AEs associated with RMM.⁵⁶

- Cervical epidural hematoma and brown in 1 case of Sequard syndrome caused by cervical spine.⁵⁷ Massage therapist rotated neck. Near recovery after surgery 3 weeks.
- death induced by neck massage.⁵⁸
- One case of atlantoaxial rotatory dislocation caused by fixed neck massage - Near full recovery after surgery after surgery 3 months.⁵⁹

The review of case studies of adverse events associated with RMM suggests that there is potential for serious injury. This particularly applies when RMM is provided by untrained persons who do not understand the risks of RMM, the means to balance risks with benefits and the boundaries of competent practice to avoid negative outcomes. Many of these AEs may be avoided by standard professional practices relying on proper training and education. Currently there is limited control over entry in the RMM profession and few indications of quality for this profession.

Connection with sex industry

One of the difficult issues which have arisen for the RMM profession is the unfortunate connection that exists between it and the sex industry.⁶⁰ Most massage therapy students enter professional

⁵³ Trotter JF, 'Hepatic hematoma after deep tissue massage', (1999) 341 *The New England Journal of Medicine*, 2019–2020.

⁵⁴ Yeo TC, Choo MH, Tay MB, 'Massive haematoma from digital massage in an anticoagulated patient: a case report,' (1994) 35 *Singapore Medical Journal*, 319–320

⁵⁵ Kalinga MJ, Lo NN, Tan Sk, 'Popliteal Artery pseudoaneurysm caused by an osteochondroma – a traditional medicine massage,' (1996) 37(4) *Singapore Med J*, 443-445.

⁵⁶ Ping Yin, Ningyang Gao, Junyi Wu, Gerhard Litscher, and Shifen Xu, 'Adverse Events of Massage Therapy in Pain-Related Conditions: A Systematic Review', (2014) *Evidence-Based Complementary and Alternative Medicine*.

<https://www.hindawi.com/journals/ecam/2014/480956/>

⁵⁷ J. Jiang, 'Cervical epidural hematoma and brown in 1 case of Sequard syndrome caused by cervical spine,' (2008) 17 *Journal of Emergency in Traditional Chinese Medicine*, 712–713.

⁵⁸ Jin et al, 'One case report of death induced by neck massage,' (2010) 26 *Journal of Forensic Medicine*, 230–23.

⁵⁹ D. Zhang, H. S. Ma, R. Tan, D. Wang, W. Yuan, and C. Chi, 'One case of atlantoaxial rotatory dislocation caused by fixed neck massage,' (2011) 21 (8) *Chinese Journal of Spine and Spinal Cord*, 703–704.

⁶⁰ Lisa Casanelia, David Stelfox, *Foundations of Massage*, (3rd edition 2009) 56-57; Michael Weir, 'Regulation of Complementary and Alternative Medicine Practitioners', Law in Context special issue vol 23 in *Regulating Health Professions* (Ian Freckelton, edit 2006 Federation Press) 189; <https://www.sunshinecoastdaily.com.au/news/sex-workers-457s-massage-therapists-under-scrutiny/3171177/>; <http://www.heraldsun.com.au/leader/north-west/hundreds-of-illegal-brothels-masquerading-as-massage-shops-karaoke-bars-and-beauty-salons-in-melbourne/news-story/50fef473d0f6ae4cceb9f9dab2f0b8f2>; <http://www.news.com.au/finance/work/at-work/if-you-looked-hard-enough-you-might-find-a-massage-parlour-that-doesnt-offer-sex/news-story/ef8e3d61d0179d1c3c86083de6e44e64>; <http://www.smh.com.au/nsw/medibank-clamping-down-on-remedial-massage-parlours-offering-rebates-for-sex-services-20131123-2y2m7.html>; <http://www.sharonlivingstonmassage.com.au/not-masseuse/>; <http://www.9news.com.au/national/2017/08/07/06/37/massuer-photos-clients-instagram>

education with strong intrinsic altruistic values with intentions to help others.⁶¹ For many years the sex industry has traded on references to various types of massage to market sexual services. In that sense ‘therapeutic massage occupies a unique position as against other hands-on bodywork therapies.’⁶² This has created a difficult and frustrating environment for the process of professionalization of RMM. In an environment where any person is entitled to hold themselves out as a massage therapist there has been little control over entry to the profession. This has been exacerbated by the nature of the practice of RMM. RMM will normally involve a practitioner in a secluded, relatively unsupervised and private place often with the client alone with the practitioner. The client will normally be supine in a state of undress other than underwear.⁶³ The massage will normally involve the massage of most of the body other than breast tissue and genital areas. There is nothing illegal in massaging the breast and genital area, but this is an act which would require the clear consent of the client. In a professional context this issue should normally not arise as codes of conduct for some RMM professional associations provide massage of these areas is not permitted⁶⁴ or there are specific consent protocols for that practice.⁶⁵

This submission suggests that based upon the nature of the profession and the lack of control over entry into the profession members of the public who seek the services of a person who holds him or herself out as a massage therapist may not be aware that this person may have little understanding or commitment to ethical professional practice. Absent some form of statutory regulation it is very difficult for a consumer to differentiate between those with or without training or a professional perspective practicing within an effective disciplinary regime. This may result in some consumers experiencing negative outcomes which any ‘after the fact’ regulation such as a Code of Conduct, whether statutory or not, cannot make good.

In addition, one aspect of good professional practice is a very careful description of what is intended to be done as part of the massage treatment including whether buttocks are included. For some massage therapists (most of which are either not trained at all or are trained at a low level) the combination of these circumstances has led to concerning cases of inappropriate and criminal behaviour. **Refer to Schedule A.** These incidents have led to charges, convictions, complaints and prohibition orders discussed below dealing with sexual assault and rape during the provision of RMM. The RMM professional associations have been awake to this issue and some professional associations apply professional level educational standards for membership such as a diploma or degree standard, CPE training dealing with matters relevant to this issue, specify the parts of the body a RMM therapist must not touch and have promulgated codes of practice and conduct. The control of such behaviour is currently regulated through:

- Criminal law proceedings for sexual assault or rape which may have deterrence impacts.
- Professional Association discipline which may lead to expulsion though the practitioners may seek membership with another professional association.
- Loss of access to Health fund rebates for those who had such access though untrained practitioners would not have such access in any event.
- Health Complaints actions after a complaint by a consumer potentially leading to an interim or permanent prohibition order in NSW, Qld, Victoria and SA (soon to be nationwide).

⁶¹ Paul Finch, ‘The motivation of massage therapy students to enter professional education’, 26 (8) *Medical Teacher* 729-731.

⁶² Sarah Oerton, ‘Bodywork Boundaries: Power, Politics and Professionalism in Therapeutic Massage’, (2004) 11 *Gender Work and Organization* 543-565.

⁶³ Ibid 550.

⁶⁴ http://www.atms.com.au/visageimages/Policies%20%26%20Conduct/ATMS-OFFICIAL-POLICIES-Information_July2015.pdf

⁶⁵ <https://massagemyotherapy.com.au/wp-content/uploads/Informed-Consent-Anterior-and-Lateral-Chest-Massage-December-2016.pdf>; <http://www.amt.org.au/downloads/practice-resources/AMT-code-of-practice-final.pdf>

All of the above measures have value but they apply only 'after the event' in retrospect after an act has already caused physical and mental anguish to the client.

The purpose of this submission to argue for a greater level of security for clients of RMM clients through statutory regulation to provide a more robust regulatory environment for the public benefit. Statutory regulation will have the benefit of high level educational requirements for registration; probity and background assessment; clear statutory codes of conduct and a statutorily backed disciplinary process and importantly a limitation on the use of a restricted titles. If a restricted title such as 'Remedial Massage therapist,' 'Myotherapist' or other similar title was restricted this will not permit 'holding out' by non-registrants and will deal with the consequences of negligent practice and unprofessional practices by untrained RMM practitioners.

Below are a number of prohibition orders issued by both the Queensland Office of Health Ombudsman and the New South Wales Health Care Complaints Commission in recent years relevant to the practice of RMM. In addition, Schedule A below shows in chronological order documented examples of adverse events reflected in decisions of Australian and Canadian courts involving criminal prosecutions of persons providing RMM. Schedule A indicates what modality is involved, the nature of the charge made and the source of the report.

*Queensland Office of the Health Ombudsman Prohibition Orders*⁶⁶

13 December 2016 Ms Pacharaoan Chandechmontree - Massage Therapist - Interim prohibition against provision of massage therapy or health service against female person involving physical contact or promote herself as providing massage therapy

10 October 2016 Mr Nourdine Abdelkdari - Interim prohibition against provision of massage therapy or health service against female person involving physical contact or promote herself as providing massage therapy

14 September 2016 Mr Paul Kirk - Interim Prohibition prohibited from providing any health service in a clinical or non-clinical capacity

31 May 2016 Mr Adrian Paul Hicks - Interim prohibition against provision of massage therapy or health service against female person involving physical contact or promote herself as providing massage therapy against provision of massage therapy or health service against male person

13 January 2016 Mr Joerg Schoebel - Interim prohibition against provision of massage therapy or health service or massage therapy or health service against any client involving physical contact or promote himself as providing massage therapy

23 December 2015 Ms Sharon Ward - Interim Prohibition Practitioner prohibited from engaging in any employment or providing any services (paid or otherwise) in a clinical or non-clinical capacity, which relates to the provision of a health service

5 December 2015 Paul Denny - interim prohibition against provision of massage therapy or health service or massage therapy or health service against any client involving physical contact or promote himself as providing massage therapy

18 November 2015 Chun Chieh Liu - interim prohibition against provision of massage therapy or health service or massage therapy or health service against any client involving physical contact or promote himself as providing massage therapy

⁶⁶ <http://www.oho.qld.gov.au/news-updates/immediate-actions/prohibition-orders/>

2 November 2015 Mr Charles William Davidson - interim prohibition Practitioner prohibited from any employment (paid or otherwise) in a clinical or non-clinical capacity, which relates to the provision of any health service. 1 March 2018 - convicted in District Court of 18 counts of sexual assault and one of rape.

19 August 2015 Harish Shetty - interim prohibition against provision of massage therapy or health service or massage therapy or health service against any client involving physical contact or promote himself as providing massage therapy

*NSW Health Care Complaints Commission prohibition orders*⁶⁷

2012 Oscar Gettar - It was found Mr Gettar massaged a naked patient including rubbing his bare chest up and down her body, touching the patient's genitals without consent and inappropriately hugged the patient. A prohibition order required Mr Gettar to cease practising, advertising or otherwise promoting himself as a massage therapist until he had completed a recognised massage qualification and has gained accreditation with a recognised massage professional association.

2012 Mr Juan Valenzuela - was found to have sexually assaulted a patient in the course of a Reiki treatment and developed an inappropriate relationship with his much younger client. Mr Valenzuela was convicted of three counts of indecent assault relating to this matter. A prohibition order required Mr Valenzuela to cease providing any form of health service for the duration of his good behaviour bond. After this time, if he wished to resume providing health services, Mr Valenzuela was required to join a recognised professional association.

2013 Mr Hatem Hoso Serdah - was found to have failed to offer his female patient appropriate draping with a towel during the massage, inappropriately and without clinical justification lifted and separated the patient's exposed buttocks, touched the patient's genital area on a number of occasions, massaged the patient's breasts and touched her nipples and offered the patient a vaginal massage. Mr Serdah was prohibited from practising as a massage therapist for two years in either a paid or voluntary capacity.

29 July 2015 Mr Leslie Raymond Lever - Prohibition from providing any health services in either a paid or voluntary capacity for a period of five years based upon conviction for three counts of assault with an act of indecency under section 61 L of the Crimes Act 1900 while performing therapeutic massage. On 11 March 2015 Mr Lever was convicted on three counts of assault with an act of indecency (section 61L of the Crimes Act 1900).

14 October 2015 Mr Qing Cai David Wang - massage therapist prohibited from providing any health services for seven years. Also convicted of rape in NSW in District Court.⁶⁸ In 2008, the Chinese massage practitioner was given a two-year suspended sentence after pleading guilty to four counts of indecent assault in relation to two female clients at Shellharbour on the NSW South Coast.

28 January 2016 Richard Stouple - interim prohibition order in regard to massage therapy breach of appropriate physical boundaries by allowing his body to have contact with a client's body in the course of providing massage services; engaged in inappropriate touching without therapeutic

⁶⁷ <http://www.hccc.nsw.gov.au/Hearings---decisions/Register-of-Prohibition-Orders-in-Force/List-of-Prohibition-Orders-in-Force>

⁶⁸ <http://www.smh.com.au/nsw/lane-cove-massage-therapist-qing-cai-wang-jailed-for-three-years-jail-for-sexually-assaulting-patient-20150710-gi9i5j.html>

justification or consent in the course of providing massage services. On 28 January 2016 interim prohibition order lifted on evidence of completion of Manage Legal and Ethical Compliance subject.

Complaints to Health Complaints Bodies

The level of complaints about health issues may provide a profile of the risk of particular therapies and the activities of specific practitioners. There are health complaint bodies in all States and Territories in Australia which compile and publish health complaint statistics.⁶⁹ The La Trobe report looked at examples of complaints against alternative medicine practitioners to Health Complaints Commissioners in a number of jurisdictions over the period for the period 1997-2004.⁷⁰ The ACT, Tasmania and the Northern Territory health complaints body made no mention of alternative or other providers in its statistics. The difficulty with the evidence provided by health complaints bodies for the purpose of analysing the complaint profile for RMM was that in most cases little detail was provided about the modalities complained against with most categorised under the term ‘alternative health providers, alternative therapists, alternative health, alternative providers or other providers’.

More recently, the New South Wales Health Care Complaints Commission Annual Report 2013-2014 contained records of 17 complaints against massage therapists associated with issues relevant primarily to professional conduct (8) and treatment (5).⁷¹ Of those complaints three were investigated by the Commission and two were referred to another body. Recent data provided by the New South Wales Health Care Complaints Commission Annual Report 2015-2016 contained records of complaints against RMM from 2011-2012 to 2015-2016 showing 27 complaints.⁷²

Criterion 2, Conclusion

Based upon the level of demonstrated serious risk that applies for the practice of RMM; the concerns about the current freedom for uneducated RMM practitioners to practice relatively freely; the inability for consumers to readily ascertain which practitioner has the requisite education and training; and the fact that RMM practitioners may practice as primary health practitioners is suggestive of the need to provide greater regulatory control over this profession.

Criterion 3:

Do existing regulatory or other mechanisms fail to address health and safety issues?

Once the particular health and safety issues have been identified, they are addressed through:

- other regulations, for example, risk due to skin penetration addressed via regulations governing skin penetration and/or the regulation of the use of certain equipment, or industrial awards;
- supervision by registered practitioners of a related occupation; and
- self-regulation by the occupation.

⁶⁹ *Healthcare Complaints Act 1993* (NSW); *Health Complaints Act 2016* (Vic.); *Health Ombudsman Act 2013* (Qld); *Health and Disability Services (Complaints) Act 1995* (WA); *Health Complaints Act 1995* (Tas); *Health and Community Services Complaints Act 2004* (SA); *Human Rights Commission Act 2005* (ACT); *Health and Community Services Complaints Act 1998* (NT).

⁷⁰ La Trobe University Report, *The Practice and Regulatory Requirements of Naturopathy and Western Herbal Medicine November 2005* (School of Public Health – La Trobe University), V Lin, A Bensoussan, S P Myers, P McCabe, M Cohen, Sophie Hill and G Howse.

http://health.vic.gov.au/__data/assets/pdf_file/0004/320188/naturopathy-final1106.pdf, 35.

⁷¹ New South Wales, Health Care Complaints Commission *Annual Report 2013-2014*, 123.

⁷² *Ibid*

The health and safety risks of the provision of RMM are documented above and include the reported adverse outcomes reflected in court decisions documented in Schedule A. These health and safety risks have resulted in some cases in very serious health outcomes. Current professional regulation of RMM is primarily based upon self-regulation which is inadequate to deal with the risks of RMM.⁷³ The regulation of RMM involves both the application of general legislative provisions dealing with the activities of any health professional (such as the Australian Consumer Law) and some legislation which deals with more specific issues for RMM such as negative licensing provisions discussed below. The primary regulation of RMM involves self-regulation through membership of a professional association.

Self-Regulation

The current regulatory framework is fragmented and lacks a level of coherence available through statutory regulation. There is little control on entry into the profession or practicing RMM in Australia.⁷⁴ Even if a RMM practitioner is not a member of a specific professional association because (a) the practitioner does not comply with required educational standards or (b) for financial reasons or (c) their membership is withdrawn after disciplinary action leading to expulsion, that person can either seek membership with another professional association or continue their practice with some limitations. A person stating that they are a RMM practitioner or a former professional association member, deregistered health therapists such as chiropractors, osteopaths or TCM practitioners cannot be prevented from holding out they are RMM practitioners.⁷⁵ This applies unless the practitioner acts in a manner that breaches consumer legislation such as indicating they have qualifications or membership they do not have resulting in a court order requiring cessation of that activity or the practitioner is subject to a prohibition order under a negative licensing regime. Many breaches may not be detected by regulators who are averse to commencing regulatory action except in cases of clear breaches.⁷⁶ This suggests that these practitioners cannot be effectively policed in the current self-regulatory setting.

Under self-regulation, professional associations normally establish standards of practice. Numerous professional associations represent RMM practitioners each with its own standards of practice, minimum educational qualifications for entry and disciplinary procedures. This results in industry standards that are piecemeal and inconsistent and disciplinary procedures that lack transparency and consistency.⁷⁷ Smaller professional associations have resisted amalgamation into larger professional associations to allow an orderly movement to professional status. This has resulted in a plethora of inconsistent standards of practice and education and a lack of expertise in developing a transparent, consistent, rigorous and fair mechanism for complaints and investigation with appropriate avenues of appeal. The size of some professional associations means the complaint processes may not be properly funded.⁷⁸ Market pressures to attract membership by professional associations may result in lower standards and differences in standards and may have been a reason for the fragmentation of

⁷³ Above n 70, 295-296.

⁷⁴ Australian Health Ministers Advisory Council, Final Report, *Options for Regulation of Unregistered Health Practitioners*, April 2013, 28.

⁷⁵ J Wardle, A Steel and J Adams, 'A Review of Tensions and Risks in Naturopathic Education and Training in Australia: A Need for Regulation,' (2012) 18 (4) *The Journal of Alternative and Complementary Medicine* 363, 364.

⁷⁶ <https://www.tga.gov.au/regulatory-compliance-framework>

⁷⁷ Wardle, above n 75, 364; Australian Health Ministers Advisory Council, Final Report, *Options for Regulation of Unregistered Health Practitioners*, April 2013, 17.

⁷⁸ Australian Health Ministers Advisory Council, Final Report, *Options for Regulation of Unregistered Health Practitioners*, April 2013, 54.

professional associations exacerbating differentiation in standards.⁷⁹ Further, internal divisions within the professions tend to exacerbate these issues.⁸⁰

Consumer Legislation

It is worthwhile to consider some of the legislative provisions which specifically or generally regulate RMM in Australia. The current legislative framework that exists in Australia as it applies to the practice of RMM is deficient. This regulatory structure as outlined below provides regulation under consumer legislation, health complaints legislation and negative licensing. The integrity of this regulatory structure relies to a great extent on the professional standards of the RMM practitioners who are required to satisfy these legislative standards. For many RMM practitioners the responsibility provided by self-regulation and the legislative framework is accepted but the capacity to control level of education, training and probity of practitioners would be enhanced by a more a formal process of regulation.

Like any business, RMM practitioners in Australia are subject to consumer legislation that imposes obligations on the practitioner as to how goods and services are advertised and supplied. The most important statutes are the *Sale of Goods Act* (SGA) (almost identical provisions in all States)⁸¹ and the Commonwealth *Competition and Consumer Act 2010* (CCA) (similar provisions applicable in all States).⁸² The CCA includes the Australian Consumer Law (ACL), which applies across all jurisdictions in Australia. Many RMM practitioners sell goods such as oils and massage equipment. These sales are also subject to the SGA. The SGA deals with transactions relating to ‘goods’ on matters such as how a contract of sale is formed, implied warranties as to quality, undertaking as to title, when title to the goods pass and how the performance of the contract should occur. Goods are defined to include most items and substances sold by RMM practitioners.

Misleading or deceptive behaviour

The ACL provides that:⁸³ ‘A person shall not, in trade or commerce, engage in conduct that is misleading or deceptive or is likely to mislead or deceive.’ This is a very broad provision that covers many specific circumstances dealt with under other sections. A breach of this provision might include exaggerated claims of the effect of services, such as miracle slimming techniques where the claims are not verifiable. Another example is unjustified claims made about the curative effects of certain massage procedures sold by practitioners.

Unconscionable conduct

A person is obliged not to take advantage of a vulnerable client.⁸⁴ This is fundamental to appropriate professional practice and is reflected in the ACL provision that ‘a supplier shall not, in trade or commerce, in connection with the supply or possible supply of goods or services to a person (“the customer”), engage in conduct that is, in all the circumstances, unconscionable’. The provision describes examples of unconscionable conduct such as the use of unequal bargaining power or where undue influence or unfair tactics were used in connection with the supply of goods or services. Liability might arise if a client under a disability, such as inexperience or limited English or understanding, was convinced to undertake a course of treatment or to purchase goods in circumstances where the practitioner used his or her position as a health professional to unfairly

⁷⁹ Wardle, above n 75, 364, 365.

⁸⁰ Australian Health Ministers Advisory Council, Final Report, *Options for Regulation of Unregistered Health Practitioners*, April 2013, 54.

⁸¹ Weir, *Law and Ethics in Complementary Medicine* (5th edit, 2016) Allen and Unwin 191-193.

⁸² Ibid 194-196

⁸³ Ibid *Australian Consumer Law* s 18.

⁸⁴ Ibid 195 *Australian Consumer Law* s 20.

influence this transaction.

False representations

Goods and services should be marketed fairly without misrepresentation.⁸⁵ The ACL provides that a person shall not, in trade or commerce in connection with the supply or possible supply of goods or services or in connection with the promotion by any means of the supply or use of goods or services, make representations such as:

- falsely representing that goods are of a particular standard, quality, value, grade, composition, style or model or have had a particular history or particular previous use;
- falsely representing that services are of a particular standard, quality, value or grade;
- falsely representing that goods or services have sponsorship, approval, performance characteristics, accessories, uses or benefits they do not have; and
- making a false or misleading representation concerning the need for any goods or services.

In New South Wales, s 99 of the *Public Health Act 2010* penalises the promotion or advertisement of health services (this includes complementary medicine) which is false, misleading or deceptive, or likely to be misleading or deceptive. In addition, this provision penalises promotion or advertisement of health services that creates an unjustified expectation of beneficial treatment.

The limitation of this form of regulation is that financial injury might arise for a consumer from dealing with a practitioner who unbeknownst to the consumer is acting in a misleading or deceptive manner or any physical injury occurs before the breach of consumer legislation is established. Although a remedy for a breach of these provisions may be available through the relevant regulator the Australian Competition and Consumer (ACCC) or other state consumer bodies, obtaining that remedy will be time consuming and perhaps expensive for consumers. It has been suggested that ‘while consumer protection regulators have successfully prosecuted in some cases, results are mixed and relying on consumer protection legislation to deal with repeated and wilful unethical conduct of unregistered health practitioners may be insufficient to protect public health and safety.’⁸⁶

Health Complaints

Health Complaints Commissioners in Australia’s States and Territories can receive complaints about the professional conduct of RMM practitioners.⁸⁷ This legislation focuses on investigation, conciliation and the resolution of disputes.⁸⁸ The avenues for disciplinary action against unregistered practitioners are few, particularly if practitioners are not receptive to conciliation. Subject to the discussion of negative licencing applied in some jurisdictions including prohibition orders in some cases the ability to enforce standards of treatment under this legislation is limited because there are no sanctions available for unregistered professions unless there are grounds for referral to the police for criminal matters or by civil litigation. The embarrassment and inconvenience of a complaint made against a practitioner may not always be sufficient to improve their performance.

⁸⁵ Ibid 195-196, *Australian Consumer Law* s 29.

⁸⁶ Australian Health Ministers Advisory Council, Final Report, *Options for Regulation of Unregistered Health Practitioners*, April 2013, 52.

⁸⁷ *Health Care Complaints Act 1993* (NSW); *Health Complaints Act 2016* (Vic.); *Health Ombudsman Act 2013* (Qld); *Health and Disability Services (Complaints) Act 1995* (WA); *Health Complaints Act 1995* (Tas); *Health and Community Services Complaints Act 2004* (SA); *Human Rights Commission Act 2005* (ACT); *Health and Community Services Complaints Act 1998* (NT).

⁸⁸ *Health Complaints Act 2016* (Vic) s154, *Healthcare Ombudsman Act 2013* (Qld) s 288 and Regulation 5.

Negative Licensing

Concern has been expressed in Australia with regard to the activities of some unregistered health professionals, including formerly registered health professionals who now practise in related fields after being suspended or deregistered. The discipline and enforcement provisions available under registration statutes are not available to stop some unfair, unethical, criminal and dangerous practices by a small proportion of unregistered health practitioners.⁸⁹ This gap in the legislation and a number of concerning cases of unethical and dangerous acts by unregistered health practitioners led to New South Wales and later South Australia enacting a Code of Conduct for unregistered health practitioners to regulate the activities of those health workers giving powers to grant prohibition orders against their activities.⁹⁰

These Codes of Conduct are a form of 'negative licensing' which means there are limited controls on entry into the profession, but they provide a power to prohibit a person to practice in some practice areas or prohibit practice entirely based upon a breach of the relevant code. A review of this issue by the Australian Health Ministers Advisory Council culminated in a decision by the COAG Health Council in April 2015 for a code of conduct for health workers (similar but not the same) as the New South Wales example to be enacted in all jurisdictions in Australia.⁹¹ The implementation of this process may take some time to unfold. When fully realised this process will mean that regulation similar to the New South Wales model will apply across Australia. This regulation will include the significant remedies to apply interim or permanent prohibition orders against the practices of unregistered practitioners who are in breach of the Code of Conduct. Queensland has already enacted the National Code of Conduct for Health Care Workers (Queensland) reflecting the national model under Regulation 5 of *the Health Ombudsman Regulation 2014* as has Victoria under the *Health Complaints Act 2016* (Vic) Schedule 2. The use of this form of regulation is welcome but it provides retrospective regulation that applies only after negative outcomes have arisen and does not provide proactive prior statutory regulation of the quality of training, education and probity of RMM practitioners.

Fragmented Regulatory Framework

The practice of RMM is framed by a myriad of incoherent complex and confusing legislation and regulations at both State and Federal levels. These legislative and regulatory measures are based upon different policy imperatives which are significant in their own right such as health care complaints but it is not easy to point to a clear regulatory structure for the practice of RMM.

Consideration of overseas regulatory models such as that applying in the USA and Canada is relevant to Australian policy development.⁹² The protection of the consumers is best attained through the development of a register of practitioners, based upon specified standards of practitioner probity and professional practice, education and training. This will assist in prospectively avoiding adverse outcomes, but if they occur, to provide a statutory mechanism for investigating allegations of unprofessional conduct to provide a response to ensure the practitioner does not repeat that behaviour

⁸⁹ J Wardle, 'The National Registration and Accreditation Scheme: what would inclusion mean for naturopathy and Western herbal medicine', (2010) 22(4) *Australian Journal of Medical Herbalism* 114.

⁹⁰ http://www.health.nsw.gov.au/phact/Documents/Code_of_Conduct_unregistered_health_practitioners_-_poster_-_2012_Regulation.pdf

⁹¹ Refer to the COAG, Final Report: *A National Code of Conduct for Health Care workers* (17 April 2015) in relation to the details of this proposed National Code of Conduct.

<http://www.coaghealthcouncil.gov.au/Announcements/ArtMID/527/ArticleID/54/Final-Report-A-National-Code-of-Conduct-for-health-care-workers>

⁹² Refer to discussion below at page 35-38.

and to provide lessons that can be applied generally in the regulatory structure. This is what currently applies under the National Law in Australia for health professions subject to statutory regulation.

Criterion 4:

Is regulation practical to implement for the occupation in question?

When considering whether regulation of the occupation is possible, the following needs to be considered:

- is the occupation well defined;
- does the occupation have a body of knowledge that can form the basis of its standards of practice;
- is this body of knowledge, with the skills and abilities necessary to apply the knowledge, teachable and testable;
- where applicable, have functional competencies been defined; and
- do the members of the occupation require core and government accredited qualifications?

RMM Workforce

There is a reasonable level of information about the nature of the RMM workforce in Australia dealing with the size of the profession, the relationship with orthodox medicine and the role that RMM takes in the provision of health services in Australia. A 2015 study suggests that massage therapy is amongst the most commonly used forms of CAM in Australia and there is a high rate of referrals to RMM practitioners by medical doctors.⁹³ The significance of the role of RMM is indicated by the ABS Census from 2006 which suggested that there were 8,199 persons who report RMM as their primary source of income in Australia.⁹⁴ This would not identify those CAM practitioners who use RMM as an adjunct of another modality. The workforce size was expected to reach a sum of 15,100 by 2020 according to government sources.⁹⁵ These statistics may underestimate the number of practitioners as professional associations representing RMM represent over 15,000 practitioners though this may relate to dual memberships or membership by persons who are not actually practicing.⁹⁶ Statistics suggest that there are more MT practitioners in Australia than chiropractors and naturopaths.⁹⁷

The utilization of RMM is not entirely clear as data is not available⁹⁸ but there is evidence from one study that 20% of Australians had a consultation with a RMM practitioner in the following year.⁹⁹ In addition there is a high degree of utilization of RMM for specified health purposes such as pregnancy issues and back pain.¹⁰⁰

⁹³ J Wardle, R Barnett and Jon Adams, 'Practice and Research in Australian Massage Therapy: A national workforce survey' (2015) 8 *International Journal of Therapeutic Massage and Bodywork* 2-10 at 2.

⁹⁴ Department of Health. Attachment D: Australian Bureau of Statistics, *census of population and housing 2006: employed persons in health-related occupations*. Canberra: Australian Bureau of Statistics; 2008.

⁹⁵ Department of Employment Job Outlook Austr Gov Website *Massage Therapist: Statistics* <http://joboutlook.gov.au/occupation.aspx?search=&tab=stats&cluster=&code=4116> accessed 29/11/2017

⁹⁶ Wardle above n 93, 2.

⁹⁷ Wardle, above n 93, 2 Quoting from ABS Complementary Therapies: Australian BS Australia *Social Trends 2008* Section 4102.0 Canberra ABS 2008 1

⁹⁸ Wardle, above n 93, 2. Refer also to Amie Steel, Jon Adams, David Sibbritt, Alex Broom, Candy Galois, Jane Frawley, 'Utilization of CAM practitioners within maternity care provision: results from a nationally-representative cohort study of 1835 pregnant women', (2012) 12 *BMC Pregnancy and Childbirth*, 146.

⁹⁹ Xue C, Zhang A, Lin V, Da Costa C, Story D, 'Complementary and alternative medicine use in Australia: A national population-based survey', (2007) (13(6) *J Alternative Medicine* 643-650.

¹⁰⁰ Wardle, above n 93, 3.

Significantly there is support by Australian GPs for greater incorporation of RMM in primary health care.¹⁰¹ A national survey of Australian GP's in 2005 suggested that 17% of respondents had some formal training (many with a desire to have more training) in RMM and 11 % had used RMM in their practice. Nearly one half of the GPs surveyed considered it appropriate for GPs to practice RMM and that it would be appropriate for this be funded by Medicare.¹⁰²

Massage therapists may not necessarily practice as a primary health provider¹⁰³ however it is likely that on many occasions the RMM practitioner will be a primary health provider for the types of maladies considered to be relevant to RMM such as musculoskeletal conditions. The role of RMM is said to be a conjunctive rather than a competitive role for RMM in terms of other health practitioners.¹⁰⁴ RMM is normally focused on specific health issues rather than maintenance of general health problems

In regard to the focus on the research Wardle suggests that CAM including RMM needs to focus on research to provide an accepted evidence base and evidenced based practice.¹⁰⁵ A focus on research about RMM has been shown to positively affect the clinical skills of a RMM practitioner and assist in the progress of the profession though there is limited research about the connection between the RMM profession and research.¹⁰⁶ ANTA provides to its RMM members free access to scientific resources including ESBCO Host, eMIMS, IMgateway and iTherapeutics and two major RMM professional associations focussed on RMM have prepared portfolios outlining published research about efficacy of MT. Refer to discussion below.

In regard the profile of the RMM profession research reveals a number of significant statistics about the profile of the MT profession:

Gender - Approximately 2/3 of the workforce is female¹⁰⁷ which matches generally the ABS Job Outlook statistics which suggest 65% were female.¹⁰⁸

Time in practice – 58% had been in practice for more than 5 years and nearly 30% in practice for more than 10 years

Employment load – 14.6% working full time ie 30 hours a week or more with the balance on part time work.

Employment status – 81.7% were self-employed.

Place of training – 98% were trained in Australia with 45% having a qualification pre-dating the 2002 national competency standards

Income – 5.7% suggested their income was over \$50,000. More than one half (55%) of the massage therapists indicated RMM was their sole source of income.

¹⁰¹ Wardle, above n 93, 3. Refer also to Cohen M, Penman S, Pirota M and Da Costa C, 'The Integration of complementary therapies in Australian General Practice: Results of a national survey' (2006) 11 (6) *J Alternative Complem Med*, 995-1004.

¹⁰² Cohen M *ibid*.

¹⁰³ Wardle, above n 93, 3.

¹⁰⁴ *Ibid*

¹⁰⁵ Wardle, above n 93, 3.

¹⁰⁶ Wardle, above n 93, 3.

¹⁰⁷ Wardle, above n 93, 4.

¹⁰⁸ <http://joboutlook.gov.au/occupation.aspx?code=4116&search=&Tab=stats&graph=EL>

Referrals – nearly three quarters of RMM practitioners (73.4%) reported receiving less than 10% of clients by referral.

Private Health insurer use – 30.9% reported that over 70% of clients accessed a claim for private health insurance.

Continuing Professional Education (CPE) – 43.3% Reported regularly exceeding their CPE quota.

Access to research – 56.1% relied upon professional association to keep up to date for research while 39.2% also accessed articles online and in journals.

Level of Education – The ABS Job Outlook statistics suggest that 17.8 % of massage therapists hold a bachelor degree;¹⁰⁹ 58.9% hold an advanced diploma or diploma ¹¹⁰ and 23.3% hold a certificate.¹¹¹

As myotherapy and musculoskeletal degrees become more common it is likely the percentage of practitioners with degree level qualifications will increase. The statistics compiled by Leach provide further statistical information. ¹¹² According to Leach’s statistics RMM in Australia had the most numbers of practitioners per head of population at 1:2424 as against other CAM practitioners.¹¹³

Level and Nature of Education of RMM

The current educational standard for RMM reflects a health profession in transition to a higher level of professionalization and educational standards beyond certificate level and diploma qualifications towards degree level education. For most professional associations full membership requires either a certificate, diploma or degree level qualification. ANTA currently does not accept full membership in myotherapy unless an applicant has completed an accredited advanced diploma or bachelor degree outlined below. In regard to remedial massage ANTA requires the completion of a diploma for full membership.

The level of education and professional practice required for health practitioner statutory registration normally requires a degree level qualification and training or qualification through a grandparenting process. The degree level of education for remedial massage and myotherapy is currently available under a bachelor degree in myotherapy undertaken at three higher education institutions specified below. This submission is made on the basis that the minimum level of education for registration of RMM should be a degree level educational qualification with provision for a period of grand-parenting for practitioners without accepted qualifications and/or evidence of professional practice in RMM over a sufficient period of time to provide equivalence. This will align with the professionalization process applied in the statutory registration process for Chinese Medicine and as currently underway for Paramedicine.¹¹⁴ Outside of that grand-parenting process a practitioner may be able to obtain the required qualification for registration by completion of a degree level standard of qualification in myotherapy or remedial massage required for registration during the grand-parenting period through upgrading a qualification or by completing a degree level qualification.

¹⁰⁹ <http://joboutlook.gov.au/occupation.aspx?code=4116&search=&Tab=stats&graph=EL>; Leach 372 suggested this figure was 13.1% M J Leach, ‘Profile of the Complementary and Alternative medicine workforce across Australia, New Zealand, Canada, US and UK, (2013) 21 *Complementary Therapies in Medicine*, 364-378 at 372.

¹¹⁰ Leach suggested 49.2% *ibid*.

¹¹¹ Leach suggested 27.6 % had a certificate or high school qualification) and none had education below certificate III. Leach also suggested that 1.2% had a postgraduate degree, 372.

¹¹² M J Leach, ‘Profile of the Complementary and Alternative medicine workforce across Australia, New Zealand, Canada, US and UK’, (2013) 21, *Complementary Therapies in Medicine*, 364-378.

¹¹³ *Ibid* 368

¹¹⁴ Part 13 *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2017*. It is expected that equivalent legislation for Paramedicine will eventually also be passed in all states and territories. It is expected that equivalent legislation for Paramedicine will eventually also be passed in all states and territories. <http://www.ahpra.gov.au/Registration/Regulation-of-paramedics.aspx>

The grand-parenting of practitioners was applied for Chinese Medicine under the Chinese Medicine Board of Australia Grand-parenting and General Registration Eligibility Registration Standard for the period of applications for registration between 1 July 2012 to 1 July 2015. A process for RMM will require an amendment of the National Law and the approval of a standard to enforce this requirement in line with the Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017 (Qld) which was enacted in Queensland on 13 September 2017. This legislation establishes the Paramedicine Board of Australia which will specify accepted qualifications and training for general registration.¹¹⁵ Qualification for registration will also be allowed for (a) a qualification or prior or board required study, training or supervised practice or (b) based upon practice in paramedicine during the 10 years before the participation day¹¹⁶ or a consecutive period of 5 years or for any periods which together amount to 5 years and satisfies the Paramedicine Board that a person is competent to practise paramedicine.¹¹⁷ This legislation provides for a period of 3 years within which an individual can apply for registration based upon qualifications or training.¹¹⁸

When this grand-parenting period is completed only the completion of an accredited degree three-year degree qualification should be accepted for registration under any statutory regulation process. It should be noted that any unregistered RMM practitioner who does not comply with any eligibility requirements under the National Law or who does not seek or obtain registration would still be able to practice RMM but they would not be entitled to use the restricted titles specified which may apply for RMM such as ‘remedial massage therapist’ or ‘myotherapist.’

The Certificate of Massage HLT42015

There is a Certificate IV in Massage Therapy (Release 2) available for initial training and education in RMM offered at New South Wales School of Massage; Q Academy, Evolve College, Australian Institute of Fitness.

‘This qualification reflects the role of massage therapists who provide general health maintenance treatments. It does not reflect the role of a remedial massage therapist. Practitioners may be self-employed or work within a larger health service.

To achieve this qualification, the candidate must have completed at least 80 hours of work as detailed in the Assessment Requirements of units of competency.¹¹⁹ This qualification is not normally accepted by health funds as sufficient for a provider number for health practitioners.

Qualification details

‘HLT42015 - Certificate IV in Massage Therapy (Release 2)

The qualification has the following volume of learning and required learning areas:

Total number of units = 13

¹¹⁵ Section 312.

¹¹⁶ Section 306 - means a day prescribed by regulation after which an individual may be registered in paramedicine under this Law. *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2017 (Qld) s 306.*

¹¹⁷ Section 311.

¹¹⁸ Sections 306, 310-311.

¹¹⁹ <https://training.gov.au/Training/Details/HLT42015>.

- 10 core units
- 3 elective units, consisting of:
 - at least 1 unit from the Business Management group below
 - up to 2 units from the electives listed below, any endorsed Training Package or accredited course – these units must be relevant to the work outcome

All electives chosen must contribute to a valid, industry-supported vocational outcome.

Core units

CHCCOM006	Establish and manage client relationships
CHCDIV001	Work with diverse people
CHCLEG003	Manage legal and ethical compliance
HLTAAP002	Confirm physical health status
HLTAID003	Provide first aid
HLTINF004	Manage the prevention and control of infection
HLRMMSG001	Develop massage practice
HLRMMSG002	Assess client massage needs
HLRMMSG004	Provide massage treatments
HLTWHS004	Manage work health and safety

Elective units

Business Management

BSBSMB403	Market the small business
BSBSMB404	Undertake small business planning
BSBSMB405	Monitor and manage small business operations
BSBSMB406	Manage small business finances

Other electives

CHCAGE001	Facilitate the empowerment of older people
CHCCCS001	Address the needs of people with chronic disease
CHCCCS027	Visit client residence
CHCDIS007	Facilitate the empowerment of people with disability

CHCMHS001	Work with people with mental health issues
CHCPRP003	Reflect on and improve own professional practice
HLTARO001	Develop aromatherapy practice
HLTARO002	Source and prepare aromatherapy products
HLTREF002	Provide reflexology for relaxation'

*HLT 52015 Diploma of Remedial Massage*¹²⁰

This diploma is the required minimum standard of qualification for full membership for ANTA and is accepted by all professional associations.

The units of competency of this qualification are as follows:

Qualification Description

'This qualification reflects the role of remedial massage therapists who work with clients presenting with soft tissue dysfunction, musculoskeletal imbalance or restrictions in range of motion (ROM). Practitioners may be self-employed or work within a larger health service. To achieve this qualification, the candidate must have completed at least 200 hours of work as detailed in the Assessment Requirements of units of competency.

Packaging Rules

Total number of units = 21

16 core units

5 elective units, consisting of:

at least 1 unit from the Business Management group below and up to 4 units from the electives listed below, any endorsed Training Package or accredited course – these units must be relevant to the work outcome

All electives chosen must contribute to a valid, industry-supported vocational outcome.

Core units

CHCCOM006 Establish and manage client relationships

CHCDIV001 Work with diverse people

CHCLEG003 Manage legal and ethical compliance

CHCPRP003 Reflect on and improve own professional practice

CHCPRP005 Engage with health professionals and the health system

HLTAAP003 Analyse and respond to client health information

¹²⁰ <https://training.gov.au/Training/Details/HLT52015>.

HLTAID003 Provide first aid
HLTINF004 Manage the prevention and control of infection
HLRMMSG0 Develop massage practice
01
HLRMMSG0 Assess client massage needs
02
HLRMMSG0 Perform remedial massage musculoskeletal assessments
03
HLRMMSG0 Provide massage treatments
04
HLRMMSG0 Provide remedial massage treatments
05
HLRMMSG0 Adapt remedial massage practice to meet specific needs
06
HLRMMSG0 Monitor and evaluate remedial massage treatments
08
HLTWHS004 Manage work health and safety

Elective units

Business Management

BSBSMB403 Market the small business
BSBSMB404 Undertake small business planning
BSBSMB405 Monitor and manage small business operations
BSBSMB406 Manage small business finances

Other electives

CHCAGE001 Facilitate the empowerment of older people
CHCCCS001 Address the needs of people with chronic disease
CHCCCS027 Visit client residence
CHCDIS007 Facilitate the empowerment of people with disability
CHCMHS001 Work with people with mental health issues
CHCPOL003 Research and apply evidence to practice
CHCPRP001 Develop and maintain networks and collaborative partnerships
CHCPRP002 Collaborate in professional practice
HLTARO001 Develop aromatherapy practice
HLTARO002 Source and prepare aromatherapy products
HLTARO003 Perform aromatherapy health assessments

HLTARO004	Provide therapeutic aromatherapy treatments
HLTARO005	Provide aromatherapy massage treatments
HLTHPS010	Interpret and use information about nutrition and diet
HLRMMSG007	Adapt remedial massage practice for athletes
HLTREF002	Provide reflexology for relaxation
SISFFIT013	Instruct exercise to young people aged 13 to 17 years
SISFFIT014	Instruct exercise to older clients
SISFFIT031	Implement injury prevention strategies
SISSSCO307	Provide nutrition information to athletes
SISSSPT307	Conduct advanced taping
A	
SISSTC301	Instruct strength and conditioning techniques
A	
SISSTC402	Develop strength and conditioning programs
A'	

A diploma level qualification is considered to be the practitioner level qualification and is required by all health funds in Australia.

Myotherapy

This area of practice has qualifications in both advanced diploma and degree standards. The Advanced Diploma of Myotherapy 22316 VIC from 1 January 2017 to 31 December 2021 provides for the provision of 855 nominal hours duration of the course.

The Advanced Diploma course is offered in the following colleges in Victoria:

- Australian College of Fitness & Bodywork
- Endeavour College of Natural Health (Melbourne)
- Max Therapy Institute
- Melbourne Institute of Massage Therapy
- Max Therapy Institute
- Melbourne Institute of Massage Therapy
- Melbourne Polytechnic
- RMIT University RMIT
- Southern School of Natural Therapies
- VFA Learning

Degree level qualification

The provision of remedial massage has in recent years included three-year higher education degrees in myotherapy. Educational providers in this space are:

Q Academy Brisbane – Degree of Myotherapy

Endeavour College of Natural Health – Degree of Myotherapy in Adelaide, Brisbane, Sydney, Melbourne

Southern School of Natural Therapy Bachelor of Health Science (Clinical Myotherapy) Melbourne

The bachelor degree programs may see a rationalisation of course providers because of the higher standards expected of that form of education and because of stricter Tertiary Education Quality and Standards Agency (TEQSA)¹²¹ audit and quality control over colleges that deliver these degrees. Australian Skills Quality Authority (ASQA), which is the VET sector regulator previously governed audits and quality control over advanced diplomas at a less stringent level. The move to bachelor degree programs has been supported by most associations.

The fact that there are currently three educational institutions in most parts of Australia suggests that there will be adequate access for students to comply with the required educational standard including upgrading of certificate, diploma and advanced diploma degrees.

Significance of adoption of bachelor level educational standard

A useful discussion is provided by ANTA¹²² in regard to the different educational standards that will apply under the bachelor degree standard as against the standard specified under the Diploma based upon the AQF specifications.¹²³

Under the Bachelor Degree (AQF Level 7) the expectations of graduate outcomes are:¹²⁴

‘Knowledge: Graduates at this level will have broad and coherent theoretical and technical knowledge with depth in one or more disciplines or areas of practice.

Skills: Graduates at this level will have well-developed cognitive, technical and communication skills to select and apply methods and technologies to:

- Analyse and evaluate information to complete a range of activities
- Analyse, generate and transmit solutions to unpredictable and sometimes complex problems
- Transmit knowledge, skills and ideas to others

Application of Knowledge and Skills: Graduates at this level will apply knowledge and skills to demonstrate autonomy, well developed judgement and responsibility:

- in contexts that require self-directed work and learning
- within broad parameters to provide specialist advice and functions’

‘Public and industry expectations now require natural therapy practitioners to:¹²⁵

- have skills to exercise critical thinking and problem solving
- have skills to critically review and analyse information and knowledge
- have the knowledge and ability to act independently

¹²¹ TEQSA is the Higher Education statutory regulator under the discussed in more detail below. <http://www.teqsa.gov.au/>.

¹²² ANTA, Submission to Community Services & Health Industry Skills Council on Complementary & Alternative Health Alignment of Qualifications to the Australian Qualifications Framework 26th November 2013, 4-6

¹²³ Australian Qualifications Framework (second edition January 2013) 41, 42.

¹²⁴ Ibid 47-48.

¹²⁵ Ibid

- be able to adapt knowledge and skills in diverse contexts

The above attributes are typically found in bachelor degree programs.’

Higher Education Regulation

Myotherapy degrees are regulated by TEQSA which is Australia's independent statutory regulator of the higher education sector.¹²⁶ TEQSA indicates that its role and impact on the higher education is based upon the need to:¹²⁷

‘safeguard the interests of all current and future students studying within Australia’s higher education system. It does this by regulating and assuring the quality of Australia’s higher education providers. TEQSA is responsible for the registration and re-registration of providers and the accreditation and re-accreditation of courses.’

TEQSA’s regulatory approach is standards and risk-based. It is guided by three regulatory principles - regulatory necessity, reflecting risk and proportionate regulation, when exercising its powers.

Standards based regulation:¹²⁸

- ‘provider entry to and continued operations within Australia’s higher education sector are determined by demonstrated compliance with the Higher Education Standards Framework (Threshold Standards)
- the standards are developed and promulgated independently of TEQSA by the Higher Education Standards Panel
- the standards apply to all providers, offering courses leading to a regulated higher education award, irrespective of where and how a course is delivered
- while all providers must demonstrate adherence to the Threshold Standards, TEQSA assesses these in the context of each provider’s circumstances
- the standards are applied flexibly and with regard to the diversity of teaching methods and delivery modes that exist and are emerging within the sector. The standards are not intended, or applied, to limit higher achievement.’

Education providers offering a bachelor degree will need to satisfy the Higher Education Standards Framework (Threshold Standards) including the profession specific obligations in relation to Learning Outcomes and Assessment clause 1.4 (set out in **Schedule B** to this submission) including knowledge and skills that characterise the field of education or disciplines involved, knowledge and skills required for employment and skills in independent and critical thinking suitable for life-long learning.

Risk-based Regulation

‘TEQSA’s risk-based approach ensures that resources are directed to areas of higher risk based on validated, quality intelligence about a provider. Key aspects of this approach include the Higher Education Standards Framework, the Case Manager model, the Agency's Regulatory Risk Framework, the use of experts and engagement with professional bodies.’¹²⁹ This means that any higher education providers of RMM are subject to TEQSA oversight and the standards required by

¹²⁶ <http://www.teqsa.gov.au/>

¹²⁷ <http://www.teqsa.gov.au/regulatory-approach>

¹²⁸ <http://www.teqsa.gov.au/regulatory-approach>

¹²⁹ <http://www.teqsa.gov.au/regulatory-approach>

all higher education providers. In the case of universities which are self-accrediting institutions their regulation is more light touch while in the case of non-university institutions such as private colleges, these are generally non self-accrediting institutions which are subject to greater scrutiny by TEQSA including reviewing and approving courses and programs, applying performance conditions to approvals during a specified accreditation period which relate the specific degrees or courses.¹³⁰ The heightened supervision by TEQSA against the training for industry approach of ASQA will mean that that their activities will be monitored for quality and educational outcomes at a higher standard of professional practice.

Research

The provision of RMM has a well-developed and rapidly burgeoning body of knowledge that can form the basis of its standards of practice. Funding for research into CAM including RMM comes from both the government and private funding sources.¹³¹ The National Health and Medical Research Council (NHMRC) prompted by reports about the use of treatments, including CAM, without an adequate evidence basis to treat chronic, or serious medical conditions has placed a greater focus on this issue.¹³² The increasing interest by regulators in CAM is reflected in the inclusion in the NHMRC Strategic Plan 2010–2012, of ‘examining alternative therapy claims’ as a major health issue for consideration by the organisation, including the provision of research funding. In the current Strategic Plan 2013–2015, NHMRC has broadened its focus to investigate the general issue of ‘Claiming benefits for human health not based on evidence.’

‘With regard to CAM, NHMRC is undertaking a number of activities that align with its commitment outlined in its Strategic Plan 2013–2015 with the aim of assisting Australians in making informed decisions about their health care. This includes consideration of the potential benefits and risks of each option using the available evidence. Current activities include:¹³³

- Developing a resource for clinicians to facilitate discussion with patients regarding their use of CAM.
- Continuing to increase knowledge through the funding of investigator-driven research on CAM through NHMRC's competitive, peer-reviewed grant application processes.
- Reviewing the effectiveness of a range of CAM using established methods for identifying and assessing evidence.’

NHMRC, under the guidance of the Health Care Committee, has developed a resource for clinicians to facilitate discussion with patients regarding their use of CAM.

A notable research institute in Australia on issues relevant to RMM is The National Institute of Complementary Medicine at Western Sydney University.¹³⁴ The Institute’s website indicates it is active in clinical trials, publications, provision of scholarships, international collaborations and continuing professional development. The Institute has benefited from millions of dollars of research

¹³⁰ <http://www.teqsa.gov.au/regulatory-approach/teqsa-and-quality-assurance>

¹³¹ <http://theconversation.com/industry-has-a-role-in-funding-alternative-medicine-research-23418>

¹³² <https://www.nhmrc.gov.au/health-topics/complementary-medicines>

¹³³ <https://www.nhmrc.gov.au/health-topics/complementary-medicines>

¹³⁴ <http://www.nicm.edu.au/>

funding from industry and benefactors.¹³⁵ In 2013 the Research Centre released the Research Priorities for Complementary Medicine in Australia report:¹³⁶

‘To help identify priorities for research in Australia, a review was commissioned of the available evidence for the therapeutic use of CM in Australia's National Health Priority areas. This report documents the key findings of the review, and the processes undertaken to arrive at the findings.’

The report seeks to 'narrow the field' and identify those treatments that offer the greatest potential to meet Australia's healthcare needs. The approach involved harnessing the expertise of some of Australia's leading experts, in a cooperative and collaborative process, to shortlist the best candidates for future research investment.

The end result is a considered perspective of where future research investment should be directed.’

Chapter 6 of this report is focused on Arthritis and Musculoskeletal Conditions which includes references to and the value in treatment from RMM. There are eleven references to massage in this document indicating its role in the research agenda of this research centre.

Another significant research centre involved in research in regard to CAM which includes RMM is the Australian Research Centre in Complementary and Integrative Medicine (ARCCIM) at the Faculty of Health, University of Technology, Sydney.¹³⁷

ARCCIM states:

‘it is the world-leading critical public health research centre focusing on complementary and integrative health care. The scientific investigation of complementary and integrative medicine is paramount when addressing contemporary health systems and global health challenges. At ARCCIM, we believe this requires a synergy of critical perspectives, genuine collaboration and a commitment to produce meaningful insights.’

ARCCIM states it has been involved in the following research achievements:¹³⁸

- ‘\$11 million in external competitive grant funding, including 18 grants funded by the National Health and Medical Research Council and Australian Research Council
- 5 prestigious government-funded (NHMRC and ARC) Research Fellowships
- \$3.5 million in industry/community partnership funding
- authoring 700+ peer-reviewed publications, including 11 research books with prestigious international publishing houses
- the largest concentration of PhD students focused upon complementary and integrative health care in Australia.’

ARCCIM is the first centre worldwide dedicated to conducting and promoting critical CAM research via a wide range of established methods and perspectives from public health and health services research. Significantly in 2017 ARCCIM announced the International Complementary Medicine Research Leadership and Capacity Building Program (Massage Therapy Fellowship in partnership with the Massage and Myotherapy Australia). ARCCIM has recruited a Fellow with a track record and commitment to massage and/or myotherapy research. The candidate must have an emerging

¹³⁵www.westernsydney.edu.au/newscentre/news_centre/research_success_stories/leading_national_complementary_medicine_agency_to_receive_significant_funding

¹³⁶ https://www.westernsydney.edu.au/__data/assets/pdf_file/0009/537840/Research_Priorities_for_CM.pdf at page 4

¹³⁷ <http://www.uts.edu.au/research-and-teaching/our-research/arccim/about-centre/vision-and-mission>

¹³⁸ Ibid

track record in massage therapy-focused scholarship and research output and the potential and commitment to develop and this research output in the area of massage and myotherapy research.¹³⁹

There has been criticism of the lack of research outputs from private colleges.¹⁴⁰ One study suggested there was dominance by public universities in CAM related research outputs and a lack of commitment to building research capacity with a drop off in research by researchers after commencing teaching at a private college.¹⁴¹ The Endeavour College of Natural Health has in the last two years established an Office of Research including a research committee, a research ethics committee and has funded internally and externally research projects on RMM and has commenced a collaborative partnership with the ARCCIM.¹⁴² Some major professional associations provide funding or access to participants for research projects by researchers as part of their day-to-day function.¹⁴³

The focus on research by the profession is exemplified by reports and the provision of access to research information for practitioners and researchers about MT. ANTA provides to its members free access to scientific resources including ESBCO Host, eMIMS, IMgateway and iTherapeutics.¹⁴⁴ AMT and Massage & Myotherapy Australia, both major professional associations have commissioned reports on research about the scientific evidence of the risks and benefits of RMM.¹⁴⁵ Massage & Myotherapy Australia has a partnership with ARCCIM (Australian Research Centre in Complementary and Integrative Medicine). Massage & Myotherapy Australia offered one week's postgraduate learning at the Australian Institute of Sport in Soft Tissue in 2017.¹⁴⁶ A recent massage research output from ARCCIM is on the topic: Is there an association between women's consultations with a massage therapist and health-related quality of life? Analyses of 1800 women aged 56 – 61 years: *Journal of Bodywork & Movement Therapies* (2016) 20, 734-739. Articles focusing on research are regularly part of the profession association journals.

Institutional Recognition

Private Health Funds

The increasing popularity of RMM has resulted in responses from many government and private sector organisations including health insurance, professional indemnity insurers, ATO, higher education and NHMRC. Many health insurance providers offer rebates on health practitioner fees for RMM.¹⁴⁷ Based upon the ANTA website¹⁴⁸ which regularly provides an update of health insurance rebates the following health insurers provide rebates for the provision of RMM modalities namely:

¹³⁹ <https://www.uts.edu.au/research-and-teaching/our-research/arccim/news/applications-open-massage-therapy-fellowship>

¹⁴⁰ J Wardle, A Steel and J Adams, 'A Review of Tensions and Risks in Naturopathic Education and Training in Australia: A Need for Regulation,' (2012) 18 (4) *The Journal of Alternative and Complementary Medicine* 363, 364. 366, 367.

¹⁴¹ *Ibid* 364.

¹⁴² <http://www.endeavour.edu.au/research/office-of-research>

¹⁴³ ANTA <http://www.australiannaturaltherapistsassociation.com.au/resources/ebscohost.php>. Refer to Schedule C 61. And exemplified by Kat Boehringer, AMT, *In Good Hands* March 2014 Research Study Update, 14-15

¹⁴⁴ <http://www.australiannaturaltherapistsassociation.com.au/resources/ebscoho> Refer to Schedule C pp 65.

¹⁴⁵ <http://www.amt.org.au/massage-and-you/benefits-of-massage.html>; <http://www.amt.org.au/downloads/practice-resources/AMT-Classified-Research-January-2015.pdf>

<https://massagemyotherapy.com.au/wp-content/uploads/2011/11/AAMT-Research-Report-10-Oct-11.pdf>

¹⁴⁶ <https://massagemyotherapy.com.au/massage-myotherapy-australia-ais-soft-tissue-department-postgraduate-sports-scholarship-scheme-2017/>

¹⁴⁷ Federal Minister of Health Greg Hunt in a Media Release 16 October outlined future limits on health insurance rebates for some complementary medicines including Naturopathy, Herbalism, Homeopathy as well as Alexander

Traditional Chinese Medicine Massage - 13 Health Funds (require diploma in modality)

Myotherapy - 12 Health Funds

Remedial Therapies - 17 Health Funds

Shiatsu 3 - Health Funds (require diploma in modality)

This indicates a broad acceptance of the role of RMM in the provision of health care in Australia. In the absence of registration status for RMM it is necessary for the health funds to provide a process to establish the credentials of RMM practitioners to ensure they are appropriately qualified. Under the *Private Health Insurance (Accreditation) Rules 2011* there are specific requirements before a health practitioner can offer a rebate to clients for their services under the private health insurance policy based upon the terms of each policy. Treatment provided by complementary medicine practitioners is only eligible for coverage by private health insurance if the practitioner is duly registered such as applies to chiropractic, osteopathy and Chinese Medicine for the treatment contemplated by that registration. For other unregistered complementary medicine practitioners to be eligible for private health rebates they must be a member of a national professional association which assesses the training and education qualifications of members; the professional association must conduct a compulsory professional development scheme for members; it must have an enforced code of conduct and a formal disciplinary procedure to suspend or expel members and an appropriate complaints procedure.¹⁴⁹ In addition, any State or Territory premises legislative requirements must be satisfied.¹⁵⁰

Most private health insurers have additional requirements before recognising a complementary medicine practitioner as eligible for the health fund rebate for clients. These requirements normally relate to having suitable professional indemnity insurance, requirements about keeping good records, demonstrated participation in continuing professional education, the ability to lodge information electronically and the practitioner having a current first aid certificate. Not all health insurance companies cover complementary medicine and those that do cover these services do not cover all modalities. This suggests that as the access to health insurance rebates is a significant financial issue for practitioners that the control over access to health rebates applied by health funds is an aspect of the regulatory control over the practice of RMM.¹⁵¹ No doubt the move to bachelor degree status for some RMM providers will result in a review of the required educational standards for eligibility for health rebates after a period of grand parenting. It should be noted that it is still possible to practice and hold out as a RMM practitioner without access to health fund rebates.

Worker Compensation Insurance

There is access to the benefits provided by Work Cover for the provision of RMM in some jurisdictions normally focussed on the potential for the provision of remedial physical therapies. RMM is not specifically mentioned in workers compensation legislation though in South Australia there is provision for treatment by remedial physical therapies for diploma qualified practitioners.¹⁵²

Technique, Aromatherapy, Bowen Therapy, Buteyko, Feldenkrais, Iridology, Kinesiology, Pilates, Reflexology, Rolfing, Shiatsu, Tai Chi and Yoga. <http://www.greghunt.com.au/Media/MediaReleases/tabid/86/ID/4390/Major-reforms-to-make-private-health-insurance-simpler-and-more-affordable.aspx>. These proposed changes which are to commence in 2019 appear to have limited impact on RMM. Refer also to ANTA comments at http://www.icontact-archive.com/TfWiFvrku1_2VLqaoi9I2j9rvdPLq6iN?w=3

¹⁴⁸ <http://www.australiannaturaltherapistsassociation.com.au/resources/healthfundlist.php>

¹⁴⁹ *Private Health Insurance (Accreditation) Rules 2011* clause 10.

¹⁵⁰ *Ibid* clause 11.

¹⁵¹ The details of the educational and training requirements for accreditation for health funds is outlined:

http://www.australiannaturaltherapistsassociation.com.au/members/health_funds/health_funds.php

¹⁵² <https://www.rtwsa.com/service-providers/supporting-recovery/non-medical>

Therapeutic Massage is accepted in NSW and ACT jurisdictions for the provision of treatment for workplace accidents and is often mentioned in case law as part of the rehabilitation in regard to damages associated motor vehicle accidents.¹⁵³

Professional Indemnity Insurance

A number of insurance providers provide professional indemnity insurance for RMM practitioners. It is possible for individual practitioners to approach a professional indemnity insurance company individually, but most major professional associations have a negotiated indemnity arrangement with an insurance company which accepts the standard of education and training required for membership of the professional association as sufficient for acceptance of the practitioner. All major professional associations require professional indemnity insurance as a condition of membership. Some of the professional indemnity insurance companies are:

Therapy Sure¹⁵⁴

Arthur J Gallagher¹⁵⁵

BizCover¹⁵⁶

Fenton Green¹⁵⁷

If there was a national standard for education this would likely reduce the time necessary for underwriters to be satisfied about the quality of education of practitioners.¹⁵⁸

Conclusion, Criterion 4

RMM is at its best a well-defined profession, with well-developed professional standards where some modalities now require a higher education level for normal acceptance into the profession. Many other institutions and bodies such as health funds and professional indemnity insurers are prepared to regulate or endorse the practice of RMM. This suggests that there is a secure basis to implement regulation. Although practitioners are currently permitted to access health fund rebates for the benefit of clients, professional indemnity insurance for their clients' protection the regulatory structure RMM may be subject to change or exclusion as time proceeds. A much more solid basis for the continuation of high quality RMM and the protection of consumers is through statutory regulation.

Criterion 5:

Is regulation practical to implement for the occupation in question?

When considering whether regulation of the occupation is practical the following should be considered:

¹⁵³ http://www.icontact-archive.com/TfWiFvrku1_2VLqaoi9I2iM0ws4_Pbqf?w=3; In s 59 *Workers Compensation Act 1987* (NSW) s 59.

Workers Compensation Act 1951 (ACT) S 2, Dictionary and s 70

¹⁵⁴ <http://www.therapysure.com/>

¹⁵⁵ <http://www.ajg.com.au/industries/natural-therapies-insurance>

¹⁵⁶ <http://www.bizcover.com.au/professional-indemnity/>

¹⁵⁷ <http://www.fentongreen.com.au/allied-health-practitioners.php>

¹⁵⁸ La Trobe report, above n 70, 208.

- are self-regulation and/or other alternatives to registration practical to implement in relation to the occupation in question;
- does the occupational leadership tend to favour the public interest over occupation self-interest;
- is there a likelihood that members of the occupation will be organised and seek compliance with regulation from their members;
- are there sufficient numbers in the occupation and are those people willing to contribute to the costs of statutory regulation;
- is there an issue of cost recovery in regulation; and
- do all State Governments agree with the proposal for regulation.

Size of RMM profession

There are many RMM practitioners in Australia (in excess of 15,000) according to one source.¹⁵⁹ As indicated above, CAM practitioners provide a significant part of the provision of health care in Australia. Generally (though not all) RMM practitioners and their professional associations favour statutory regulation. ANTA, founded in 1955 is the largest national democratic association of 'recognised professional' traditional medicine and natural therapy practitioners (including a large percentage of RMM practitioners) who work in the areas of health care and preventive medicine. The full profile of ANTA is found at **Schedule C** of this submission.

Professional Associations

Most professional associations favour statutory registration for RMM. The ANPA,¹⁶⁰ Complementary Medicines Australia,¹⁶¹ Massage and Myopathy Australia¹⁶² Association of Massage Therapists Ltd¹⁶³ and ANTA strongly support statutory registration.¹⁶⁴

By contrast Australian Traditional Medicine Society (ARMMS) does not support statutory regulation.¹⁶⁵ It is stated on its website that:

‘ARMMS adopted the self-regulation model, later to become the Co-Regulation model. This was opposed to the Statutory Registration model that was sought by TCM. It was felt this model was not appropriate for the occupations that fall under the umbrella of natural medicine. Regulation of the occupations has always been a major point of difference between ANTA, NHAA and ARMMS, the former supporting statutory registration, ARMMS never wavering from the opposite view.’¹⁶⁶

International Examples of Statutory Regulation of RMM

¹⁵⁹ Above n 12.

¹⁶⁰ <http://www.anpa.asn.au/images/stories/anpa-ahmac-submission-april-2011.pdf> .

¹⁶¹ <http://cma.asn.au/about-cma/aims-of-cma/>; <http://www.cmaustralia.org.au/Registration-of-Practitioners>

¹⁶² <https://massagemyotherapy.com.au/wp-content/uploads/AAMT-Strategic-Plan-2014.pdf>

¹⁶³ <http://www.amt.org.au/downloads/position-statements/AMT-Position-Statement-Regulation.pdf>

¹⁶⁴ <http://www.nhaa.org.au/> Refer to ANTA profile Schedule C below, 49.

¹⁶⁵ <http://www.atms.com.au/>

¹⁶⁶ <http://www.atms.com.au/page.php?id=26>

There are a number of international jurisdictions that provide for a form of statutory regulation indicating there is in those jurisdictions a policy imperative to provide for public safety in the provision of RMM and that statutory regulation is possible for RMM. These examples indicate that the provision of statutory regulation of RMM is possible and deemed necessary in these jurisdictions. This analysis will focus on two jurisdictions namely the USA and Canada which provide for statutory regulation of RMM.

USA

The USA regulatory structure for RMM has features not present in Canada or Australia. In the USA there is strict regulation of ‘the practice of medicine’ involving a broad definition of that term with legislation intent to proscribe health practices performed by non-registrants such as CAM practitioners which might trespass into the practice of medicine unless they enjoy statutory registration or acknowledgement. This promotes the provision of registration of various CAM therapies such as TCM, naturopathy and RMM. There are 47 states of the USA which have massage practice laws covering RMM.¹⁶⁷

The American Massage Therapy Association (AMTA) suggests:¹⁶⁸

“Massage therapy has a significant impact on a person’s health and well-being. The public has a right to expect that a massage therapist has the qualifications needed to practice effectively and safely. So, legal recognition of the practice of massage therapy and clearly-stated requirements to practice are essential to promote the profession and protect the health, safety and welfare of the general public.” The AMTA suggests legal recognition of RMM through state licensure:

- creates standards of minimum competency measured and enforced through formal education, training, and examination requirements.
- it ensures that individuals have met the eligibility requirements needed to practice massage therapy and are qualified to represent themselves to the public as state licensed massage therapists.
- a legal definition of the scope of massage therapy practice, assists consumers identify the responsibilities and services unique to a massage therapist and to select the most appropriate massage therapy professional with a transparent the selection process.
- provides the ability to discipline a massage therapist for non-compliant practitioners.
- protects the public by establishing a consistent standard of practice which is enforceable by a professional code of ethics and establishes a formal grievance process for consumers.¹⁶⁹

A typical example of regulation is the New York State Board of Massage Therapy which provides for York licensed massage therapists who have completed a massage training program, including the following:

- courses in anatomy, physiology, neurology, myology (study of muscles and their function), pathology, hygiene, first aid, CPR, and infection control procedures

¹⁶⁷ <https://www.amtamassage.org/about/lawstate.html>

¹⁶⁸ <https://www.amtamassage.org/regulation/Why-We-Need-Massage-Therapy-Regulations.html>

¹⁶⁹ *Ibid*

- course work, training and practice in the theory and techniques of both oriental and western massage
- State licensing examination including 1000 hours of training.¹⁷⁰

Most states regulate the massage therapy profession. Depending on the state, this could be in the form of a license, registration or certification. Cities, counties or other local governments also may regulate massage. Licensing is the strictest form of professional regulation, making it illegal for anyone to work as a massage therapist unless he or she has a license.

An example of a licensure provision is in South Carolina which limits the practice massage/bodywork without a licence.¹⁷¹ Under Chapter 30 of the Massage/Bodywork Practice Act s 40-30-100 provision for licencing of this modality is established.

SECTION 40-30-100. Practice without license.

No person may practice massage/bodywork without a license issued in accordance with this chapter by the director; however, a person licensed by the State under this title or any other provision of law whose scope of practice overlaps with the practice of massage/bodywork is not also required to be licensed under this chapter unless the person holds himself out to be a practitioner of massage/bodywork. Nothing in this chapter may be construed to authorize a massage/bodywork therapist licensed under this chapter to practice physical therapy or chiropractic or to utilize chiropractic therapeutic modalities except where the scope of practice for massage/bodywork, as provided for in this chapter, overlaps with the practice of physical therapy or chiropractic.

Interpretations of section 40-30-30

A. A person who advertises as a massage/bodywork therapist when a person uses or adopts any title or description, including but not limited to "massage practitioner," "massage therapist," "manual therapist," "muscle therapist," "massotherapist," "myotherapist," "bodywork therapist," "body therapist," "masseur," "masseuse," "massagist" or any other derivation of these terms implying the practice of massage/bodywork therapy.

B. A person who is licensed to practice massage/bodywork therapy shall not diagnose illness or disease, perform medical procedures, chiropractic adjustments, utilize electro-therapeutic devices as defined in Section 40-30-30, prescribe medicines, or engage in practices for which a license to practice medicine, chiropractic, nursing, physical therapy, occupational therapy, acupuncture or podiatry is required by law, unless the person is duly licensed in that profession.¹⁷²

Canada

Canada has a number of jurisdictions that provides for statutory regulation of RMM. Massage therapy is governed by provincially-legislated regulatory and registration authorities. Massage therapy is a regulated health profession in the provinces of Ontario, British Columbia, New Brunswick, Newfoundland and Labrador. There are established regulatory authorities (Colleges) which regulate the standards of practice and conduct of massage therapists to protect the public interest.

¹⁷⁰ <http://www.op.nysed.gov/prof/mt/mtlic.htm>

¹⁷¹ <http://www.scstatehouse.gov/code/t40c030.php>

¹⁷² http://www.llr.state.sc.us/POL/MassageTherapy/index.asp?file=interpretations_of_the_message_p.htm

In all three provinces that regulate Massage Therapy the regulation entails protection of title. In the British Columbia *Health Professions Act* (HPA) reference is made to the creation of Colleges that regulate health professions in BC such as Chiropractors, dentists etc. Under BC regulation BC 280/2008 the College of Massage Therapists of British Columbia is established under the HPA including a specified definition of MT with the titles ‘Massage therapist’, ‘registered massage therapist’, ‘massage practitioner’ and ‘registered massage practitioner’ being reserved only for registrants. Administration of drugs, anaesthetics, a recent bone fracture, medical electricity or high velocity low amplitude thrust is prohibited for massage therapy registrants.

Similarly, the Ontario *Massage Therapy Act 1991* establishes the College of Massage Therapies of Ontario under S0 1991 Chapter 27. This legislation sets out a scope of practice and restricted titles of ‘massage therapist’ or ‘registered massage therapist’ which only registrants can use. Massage therapy is deemed to be a Self-Governing Health Profession under Schedule 1 of the Regulated Health Professions Act, 1991, S.O. 1991, c. 18. Section 4 of this legislation incorporates into the Massage Therapy Act a procedural code in relation such as disciplinary matters.

Under the *Massage Therapy Act 2005* St John’s, Newfoundland and Labrador establishes a Newfoundland and Labrador Massage Therapists Board, limits the use of titles ‘Massage therapist’, ‘registered massage therapist’, ‘licensed massage therapist’ and the term ‘RMT’ to registrants.

Chinese Medicine Model in Australia

For Chinese Medicine, protected titles under the National Law are Chinese medicine practitioner, Chinese herbal dispenser, Chinese herbal medicine practitioner, Oriental medicine practitioner, and acupuncturist. For the Chinese Medicine Registration Board of Victoria and now under the national board, there have been practical challenges in the normal issues involved in professionalisation. These include the limits of ‘grand parenting’ practitioners who may seek to obtain registration based on clinical experience; setting the appropriate standards for education including learning outcomes; educating the profession, private health funds, and the public about the role of the board. In addition, it is necessary to align standards for practice with other registration boards to ensure this regulation deals with national standards of practice and the costs of regulation in terms of the impact on practitioner and governmental costs of regulation.¹⁷³

It is likely that similar practical issues will emerge for RMM should statutory regulation be undertaken, but the problems are not insurmountable. It is likely the number of RMM potential registrants will be higher than for Chinese Medicine. This may reduce the cost to government of regulation and for practitioners based upon the greater numbers of practitioners providing registration fees. In addition, some of the cost of dealing with the evidence of training and education from overseas institutions in a foreign language as well as the difficulties of cultural fit may be less problematic.

The major practical issue is the question of how to define the professions. It is clear that RMM involves definable practices and a definable profession. For a RMM practitioners in the context of where there are no protected titles any person even one with limited training and education can use generic professional titles (such as massage therapist) or in terms of the individual modalities that they offer. If titles do become protected for RMM, a designated generic and/or specific title(s) will need to be determined. These protected titles might conflict with some of the titles currently being used by practitioners who may be unable to become registered for reasons of lack of education or clinical experience. This will also impact on education providers, professional associations, private

¹⁷³ La Trobe report above n 70, 299-302.

health funds, and taxation authorities (under the GST exemption legislation). Although this is an issue, it was dealt under the regulation of Chinese Medicine and will no doubt result in a rationalisation of the marketplace for some non-registered practitioners. Any registration board for RMM will need to make informed, responsible and evidenced based decisions about what titles should be restricted focussing on the public interest which is the primary focus of this regulation.¹⁷⁴

Criterion 6:

Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?¹⁷⁵

Benefits:

- It will greatly enhance the ability of consumers to identify qualified RMM practitioners bound by statutorily enforceable disciplinary procedures regulated by AHPRA.
- The move to statutory regulation would permit by statute under the National Law access to an objective transparent and accountable system for managing complaints and professional misconduct (including access to an appeals process) which will involve community and practitioner representatives with statutory backing for determinations made including fines, conditions of practice, further education, suspension and exclusion primarily focussed on public interest considerations.¹⁷⁶
- The use of statutory regulation is likely to result in improved quality and safety in healthcare as a result of better communication and referral among qualified practitioners including orthodox medicine practitioners who will both share the status of being registered health practitioners.¹⁷⁷
- The greater level of scrutiny by a well-resourced regulatory body and the role of AHPRA is likely to result in better information and protection for consumers.
- The qualification for registration will require the imposition of improved and consistent standards of education which will include policies, guidelines and requirements provided by the relevant registration board which will result in better quality assurance processes and foster greater research in the modality for the benefit of consumer safety.¹⁷⁸
- Better assurance for insurers and employers of appropriate standards of training of practitioners leading to better public safety outcomes.
- The use of registration of RMM will support community confidence in the professions and bring enhanced status for practitioners.¹⁷⁹
- Statutory regulation will support the process of integrating complementary and alternative healthcare practices into the health system.

¹⁷⁴ Ibid

¹⁷⁵ La Trobe report, above 70, 303.

¹⁷⁶ For example, under *Health Practitioner Regulation National Law Act 2009 (Qld)* ss 155, 191 and 196.

¹⁷⁷ La Trobe report, above 70, 13

¹⁷⁸ Ibid

¹⁷⁹ Ibid 303

- Statutory regulation will result in increased collaborations between public hospitals, universities and government institutions and private sector health providers, educators and professional associations in the health and education sectors.
- Statutory regulation will result in decreased administrative burden for funds and insurers as the standards of training and education will be clarified and standardised with efficiencies that may lead to lower costs for funds and insurers.¹⁸⁰
- Statutorily enforced compulsory professional indemnity insurance will protect patients from the financial consequences of negligent practice when injuries occur.¹⁸¹

Negative Impacts

Many of these potential negative impacts are natural consequences of limiting registration to only those practitioners who comply with registration standards.

- The potential increase in fees for practitioners (including registration costs and in addition membership of professional associations) may mean higher fees charged to consumers.¹⁸²
- Increased restrictions to entry to practice of the profession which may result in a lessening of competition in the marketplace which may result in higher professional fees.¹⁸³
- Statutory regulation may increase costs for some educational institutions to upgrade courses which may result in higher fees for students.¹⁸⁴
- Statutory regulation may result in a loss (or diminution) of income for practitioners precluded from registration who are not able to use grand parenting provisions.¹⁸⁵
- Statutory regulation may require practitioners to fund what may be required to upgrade qualifications to achieve registration.¹⁸⁶
- Statutory regulation may result in loss of market share or closure for educational institutions unable to upgrade to meet higher standards.¹⁸⁷

The benefits of promoting public safety clearly outweigh the potential negative impacts of occupational regulation which primarily relate to personal financial impacts to registrants, non-registrants and colleges.¹⁸⁸

Overall assessment against IGA Criteria

¹⁸⁰ Ibid

¹⁸¹ Ibid

¹⁸² Ibid

¹⁸³ Ibid

¹⁸⁴ Ibid

¹⁸⁵ Ibid

¹⁸⁶ Ibid

¹⁸⁷ Ibid

¹⁸⁸ La Trobe report, above n 70, 302.

The data above dealing with the extent of involvement of CAM in the health sector shows that the use of CAM is widespread.¹⁸⁹ This submission concludes that:¹⁹⁰

- the regulation of RMM is within the appropriate responsibility of health ministers;
- evidence suggests some RMM practices and practitioners pose a significant risk of harm which will be alleviated by statutory regulation;
- existing regulatory mechanisms are inadequate for safeguarding and protecting consumers of RMM;
- there are definable modalities within RMM such that it is possible to implement a form of statutory regulation as discussed in this submission;
- there will be some practical challenges for statutory regulation, but lessons can be drawn from overseas experience and the Victorian and national statutory regulation of Chinese Medicine and Paramedicine in Australia; and
- the benefits of protecting public safety through statutory regulation does outweigh the potential negative impacts.

Options for Regulatory Models

There may be six general models for the regulation of the health workforce:¹⁹¹

- Self-regulation –membership of a professional association could provide evidence that the practitioner has suitable qualifications, is safe to practise and is subject to a disciplinary scheme to deal with unethical or unprofessional practice.
- Negative licensing – a practitioner may enter and practise a self-regulated profession unless the practitioner is shown to have breached the provisions of a code of conduct making the practitioner ineligible or limited in their ability to practise by order of the regulator.
- Co-regulation – members of a professional association are regulated by an association with government involvement.
- Reservation of title only – a statutory registration board registers members of a profession and reserves the use of restricted titles for registrants only.
- Reservation of title and core practices – certain procedures considered to be high risk normally applied in the practice of a profession are by statute restricted to registrants and other specified registered health professions.

¹⁸⁹ Charlie C Xue et al, 'Complementary and Alternative Medicine Use in Australia: A National Population-Based Survey' [2007] (July-August) 13 (6) *Journal of Alternative and Complementary Medicine* 643, 643; Jon Wardle et al, above n 11, 199.

¹⁹⁰ La Trobe report, above n 70, 304.

¹⁹¹ Ibid 304

- Reservation of title and whole practice restriction – this model restricts the use of restricted titles, within the defined scope of practice of a profession, and prohibits non-registrants from practising the profession.

Self-Regulation¹⁹²

The model of *self-regulation* assumes that the industry normally through professional association membership has appropriate mechanisms and financial capacity to monitor and discipline members of the profession. RMM is primarily self-regulated at present though the level of regulation is limited. Although myotherapy has moved to a bachelor degree level of education and there is a process of upgrading of educational standards for RMM this will be to some extent stymied by the continuation of professional associations which have lower level educational qualifications. The primary regulatory limitation of self-regulation is that any standards required by professional associations may be difficult to enforce owing to a lack of resources of some professional associations and any breach resulting in professional discipline may not stop the practitioner from continuing in the profession as they may seek to become a member of another professional association or remain in practice without membership in a professional association.

Co-Regulation

Co-regulation, a form of government monitored self-regulation, has been proposed by some professional associations within the sector in particular ARMMS. Under such a model, there would be governmental oversight of mechanisms and procedures.¹⁹³ This would most likely require the government either to monitor numerous bodies or facilitate the establishment of a single regulatory authority separate from professional associations. This may become an intrusive process and could involve high transaction costs which may be borne by taxpayers.¹⁹⁴

Negative Licensing

A system of negative licensing could offer protection to the community against negligent or inappropriate behaviour. There have been substantial initiatives in the form of regulation as discussed above and culminating in the proposal for a National Code of Conduct for Health Care Workers. Queensland has already enacted the National Code of Conduct for Health Care Workers (Queensland) reflecting the national model under Regulation 5 of *the Health Ombudsman Regulation 2014* as has Victoria under the *Health Complaints Act 2016* (Vic) Schedule 2.

The Code is a form of negative licensing which:

‘sits on a continuum of regulations between self-regulation and statutory regulations. It is more targeted, less restrictive and is a less costly form of regulation than statutory regulation, since it provides the regulatory tools to deal directly with those who behave illegally or in an incompetent, exploitative or predatory manner and, if necessary prohibit them from practicing. It leaves the vast majority of ethical and competent members of an unregistered health profession to self-regulate,

¹⁹² Ibid

¹⁹³ Australian Health Ministers Advisory Council, Final Report, *Options for Regulation of Unregistered Health Practitioners*, April 2013, 19.

¹⁹⁴ La Trobe report, above n 70, 305

but provides an additional level of public protection with respect to unregistered practitioners, at minimal cost to the community.¹⁹⁵

This form of regulation does not impose substantial regulatory costs upon practitioners if they comply with the Code while allowing a disqualification for specified attributes, events or offences.¹⁹⁶ This allows the enforcement of a minimum standard of practice without the cost of a statutory registration board.¹⁹⁷ Those who are shown to not be fit to provide health services can be prevented from doing so. In this way rogue practitioners can be controlled without a substantial cost to the community.¹⁹⁸ From a regulatory perspective, a significant limitation of this type of regulation is that the regulation is reactive, not proactive, as the remedies will only be available when a breach of the code of conduct has occurred, which may mean that a negative outcome has already arisen.¹⁹⁹

Statutory Regulation

The following models are all forms of statutory regulation

- Reservation of title only;
- Reservation of title and core practices;
- Reservation of title and whole practice restriction.

The focus under the National Law has been away from any regulation involving a whole of practice restriction and a reservation of title that was up until the 1990s the normal model for the regulation of health professions in Australia. Since the Competition Policy Review, the role of the state in regulating professions was questioned owing to its potential to create anti-competitive outcomes. Statutory regulation is a well-established model for health professions across Australia. The legislative frameworks and operational arrangements used in other health professions can be readily adapted and applied to RMM —as has already been done in the case of Chinese Medicine. The current National Registration and Accreditation Scheme for the Health Professions (NRASHP) framework also represents a form of co-regulation in that it is a co-operative arrangement between government and profession. A RMM board could be integrated with existing boards (for example, the Chinese Medicine Registration Board) to improve efficiency of operation and reduce the cost to government and registrants. The use of a reservation of title only would appear to be the most cost effective and appropriate form of statutory regulation for RMM and this could easily be aligned with the NRASHP.

Conclusion and Recommendations

In considering the application of the IGA criteria for health workforce regulation to the current state of RMM practice within Australia, it is concluded that a negative licensing model currently becoming a national Code of Conduct is a useful regulatory mechanism. It prevents those practitioners who engage in seriously unethical or illegal conduct from continuing to practice or practising without scrutiny but it does not protect from clearly unethical and untrained practitioners from entering the workforce. Statutory regulation is desirable and warranted for the following reasons:

¹⁹⁵ Australian Health Ministers Advisory Council, Final Report, *Options for Regulation of Unregistered Health Practitioners*, April 2013, 24-25.

¹⁹⁶ Ibid

¹⁹⁷ Ibid 31; Arie Freiburg, *The Tools of Regulation* (The Federation Press, 2010), 151.

¹⁹⁸ Australian Health Ministers Advisory Council, above n 195, 24-25.

¹⁹⁹ Freiburg, above n 197, 150.

- there is a level of risk in RMM comparable to other regulated professions;
- existing regulatory frameworks are insufficient to protect against professional misconduct and to protect consumers.

‘The public are entitled to accessible health services and they have the right to be assured that these practitioners are bound by minimum standards of practice and training, and to be able to make informed choices based on these factors. Regulation should not be primarily focussed on the practitioner but upon the patient.’²⁰⁰

²⁰⁰ Jon Wardle, ‘The National Registration and Accreditation Scheme: what would inclusion mean for naturopathy and Western Herbal Medicine’, (2010) 22 (4) *Australian Journal of Medical Herbalism* 113,114.

Schedule A

Date	Modality	Qualifications	Charge	Citation and Jurisdiction
2016	Therapeutic Massage	Unclear	Assault and act of indecency	<i>Baines v R</i> [2016] NSWCCA 132 (NSW)
2015	Therapeutic Massage	Some training	Indecent assault	<i>DPP v Van Dorp</i> [2015] VCC 1748 (Vic)
2013	Massage therapy	Qualified Masseur	unlawful and indecent dealing with a child under 16 years	<i>R v McCallum</i> [2013] QCA 254 (Qld)
2014	Massage therapy	Unclear	Sexual assault	<i>Queen v Gary Joseph Bourdon</i> 2014 ABCA 34 (Canada – British Columbia)
2012	Remedial Massage	Unclear	rape non-custodial supervision order for mental impairment	<i>DPP v Soliman</i> [2012] VCC 658 (Vic)
2013	Therapeutic Massage	Unclear	indecent assault	<i>R v England</i> [2013] SASCF 79 (20 August 2013) (SA)
2012	Therapeutic Massage	Certificate	Rape and Indecent assault	<i>Brennan v The Queen</i> [2012] VSCA 151 (Vic)
2012	Therapeutic massage	Unclear	Sexual assault	<i>Queen v Dacpano</i> 2012 ONSC 1232 (Canada - Ontario)
2011	Swedish massage and bowen therapy	yes	Indecent, assault, rape, sexual penetration of a child, indecent acts in presence of a child	<i>Wilson v The Queen</i> [2011] VSCA 328 (Vic)
2010	Therapeutic Massage	Diploma	sexual intercourse w/o consent and indecency	<i>Jiang v R</i> [2010] NSWCCA 277

Date	Modality	Qualifications	Charge	Citation and Jurisdiction
2010	Therapeutic Massage	Unclear	sexual intercourse w/o consent and indecency	<i>Salmond v R</i> [2010] NSWCAA 141 (NSW)
2010	Therapeutic massage	Unclear	sexual assault	<i>R v Piper</i> 2010 BCPC 108 (Canada – British Columbia)
2008	Massage therapy	Unclear	sexual assault	<i>R v Owen</i> [2008] QCA 171 (Qld)
2008	Massage therapy	Unclear	indecent assault	<i>R v Sutton</i> [2008] QCA 249 (Qld)
2008	Therapeutic massage	Unclear	indecent assault	<i>Fernando v R</i> [2008] NSWCC 97 (NSW)
2008	Therapeutic Massage	Unclear	sexual intercourse w/o consent and indecency	<i>Campbell v Richardson</i> [2008] NSWC 122 (NSW)
2006	Therapeutic Massage	Unclear	sexual intercourse w/o consent and indecency	<i>R v Qin</i> [2008] NSWDC 41
2006	Massage therapy	Unclear	indecent assault	<i>R v Coram</i> [2006] QCA 313 (NSW)
2005	Therapeutic massage	Unclear	sexual intercourse without consent	<i>Jackson v R</i> [2005] NSWCCA 411 (NSW)
2005	Therapeutic massage	Unclear	indecent dealing, rape and sexual assault	<i>R v Bas</i> [2005] QCA 97 (Qld)

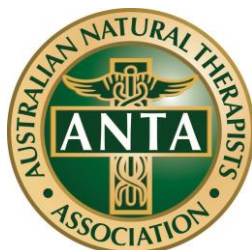
Date	Modality	Qualifications	Charge	Citation and Jurisdiction
2003	Remedial Massage	Unclear	sexual intercourse without consent	<i>R v Porteus</i> [2003] NSWCCA 18 (NSW)
2002	Therapeutic massage	Professional Masseur?	sexual Assault	<i>R v Graham</i> [2002] NSWCA 458 (NSW)
2002	Massage therapy	Likely	sexual intercourse (digital) and acts of indecency with young girls	<i>Queen v Williamson</i> [2002] ACTSC 95 (ACT)
1996	Polarity therapy	TAFE trained	rape in massage	<i>McEachern v R SCCM</i> [1996] SASC 5668 (SA)

Schedule B

Higher Education Thresholds – Learning Outcomes and Assessment

1. The expected learning outcomes for each course of study are specified, consistent with the level and field of education of the qualification awarded, and informed by national and international comparators.
2. The specified learning outcomes for each course of study encompass discipline-related and generic outcomes, including:
 - a. specific knowledge and skills and their application that characterise the field(s) of education or disciplines involved
 - b. generic skills and their application in the context of the field(s) of education or disciplines involved
 - c. knowledge and skills required for employment and further study related to the course of study, including those required to be eligible to seek registration to practise where applicable, and
 - d. skills in independent and critical thinking suitable for life-long learning.
3. Methods of assessment are consistent with the learning outcomes being assessed, are capable of confirming that all specified learning outcomes are achieved and that grades awarded reflect the level of student attainment.
4. On completion of a course of study, students have demonstrated the learning outcomes specified for the course of study, whether assessed at unit level, course level, or in combination.
5. On completion of research training, students have demonstrated specific and generic learning outcomes related to research, including:
 - a. a detailed understanding of the specific topic of their research, within a broad understanding of the field of research
 - b. capacity to scope, design and conduct research projects independently
 - c. technical research skills and competence in the application of research methods, and
 - d. skills in analysis, critical evaluation and reporting of research, and in presentation, publication and dissemination of their research.
6. Assessment of major assessable research outputs for higher degrees by research, such as theses, dissertations, exegeses, creative works or other major works arising from a candidate's research incorporates assessment by at least two assessors with international standing in the field of research, who are independent of the conduct of the research, competent to undertake the assessment and do not have a conflict of interest, and:
 - a. for doctoral degrees, are external to the higher education provider, and
 - b. for masters degrees by research, at least one of whom is external to the higher education provider.
7. The outputs arising from research training contribute to the development of the field of research, practice or creative field and, in the case of doctoral degrees, demonstrate a significant original contribution.

Schedule C



Profile of the

Australian Natural Therapists Association Ltd

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The Australian Natural Therapists Association Limited (ANTA) is the largest national democratic association of '*recognised professional*' *traditional* medicine and natural therapy [Complementary Medicine] practitioners who work in the areas of health care and preventive medicine.

ANTA was founded in 1955 and represents the multi-disciplinary interests of approximately 10,000 accredited practitioners Australia-wide. ANTA is one of the original *Schedule 1* bodies as defined in the regulations of the Therapeutic Goods Act 1989.

ANTA was recognised by the Australian Taxation Office, in November 2002, under a private ruling as '*...a professional association that has uniform national registration requirements for practitioners of traditional medicine and natural therapies...*' thereby allowing ANTA practitioners of Acupuncture, Chinese Herbal Medicine, Naturopathy and Western Herbal Medicine to practise GST- free.

ANTA:

- provides an egalitarian representation of all disciplines accredited by the association
- possesses infrastructure, systems, policies and procedures which enables the Association to encompass all aspects of the profession
- represents the interests of individual disciplines
- acts as advocate for practitioners of all disciplines accredited by the Association
- promotes the health and safety of consumers of traditional medicine and natural therapy health services

The disciplines recognised by ANTA and accredited by the Australian Natural Therapists Accreditation Board (ANTAB) are:

Acupuncture	Aromatherapy
Ayurvedic Medicine	Chinese Herbal Medicine
Chiropractic/Osteopathy	Homoeopathy
Naturopathy	Nutritional Medicine
Oriental Remedial Therapy	Remedial Massage Therapy
Traditional Chinese Medicine	Myotherapy
Counselling	Musculoskeletal Therapy
Western Herbal Medicine	Shiatsu

ANTA supports Statutory Registration of Natural Therapists

ANTA is committed to continuous quality improvement and providing the Australian public with the highest possible standards for the conduct and safety of traditional medicine and natural therapy practitioners, and addresses standards for conduct and safety through:

- The high standard of entry requirements for potential members
- Yearly review of entry standards to maintain currency and ensure relevance
- Active participation in setting standards at national and state levels via industry reference group and working committee participation
- Free student membership to the Association
- Yearly review of the courses on offer within the profession, and courses currently accredited by ANTAB
- Compulsory yearly proof of minimum continuing professional education requirements of members
- Provision of “free” continuing professional education seminars in all states of Australia
- Provision of online continuing professional education services for members
- Provision of free continuing professional education webinars for members
- Compulsory up-to-date first aid certificates
- Compulsory specialised professional indemnity insurance
- The Association enforces a strict Code of Professional Ethics
- The Association maintains effective public complaints handling and resolution mechanisms outlined in the Constitution
- The Association maintains a National Administration Office, which is open five days a week and staffed by an Executive Officer and fully trained support staff
- The Association maintains fully computerised membership, accreditation and course recognition databases and systems
- Provision of communication via the members' page on the ANTA website of the most up to date information related to the profession
- Provision of regular newsletters and ANTA e-News detailing information of current interest to the profession
- Provision of a professional publication ‘The Natural Therapist’, four times a year offering the latest information available on topics of interest to the profession
- Provision of an ANTA website to allow interested persons and consumers to obtain information about the Association, natural therapies and traditional medicine and the location of accredited practitioners of the Association
- Provision of a free Natural Therapies App to allow interested persons and consumers to obtain information about natural therapies and details of ANTA practitioners in their area
- Provision of free access by members to the latest scientific publications and health resources published by eMIMS
- Provision of free access by members to the latest scientific publications and health resources published by EBSCO Host including:
 - 2800+ full text medical journals
 - Access to the world’s most reputable bibliographic indexes for medicine, allied health and complementary/alternative medicine (CINAHL, MEDLINE & AMED)
 - 700+ evidence based articles for consumer health researchers

- 300+ full text books and monographs
- Hundreds of special reports and booklets and much more.
- Provision of free access by members to the latest up to date scientific information and health resources published by IM Gateway including:
 - 300 Herbs
 - 350 Diseases and Conditions
 - 250 Supplements
 - Herb – Drug Interaction Guide
 - Supplement – Drug Interaction Guide
 - Treatment Options
 - Organ and Body Systems
 - Drug Induced Depletions
 - Evidenced Based & Peer Reviewed Information
- Provision of funding grants for research into traditional medicine and natural therapies
- Provision of online resources and latest research for members
- Provision of annual ANTA Student Bursary Awards totalling \$12,000 p.a. to encourage excellence in the study of traditional medicine and natural therapies
- Setting of standards for clinics, hygiene and infection control
- Setting of standards for skin penetration
- Setting of standards for keeping and maintaining patient records
- Making public the requirements for recognition of traditional medicine and natural therapy courses by ANTA for membership purposes
- Making public details of traditional medicine and natural therapy courses recognised by ANTA for membership purposes
- Only recognising government accredited courses that meet ANTA’s stringent requirements (note - ANTA does not recognise courses delivered totally by distance education)
- Making public details of ANTA membership criteria and qualifications
- Consultation with members on matters of importance. The Association uses the Members' web page, consultation meetings, newsletters, ANTA e-News, social media and the magazine to consult with members
- A '1800' free-call number promoted to consumers and practitioners, facilitating a direct path of communication with the Association's national administration office staff
- A '1800' free-call number and web page promoted to consumers and practitioners, to identify appropriately qualified practitioners in the consumer's geographical area
- Undertaking ongoing internal audits of its policies and processes of operation and all matters to do with professional practice
- External audits of procedures, policies and processes to ensure compliance with the principles of best practice
- Publishing an annual report on the activities and performance of the Association
- Undertaking a yearly audit of its Constitution which includes the Association's Complaints, Ethics and Disciplinary Panels
- Undertaking a yearly audit of its Code of Professional Ethics
- Ongoing consultation and collaboration with other professional associations
- Ongoing dialogue and correspondence with ministers, government departments and regulatory bodies

- Ongoing research of policies in overseas professional associations and policies of overseas governments
- Maintaining a Natural Therapy Adverse Events Register
- On line polling of members and the public on relevant professional and health issues
- Democratic voting system for the election of directors by members

ANTA is a public company limited by guarantee, and is governed by a National Council [Board of Directors] which is elected by the members of the Association for a term of three years. The Council in turn elects all office bearing positions within the Association, which are for a term of one year.

National Council is supported by the services of a full time Executive Officer, full time Company Secretary and full time National Administration Office staff.

ANTA practises a policy of consultation with representatives of all stakeholders of traditional medicine and natural therapies, as well as being available to all government and regulatory bodies associated with the professions.

Persons wishing to discuss with ANTA any matters relevant to the professions of traditional medicine and natural therapies should contact:

Brian Coleman

Executive Officer

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