Experience of Asian Pacific countries in the healthcare professional regulation

Workshop led by:

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  Chinese University of Hong Kong
Workshop on “Experience of Asian Pacific Countries on the Healthcare Professional Regulation”

International Association of Medical Regulatory Authorities (IAMRA) 2014 Conference

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The Jockey Club of School of Public Health and Primary Care, Faculty of Medicine, The Chinese University of Hong Kong, HONG KONG

10 September, 2014
10 Key Messages from International Review

1. Reform of regulation is to protect patients and improve quality of care
2. Legislative change is needed to reform structures
3. Umbrella organizations for overarching common principles of governance are emerging
4. Moving towards self regulation in partnership
5. Lay representation is becoming the norm
6. Relationships between professional regulators and others with regulatory responsibility in the healthcare system are variable
7. Compulsory Continuous Professional Development is the norm
8. Emerging emphasis is on detecting and dealing with poor performance and improving quality of care
9. Greater separation of roles is occurring
10. Overseas graduates are admitted in different ways
Workshop’s Focus

• Model of medical regulation and its governance and accountability

• Existing mechanisms for upholding and maintaining professional standards and continuing competence
### Discussants

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Name (Organisation)</th>
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| Hong Kong    | Prof EK Yeoh (The Chinese University of Hong Kong)  
               Prof Sian Griffiths (The Chinese University of Hong Kong) |
| Australia    | Dr Joanna Flynn (Medical Board of Australia) |
| New Zealand  | Mr Andrew Connolly (Medical Council of New Zealand) |
| India        | Dr Girish Tyagi (Delhi Medical Council) |
| Japan        | Dr Osamu Fukushima (Jikei University School of Medicine) |
Regulations

• Regulation is the range of factors exterior to the practice or administration of medical care that influences behaviour in delivering health care

Brennan and Berwick (1996)
Regulations

Three basic categories

- Regulation as setting forth mandatory rules that are enforced by a state agency
- Regulation incorporates all efforts by state agencies to steer the economy… include state ownership and contracting, taxation and disclosure requirements
- Regulation to include all mechanisms of both intentional and unintentional social control

Saltman and Busse (2002); Baldwin et al (1998)
Regulations

- Government's use of its coercive power to impose constrains on organizations and individuals.

Marc J. Roberts, William Hsiao, Peter Berman, Michael R. Reich (2008)
# Regulatory Mechanisms

<table>
<thead>
<tr>
<th>Mechanisms</th>
<th>Description</th>
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<tr>
<td><strong>Command and Control</strong></td>
<td><em>Exercise of influence by government through imposing standards, usually backed by sanctions</em></td>
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<tr>
<td></td>
<td>• Non-voluntary</td>
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<tr>
<td></td>
<td>• Legal restrictions or controls</td>
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<td></td>
<td>• Rules and guidelines</td>
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<td>• Examples: Licensing, Registration</td>
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<tr>
<td><strong>Incentives</strong></td>
<td><em>Use to influence providers’ behaviour</em></td>
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<td></td>
<td>• Voluntary</td>
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<td></td>
<td>• Financial vs non-financial incentives</td>
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<td></td>
<td>• Transfers</td>
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<td>• Examples: Contracting, Accreditation</td>
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Harding and Preker (2003); Baldwin and Cave (1999)
Regulatory Objectives

Primary goal: Protecting patients

• To improve performance and quality
• To provide assurance that minimum standards are achieved
• To provide accountability with respect to performance levels and value for money

Sutherland and Leatherman (2006)

From an economic perspective (Ball et al., 2012), regulation is a tool to correct market failures relating to
(i) Information imbalance about quality of care between the supplier of care and the recipient of care,
(ii) Inability or incapacity of individuals to determine their best long run interests, and
(iii) The negative impact that individuals’ decision regarding healthcare can have on others
Models of Regulation

• A “buyer-beware” approach
• Voluntary self-regulation
• Employer-led regulation
• A licensing regime
• Statutory regulation

Department of Health of UK (2009)
Light Touch Regulation: “Buyer Beware”

• Primary responsibility by the individual patient or public

• Informed by objective information about associated risks, expected standards and guidance

Department of Health of UK (2009)
Voluntary Self Regulation

• Professionals collaborate and agree a set of standards and practices and codes of conduct, independent of any statutory framework

• Responsible for registering its members, setting standards, maintaining a register of practitioners and removing members

Department of Health of UK (2009)
Voluntary Self Regulation

- Degree of protection

- Potential weaknesses
  - May be insufficiently rigorous in its standards and fitness to practise arrangements
  - No legal impediment to a disbarred registrant from continuing to practise
  - Rival groupings within profession

- Accredited Voluntary Registers: A stronger degree of assurance and protection

Department of Health of UK (2009)
Employer-led Regulation

- Induction standards
- Code of Conduct for Healthcare Workers
- Code of Practice for Employers
- Centrally held list of names of those who meet the standards

Department of Health of UK (2009)
Licensing

- Appropriate standards based training/ qualifications
- Adherence to a code of conduct
- Those whose conduct do not meet the required standard are barred

Department of Health of UK (2009)
Analytical framework for analysis of regulation of healthcare professionals: Policymaker, Providers, Professionals and Patients (4P)

Core function:
1. Quality assurance of pre-qualification
2. Licensure and registration
3. Setting and enforcing standards of care
4. Accreditation system
5. Maintaining competence
6. Discipline
Integrated Mechanisms for Regulation

- Personal regulation
- Team-based regulation
- Organisational regulation
- National professional regulation system
- Meta-regulation
- Patient and public assurance

Department of Health of UK (2009)
Integrated Mechanisms for Regulation

• **Personal regulation**: innate or acquired professional values of the individual practitioners

• **Team-based regulation**: values, systems, peer and managerial oversight

• **Organisational regulation**: systems, values, performance management and governance management

• **National professional regulation system**: sustain and support these three components and investigate and take necessary action

Department of Health of UK (2009)
Experience of Hong Kong Special Administrative Region
Hong Kong’s Health Systems

- A **mixed healthcare system** with both public and private sectors providing primary and secondary care services
  - **Inpatient services**: ≥ 90% are provided by public hospitals
  - **Outpatient services**: ~70% are provided in the private sector
Lifecourse for a Medical Doctor

Local-trained doctor

1. 6-year medical study for MBChB/ MBBS from 2013/14
2. Internship in recognized hospitals: 12-month Internship
3. Specialist training [Not compulsory]: Standard 6-year format for basic and higher training

Medical student

Intern

Registered doctor (Non-specialist)

Medications to population ratio: 1:544 as at end-2011

No. of GPs with full registration but not on Specialist Register: 7,547

No. of Specialists: 5,271
Model of Regulation: Government Sanctioned Self-Regulation

Western Medical Doctors - Using 4Ps (Policymaker, Providers, Professionals, Public/Patients)

Analytical Framework

**Policymakers/ Regulators**
- Food and Health Bureau (FHB)
- Department of Health (DH) [Secretariat role]
- The Medical Council of Hong Kong (MCHK)

**Providers [Employers]**
- Hospital Authority (HA)
- Department of Health (DH)
- Private Sector
- NGOs
- Universities

**Public/ Patients**
4 lay members out of 28 members (14%) in MCHK

**Training of specialists**

**Registration and regulation of the medical profession**

**Unions**

**Professionals**
- Hong Kong Academy of Medicine (HKAM) & its 15 Colleges
- Hong Kong Medical Association (HKMA)
- Hong Kong Doctors Union (HKDU)
- Hong Kong Public Doctors’ Association (HKPDA)
- Other doctor’s associations

**Training of medical students**

Medical Registration Ordinance (Cap. 161)
## Composition of Medical Council of Hong Kong

<table>
<thead>
<tr>
<th>Composition – 28 members</th>
<th>Nominated by</th>
<th>Appointed by</th>
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<tr>
<td>2 registered medical practitioners</td>
<td>Director of Hong Kong (Government)</td>
<td>The Chief Executive has delegated the authority to the Secretary for Food and Health</td>
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<tr>
<td>2 registered medical practitioners</td>
<td>The University of Hong Kong (Academics)</td>
<td></td>
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<tr>
<td>2 registered medical practitioners</td>
<td>The Chinese University of Hong Kong (Academics)</td>
<td></td>
</tr>
<tr>
<td>2 registered medical practitioners</td>
<td>Hong Kong Academy of Medical (Profession)</td>
<td></td>
</tr>
<tr>
<td><strong>4 lay members</strong></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>7 registered medical practitioners who are members of Hong Kong Medical Association</td>
<td>Hong Kong Medical Association’s Council members (Profession)</td>
<td>N/A</td>
</tr>
<tr>
<td>7 registered medical practitioners registered in Part I of the General Register (GR) and ordinarily resident in HK</td>
<td>(Elected by) All registered medical practitioners registered in Parts I &amp; III of the GR</td>
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Section 3 of the Medical Registration Ordinance, CAP 161
Existing Mechanisms for Upholding Professional Standards & Continuing Competence

- **Specialists:** Mandatory CME/ CPD programme in order to remain in Specialist Registers

- **Non-specialists:** Voluntary CME scheme organised by the Medical Council of Hong Kong (21% out of 7,547 non-specialists obtained a valid ‘CME-Certified’ status as at 31 December 2011)

- **No formal assessment system** of doctors’ performance or competence after initial qualification

- Monitoring systems for identifying poor performance mainly **through complaints**
Key Questions for the Future in Hong Kong:

1. Is change needed?

2. Should mandatory CME/ CPD for ALL doctors be introduced?

3. Should revalidation/ recertification be considered?

4. Are the Systems for Identifying Poor Performance fit for purpose?

5. How can change be stimulated?
Issues & Challenges

• High social status and esteem, well paid
• Specialized and highly skilled work
• Strong degree of self regulation
• Political power
• Public trust and confidence
Experiences sharing: Australia

Dr Joanna Flynn
Medical Board of Australia
Medical regulation in Australia

Dr Joanna Flynn
Chair, Medical Board of Australia
Australia

- 23 million people
- Federal system of government
- 9.3% of GDP on health
- Joint government funders
- 70% public – 30% private mix
- Good health status overall
- Major gap for indigenous health
- Maldistribution of health workforce
- Significant international workforce
- ~100,000 registered doctors
Lifecourse for a medical practitioner

Australian trained doctor

- Medical school: (4.5 – 6 years)
- Intern: (1 year)
- Hospital Medical Officer: (1 + years)
- Specialist trainee: (3 – 6 years)

Number of specialists: 55,887

Prevocational training
Vocational training
Model of regulation

Australian Health Practitioner Regulation Agency
Medical Board of Australia (MBA)

- Appointed by Health Ministers Council
- 8 practitioners (not <half or >2/3)
- 4 community members
- Practitioner from every jurisdiction
- Funded solely by registration fees - $695AUD pa
- State and Territory Boards – committees of MBA
  - same composition
  - appointed by local health minister
  - deal with registrations and complaints locally
Current regulatory mechanisms for upholding standards & ensuring competence

• Registration standards established by MBA
  – CPD programs – frameworks set by specialist colleges or by MBA for general registrants
  – Recency of practice – restricts change of scope and sets requirements for re-entry

• Investigating notifications, mandatory notifications

• Monitoring impaired practitioners

• Annual declarations and requirements to inform restriction of practice or billing rights

• Random audit of compliance
Key questions

• Interface between professional regulation and health system regulation and clinical governance?
• Can or should College CPD evolve to provide assurance of competence and professionalism?
• Should we introduce Revalidation in Australia?
• For everyone or for high risk groups?
• Focus on testing or focus on learning and demonstrating mastery?
• How can we enhance rather that undermine professionalism?
Experiences sharing: New Zealand

Andrew Connolly
Medical Council of New Zealand
Experience of Asian Pacific Countries on the Healthcare Professional Regulation

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New Zealand

Andrew Connolly
Chair
MCNZ
Overview of Health Care

- Population of 4.3 Million
  - 13,000 doctors
  - High reliance on international medical graduates
- State-funded free Public Hospital system
- State-subsidised/free Primary Care
- Private Primary Care
- Private Secondary Care
- Mix of State and Privately funded Aged-Care
- No-fault treatment-injury compensation system
- Independent Health and Disability Commission
Medical Training

• Competitive entry to Medical School following a year of Health Sciences
• 5 years Medical School, final year spent purely in clinical roles
• 2 Intern years (PGY-1 & 2)
• Variable time to enter Vocational Training
• 3-6 years Vocational Training
  – Mainly bi-national with Australia
• Can remain a General Registrant and not do Vocational Training
Model of Regulation

• All registered Health Care workers including doctors covered by the Health Practitioners Competency Assurance Act, 2003
• Work in a defined scope of practice or in a collegial relationship with a vocationally registered doctor
• Medical Council tasked with Protecting Public Health and Safety irrespective of how care funded/sited
  – Registration including IMGs
  – Competency
  – Conduct
  – Health of Practitioners
  – Standards and Profession-policy development
Standards & Competence

• Recertification & continuing professional development are mandatory for all doctors
• Devolved specific content to the Vocational Colleges
• Desirable components:
  – Regular Practice Review
  – Multisource feedback
  – Peer review
• Mandatory Council-defined program for General Registrants contains the “desirable components”
• Council has the power to act if concerns arise
  – Participation or completion
When Concerns Arise

• Most referred via Health & Disability Commission
• Council has a Complaint Triage Process
• Proportion go to full Council for debate
• Competence: performance assessment or a recertification program
• Conduct: can refer to a Professional Conduct Committee - has the power to lay a charge at Health Practitioners Disciplinary Tribunal (HPDT)
• Council can interim-suspend or impose conditions prior to HPDT
• HPDT can suspend or cancel registration & impose fines and make other orders
• Each body functions independent of the others
Key Issues, Challenges & opportunities

• Highest standards are essential for self-regulation
• Maintenance of Competence within rapid changing clinical and fiscal environments
  – Changing scopes of practice & methods of delivery
  – Costs vs. ability to fund
• Workforce challenges
  – Urban concentration of doctors
  – “Hospital-centric” in early years of career
• Training challenges
  – Divergence in approach by bi-national Colleges
    • Australia & New Zealand are different
  – Funding, time, productivity all impact on training
Opportunities & Solutions

• Enhanced Recertification programs for public & regulator confidence in the profession
• Paradigm shift in Prevocational education & training
  – Curriculum framework over 2 years
  – Link Medical School through to Vocational training
  – Portfolio of learning
  – Professional development plan
  – Mandatory community-focused attachment
• Continue our close collaboration with Australia especially given our bi-national Colleges
• Ensure training is seen as essential throughout the health system
Experiences sharing: India

Dr Girish Tyagi
Delhi Medical Council
Experience of Healthcare Professional Regulation at Delhi Medical Council

Dr Girish Tyagi
Registrar Cum Secretary
Delhi Medical Council
Health System in Delhi

- Total population in Delhi → 1.8 Billion
- Number of Medical College → 7
- Number of doctors registered with Delhi Medical Council → 45000
- Doctor’s Population Ratio → 1:400
  - INDIA = 1:1700
  - WHO = 1:1000
Medical Doctor's Course Duration

- MBBS → 4½ Year
- Provisional Registration → 1 Year
- Permanent Registration → 5 Years
- Post Graduation → 3 Years/5 Years
- Renewal of Registration → 5 Years
Disciplinary Procedure at DMC

- Chairman.
- M.L.A
- Legal Expert.
- Eminent Public Person.
- Eminent Medical Specialist.
- Representative of Delhi Medical Association
Disciplinary Action

- Principles of Natural Justice.
- Power of Civil Courts.
- Inquiries - Judicial Proceedings.
- Warning.
- Name Removal.
Maintenance/Development - Knowledge/Skill

- IT/Media.
- Principles of Natural Justice.
- CME/CPD.
- Guideline/Protocol.
- Public Notices/Circulars.
- Stakeholders Meetings.
Key Issues

- Justice.
- Transparency.
- Document Verification.
- Acceptance by the Profession and Public.
- Uniform Standard.
Opportunities

- Sharing of Information.
- Forum for Patients & Doctors.
- Self Regulation.
- Ethical Practices.
- Guidance to Legal Authorities
- Speedy Dispensation of Justice.
Challenges

- Doctor’s Protection.
- FMG Registration.
- OCI Document Verification.
- Negligence Complaints.
- Conflict of Interest.
- Crosspathy/Quacks
THANK YOU
Experiences sharing: Japan

Dr Osama Fukushima
Jikei University School of Medicine
Experiences of Japan

Osamu Fukushima
Centre for Medical Education
Jikei University School of Medicine, Tokyo, Japan
Workshop on “Experiences of Asia Pacific Countries on the Healthcare Professional Regulation” on 10 Sept. 2014
The health system in Japan

- Universal health insurance coverage
- Nationally uniform fee schedule
- Patients’ free access to medical facilities

- Health care cost is 38,585,000,000,000 Yen (GDP: 8.15%, Public expenditure: 38.4%)
- The insured must pay 30% of total fee (10% for the elderly)
Now, the number of medical doctor is about 300,000 (237.8 doctors per 100,000 population) in Japan. And almost 4,000 doctors increased every year (from MHLW 2012 report).

In Japan there is no gate-keeper such as GP in the UK. And increasing number of elderly, and number of bed in medical institutions (1,703,853 beds per 127,515,000 populations) are also a part of causes of shortage of medical doctors.
Life-course for a Medical Doctor

6-years medical education

- Common Achievement Test (CBT & OSCE)
  Before entering to clinical training (Year 4)

Mandatory Clinical Training for 2 years
Registration (2)
Interruption rate: 1.3%

PGY3 enters to specialty training programme

18 years-old
Graduated from High School

National Exam for Medical Practitioner
Pass rate: 90%
Registration (1)
Y6 student number at 2013: 7,721
PGY1 Clinical training at 2014: 7679

Qualified specialty
Certified by academic socialites
After 30 – 34 years from graduation, 64% of doctors have any specialty certification.
Model of Regulation

- The contents and coverage of the medical doctor are defined by Medical Practitioners Law.
- The Medical Ethics Council are under the jurisdiction of the Ministry of Health, Labor and Welfare (MHLW). The council fixes administrative dispositions (deprivation and suspension of the licenses, and reprimand).
In 2013/2014, the Medical Ethics Council proctorized 38 medical doctors: Cancel (8), Suspend for 3 years (5), suspend for 2 years (1), suspend for 1 year (5), and suspend less than 1 year (15), and reprimand (4). The main reasons of administrative dispositions are fatal professional negligence, drug abuse, unfair billings, sexual vices, casualty including traffic accident, mental disease.
Composition of Medical Ethics Council

- 29 members at 2013
- President of Japan Medical Association, President of Japan Dental Association, Persons commissioned by Chief of Ministry of Health, Labor and Welfare: MD, DD, Nurse, Apothecary, and non-Medical (4 Professors of Welfare, Jurisprudence, and Liberal Art)
1. “Center for supporting safety in medical treatment” : The centers have received and searched complaints from patients and relatives, and offered advises to hospitals, clinics, and maternity centers (midwife’s office) from 2007.
According to Medical Service Law (2006), the roles of “Center for supporting safety in medical treatment” are:

① Receive complaints from patients and relatives,

② Offer suggestion to medical institutions (after analysis of complaints),

③ Supply information to patients and relatives, and medical institutions in the community for keeping patient safety,

④ Supply patient safety seminars to medical staffs in the community.
2. “Center of support and search for medical accident” (from 2015): The accident report must be sent to the center, and the center accumulates data and analyze for preventing medical accidents. When bereaved relatives cannot accept the explanations from the institute, they can ask to review the case to the center. The center will not announce search results to the police department which investigated the cause of medical accident as a fatal professional negligence.
Patients’ free access “right” to medical facilities: Patients are free to choose they seek medical consultations. They can use any medical institutes including attached hospitals in the community. Patients have a right to exchange doctors at any time. Therefore, poor competent doctors lose “customs”. It works as a part of keeping patient safety system.
Existing Mechanisms for Upholding Professional Standards & Continuing Competence

- There is no mandatory CPD system for keeping medical licenses. MHLW do not supply CPD programme to those qualified health care professions. But MHLW has started re-education system (from half-day to 2days workshop) only for administrative penalty-doctors to resume their practice from 2005.
Japan Medical Association (number of members/all medical doctors: 160000/300000 = 53%) offers CPD programmes to members from 1987 using seminars, e-learning, work-study so on.

About 65 % of medical doctors are qualified as a specialist by the respective academic society. Academic societies offer CPD programmes for their members to renew specialty certification. They are responsible to renew specialists’ certification. There are many discussions whether an academic society keeps the right to certify specialist on the basis of “conflicts of interests.”
Key issues, Challenges and opportunities

- With regard to clinical education, we need to introduce the consistent system on quality assurance from undergraduate education through CPD governed by the organization something like GMC in the UK.
- Remodeling of specialty certification system is in discussion. From 2017, a new specialty certification and quality assurance system will start.